

LETTERS TO THE EDITOR

Syncope as the clinical presentation in a case of acute gastric volvulus

Síncope como debut clínico de un vólvulo gástrico agudo

To the editor:

Syncope is a frequent reason (35%) for consultation in the emergency department. Neuromediated syncope is the most common type (66%), followed by cardiac syncope (10%-20%) and orthostatic hypotension (10%)¹.

A 67-year-old man with a history of dyslipidemia and no other cardiological risk factors. He attended the emergency department for syncope while seated after ingestion, recovered without sequelae. Subsequently, he had epigastric pain with nausea and vomiting, without chest pain, palpitations or dyspnea. There were no symptoms suggestive of neurological focality or infectious symptoms. An electrocardiogram was performed to rule out possible cardiac origin of syncope, which showed sinus rhythm at 75 bpm, narrow QRS with ST elevation in leads V2-3 and

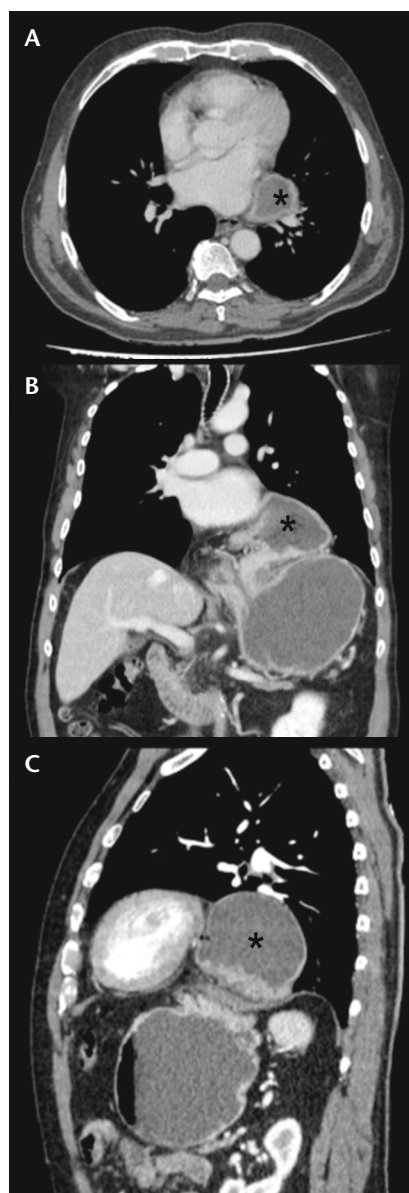


Figure 1. Thoracoabdominal computed tomography: giant paraesophageal hernia including gastric antrum (asterisks), secondary to gastric volvulus with rotation on its short axial mesenteric axis. Given its size, it compresses the left atrium and ventricle. The fundus and gastric body remain in the abdominal cavity. A) Axial view. B) Coronal view. C) Sagittal view.

negative T in the rest of the precordial leads. Following these findings, transthoracic echocardiography showed hypertrophic cardiomyopathy and an extracardiac image of cystic appearance with mobile echogenic content inside (6-8 cm), which compressed the left cardiac cavities. The study was completed by thoracoabdominal computed tomography (CT), which

showed a large paraesophageal hernia, with axial mesenteric gastric volvulus that compressed the left atrium and left ventricle (Figure 1). A decompressive nasogastric tube was placed, endoscopic gastric devolvment was performed in the first 24 hours, and gastric mucosal necrosis or perforation was ruled out. The patient evolved favorably with medical treatment. Subsequently, a Nissen-type laparoscopic fundoplication was performed on a scheduled basis with satisfactory postoperative evolution.

In the initial evaluation of any patient with syncopal symptoms, a detailed clinical history, thorough physical examination and electrocardiogram should be performed to reach a presumptive diagnosis². Gastric volvulus is a rare entity and its initial presentation as a syncopal picture is even more exceptional, and it is a potentially fatal pathology. Acute gastric volvulus is clinically characterized by Borchardt's triad in 70% of cases: retching without vomiting, epigastralgia and impossibility of nasogastric tube placement³. Cases of syncope due to food ingestion have been described in patients with giant hiatal hernias due to different mechanisms⁴. In this case, there is direct compression of the left atrium and ventricle, which conditions the decrease in cardiac output that produces syncope. These syncopes can be erroneously classified as neuromediated due to increased vagal tone in relation to swallowing, which can delay their correct treatment. For all these reasons, having a high diagnostic suspicion of this disease is complicated. In this case, it was the incidental finding of an extracardiac mass on transthoracic echocardiography and confirmation by CT of the giant paraesophageal hernia with gastric volvulus compressing the heart that made it possible to determine the causal origin of the syncope.

Symptomatic treatment consists of gastric decompression with nasogastric tube and early endoscopic devolvment. Gastroscopy showed that there was no vascular compromise of the gastric mucosa, which allowed deferring surgical treatment, which has better results. The definitive curative treatment is surgery (open or laparoscopic) of the hernia by reduction, fundoplication and gastropexy⁵.

Sara Alonso-Batanero¹,
Omar Abdel-lah Fernández^{1,2},

Felipe Carlos Parreño Manchado^{1,2}

¹Servicio de Cirugía General y del Aparato Digestivo, Complejo Asistencial Universitario de Salamanca. Salamanca, España.

²Unidad de Cirugía Esofagológica y de la Obesidad, Complejo Asistencial Universitario de Salamanca. Salamanca, España.

sabbatanero@gmail.com

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