

## Pseudo-pylorus: An Unusual Finding in a Patient with Gastric Ulcer

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### Abstract

*Peptic ulcer disease is a common condition, usually resulting from Helicobacter pylori infection or use of non-steroidal anti-inflammatory drugs. The clinical presentation is with abdominal pain, gastrointestinal bleeding or peptic perforation. The management is guided by the underlying presentation and use of proton pump inhibitors, treatment of underlying H. pylori infection and removal of predisposing factors. We report an unusual endoscopic finding of a double pylorus in a patient who presented with hematemesis.*

**Key words:** Gastric ulcer; gastrointestinal bleeding; pylorus; endoscopy.

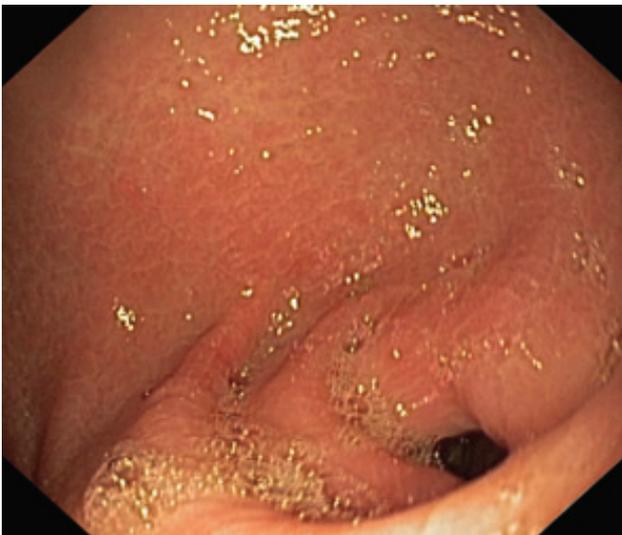
### Introduction

Peptic ulcer disease is a common cause of upper gastrointestinal bleeding and may be due to gastric or duodenal ulcers. The predisposing factors could be *Helicobacter pylori* infection, nonsteroidal anti-inflammatory drug (NSAID) abuse, stress and intensive care unit admission, use of steroids, smoking and underlying conditions like gastrinoma. Some unusual endoscopic findings may occur with peptic ulcers like double pylorus, pseudopylorus, diverticulae, etc.<sup>1-3</sup>.

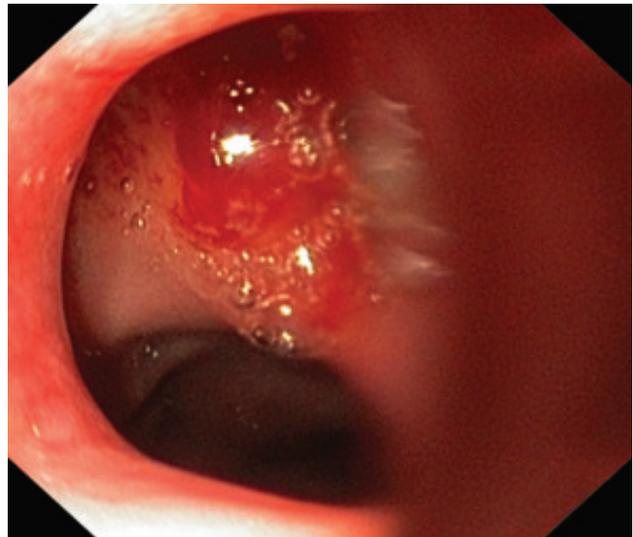
### Case report

A 25-year-old male presented with history of multiple

episodes of hematemesis for one day. The patient also had associated melena and hypotension. He had been taking diclofenac tablets for 3 months for alleviation of pain due to knee injury sustained while playing cricket. His haemoglobin was 6 gms/dl, and he had tachycardia and hypotension at presentation. The patient underwent volume resuscitation with intravenous fluids and transfusion of packed red cells. He then underwent gastroduodenoscopy for evaluation of cause of bleeding. A narrowing which appeared like pylorus (Fig. 1) was noted beyond which a large gastric ulcer was seen, which was actively oozing (Fig. 2). The ooze was controlled by injection adrenaline around the ulcer and spraying Hemoseal powder. Beyond this ulcer, the actual antrum and pylorus were seen (Fig. 3).



**Fig. 1:** The pseudo-pylorus.



**Fig. 2:** The oozing gastric ulcer just beyond the pseudo-pylorus.

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**Fig. 3:** The true pylorus.

The antral biopsy for *Helicobacter pylori* was negative. His HIV serology and VDRL were negative. The patient was discharged two days later, with advise to avoid NSAIDs and continue proton pump inhibitor.

## Discussion

The term pseudo-pylorus has been used to describe the

appearance seen in patients undergoing vertical banded gastroplasty<sup>1</sup>. In such a scenario the pseudo-pylorus is iatrogenic and expected by the endoscopist. However, in the index case, the narrowing caused by the gastric ulcer resulted in a pseudo-pyloric opening beyond which lay the ulcer and the true pylorus. Although this appearance has been reported in 10% of endoscopies in an older report, the reasons are not certain as ulcers, polyps and malignancies were all reported as causes of pseudopylorus<sup>2</sup>. This suggests that any narrowing, proximal to the true pylorus, was termed as pseudo-pylorus, whereas in the present case, not only a narrowing was noted proximal to the true pylorus, but it was similar in endoscopic appearance to the true pylorus. Other findings reported with gastric ulcers include double pylorus and deformed pylorus<sup>3</sup>.

## References

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