A 76-year-old woman was referred for diagnostic esophagogastroduodenoscopy (EGD) because of melena and iron deficiency anemia without other symptoms of gastrointestinal disease. Although the patient was a smoker, she had no major signs of chronic obstructive lung disease with an oxygen saturation of 90%. EGD with conscious sedation using midazolam was performed by a physician in training and supervised by an expert gastroenterologist. Esophageal intubation went smoothly and the stomach was carefully insufflated by an expert gastroenterologist. Gastric rupture as a rare complication in diagnostic upper gastrointestinal endoscopy

Diagnostic EGD is a very safe procedure with the reported incidence of perforation being below 0.05% [1]. Gastric perforations due to malignancy and therapeutic endoscopy may occur anywhere in the stomach [2]. In contrast, most cases of gastric rupture due to increased intra-abdominal pressure (cardiopulmonary resuscitation, Heimlich maneuver and blunt abdominal trauma), as well as over distension by food or air, and barotrauma occur in the proximal part of lesser gastric curvature [3–5]. In the present case, it is assumed that the choking and coughing, possibly related to her smoking history and aspiration of saliva, together with insufflation-induced gastric distension led to increased intra-abdominal pressure, thereby causing the gastric rupture. Indeed, vomiting and forceful coughing have been previously reported to provoke gastric rupture [4]. This case also indicates the need for careful attention to be paid to the airway at all times during upper gastrointestinal endoscopy, in order to prevent choking and forceful vomiting.

Although gastric rupture is an exceptionally rare complication in diagnostic EGD, patients should be informed of the risk. Endoscopists should be aware of this severe and potentially life-threatening complication in all upper gastrointestinal endoscopic procedures.

References