Phytobezoar of the Stomach

Jeon-Woo Park Hyun-Dong Chae

Department of Surgery, School of Medicine, Catholic University of Daegu, Daegu, South Korea

A 53-year-old man was admitted with epigastric pain, early satiety, nausea, and vomiting.

Physical examination revealed no abnormalities. His medical history included gastric ulcers leading to a truncal vagotomy with partial gastrectomy performed several years previously and barbiturate medication. An abdom-

inopelvic CT scan demonstrated a low-density, well-encapsulated massive gastric mass measuring 11 cm in diameter in its largest dimension (fig. 1). Gastroduodenoscopy found an intrinsic foreign body in the stomach (fig. 2). Endoscopic removal was attempted after chemical dissolution, but failed. After that, surgical removal by

Fig. 1. Preoperative abdominal CT shows a hypodense, well-encapsulated mass, measuring 11 cm in diameter in its largest dimension, filling the stomach.

Fig. 2. Gastroduodenoscopic findings. Endoscopy shows an intrinsic foreign body with cratered ulcer in the stomach, and endoscopic removal of bezoar is attempted.

Fig. 3. Intraoperative finding shows a giant phytobezoar in the stomach with friable materials.

gastrotomy was performed (fig. 3). The final pathologic diagnosis was gastric phytobezoar.

Gastric phytobezoars are a rare finding resulting from the accumulation of ingested fibrous material. After vagotomy, gastric stasis, disturbed gastric motility, and delayed emptying, combined with a reduced capacity of the stomach, favor the formation of phytobezoars. They are found in fewer than 1% of patients undergoing gastro-duodenoscopy [1, 2]. Modern management of bezoars usually begins with attempts at chemical dissolution. A multitude of dissolving agents have been described, in-

cluding cellulose, acetylcysteine, papain, and Coca-Cola™, and are associated with varying degrees of success. Endoscopy is a second treatment modality regardless of bezoar composition, and surgery is usually performed in cases where other measures have failed.

References

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