



UNIVERSITY of
ROCHESTER
MEDICAL CENTER

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DEPARTMENT OF IMAGING SCIENCES

Imaging Sciences Interesting Cases

CASE 33

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CLINICAL PRESENTATION: Patient is 53-year-old male with a history of radiation to the entire periaortic area for testicular cancer, as well as laparotomy with SMA exploration and bowel resection.

IMAGING FINDINGS:



Figure 1. CT abdomen with oral and IV contrast shows marked distention of the stomach and proximal small bowel extending to the level of the third portion of the duodenum.



Figure 2. Upper GI with small bowel follow through shows no passage of contrast through the third portion of the duodenum. There is dilation of the third portion of the duodenum.

DIAGNOSIS: Duodenal Obstruction secondary to adhesions

DISCUSSION: Duodenal obstruction in adults may be secondary to chronic pancreatitis (5% of patients with chronic pancreatitis experience symptomatic duodenal stenosis), pancreatic cancer, annular pancreas, Crohn's disease (2-4% of patient's with Crohn's), vascular compression (SMA syndrome), and hematoma secondary to trauma.

Duodenal obstruction in the pediatric or neonatal population is often secondary to a congenital anomaly. Malrotation with midgut volvulus and/or Ladd bands, duodenal atresia or stenosis, intraluminal diverticula (may manifest at any age), duplication cysts, and annular pancreas (also presents in adults) may present with duodenal obstruction.

Patients present with nausea, vomiting, abdominal pain, and weight loss. Diagnosis is confirmed radiologically with plain film, upper GI barium study, or CT, depending on the etiology. Treatment is often surgical.

REFERENCES:

1. Sleisenger MH, Feldman M, Brandt LJ. Sleisenger and Fordtran's Gastrointestinal and Liver Disease: Pathophysiology, Diagnosis, Management, 2-vol., 8th ed. Elsevier Health Sciences, 2006.
2. Townsend C, Mattox KL, Evers BM, Beauchamp RD. Sabiston Textbook of Surgery, 17th ed. Elsevier Health Sciences, 2004.