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Astrid A. Gleaton
Maine Medical Center

Et al.

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A Rare Entity: Case Report of Recurrent Hypertrophic Pyloric Stenosis

Authors
Astrid A. Gleaton and Kartikey Pandya

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A male neonate born after 39 weeks and 2 days gestation was diagnosed with hypertrophic pyloric stenosis (HPS) and underwent laparoscopic pyloromyotomy at 3 weeks old. By postoperative day 1, he was tolerating feeds and was discharged. At a follow-up visit at 7 weeks old, he was doing well, taking in approximately 120 mL of infant formula every 3 to 4 hours and gaining 0.3 to 0.6 kg/week. At 11 weeks old, he presented to the hospital with projectile nonbilious emesis and hypochloremic metabolic alkalosis.

His symptoms continued despite hydration and metabolic derangement correction. An abdominal ultrasound revealed a hypertrophic pylorus nearly identical to his ultrasound at initial presentation (Figure 1A and 1B). He was also evaluated with an upper gastrointestinal contrast (UGI) study, which showed a partial gastric outlet obstruction. We consulted pediatric gastroenterology, who recommended a nasoduodenal tube to see if post-pyloric feeds were tolerated, which would provide nutrition and rule out a duodenal web. The tube could not pass the obstructed pyloric channel. Diagnostic laparoscopy showed a thickened pylorus (Figure 2A), prompting repeat pyloromyotomy (Figure 2B). He was again treated by our standard post-pyloromyotomy protocol, such that after 4 hours of bowel rest, he was fed 20 mL/kg of formula every 3 hours. After tolerating 2 sequential feeds, he was advanced to ad lib feeds and discharged on postoperative day 1. On postoperative day 4, he had an emesis of feeds more than 20 mL/kg. However, by postoperative day 7, he was tolerating larger feeds without emesis nor any other concerns.
DISCUSSION

HPS is a common disease in pediatric surgery and has good postoperative outcomes (low risks of mucosal perforation and incomplete myotomy, and prompt resumption of feedings).\(^3\) At our institution, most patients are discharged 1 to 2 days after a pyloromyotomy (open or laparoscopic). Recurrent HPS (rHPS), however, rarely occurs after pyloromyotomy, with an estimated incidence of 0.07%.\(^4\) Because rHPS is rare, our initial differential was quite broad, including formula intolerance, gastroesophageal reflux, over-feeding, gastroparesis, and perforated duodenal web. Incomplete pyloromyotomy was also considered; however, multiple weeks of feeding well and weight gain was inconsistent with this diagnosis. The ultrasound and UGI study ruled out many of these considerations by showing a mechanical obstruction. Even so, we were not confident in our diagnosis before going to the operating room, in part because ultrasound can show an abnormal pylorus for months after pyloromyotomy.\(^5\) We anticipated that if a normal pylorus was found intraoperatively, pediatric gastroenterology would perform an upper endoscopy to look for a duodenal web at the same anesthetic event. Although making this diagnosis posed a challenge, the exercise was good for practicing a broad differential.
The literature does not well define rHPS, as most publications on the topic are limited to sparse case reports.\textsuperscript{3,4,6-8} In 2018, a case report defined recurrence as a period of weeks post-pyloromyotomy without significant emesis and adequate weight gain before presenting again with nonbilious emesis.\textsuperscript{6} This clear, symptom-free interval after the first pyloromyotomy was similarly seen in our patient and described in other case reports.\textsuperscript{3,4,6,7} Although not formally established, this interval appears to be a defining characteristic of this disease process. Also, this study population should exclude patients with incomplete myotomy because they likely have immediate persistent emesis and will not tolerate full-volume feeds or consistently gain weight.

With such an uncommon diagnosis, treatment of rHPS is unclear. Repeat laparoscopic and open pyloromyotomy have been successful.\textsuperscript{6,7} One institution successfully treated 1 patient with endoscopic balloon dilation, although this approach failed in another patient who then required repeat open pyloromyotomy.\textsuperscript{4} In another case report, rHPS did not improve after a repeat open pyloromyotomy, which prompted a third surgical exploration and removal of part of the pyloric muscle.\textsuperscript{8} We do not know whether the third operation was for recurrent pyloric stenosis or incomplete pyloromyotomy, because a symptom-free interval did not occur between the second and third operation. A novel approach to treating pyloric stenosis, although not yet trialed in rHPS, is endoscopic pyloromyotomy. In one study, a gastroenterologist successfully treated 10 patients with HPS using endoscopic pyloromyotomy with no reported complications.\textsuperscript{9} An endoscopic pyloromyotomy in rHPS may lead to higher mucosal perforation because, presumably on one side of the pylorus, the longitudinal and circular muscles have been divided, leaving only the intact pyloric mucosa. Overall, multiple modalities can address rHPS, although no procedure is superior to another.

The pathophysiology of HPS is currently unknown. It may be related to poorly controlled pylorospasm, possibly due to diminished nitric oxide synthase activity that leads to hypertrophy.\textsuperscript{10} Even less is known about the mechanism for rHPS. One case report speculated that recurrence could represent either operating early on a pylorus that continues to hypertrophy or an acquired insult that causes a second hypertrophic event.\textsuperscript{6} The latter process is favored, given several case reports of adults presenting with hypertrophic pyloric stenosis.\textsuperscript{11,12} Overall, despite having multiple modalities of treatment, more information is needed to better understand both HPS and rHPS.

Conflict of Interest: None

REFERENCES