Image of the Month

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An 18-year-old woman with no unusual medical history presented to the emergency department with a 3-week history of abdominal pain, intractable nausea, and vomiting. She reported progressive anorexia and an inability to tolerate even liquids by mouth, leading to a 6.8-kg weight loss. At presentation to her local hospital, she was lethargic and in mild distress. Her heart rate was 91 beats/ and blood pressure was 113/59 mm Hg with evidence of orthostatic hypotension while sitting or standing. Her abdominal examination demonstrated tenderness to palpation over the right upper quadrant and hypoactive bowel sounds. There was no palpable abdominal mass. Her blood chemistry panel was consistent with severe dehydration secondary to gastric losses, with a hypokalemic hypochloremic metabolic alkalosis (sodium 136 mmol/L, potassium 2.3 mmol/L, chloride 86 mmol/L, bicarbonate 36 mmol/L, serum urea nitrogen 25 mg/dL [to convert to millimoles per liter, multiply by 0.357], creatinine 1.6 mg/dL [to convert to micromoles per liter, multiply by 88.4] and glucose 79 mg/dL [to convert to millimoles per liter, multiply by 0.0555]). Her hemoglobin was slightly elevated compared to her baseline at 15.7 g/dL (to convert to grams per liter, multiply by 10.0); the remainder of her blood count and her amylase, lipase, and liver enzyme levels were within normal limits. A pregnancy test was negative.

An abdominal ultrasound was obtained following fluid resuscitation. This study suggested a 5 × 4-cm cystic mass with a thick, enhancing wall near the gastric outlet. The patient was transferred to a tertiary care center for definitive care. A computed tomographic scan was also obtained, which showed marked gastric distention and a cystic lesion at the gastric outlet (**Figure 1**).

To determine whether the lesion was amenable to laparoscopic resection, an upper endoscopy was performed. This study demonstrated a 5-cm intraluminal cystic lesion in the antrum of the stomach on the anterior wall, completely blocking the opening to the pylorus (**Figure 2**).

What Is the Diagnosis?

A. Pancreatic pseudocyst
B. Gastric duplication cyst
C. Choledochal cyst
D. Gastric carcinoma

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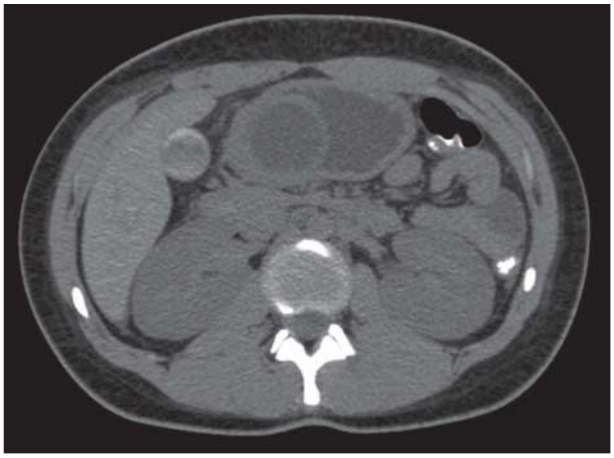

Figure 1. Abdominal computed tomographic scan demonstrating cystic structure in the antrum of the stomach, with dilatation of the gastric lumen.

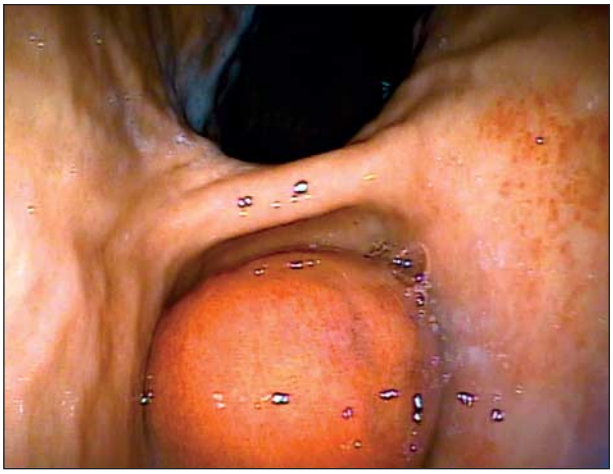

Figure 2. Upper endoscopic image at the gastric antrum directly visualizing the pylorus-blocking intraluminal cyst seen on abdominal computed tomography.