plain radiography so that the best method of retrieval can be chosen, then grasp the foreign body firmly and remove it without damaging the mucosa.

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IMAGE

Large lipomatous duodenal polyp causing intermittent gastric outlet obstruction

A 72-year-old lady with portal hypertension due to cirrhosis presented with features of intermittent gastric outlet obstruction (GOO). Endoscopically, a large polypoidal lesion of the size of 8×2 cm was identified in the duodenum. The long polyp with smooth surface was rooted to the first part of duodenum with a broad stalk. The globular tip reached deep D2 crossing the ampulla (Fig. 1). Polypectomy was deferred due to coagulopathy and also since the stalk was located in proximal most part of D1, which made snaring to the base difficult.

Endoscopy during the second episode of GOO showed that the polyp had prolapsed into the stomach; surface was edematous and the polyp body was tightly fitting in the pyloric opening (Fig. 2). Patient was kept nil per orally for one day, with gastric lavage performed through 18 F Ryles tube and four units of fresh frozen plasma were infused. After intravenous injection of 'hyoscine' the polyp was pushed into D2. The stalk was snared using jumbo oval

Fig. 2 The polyp seen prolapsed into the stomach during an episode of intractable non-bilious vomiting

snare and cauterized. Oozing from the stalk was arrested by band ligation since repeated injection of adrenaline failed. Hemoclip application could not be done due to the difficult location in proximal D1.

Although gastric polypoidal lesions prolapsing in to the duodenum have been reported, duodenal polyps causing GOO is rare.¹ Among duodenal polypoidal lesions, lipomatous polyps are extremely rare; commoner being adenomatous polyps and Brunner gland hyperplasia. To our knowledge, only one case of large lipomatous polyp of first part of duodenum causing GOO has been reported before;² endoscopic removal of the same has not been reported earlier.

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Fig. 1 The long polyp hanging down from D-1 to D-2

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