PICTURE IN DIGESTIVE PATHOLOGY

Crack cocaine abuse as an undescribed cause of gastric outlet obstruction

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CASE REPORT

The case was a 32-year-old male smoker, with a history of alcohol consumption and crack-cocaine abuse for ten years of 300 g/day. He started with epigastric abdominal pain, intensity 10/10 and went to another hospital where a perforated peptic ulcer was suspected and a laparotomy was performed, with no findings. Subsequently, he had symptoms such as vomiting and weight loss so he presented to our hospital. On admission, a gastric outlet obstruction (GOO) was suspected and a computed tomography (CT) scan showed a concentric duodenal growth. An upper endoscopy was performed identifying a duodenal bulb stenosis with a Forrest-III ulcer and biopsies reported acute and chronic duodenitis. Fluoroscopy finding was a complex stenosis of 6 cm in length, and he was not a candidate for dilation. Roux-en-Y gastrojejunal anastomosis was performed, identifying duodenal thickening, without malignancy. There were no obstruction symptoms, weight gain and drug use during follow-up.

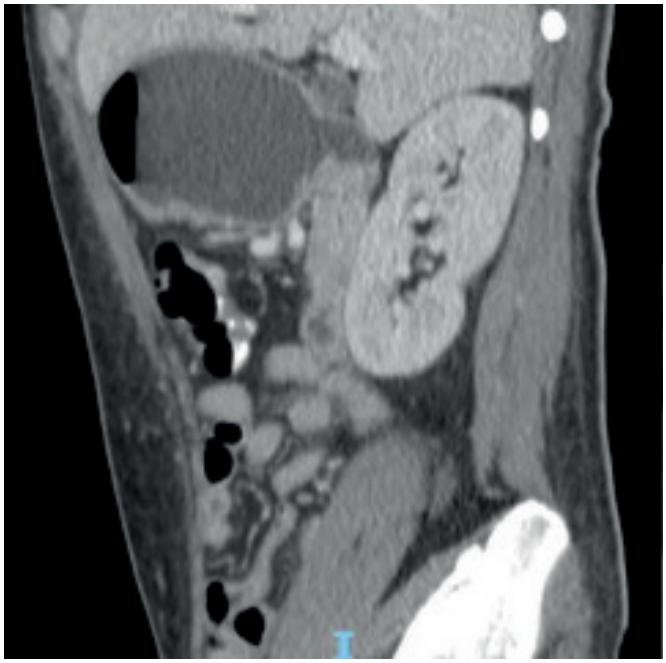

Fig. 1. *Abdominal CT scan in the sagittal plane shows a concentric thickening in the duodenum causing mechanical obstruction as a cause of GOO symptoms.*

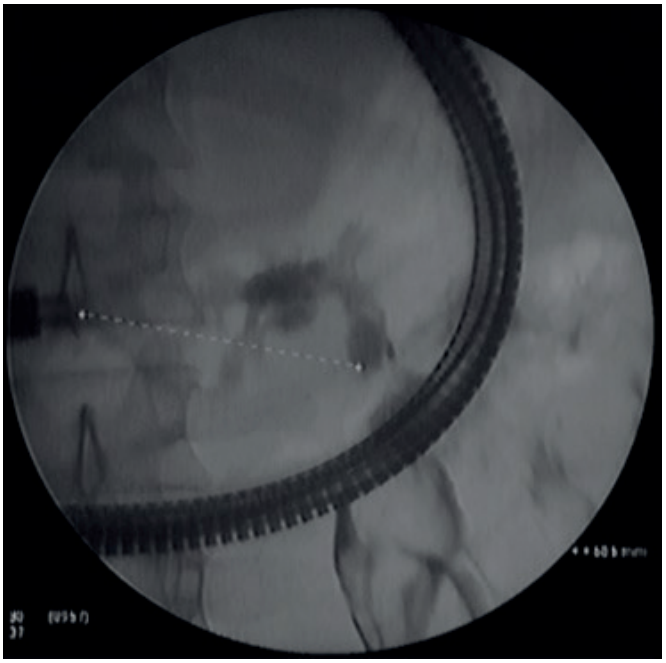

Fig. 2. *Fluoroscopy image showing a complex stenosis of 6 cm in the duodenal bulb.*

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DISCUSSION

GOO is a syndrome characterized by epigastric pain and postprandial vomiting caused by mechanical obstruction, which is usually in the anthropyloric, bulbar or post-bulbar region (1,2). The etiologies include benign tumors, use of nonsteroidal anti-inflammatory drugs (NSAIDs), peptic ulcer, caustic intake, inflammatory, etc. (3). Crack is a form of cocaine, an insoluble alkaloid, resulting from the combination of cocaine hydrochloride and bicarbonate. Its use has organic manifestations; it can cause ischemia, ulcers and perforation in the gastrointestinal system. The proposed pathophysiology is intense agonist activity at alpha-adrenergic receptors causing arterial vasoconstriction of the gastric and mesenteric arteries with resulting ischemia (1). To date, there are no case reports documenting crack-cocaine abuse as a cause of GOO, this being the first case published.

Conflict of interest: the authors declare no conflict of interest.

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COMMENTARY

Gastric outlet obstruction adds to other, already reported, severe injuries in the digestive tract, related to cocaine addiction (1). Cocaine is often mixed with other toxic substances and used through nasal, parenteral and oral routes with different consequences, but with a similar mortality or surgical outcome (2). In any case, the need for an even more complex, comprehensive, multidisciplinary and continuous care for these patients is evident.

Luis Fernández Salazar
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