Retrograde jejuno-gastric intussusception following Billroth II gastrectomy with Braun's jejuno-jejunostomy

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Introduction
Retrograde jejuno-gastric intussusception is a potentially fatal complication of a Billroth II gastrectomy [1, 2]. In all, there are just over 200 cases reported [2]. The condition may present with varied clinical presentations like abdominal pain, vomiting, haematemesis, gastric outlet obstruction, intestinal obstruction, and intestinal gangrene [1,3-6]. To the best of our knowledge, there are no reported cases of haematemesis presenting in a patient with retrograde jejuno-gastric intussusception through a Braun's jejuno-jejunostomy. We present a case that highlights an unusual type of retrograde gangrenous intussusception which occurred across two points of previous anastomosis i.e. jejuno-jejunostomy and gastro-jejunostomy simultaneously.

Case report
A 40-year-old male who had undergone a Billroth II gastrectomy and Braun's side-to-side jejuno-jejunal anastomosis for gastric outlet obstruction five years previously, presented to our emergency department with haematemesis for one day. He had five episodes of vomiting altered blood. He gave no history of similar affection in the past. The patient was haemodynamically stable and abdominal examination did not show signs of peritonitis. An 8×8 cm mass was palpable in his left iliac fossa. There was no hepatosplenomegaly. An upper gastrointestinal endoscopy was attempted but visualization was poor due to the presence of altered blood. An emergency CT scan of the abdomen revealed a retrograde intussusception of the jejunum into the stomach across the gastro-jejunostomy (Figure 1). The patient was stabilized and taken up for emergency laparotomy. Intraoperatively, the findings of the CT scan were confirmed. The patient had a gastro-jejunostomy and a diverting Braun's side-to-side jejuno-jejunal anastomosis. The efferent limb of the jejunum distal to the jejuno-jejunal anastomosis was seen telescoping across the jejuno-jejunostomy (Figure 2), into the stomach, through the gastro-jejunostomy. The intussuscepted segment was gangrenous and there was 500ml of altered blood in the stomach. The remainder of the bowel, including the intussuscipating segment, appeared viable. The jejuno-jejunal anastomosis was preserved. Bowel continuity was restored with two jejuno-jejunal anastomoses, one proximal and one distal to the gastro-jejunostomy. A Witzel's type feeding jejunostomy was placed distal to the second anastomotic line in the efferent loop. Postoperative recovery was uneventful. The patient was discharged from hospital after tolerating a normal diet and after removing the feeding jejunostomy. He was asymptomatic at the first and second month follow-up visits.
a gastro-jejunostomy have been managed by emergency laparotomy and appropriate resection. In our case too, the relatively early presentation, clinical suspicion and timely imaging helped in the early diagnosis, management and survival of the patient. We emphasize that a high index of clinical suspicion should be maintained in patients with gastro-enteric anastomosis who present with haematemesis, for the possibility of a retrograde jejuno-gastric intussusception.

References


