



GASTROCOLIC FISTULA : A RARE PRESENTATION

Surgery

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ABSTRACT

Gastric colic fistula is a complication of gastric carcinoma and benign gastric ulcer. With widespread use of PPI, incidence of benign peptic ulcer disease has reduced. The classical symptoms are abdominal pain, vomiting mostly feculent and weight loss. The best diagnostic method is the barium enema. The therapy of this condition remains surgical. We report a case of acute intestinal obstruction which was detected intra operatively to have gastrocolic fistula secondary to a benign condition.

KEYWORDS

Gastro colic Fistula, Carcinoma stomach, Peptic Ulcer

INTRODUCTION

Gastrocolic fistulae can arise from a variety of pathological processes, benign or malignant, spontaneous or iatrogenic, and the classical symptoms are abdominal pain, vomiting mostly feculent and weight loss. (1) With the advent of use of PPIs there has been a shift of etiology of this condition from benign to malignant. The best diagnostic method is the barium enema. The therapy of this condition remains surgical. We report a case of acute intestinal obstruction which was detected intra operatively to have gastrocolic fistula secondary to a benign condition.

CASE REPORT

70 years old male, chronic smoker and alcoholic, was symptomatic with intermittent vomiting, small bowel type of diarrhea with crampy pain, loss of appetite and significant weight loss for 06 months. His preliminary investigations were normal. UGI Endoscopy and colonoscopy were reported normal. Patient was managed symptomatically with PPI. He presented to emergency department with history of pain abdomen, vomiting and obstipation of 02 days duration. General examination revealed tachycardia and abdominal examination revealed diffuse tenderness. Nasogastric tube had faeculent aspirate. CECT Abdomen revealed luminal narrowing at the level of pylorus and dilatation of small bowel, ascending colon and caecum. (Figure 1)

Patient underwent Exploratory Laparotomy with a presumptive diagnosis of acute intestinal obstruction. Intraoperatively there was dilatation of gut loops upto mid transverse colon wherein the transverse colon was seen adherent to stomach. Blunt dissection of these adhesions revealed a gastrocolic fistula and there was inadvertent faecal spillage seen on disruption of the fistula. (Figure 2,3) The patient underwent distal gastrectomy and right hemicolectomy. This was followed by loop gastrojejunostomy, formation of end ileostomy and distal mucus fistula. Patient had a relatively uneventful recovery and was started on oral feeds by sixth post operative day. Histopathology examination of the resected stomach and colon did not reveal any evidence of malignancy.



Figure 1: Luminal narrowing at the level of pylorus

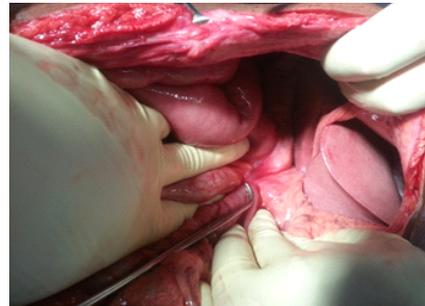


Figure 2: Transverse colon adherent to pylorus

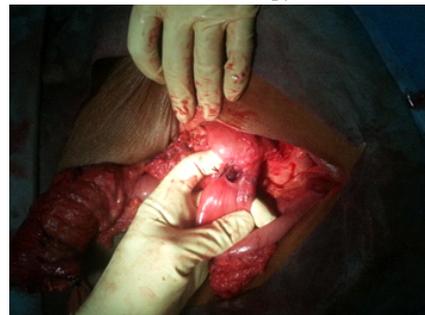


Figure 3 : Dissection revealed Gastrocolic fistula

DISCUSSION

Gastrocolic fistula was first described in 1755 by Albrecht von Haller in a case of gastric carcinoma and as a complication in benign gastric ulcer in 1920 by Douglas Firth. Adenocarcinoma of colon is most common cause for gastrocolic fistula. They are also observed in Crohn's disease, chronic pancreatitis, pancreatic abscess, carcinoid tumors of the colon, infiltrating tumors of the pancreas, duodenum and biliary tract and diverticular disease. More recently they have been reported in sleeve gastrectomy and migration of PEG feeding tubes.

Patient presents with malnutrition, visceral abdominal pain, nausea, vomiting (most times feculent), weight loss, diarrhea and complains of fecal halitosis and eructation. Though our patient reported these symptoms, they were not recognized for what they were till he presented with acute obstruction. The most reliable diagnostic method is barium enema, which confirms the diagnosis in 90 to 100% of all cases. The role of CT scan in the diagnosis is doubtful and even in our case it did not contribute anything. The diagnosis of gastrocolic fistula was an intraoperative surprise in our case.

Enbloc resection of the fistula tract entails distal gastrectomy and limited colectomy. The same was done in our case. However, as there

was faecal contamination in our case it was considered prudent not to do a colo colic anastomosis.

CONCLUSION

Gastro-colic fistula is a relatively uncommon condition. With widespread use of PPI, incidence of benign peptic ulcer disease has reduced. Hence gastro-colic fistulas as a result of benign gastric ulceration has become a rarity. This report highlights the fact that it needs to be considered as a differential diagnoses for cases presenting with faeculent vomiting, diarrhoea and weight loss.

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