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Acute gastric volvulus

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A 88 year old female was admitted to the emergency department with abdominal distention, vomiting, reduced urinary output and prostration for 3 days. Past medical history included type 2 diabetes, arterial hypertension, atrial fibrillation and hypothyroidism.
On observation, she was hypotensive, with diminished breath sounds on the left. The abdominal was distended, with decreased bowel sounds, painless. On chest and abdominal radiography, an intrathoracic stomach and marked colic distention were seen. Despite intensive resuscitation, the patient met criteria for hypovolemic shock. Multiple attempts at nasogastric tube placement failed.
Abdominal CT revealed gastric antrum and pylorus superior to fundus and proximal body, suggestive of mesenteroaxial gastric volvulus and rectal faecaloma with colic distension.
Due to the patient's hemodynamic status and comorbidities, a non surgical approach was taken, with an upper gastrointestinal endoscopy revealing nasogastric tube in the esophagus and a paraesophagic hernia, without ischemia of gastric mucosa. With the progression of the endocope, the volvulus was successfully reduced, with normalization of the clinical status.
Gastric volvulus (GV) is rare, can be primary or secondary and paraesophageal hernia is the major cause of secondary volvulus. Mesenteroaxial volvulus is due to torsion around the transverse axis of the stomach. Acute GV presents with vomiting, abdominal pain and distention and is a surgical emergency to prevent vascular compromise. If surgical risk is high, an endoscopic reduction can be tried but does not treat the underlying pathology that predisposes to torsion of the stomach.