Diaphragm disease of duodenum following long-term NSAIDs use: endoscopic management

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We report our experience with endoscopic management of 3 men (aged 62, 63 and 65 years) with duodenal diaphragm disease following NSAID use for 5-15 years. In the first patient a 24 F through-the-scope balloon dilatation was attempted but failed; he subsequently underwent gastro-jejunostomy. The other two patients subsequently underwent radial incisions of the web with mixed cutting and coagulation current using a standard 5 F sphincterotome. [Indian J Gastroenterol 2004;23:189-190]

Key words: Diaphragm disease, small bowel

Lang et al were the first to report diaphragm-like ileal strictures in 7 patients taking non-steroidal anti-inflammatory drugs (NSAIDs) for prolonged periods. Subsequently several reports confirmed the relation of these lesions in the ileum, jejunum and even colon to the use of NSAIDs.1 Anecdotal case reports documented the presence of similar lesions in the duodenum.4 Duodenal webs, unlike the ileal lesions for which surgery is the only option, may be amenable to endoscopic therapy. This is important as most of these patients are elderly and have associated co-morbid diseases. We have previously reported our success in incising multiple duodenal webs using a sphincterotome.4

Case 1: A 65-year-old man with rheumatoid arthritis for the last 15 years presented with complaint of post-prandial abdominal distension of 3 weeks' duration. He had intermittent large-volume vomiting, which relieved the distension. Physical examination showed typical deformities suggestive of chronic rheumatoid arthritis. A loud succussion splash was elicited over the epigastric region. Endoscopy revealed a post-balloon smooth concentric structure in the second part of the duodenum. This was also demonstrated on barium meal study of the stomach. Dilatation was attempted using a 24 F through-the-scope dilatation balloon (Max force; Boston Scientific, USA). There was a minor increase in the lumen of the web but the patient continued to be symptomatic and was therefore taken up for gastro-jejunostomy.
Case 2: A 62-year-old man presented with recurrent vomiting and weight loss for a period of 4 weeks. He was suffering from osteoarthritis, for which he had been taking various combinations of ibuprofen and paracetamol for the previous 5 years. He had lost nearly 6 kg of weight in the preceding 4 weeks. Physical examination revealed mild pallor and a loud succussion splash. Upper GI endoscopy revealed two webs in the duodenum, 5 cm apart; the distal web would not allow the passage of the endoscope (Fig). Barium meal follow-through study showed an additional web distal to the second web. Each of these webs was excised using a standard sphincterotome. At follow-up the patient was asymptomatic: barium meal upper GI study revealed resolution of the diaphragms. The patient gained 5 kg of weight over a period of two months.

Case 3: A 63-year-old man presented with history of abdominal pain and vomiting of 4 months' duration, suggestive of gastric outlet obstruction. Endoscopy and barium meal studies showed the presence of four webs localized to the second part of the duodenum. We have previously reported the successful management of this patent using a standard ERCP sphincterotome. Intestinal diaphragms or webs, which were initially reported in the ileum, may also occur in the duodenum and colon. Two of the three patients in our report had multiple webs spread between the second and third parts of the duodenum. The diameter of the lumen in the region of the webs ranged from a pinpoint to mild narrowing through which the endoscope could easily be maneuvered. The thickness of these webs as seen on barium follow-through studies was about 2-3 mm.

The occurrence of duodenal lesions in our patients is probably due to the fact that, unlike in the West where enteric-coated/delayed-release NSAIDs are the norm, in India and other developing countries non-enteric-coated NSAIDs are used more often. Each of our patients had been taking NSAIDs for periods ranging from 5-15 years. This is similar to the observation of Lang et al., where the median duration was 15 years. Incision of the lumen-compromising webs was carried out over 1-2 sessions using a standard sphincterotome. No immediate complications were seen. The tense strength of the web was probably responsible for the unsuccessful pneumatic dilatation in one patient.

Because of their relative rarity, the possibility of NSAID-induced intestinal diaphragms may be overlooked. These should be considered in the differential diagnosis of a patient taking these drugs who presents with features of intestinal or gastric outlet obstruction.

References


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Received February 21, 2004. Accepted June 13, 2004

Inflammatory fibroid polyp of jejunum causing jejunoo-jjejunual intussusception

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Intussusceptions originating in the jejunum are rare. We report a 20-year-old woman who had a chronic jejunoo-jjejunual intussusception due to an inflammatory fibroid polyp manifesting in the post-partum period as peritonitis. Resection-anastomosis of the intussuscepted segment was done. She is well one year later. [Indian J Gastroenterol 2004;23:190-192]

Key word: Peritonitis

Intussusception is most often encountered in children at the ileocolic level, usually due to hyperplasia of Peyer’s patches in the terminal ileum.

A 20-year-old woman was referred with complaints of severe central and lower abdominal colicky pain for the previous 3 weeks following a forceps-assisted delivery of an intrauterine death during the 8th month of pregnancy. She denied any associated loose stools, vomiting or dysuria. She had intermittent moderate fever with chills and rigors for the past 2 weeks and was treated symptomatically for urinary tract infection. She had similar attacks of mild pain associated with bloody tinged stools during the later months of her pregnancy.