

Duodenal diverticula perforation caused by an impacted bezoar successfully treated endoscopic drainage and lithotripsy: A case report and literature review

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Abstract

Duodenal diverticula perforation due to an impacted bezoar is a rare disease. Surgical treatment is associated with high rates of complications and mortality; therefore, treatment strategies must be carefully decided. Endoscopic treatment offers significant benefits to patients over surgery.

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Abstract

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Keyword

Duodenal diverticula perforation, phytobezoar, endoscopic drainage, endoscopic lithotripsy

Background

The diverticulum of the duodenum is the second most common location after the colon ¹. Most patients are asymptomatic. However, among complications, duodenal diverticula perforation (DDP) rarely occurs, but when it does, it often perforates the retroperitoneum. Furthermore, bezoar-induced DDP in duodenal diverticula is substantially rare ². DDP is the most threatening complication, and appropriate treatments for perforated duodenal diverticula remain unclear, ranging from conservative therapy to surgery, including pancreatoduodenectomy. Surgical intervention may increase morbidity and mortality rates. Therefore, non-operative management can be considered in some patients with perforated diverticulum who have stable vital signs without generalized peritonitis or in elderly patients with comorbidities ³. Recently, several cases of conservative treatment with endoscopy have been reported. We are describing the successful endoscopic drainage and lithotripsy of a DDP associated with an impacted bezoar.

Case presentation

The 52-years-old Japanese man who had undergone laparoscopic surgery for a duodenal ulcer 12 years ago presented with upper abdominal pain. His symptoms persisted from the morning of that day. On arrival at the emergency room, his blood pressure was 166/92 mmHg, pulse was 65 beats per minute, and oxygen saturation was 98% on room air. He experienced mild discomfort, with a body temperature of 39.0 °C. No signs of peritoneal irritation were noted. The laboratory data showed a high white blood cell count of 21,200/uL but c-reactive protein level of 0.3 mg/dL was at normal level (<1.0 mg/dL). Abdominal computed tomography (CT) revealed an expanded duodenal diverticulum inside the second portion of the duodenum and free air in the retroperitoneum outside the diverticulum (Fig. 1). Duodenal ulcer perforation was suspected based on the patient's history. However, CT imaging was most likely caused by perforation of a duodenal diverticulitis because past CT showed an existing duodenal diverticulum. Because there were no symptoms of peritoneal irritation, broad-spectrum antibiotics, placement of a nasogastric tube, and use of proton pump inhibitors (PPIs) were initiated. After 2 days of admission, the inflammatory findings did not improve; therefore, endoscopic drainage was performed. On endoscopy, a duodenal diverticulum with a fixed large phytobezoar and a large amount of pus was observed (Fig. 2a). Because the bezoar blocked the orifice of the duodenal diverticulum, it perforated the retroperitoneum and became an abscess cavity. The phytobezoar was so large and of hard consistency that endoscopic removal during a single session was difficult. A 7.5 Fr endoscopic nasobiliary drainage (ENBD) catheter was placed in the duodenal diverticulum. Contrast injection showed a large translucent image of the diverticulum (Fig. 3a). The duodenal diverticulum was washed daily with 20 mL of saline from the ENBD catheter. As a result, the fever resolved and inflammatory findings improved. On the second endoscopy, since the phytobezoar was slightly softer than that on the previous endoscopy, it was gradually eliminated by crushing with forceps (Fig. 2b). However, part of the phytobezoar remaining deep in the cavity could not be completely removed, so a 6 Fr ENBD catheter was placed in the cavity again (Fig. 3b). The following day, saline was injected through the tube to clean the abscess cavity, and the phytobezoar was completely removed by a third endoscopic treatment (Fig. 2c). The patient was discharged from the hospital without any complications. After 3

months, subsequent upper gastrointestinal endoscopy showed that the cavity of the duodenal diverticulum had shrunk and the mucosa of the diverticulum had regenerated (Fig. 2d).

Discussion

Duodenal diverticula are found in 5–10% of patients undergoing radiological or endoscopic procedures and in 15–23% of patients at autopsy¹. The duodenum is the most common site for gastrointestinal diverticula after the colon, especially in the parapapillary region of Vater and the horizontal and ascending portions of the duodenum^{4, 5}. Unlike colon diverticulum, duodenal diverticulum is relatively asymptomatic. However, the risk of perforation should be kept in mind⁶. Most of these perforations were seen within the second portion of the duodenum, mainly along the medial wall, within 2 cm of the ampulla of Vater. Duodenal diverticulitis was the most common cause of DDP, representing 69% of total associated cases⁷. As perforation often occurs in the retroperitoneum, typical signs of peritonitis are often absent. Due to the lack of pathognomonic signs or symptoms, DDP is often clinically mistaken for acute cholecystitis, appendicitis, and perforated duodenal or gastric ulcers. Shimada et al. evaluated all 202 cases of DDP reported worldwide between 1907 and 2020. A total of 83% of all reported cases underwent surgical treatment⁸. Simple closure of the perforated site is anatomically difficult when a duodenal diverticulum perforates the retroperitoneum. A pancreaticoduodenectomy must be performed to resect the duodenum that has the perforated site. However, this treatment appears to be highly invasive. Indeed, several cases in which surgical treatment was chosen reportedly involved only drainage for retroperitoneal perforation^{9, 10}. In addition, these patients required a longer time to achieve postoperative cure. The morbidity and mortality rate for surgical options are reaching as high as 30%¹¹, including duodenal leak and fistulization; the option of conservative treatment has become more common. The success rate of conservative treatment, initially with broad-spectrum antibiotics, is very low. Given these facts, nonsurgical drainage from a retroperitoneal abscess is an option for treating perforated diverticula. However, percutaneous drainage can be technically challenging. Therefore, if the symptoms improve with endoscopic drainage, it is a valuable option.

Bezoars are composed of vegetable matter (phytobezoar), hair (trichobezoar), or other unusual materials. Previous gastric surgery (disturbance of pyloric function, gastric emptying, and hypoacidity), poor mastication, or overindulgence with foods with high fiber content are common predisposing factors for bezoar formation. There is only one report of laparoscopic resection of a bezoar in a duodenal diverticulum¹², but duodenal diverticular perforation due to phytobezoar is rare.

We used the keywords “DDP” and “Endoscopic treatment” to conduct a PubMed search, there were several reports of endoscopic treatment of DDP. The information regarding the reported 7 patients and our case is summarized in Table 1^{10, 13–17}. Endoscopic treatment of DDP has increased since 2015. An ENBD catheter¹⁷, stent¹⁵, and endoscopic negative pressure¹⁶ were used for treatment. In all the cases, antibiotics were administered on admission, and endoscopic treatment was performed concurrently or secondarily. These reports demonstrated food debris and enteroliths in the duodenal diverticulum, which were removed using lithotomy¹⁰ or a combination of a balloon catheter, Dormia basket, and an endoscopic retrograde cholangiopancreatography (ERCP) injection catheter¹³. The symptoms improved immediately after endoscopic treatment. In this case, the retroperitoneal abscess was cleaned with the placement of an ENBD catheter in the diverticulum and endoscopic lithotripsy and was significantly effective. However, the bezoar was so hard and sticky that three endoscopic treatments were required to remove it. Flushing the ENBD catheter with saline was particularly useful because now the bezoar was smaller and softer. It has been reported that DDP can sometimes be relieved with fasting and antibiotics. However, in this case, there was no improvement in inflammatory findings or abdominal symptoms after starting antibiotics; therefore, endoscopy was performed. Endoscopic treatment was effective because the patient’s condition did not improve until the phytobezoar of the duodenal diverticulum was removed. Endoscopy can provide a more appropriate diagnosis, drainage, tube washing, and even stone removal. Endoscopic therapy, due to its therapeutic diversity, is valuable for the treatment of DDP.

In the current case, a previous CT scan revealed a duodenal diverticulum, which helped in the diagnosis of DDP. It remains difficult to distinguish DDP from duodenal perforation based on image studies and

clinical findings. However, even if the presence of a duodenal diverticulum was not evident and CT showed a localized fluid collection around the duodenum and no peritoneal irritation symptoms; DDP should be suspected and endoscopic treatment considered.

Conclusion

This is a rare case of retroperitoneal perforation of a duodenal diverticulum due to a bezoar impaction. Endoscopic treatment was successful and surgery was avoided. The endoscopic approach is minimally invasive and offers significant advantages when perforation is limited to a retroperitoneal abscess. Endoscopic drainage and lithotripsy should be considered for DDP caused by bezoars.

Authorship list

Takeshi Tadokoro: Drafted the manuscript, reviewed and edited the manuscript, and participated in patient care.

Koichi Oishi: Reviewed and edited the manuscript, and participated in patient care

Yosuke Namba: Read and approved the final manuscript

Tomoaki Bekki: Read and approved the final manuscript

Sho Okimoto: Read and approved the final manuscript

Shoichiro Mukai: Read and approved the final manuscript

Yasufumi Saito: Read and approved the final manuscript

Seiji Fujisaki: Read and approved the final manuscript

Mamoru Takahashi: Read and approved the final manuscript

Teruo Mouri: Undertook endoscopic treatment

Toshihiro Nishida: Made a pathological diagnosis

Toshikatsu Fukuda: Read and approved the final manuscript

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Conflict of interest

The authors have no conflicts of interest to declare.

Ethical approval

This manuscript conforms to the provisions of the Declaration of Helsinki of 1995 (as revised in Brazil 2013)

Consent

Written informed consent was obtained from the patient to publish this report in according with the journal's patient consent policy.

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