Prepyloric diaphragm is a rare anatomic anomaly in adults and can cause gastric outlet obstruction. A 33-year-old man presented with postprandial epigastric distress and a 10-year history of repeated nonbilious vomiting. He was otherwise healthy with no medical history of peptic ulcer or caustic ingestion. Body mass index was 15.9.

Barium swallow test revealed linear antropyloric narrowing (▶ Fig. 1). Computed tomography scan showed prepyloric web of the distal gastric antrum, about 0.5 cm proximal to the pylorus (▶ Fig. 2). Esophagastroduodenoscopy demonstrated gastric outlet obstruction with a pinhole opening and a linear scar on the posterior wall of the antrum (▶ Fig. 3).

Direct endoscopic resection was performed in a radial fashion using a Hook-Knife (Olympus, Tokyo, Japan) until the circular muscle was cut open completely (▶ Video 1). A normal pylorus was exposed and the prepyloric diaphragm was resected thoroughly (▶ Fig. 4).

The patient’s symptom resolved immediately after endoscopic therapy and he was discharged uneventfully 3 days later. Esophagastroduodenoscopy and barium swallow test were repeated 3 months later and revealed no gastric outlet obstruction (▶ Fig. 5).

The etiology of prepyloric diaphragm is controversial in adults as to whether it is congenital or acquired [1]. The association of a linear scar near the prepyloric diaphragm in the current case indicates that it was possibly caused by scarring from a gastric ulcer. Prepyloric diaphragm can be managed with surgical or endoscopic intervention. Endoscopic methods include balloon dilation, resection with a snare, needle knife, or laser [2, 3]. However, there is no standard regarding the width and depth required for sufficient resection of prepyloric diaphragm. Direct endoscopic resection until the circular muscle is cut open without building a submucosal tunnel has been used for congenital pyloric stenosis, achalasia, and other benign strictures [4, 5]. We chose this method to achieve maximum alleviation of obstruction and minimize the possibility of re-obstruction. Endoscopic resection can be performed safely in patients with prepyloric diaphragm.
Competing interests

None

The authors

Lin-Jie Guo, Chun-Cheng Wu, Bing Hu

Department of Gastroenterology, West China Hospital, Sichuan University, Chengdu, China

References


Acknowledgment

The authors want to thank the National key R&D Program of China (2017YFC0112305).

Corresponding author

Bing Hu, MD
Department of Gastroenterology, West China Hospital, Sichuan University, 37 Guoxue Road, Chengdu, Sichuan Province 610041, China
Fax: +86-028-85423387
hubingnj@163.com