Abstract: Gastric gangrene is a rare and fatal clinical entity in which a part or whole of the stomach becomes gangrenous necessitating partial or total gastrectomy and is associated with high mortality. Ours is a patient of 60 years who had gastric perforation and subsequently developed gastric gangrene on the 4th POD. Gastric gangrene may be due to variety of causes like chemical injuries, necrobiotic infections, mechanical causes, vascular causes. Only 8 cases has been reported till now. This case is presented for its rarity and for having clinical suspicion of this condition in the diagnosis of an acute abdomen.

Keyword: Gangrene, Necrobiotic infections, Volvulus, Embolism.

A 60 year old male admitted with pain abdomen 2 days, vomiting 1 day. No history of haematemasis, malena, constipation, jaundice. He is a chronic smoker and alcoholic.

Patient is toxic, dehydrated, tachycardic, tachypnoeic, CVS / RS –NAD. Per abdomen- warmth, tenderness present all over the abdomen. Guarding and rigidity present. No bowel sounds heard. Per Rectal examination -normal.

X-ray chest showed air under diaphragm.

Patient was taken for emergency laparotomy

INTRAOPERATIVE FINDINGS:

Gastric perforation of size 0.5 * 1 cm in the anterior aspect of stomach near the lesser curvature 4 cm away from antrum. Margins freshened and biopsy taken. Primary closure done and omental patch reinforcement given. Peritoneal lavage done, wound closed in layers. Patient was stable and there was no significant complaints till 4th POD. Patient had vomiting and he developed features of re perforation on the 5th POD. Patient was taken for re-laparotomy.

INTRAOPERATIVE FINDINGS:

Gangrene involving major parts of the stomach 4 cm below the OG junction up to 3 cm proximal to the antrum along with necrosis of part of the omentum. Omental patch given in the previous surgery was found in

-In view of sepsis and general condition of the patient TOTAL GASTRECTOMY, OESOPHAGASTOMY WITH DUODENOSTOMY AND FEEDING JEJUNOSTOMY WAS DONE.
DISCUSSION:
GASTRIC GANGRENE It is a rare and fatal disease with a high mortality rate of 80 to 85%.

ETIOLOGY:
1. VASCULAR CAUSES: thromboembolism and occlusion of major arteries that supply the stomach
2. CHEMICALS: ingestion of corrosive agents and smoking
3. MECHANICAL: hiatal hernia and volvulus of stomach

Histo pathology report came as full thickness necrosis of the stomach.

Microbiological culture of the peritoneal fluid has grown E. Coli. However the exact etiology of the disease was not identified.

INFECTIONS:
1. SUPPURATIVE (hemolytic streptococci, proteus, e.coli, cl.welchii)
2. NECROTISING: is a variant of phlegmonous gastritis producing gangrene due to necrobiosis infection.
3. VIRAL: Parvo virus B19

ANTIPHOSPHOLIPID SYNDROME: in females, increased anti cardiolipin antibodies.

CLINICAL MANIFESTATIONS:
Upper abdominal pain
Persistent vomiting and obstipation
Abdominal distention
Absent bowel sounds
Symptoms of shock

INVESTIGATIONS:
- Leucocytosis
- X-ray may show acute gastric dilatation.
- OGD scopy - dark coloured fluid stasis with dark thick friable mucosa with multiple ulcerations
- CT abdomen may show thickened gastric mucosa
- Angiogram

TREATMENT:
Laparotomy, resection of gangrenous portion, anastomosis if general condition is stable.
Even with best supportive and appropriate management, post gastrectomy mortality in gastric gangrene is around 80%.

CONCLUSION:
This case is presented for its rarity and to have suspicion of this condition for early diagnosis and intervention, by which mortality rate for this condition can be brought down intra and post operatively.
REFERENCES:


