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**Large symptomatic gastric diverticula: Two case reports and a brief review of literature**

Marano L *et al*.Treatment of symptomatic gastric diverticula

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**Abstract**

Gastric diverticula are rare and uncommon conditions. Most gastric diverticula are asymptomatic. When symptoms arise, they most commonly are upper abdominal pain, nausea and emesis while dyspepsia and vomiting are less common. Occasionally, patients with gastric diverticula can have dramatic presentations related to massive bleeding or perforation. The diagnosis may be difficult, as complaints can be caused by more common gastrointestinal pathologies and only be aggravated by diverticula. The appropriate management of diverticula depends mainly on the symptom pattern and as well as diverticulum size. There is no specific therapeutic strategy for an asymptomatic diverticulum. Although some authors support conservative therapy with antiacids, this latter provides only a temporary symptom relief since it is not able to resolve the underlying pathology. Surgical resection is the mainstay of treatment when the diverticulum is large, symptomatic or complicated by bleeding, perforation or malignancy, remaining over 2/3 of patients symptom-free after surgery, while laparoscopic resection, combined with intraoperative endoscopy, is a safe and feasible approach with excellent outcomes. Here we present two cases of uncommon large symptomatic gastric diverticula with a discussion of the cornerstones in management and report a minimally invasive solution, performing a brief review of literature.

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**Key words:** Gastric diverticulum; Laparoscopic gastric diverticulectomy; Abdominal pain; Dysphagia; Gastric; Diverticulum

**Core tip:** Gastric diverticula are infrequent anatomic abnormalities and usually asymptomatic. They present with variable symptoms. Although most symptomatic patients are diagnosed during evaluation of vague epigastric discomfort, severe complications including perforation and hemorrhage may occur. We report a successful laparoscopic approach as a minimally invasive solution to a symptomatic gastric diverticula with a brief literature review on this rare condition. Knowledge of the emerged pitfalls in diagnosis and treatment of a gastric diverticulum are essential for successful and complete relief of symptoms.

Marano L, Reda G, Porfidia R, Grassia M, Petrillo M, Esposito G, Torelli F, Cosenza A, Izzo G, Di Martino N. Large symptomatic gastric diverticula: Two case reports and a brief review of literature

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**INTRODUCTION**

Gastric diverticulum is an outpouching of the gastric wall having similar characteristics to duodenal, jejunal and colonic diverticula[1]. Generally it is a very rare and uncommon condition with prevalence ranges from 0.04% in contrast study radiographs and 0.01%-0.11% at upper gastrointestinal endoscopy[2,3]. These occur equally in men and women, typically in the fifth and sixth decades. Although most patients are asymptomatic occasionally abdominal symptoms occur, ranging from vague pain, epigastric fullness, bleeding or perforation[4-6]. They are usually 1–3 cm in diameter and can be divided into true diverticula comprising all gastrointestinal layers and pseudodiverticula which are often found in the antrum[7,8]. We present two cases of uncommon large symptomatic gastric diverticula with discussion of the cornerstones in management and report a minimally invasive solution, performing a brief review of literature.

**CASE REPORTS**

Two 51-year-old and 49-year-old women were referred to our Department for evaluation of symptoms of epigastralgy and upper abdomen tenderness, respectively. They denied weight loss, hematemesis and melena. The patients did not complain vomiting or any abnormal bowel function. Their abdominal exams revealed no masses or other abnormalities. Then, a barium esophago-gastric study was performed, which showed an image of outpouching in the upper gastric region (Figure 1). To confirm the diagnosis, an upper endoscopy was obtained, demonstrating diverticula directed posteriorly off the fundus of the stomach that measured 5 and 8 cm in diameter, respectively (Figure 2). The diverticula had a narrow neck while no ulcer was identified. Functional examination with esophageal stationary manometry and 24-h esophagogastric pH-multichannel intraluminal impedance monitoring showed normal values. The electrogastrography monitoring showed an increase of bradyarrhytmic gastric activity in both patients. Patients were submitted to surgery and the operations were performed laparoscopically. The interventions were substantially the same for both patients. Because inspection of the stomach did not show a diverticulum at the anterior surface, the bursa omentalis was opened by dividing the gastrocolic omentum. Under endoscopic control diverticula were resected at the neck with the EndoGIA (Universal, US Surgical Corporation, Norwalk, CO) and then successfully retrieved with a laparoscopic pouch (Figure 3). Then, the staple lines were carefully examined and tested by submerging insufflated stomach under sterile irrigation to observe for bubbles. No evidence of a leak was observed, and the insufflated stomach was spirated through the nasogastric tube. Histology confirmed a gastric diverticula of 5 and 8 cm respectively, with normal mucosa in both cases. The procedures were uneventful. Patients were placed on a regular diet on postoperative day 3 and discharged 5 d later. Patients did not show any complications after surgery. On their first six-months follow-up visit, both patients, did not complain any symptoms while normal radiographic and endoscopic, regular values of esophageal manometry and 24 h esophagogastric pH-multichannel intraluminal impedance in morphological were found.

**DISCUSSION**

Moebius in 1661 and later Roax in 1774 first described gastric diverticulum[9]. The literature suggests that most symptomatic diverticula are found in patients between 20 and 60 years[10-12] while a unique study showed that only 4% of gastric diverticula occurred in patients younger than 20 years[11] and no difference in gender incidence have been described[4]. Two types of gastric diverticula are recognized according to Akerlund[13] and Schmidt *et al*[14]: congenital (true) and acquired (false) diverticula, with congenital types being more common[2,15-17]. True diverticula have all layers of the gastric wall, and it is believed that these congenital diverticula occur as a result of splitting of the longitudinal muscular fibers at cardia level, leaving only circular muscle fibers present in gastric wall and creating in this way a weakening allowing diverticula to form during the fetal period. This hypothesis is supported by Reich[18] who reported fetal gastric diverticula and by Lewis, which described gastrointestinal diverticula in embryos in 1908[19]. False diverticula, also classified as pulsation and traction diverticula, do not carry all layers of the gastric wall[20]. Pulsation diverticula are those arising from increased intraluminal pressure, such as chronic coughing, obesity and pregnancy. Traction diverticula arise from perigastric adhesions from concurrent diseases, such as peptic ulcer disease, pancreatitis, malignancy, gastroesophageal reflux and cholecystitis[11,12]. Gastric traction diverticula have been reported after surgical procedures on the stomach, including Roux-en-Y gastric bypass[12,21,22]. Even if gastric diverticula can arise virtually anywhere along stomach, most congenital diverticula (70%) are tipically located on the posterior wall of the stomach just below the gastroesophageal junction[2], while acquired outpouchings usually are situated near the gastric antrum. Typical diverticula are 1-3 cm in diameter but large diverticula as demonstrated above can occur[2,15]. Most gastric diverticula are asymptomatic[22], however when symptoms arise, dependently on the size of the diverticular neck, they most commonly are upper abdominal pain, nausea, and emesis, described in 18%-30% of cases[2,21]. Wide-neck often go unnoticed perhaps because food and digestive juices are less likely to become trapped in the diverticula. It has been suggested that food retention with subsequent distension of the gastric diverticulum may cause pain[23,24]. Dyspepsia and vomiting are less common[21,25]. Occasionally, patients with gastric diverticula can have dramatic presentations related to massive bleeding or perforation[26] due to food retention with subsequent release of gastric juices within the mucosal sac causing diverticulitis and possibly ulceration or hemorrhage. Twice have an invasion with adenocarcinoma been reported[27,28]. The diagnosis may be difficult, as complaints can be caused by more common gastrointestinal pathologies and only be aggravated by diverticula. Methods of detection can fail, therefore, a combined approach should be used[8]. The presence of mucosal sac can be confirmed with upper gastrointestinal contrast studies and upper endoscopies. These are the most reliable diagnostic tests but reports in the literature confirm that they can still miss the lesion if it has a narrow neck that precludes entry of the contrast or scope giving false negative results[2,1129]. In a large review, Palmer[11] reported that 5% of gastric diverticula are missed during upper gastrointestinal study. Other reports recommend the use of upper endoscopy[22,30] for diagnosis, as this modality easily confirms the location and size of the diverticula and provides the opportunity to biopsy any concurrent pathology. This diagnostic tool can rule out associated pathology and may be able to reproduce symptoms with distention of the diverticulum indicating which patients would benefit from resection[15,22]. Computerized tomography scans are also used to diagnose diverticula; however, these have also been mistaken for adrenal masses[31]. The appropriate management for diverticula depends mainly on the symptoms pattern as well as on diverticulum size. There is no specific therapeutic strategy for an asymptomatic diverticulum[5,18]. However, routine surveillance with a periodic history and physical is recommended, given the potential onset of complications[20]. Diverticula exceeding 4 cm are more prone to produce complications and tend to respond less favorably to medications. Although some authors support conservative therapy with antiacids, it provides only a temporary symptom relief and it is not able to resolve the underlying pathology[20]. An essential pitfall for successful treatment with complete relief of symptoms is the association of the symptoms with the diverticulum. Palmer[11] found that in 30 of 49 symptomatic patients with a gastric diverticulum, symptoms were attributable to other gastrointestinal diseases, and in 6 of 9 patients with symptoms caused by gastric diverticulum who underwent open surgery showed excellent outcomes. Resection of gastric diverticula in all patients will lead to unsatisfactory results[22]. Surgical resection is the mainstay of treatment when the diverticulum is large, symptomatic or complicated by bleeding, perforation or malignancy, remaining over 2/3 of patients symptom-free after surgery[11]. Several surgical approaches have been described including invagination of the diverticulum as well as partial gastrectomy[32,33], however, from the first successful laparoscopic resection of gastric diverticulum in the late 1990s, this approach is now considered safe and feasible[35]. The most favourable approach providing a better exposure is by placing a midline port, right upper quadrant, and 2 left upper quadrant ports. Laparoscopic dissection has been performed by either releasing the gastrocolic ligament, thus gaining exposure of the superior posterior wall of the stomach[5,34-36]. Simple diverticulum resection with a laparoscopic cutting stapler has been reported to be successful[37]. In some cases surgical approach can be challenging because the diverticulum is often collapsed and hidden in the splenic bed. Sometimes, a resection of the wrong part of the stomach has also been described[22]. For this reason the surgical procedure should be combined with intraoperative endoscopy to find an elusive diverticula by stretching of the diverticular sac[4,34-36].

In conclusion laparoscopic resection is a safe and feasible surgery approach with excellent outcomes strongly indicated for symptomatic gastric diverticula.

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**Figure 1 A barium study reveals diverticula directed posteriorly off the fundus of the stomach that measured 5 and 8 cm in diameter respectively.**

**Figure 2 Endoscopic view of gastric diverticulum with a narrow neck.**

**Figure 3 Exposure of the neck of the diverticulum for preparation of diverticulectomy and resection at the neck with linear stapler.**