Incidentally diagnosed gastric outlet obstruction while doing AAA scan

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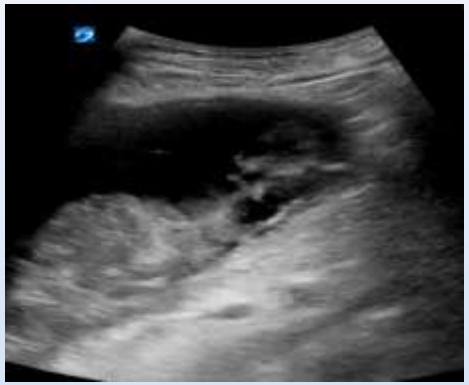
Case Presentation:

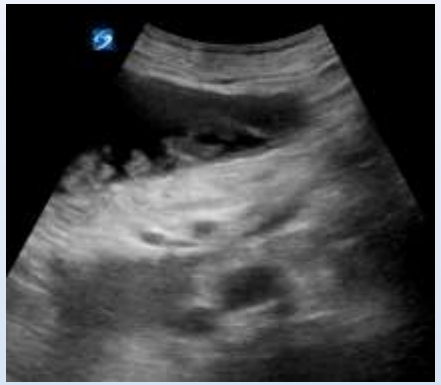
An 82 yr old male presented with abdomen pain and collapse. He had non bilious, non-bloody vomiting. He was ↑HR, ↑RR and ↓↓BP. Abdomen was globally tender with no blood/ malena on digital rectal exam. Initial venous gas showed pH 7.00 with lactate of 18 meq/L and Hb of 69g/L.

Management and Outcome:

Bedside abdominal USS showed normal caliber of aorta and incidentally a significantly distended stomach with lots of mobile and some fixed hyperechoic material. There was strong suspicion of gastric outlet obstruction. Patient had CT scan which diagnosed gastric outlet obstruction (GOO) with no ischemic gut or active blush of contrast. Later endoscopy confirmed a duodenal ulcer (DU) with a recent evidence of bleed as a cause of GOO and anemia.

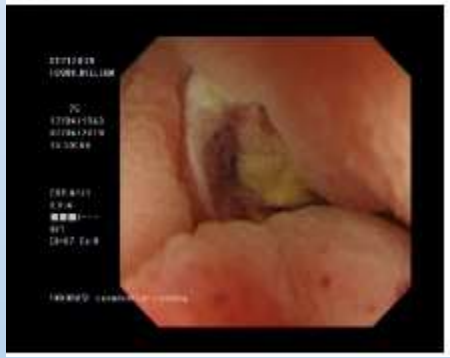
Grossly distended stomach with normal caliber aorta in the far field

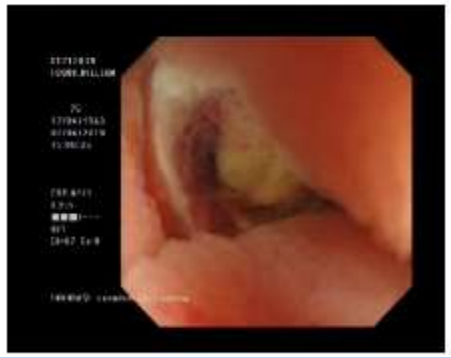




DU

Endoscopic confirmation of duodenal ulcer





Key learning points:

- **Malignancy and peptic ulcer disease are the commonest causes of GOO. Indeed our patient had bleeding DU.**
- **POCUS can pick on alternate diagnosis thus cutting short the time lag to appropriate management.**
- **Bedside USS showed a distended stomach with no dilated small bowel loops (rules out small bowel obstruction) or AAA in minutes, leading to improved decision making. This led to change of the type of abdominal imaging requested from CT abdomen/ pelvis or aortogram to CT mesenteric angiogram to ensure that ischemia & active vascular leak is ruled out, given the low Hb and acidosis with lactic academia.**