A giant gastric bezoar in billroth II stomach: A case report on successful endoscopic removal via repeated fragmentation and dissolution technique negating the need for surgical intervention

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**Declarations:**

We declared that this article has not been published previously, and it is not under consideration for publication elsewhere. We have read and understood Gastroenterology Insights’ policy on declaration of interests and declare that we have no competing interests. No funding or financial support provided for the preparation or conduct of the research. We have obtained the consent from the patient for writing, and publication of the case detail, including the endoscopic images.
Abstract

A 76-year-old gentleman presented with anemia. He had a history of perforated duodenal ulcer six years ago, with Billroth II repair performed. A large gastric bezoar (8X6cm²) with a clean base ulcer at the anastomotic junction was found during the initial Oesophago-gastro-duodenoscopy (OGDS). Rapid urease test was negative. He presented with melena during the subsequent follow up (OGDS showed a Forrest Ib prepylori ulcer).

We have successful removed the gastric bezoar with dissolution therapy initially (injection of coke-cola into the bezoar, followed by drinking 325ml coca-cola twice daily), followed by four attempts of OGDS with endoscopic fragmentation. Histopathology reported as degenerated vegetable matter, acellular debris mixed with scattered fungal and bacterial colonies, which was compatible with bezoar. Follow up OGDS showed complete clearance of the bezoar.

Coca-cola ingestion should be considered as initial treatment as it is non-invasive, and it enables further successful endoscopic fragmentation.

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Introduction

A bezoar is an indigestible mass of material, such as hair, food, seeds, that other ingested substances found in the gastrointestinal tract. Gastric bezoars are rare with estimated incidence about 0.4% on upper endoscopy.

Gastric bezoars usually result from ingestion of indigestible material in patients with impairment in the gastric motility or digestion, which could be due to previous gastric surgery (such as Billroth I or II gastrectomy) or in the patients with delaying gastric emptying (such as those with diabetic gastroparesis, mixed connective tissue disease, or hypothyroidism). Other predisposing conditions are inadequate fluid intake leading to dehydration, and anatomic abnormalities such as diverticula or gastric outlet obstruction.