



CASE REPORT

Retrograde jejuno gastric intussusception: A case report and review of the literature



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Summary Retrograde jejuno gastric intussusception (JGI) is a rare but potentially fatal complication after previous gastrectomy or gastric bypass surgery. Because of the prevalence of bariatric surgery, the number of cases of postoperative intussusception has increased markedly. Here, we present the case of a patient with retrograde jejuno gastric intussusception, having a previous history of subtotal gastrectomy and gastrojejunostomy for peptic ulcer disease. Correct preoperative diagnosis was made by plain abdominal film, upper gastrointestinal series, computed tomographic scan, and esophagogastroduodenoscopy. The diagnosis was confirmed by laparoscopic examination.

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1. Introduction

Postoperative intussusception is a rare complication in adults, especially in gastric surgery, and the incidence is <0.1%.¹ The most common type is jejuno gastric intussusception (JGI).² Early diagnosis is crucial for early surgical intervention. When the operation is performed within 48 hours, the mortality rate is about 10%. By contrast, operation delayed beyond 48 hours may be associated with a

mortality rate of up to 50%.³ The classic triad of acute JGI includes epigastric pain, vomiting with or without hematemesis, and a palpable epigastric mass. However, it presents in only 50% of patients.⁴ Emergency surgery is the treatment of choice for acute JGI. Traditionally, laparotomy for reduction or resection of the intussusception is the main surgical method.⁵ Here, we present an elderly patient with JGI manifesting as a palpable epigastric mass and associated with poor tube feeding. We performed laparoscopic examination and successful reduction of the intussusception via a minilaparotomy wound.

2. Case Report

An 83-year-old man who had undergone subtotal gastrectomy and Billroth II anastomosis for peptic ulcer disease 30

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years ago and had a ventriculoperitoneal shunt for hydrocephalus 3 years ago presented to the emergency department with conscious disturbance and mouth twitching. His initial Glasgow Coma Scale was E1M4V1, and his vital signs were stable. Because of suspicion of a seizure attack with conscious disturbance, endotracheal intubation was performed, and antiepileptic medication was prescribed. He was admitted to the intensive care unit for further management. During admission, poor tube feeding and drainage of a large amount of bile content via a nasogastric tube were noted. A physical examination revealed a palpable mass without tenderness in the left upper abdominal quadrant. His laboratory data were unremarkable.

A plain abdominal film showed a soft-tissue mass over the lesser curvature of the stomach and prominent stomach gas (Fig. 1). An upper gastrointestinal series with water-soluble contrast revealed a space-occupying lesion in the lower part of the stomach and proximal small bowel obstruction (Fig. 2). Esophagogastroduodenoscopy showed a congested intestinal loop protruding through the previous anastomosis site (Fig. 3). Abdominal computed tomographic (CT) scan showed prolapse of the gastrojejunostomy into the gastric remnant and swelling of the prolapsed jejunum with enhanced mesenteric vessels (Fig. 4).

The patient underwent emergency surgery for retrograde JGI. Laparoscopic examination revealed that the efferent loop of the jejunum intussuscepted into the remnant stomach, without evidence of gangrenous changes of the intussusception (Fig. 5). We attempted to reduce the intussusception via the laparoscopic technique but failed because of the fear of bowel injury. A 5-cm minilaparotomy wound was required for successful manual reduction of the intussusception. The reduced jejunum was fixed to the falciform ligament to prevent potential recurrence (Fig. 6). The patient resumed tube feeding after the operation.

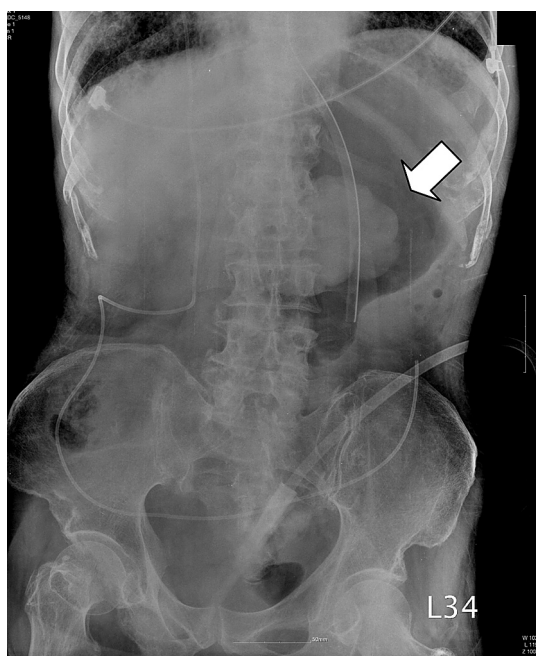


Figure 1 Soft-tissue mass (arrow) over the lesser curvature of the stomach contrasted by the prominent stomach gas.



Figure 2 Upper gastrointestinal series by water-soluble contrast revealed a space-occupying lesion (arrow) in the lower part of the stomach.

3. Discussion

Intussusception is common in children and infants, and only 5% of cases occur in adults.⁶ About 70–90% of intussusception cases in adults have a leading point lesion, and about 50% of the lesions are malignant.⁷ Postoperative intussusception after gastric surgery is a rare complication

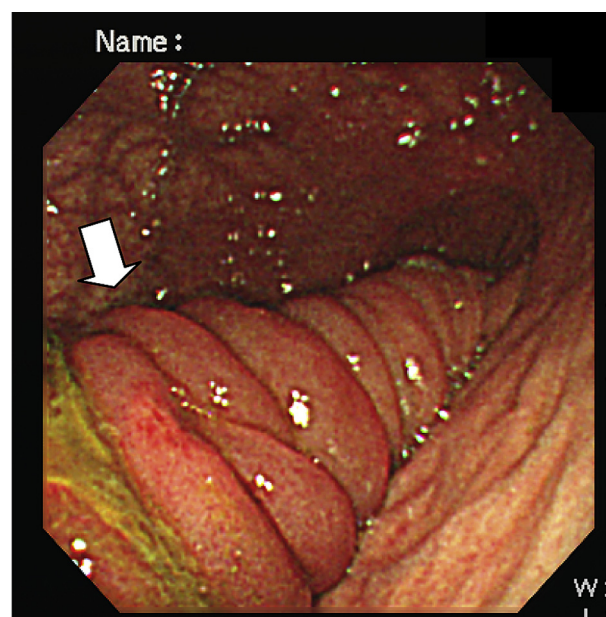


Figure 3 Endoscopy showed a congested intestinal loop (arrow) protruding through the previous anastomosis site into the remnant stomach.

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