

Abdominal Pain after Eating Caused by Gastropotosis

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Introduction

The pathogenic features of neurodegenerative diseases include mitochondrial dysfunction and the generation of derived reactive oxygen species. The neural tissue is extremely sensitive to oxidative stress, which is a major cause of both chronic and acute neurodegeneration. Based on this, therapeutic strategies that use antioxidant molecules to achieve redox equilibrium have been widely used to treat a variety of brain pathologies. Polyphenols, carotenes, and vitamins are among the most common exogenous antioxidant agents that have been tested as adjunctive therapies in neurodegeneration. Other types of antioxidants, such as hormones like the widely used melatonin, are also considered neuroprotective agents and have been used in various neurodegenerative contexts [1].

Description

Up to a third of elementary school students experience chronic abdominal pain on a weekly basis chronic abdominal pain is most frequently brought on by functional gastrointestinal disorders like irritable bowel syndrome and functional dyspepsia. These complaints may also be caused by other conditions like inflammatory bowel disease or allergic gut disorders. The greater curve of the stomach is dislocated below the level of the iliac crest in gastropotosis, a condition characterized by a downward displacement of the stomach. Imaging studies of the abdomen in an upright position can be used to make the diagnosis. Gastropotosis can lead to gastric pain, abdominal discomfort, early satiety, loss of appetite, and even disorders of the gastric emptying process [2].

Glenard's disease is another name for visceroptosis, the movement of abdominal organs below their normal position. The condition is known as gastropotosis when it affects the stomach. When the stomach is observed to be displaced downward, with its greater curve partially projected below the level of the ilia crest, while the antrum remains in its usual position, gastropotosis is diagnosed. Lenard published the first gastropotosis report in 1833. Only a few cases have been documented in the medical literature since then. According to the data that are currently available, women between the ages of 20 and 50 are more likely to develop gastropotosis, and risk factors such as low weight and abnormal posture have been identified. The mesenteric attachments to the stomach become too thin and slack under the weight of the organ, resulting in excessive laxity in the abdominal wall.

Another factor that contributes to the risk is a decrease in visceral fat in the lesser omentum even though gastropotosis doesn't have any specific symptoms, the most common ones include epigastric pain or discomfort, nausea, emetic episodes, early satiety, and flatulence, all of which are worse when you stand up and do something after eating. There have also been reports of other uncommon complications like enlarged abdominal circumference, ileus, and femoral hernia. Kusano and co. suggests that gastropotosis patients are less likely to experience dyspepsia [3].

However, such results have not been reported for populations in the West. In addition to oral barium or iodine based contrast and upper GI tract fluoroscopy, additional high resolution sequential X-rays taken in the standing position aid in diagnosis when the greater curve of the stomach is partially projected below the level of the ilia crest, gastropotosis is diagnosed. The antrum stays where it always as shown by our case, gastroparesis, a disorder of the emptying of the stomach, frequently occurs alongside the condition diabetes, viral infections, hypothyroidism, muscular astrophysics, and immaturity of the gastrointestinal tract in preterm babies are the most common causes of gastroenteritis in children endoscopic or laboratory findings alone are not sufficient to diagnose gastroenteritis., celiac disease, inflammatory bowel diseases, and various disorders of the pancreas and gallbladder ought to be included in the differential diagnosis. Additionally, bowel obstruction should be taken into account because gastric emptying disorders may accompany gastropotosis. In our instance, the patient did indeed feel full early on. Surgery was the usual treatment during Grenard's time today, only a select few cases of bowel obstruction-related complications receive invasive treatment. Optokinetic medications and a balanced diet are common components of current treatment. Physiotherapy that focuses on strengthening the abdominal and para spinal muscles also plays a significant role. Special abdominal bands are sometimes [4,5].

Conclusion

Despite the fact that our patient's medical history revealed female sex, weight insufficiency, and a postural defect the diagnosis of gastropotosis took longer due to weight loss not being reported in the current medical literature. As a result, it was determined that the aforementioned weight loss was one of the factors contributing to gastropotosis in the case that was discussed. The patient's medical

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history, which included hyperthyroidism (Graves-Basedow disease) and depression, further complicated the diagnosis. During her second hospitalization a few months later, she was also diagnosed with anorexia nervosa. A barium based upper GI tract X-ray confirmed gastro ptosis. When gastroptosis is suspected, the aforementioned diagnostic method should be considered as an imaging option because it is easy to use and interpret. The authors suggest that children with non-specific dyspeptic symptoms should be diagnosed with gastroptosis and secondary gastrointestinal tract motility disorders.

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Conflict of Interest

There are no conflicts of interest by author.

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