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Bilharzial Ulcer of the Stomach

REPORT OF A CASE

BY

I. R. ROSIN,

O.B.E., M.A., M.D. (Dub.), F.R.C.S. (Ed.)

Senior Hon. Consultant Surgeon to the Salisbury
Central Group of Hospitals;

AND

G. W. TODES, M.B., CH.B. (Rand.)

Medical Practitioner, Salisbury.

Mrs. D.G.G., aged 58 years, was referred to one of us (I.R.R.) on the 6th January, 1966, with a diagnosis of a possible gastric ulcer or carcinoma. She had been suffering from severe indigestion and nausea for some six years and had lost about 15 lb. in weight during the latter part of 1965.

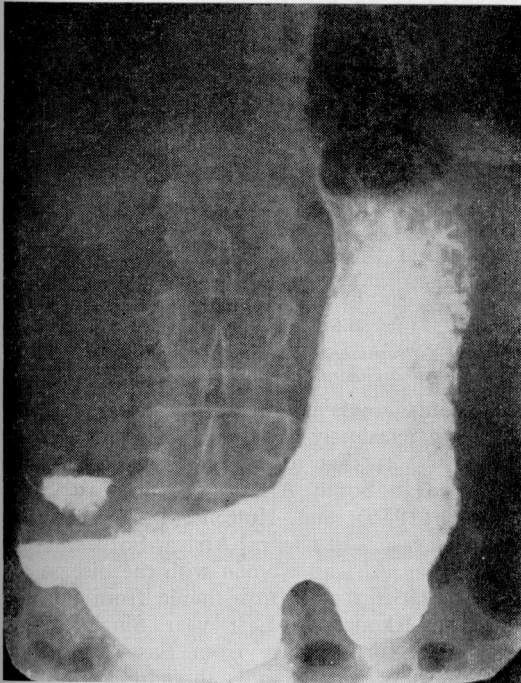


Fig. 1—Observe the marked spasm on the greater curvature of the stomach opposite to where the ulcer was found at operation.

As a result of a barium series the possibility of a neoplasm at the lower end of the greater curvature was raised.

Dr. A. Woolfson's report was:

"*Barium Meal and Follow Through.*—No lesion was demonstrated in the oesophagus. On the lower half of the greater curvature of the stomach a constant incisura was present (Fig. 1). No definite ulcer crater could be seen in this region. There was some generalised coarsening of the mucosal pattern of the stomach. The appearance of the stomach raises the suspicion of neoplasm or ulceration and repeat examination in three weeks' time is suggested. There is coarsening of the mucosal pattern of the duodenal cap, but no ulcer crater could be seen in it. There was no delay in gastric evacuation, and follow through films showed no gross abnormality in the small or large bowel."

The patient gave a history of having been treated during the period 1942-45 by her family doctor at that time for nervous dyspepsia. As she had failed to respond to all types of medical treatment during the period June to December, 1965, by one of us (G.W.T.), she was advised to consider early surgery, and when the condition was explained to her, she readily agreed.

On the 14th January, 1966, laparotomy was performed, during which she received two pints of blood. The anaesthetic was administered by Dr. D. H. Wright. A gastric ulcer about half an inch in diameter with much subacute inflammatory congestion of the surrounding stomach area was easily demonstrable at the lower end of the pylorus towards the greater curvature. A partial gastrectomy of the Billroth 1 type was performed, removing two-thirds of the stomach. No lymph glands were found.

On section, an ulcer composed of chronic inflammatory tissue was seen. There was a circumscribed area with absence of the mucosa, which was replaced by a layer of amorphous debris, beneath which lay a diffuse inflammatory process composed of round cells, large numbers of eosinophils and a few typical bilharzial tubercles, in the centre of which could be seen

the shells of ova (Fig. 2). These tubercles were present in the muscular and submucous layer at the base of the ulcer. The ulcer could be described as bilharzial, since the tubercles were so close related to the affected part of the stomach.

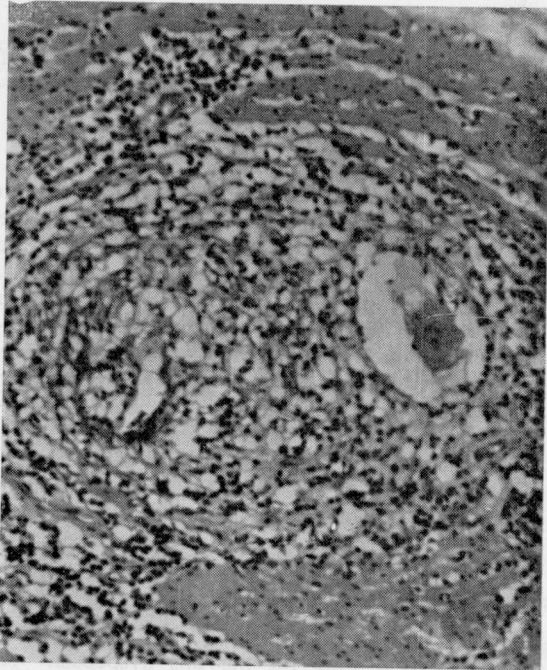


Fig. 2—Typical bilharzial granulation tissue and tubercles in the muscle layer. The base of the ulcer penetrated to this part. The shell outlines of two ova can be seen.

Dr. George Blaine, consulting pathologist, has kindly drawn a diagram giving the position of the ova in relation to the ulcer itself (Fig. 3).

PROGRESS

The patient made an uneventful recovery and convalescence, and when checked by Dr. Todes

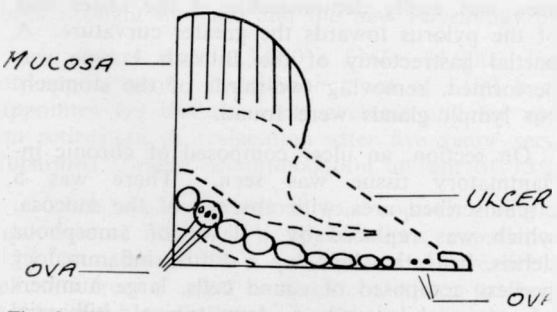


Fig. 3—The ulcer in relation to the ova. (Prepared by Dr. George V. Blaine.)

about five months later she stated that she felt very fit indeed and could eat anything she liked. Since the gastrectomy she has been given a course of intravenous S.A.T. therapy by one of us (G.W.T.) and was last seen by him on 23rd June, 1966, and was found to be in excellent health and completely free from symptoms.

COMMENT

There can be no doubt that the patient had a gastric ulcer, but what is so significant in this case is the close relationship the bilharzial tubercles had to the ulcer itself, being confined to its base. Further, the evidence that the main lesion was bilharzial is not based merely on the presence of bilharzial ova, but on the fact that bilharzial granulatous tissue constituted the base of the ulcer. It may be argued that the patient had a gastric ulcer and that the bilharzial lesions were merely coincidental, but this would seem unlikely since the typical tubercles were so closely related to the ulcer itself.

We are not aware that a bilharzial gastric ulcer has been reported before. For this reason we have considered it worth recording the case notes. We realise that this effect must be extremely rare. Some patients with bilharziasis complain of a dyspepsia, but this is usually attributed to an hepatic effect.