ABSTRACT

Gastric Outlet Obstruction implies complete or incomplete obstruction of the distal stomach, pylorus or proximal duodenum. Gastric outlet obstruction is not a single entity; it is the clinical and pathophysiological consequence of any disease process that produces a mechanical impediment to gastric emptying. Now in the era of H2 blockers and proton pump inhibitors, incidence of duodenal ulcer producing gastric outlet obstruction has been decreasing as symptomatic ulcer begin to respond to medical treatment, and at the same time the incidence of antral carcinoma of stomach producing gastric outlet obstruction has comparatively increased which may be due to increased early diagnosis of the condition with the help of flexible fibre optic endoscope.

Aims and objectives:

1. To determine the relative incidence of benign and malignant gastric outlet obstruction.
2. To study the modes of presentation of gastric outlet obstruction.
3. To study the outcome of management of gastric outlet obstruction.

Methodology:

In this study, 50 in-patients presenting with features of gastric outlet obstruction to Rajiv Gandhi Govt. General Hospital from October 2013 to September 2014 have been studied.
An elaborate study of these cases with regard to the history, clinical features, routine and special investigations, pre-operative treatment, operative findings, post operative management and complications in post-operative period is done.

**Results and Observations:**

Of the 50 cases of gastric outlet obstruction 34 had carcinoma antrum (72%) 14 had cicatrized duodenal ulcer (28%) and 1 had gastric outlet obstruction secondary to corrosive ingestion.

The age incidence of the patients in this study ranged from 29-76 years with a mean of 53.32 years. In case of obstruction secondary to duodenal ulcer the maximum age incidence is between 40-49 years. The maximum age incidence of gastric outlet obstruction due to carcinoma antrum is 50-59 years.

In this series, 36 patients (72%) were males and 14 patients (28%) were female. Male to female ratio (M:F) is 2.57:1. M:F ratio in cicatrized duodenal ulcer is 2.5:1 and in carcinoma antrum is 2.4:1. 52% of the patients were manual labourers who gave a history of irregular diet habits. 68% of patients had history of smoking and 66% had history of alcohol intake. Post – prandial vomiting and epigastric pain are the main symptoms (96%) in this series. Other symptoms included anorexia (84%), weight loss (72%), post prandial epigastric fullness (68%), haematemesis (24%), malena (64%) and constipation (48%). Pallor was present in 68% and dehydration in 62%. Blood group ‘O’ was common in
cicatrized duodenal ulcer patients (57.14%) whereas blood group ‘A’ was common in malignant cases (58.82%).

**Conclusion:**

Number of cases with cicatrized duodenal ulcer as the chief etiological factor for gastric outlet obstruction is diminishing and the number of cases of antral carcinoma of stomach as the cause of gastric outlet obstruction is increasing. Upper Gastro intestinal endoscopy should be mandatory in all suspected cases of gastric outlet obstruction. It can diagnose the cause of obstruction very effectively than any other investigative modality. Effective treatment in carcinoma stomach depends on early diagnosis.
LIST OF ABBREVIATIONS (KEY WORDS)

5-FU -- 5-Fluoro-Uracil
APD -- Acid Peptic Disease
ECF -- Extra Cellular fluid
GD -- Gastro Duodenal
GEJ -- Gastro Esophageal Junction
GI -- Gastro Intestinal
GJ -- Gastro Jejunostomy
GOO -- Gastric Outlet Obstruction
GFR -- Glomerular Filtration Rate
H2RA -- Histamine 2 Receptor Antagonist
HCl -- Hydro Chloric Acid
HSV -- Highly Selective Vagotomy
MAO -- Maximum Acid Output
MEN -- Multiple Endocrine Neoplasia
NHL -- Non-Hodgin’s Lymphoma
NSAID -- Non-Steroidal Anti Inflammatory Drugs
OGD scope -- Oesophago-Gastro-Duodenoscope
PPI -- Proton Pump Inhibitor
PUD -- Peptic Ulcer Disease
SMA -- Superior Mesenteric Artery
VGP -- Visible Gastric peristalsis.