GI Cases II
Bezoar
Caroli’s Disease

With Renal tubular ectasia
Achalasia
Pneumobilia

• DDx ...
Crohns with fistula
DUODENAL ULCER

Ulcer niche with surrounding edema

'Kissing ulcers' occurs when two ulcers abut each other on opposite walls

'Giant ulcer' when ulcer crater is greater than 3 cm. May simulate a normal but deformed bulb

'Cloverleaf' deformity occurs from chronic ulcer disease causing cicatrization fibrosis

Most ulcers previously believed due to high acid environment. Now believed due to Helicobacter pylori infection exacerbated by high acid environment
ESOPHAGEAL CANDIDIASIS

Can involve entire thoracic esophagus; usually the upper half is spared.

Earliest findings are atonic motility and dilatation; slightly later findings are small marginal serrations.

Later develop irregular cobblestone pattern due to submucosal edema with ulceration or pseudomembrane formation.

Shaggy marginal outline occurs due to coalescent deep ulcerations, sloughed mucosa, plaques and pseudomembrane formation. Double tracking of barium is seen when pseudomembrane is outlined between the esophageal wall and lumen.

Luminal narrowing due to spasm or stricture.

May sometimes appear as large solitary ulcer.
ESOPHAGEAL WEB

Thin, delicate membrane that sweeps across usually at level of cricopharyngeus muscle.

May be multiple or more rounded and mass-like in appearance

Best visualized at maximum distention (may be only for 1/10th of a second). Best seen on videofluoroscopy

Tends to arise from the anterior wall and is best visualized on lateral projection

Must be differentiated from pharyngeal venous plexus (located anteriorly but varies in appearance from swallow to swallow) and a prominent cricopharyngeus muscle (appears on the posterior wall in a typical location and pattern)
Hepatic Adenoma
Inguinal Hernia
Cholangiocarcinoma
Ischemia
Colo-vesicular Fistula Secondary to Diverticulitis
Meckle’s Diverticulum
MIRIZZI SYNDROME

Associated with an anatomic anomaly where a long cystic duct parallels the common hepatic duct.

Extrinsic compression of a common hepatic duct by gallstone impacted in the cystic duct or gallbladder neck with chronic surrounding inflammatory changes.

Frequently leads to gallbladder - common hepatic duct fistula.
ESOPHAGEAL DIVERTICULUM
(MID-ESOPHAGEAL)

Esophageal diverticula are either caused by high intraluminal pressure (pulsion type) or from tethering by periesophageal fibrosis (traction type)

Traction diverticula contain all layers of esophageal wall

In the past, mid-esophageal diverticula were primarily traction type (from scarring from histoplasmosis or tuberculosis infected perihilar/subcarinal lymph nodes). Currently, pulsion type diverticula may be more common in the mid-esophagus

Proximal and distal esophageal diverticula are usually of the pulsion type
SPIGELIAN HERNIA

A segment of bowel herniates outward through the internal oblique muscle and beneath external oblique muscle at the lateral margin of the rectus abdominis muscle.
Oriental Cholangitis

- Recurrent pyogenic cholangitis
- Stones within dilated intrahepatic bile ducts
Pseudomyxoma Peritonei
Cecal Volvulus
Jejunal Diverticulosis
Familial Polyposis