

An unexpected finding on gastroscopy: gastro-gastric fistula with *Helicobacter pylori* and *Giardia lamblia*

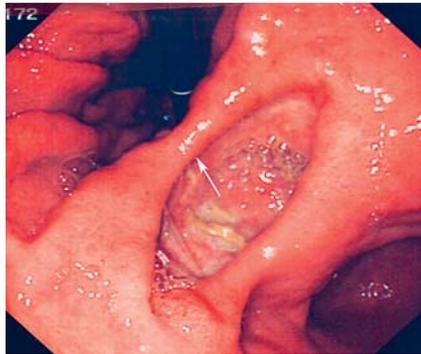


Fig. 1 View of the incisura during the index gastroscopy showing a deep cratered ulcer in a 66-year-old woman with a 6-week history of vomiting, dysphagia, black stool, with weight loss, and melena on per rectum examination. The angle of view in **Fig. 2** is indicated by the arrow.

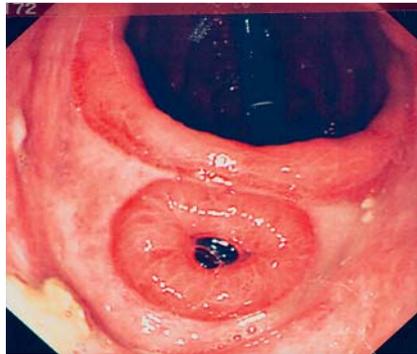


Fig. 2 J maneuver in the antrum and withdrawal, allowing a closeup view of the ulcer base, showing two fistulae in the gastric body. The proximal stomach and the proximal gastroscope are clearly seen.

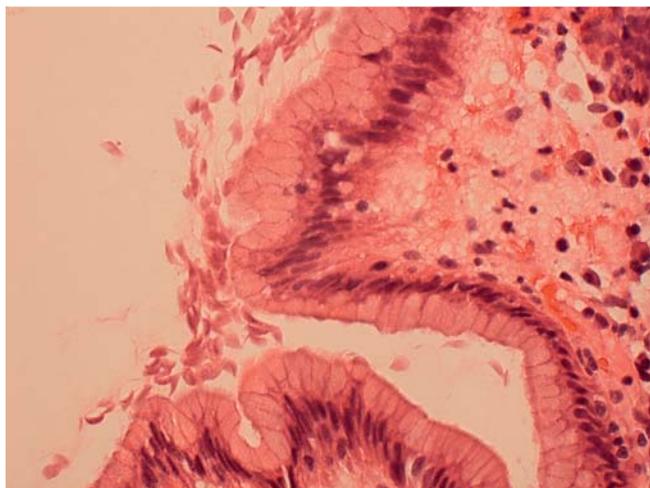


Fig. 3 Histologic section from an ulcer biopsy sample.

A 66-year-old woman presented with a 6-week history of vomiting, dysphagia, black stool, and weight loss, with melena on per rectum examination. Gastroscopy revealed a large chronic ulcer at the incisura with two gastro-gastric fistulae between the antrum and the body (**Fig. 1**). **Fig. 2** shows the proximal endoscope markings visible through a fistula. Biopsies and computed tomography (CT) of the abdomen did not show any evidence of neoplasia, but histologic examination revealed numerous *Giardia lamblia* parasites (**Fig. 3**). *Helicobacter pylori* was not seen but the rapid urease test was positive. The patient was treated with intravenous

pantoprazole, oral metronidazole, and eradication therapy, and no more bleeding was observed. *H. pylori* was successfully eradicated and following discharge the patient gained weight with no further signs of gastrointestinal bleeding. Repeat endoscopy showed healing of the ulcer but persistent incisura deformity and gastro-gastric fistulation.

Although peptic ulcer disease, Crohn's, and cancer have been postulated to cause fistulation, we could find no published data to confirm this. Reports of gastro-gastric fistulae in the literature are almost exclusively related to obesity surgery. This complication occurs in up to 1.2% of Roux-

en-Y procedures, [1] which seems to be the most common cause of gastro-gastric fistulae. The presence of *Giardia* seems incidental although it has previously been linked to *H. pylori* infection [2,3]. In a large retrospective case series of patients with giardiasis, 8.7% had gastric colonization but this was not associated with any specific gastric histology [4]. In addition, since *Giardia* is not usually associated with ulceration in its more usual habitat of the small bowel [4], it can be assumed to be an unrelated finding. We believe our patient most likely had chronic peptic ulcer disease related to *H. pylori* with, perhaps, perforation and subsequent fistula formation.

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Competing interests: None

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