Jejunojejunal intussusception after Roux-en-Y gastric bypass: A case report

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ABSTRACT

Roux-en-Y gastric bypass surgery is an appropriate treatment for obesity, including helping to control associated chronic diseases. However, complications may arise after the procedure, such as intussusception, ulcers, and obstruction, with intussusception being the rarest.

Keywords: Bariatric surgery, Complications, Intussusception.

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INTRODUCTION

Roux-en-Y gastric bypass surgery is an appropriate treatment for obesity, including helping to control associated chronic diseases. However, complications may arise after the procedure, such as intussusception, ulcers, and obstruction, with intussusception being the rarest.

CASE REPORT

A 34-year-old female patient, BMI 41 kg/m2, underwent laparoscopic Roux-en-Y gastric bypass 4 years ago at another service. After a normal postoperative period, the BMI was 23 kg/m2. Currently with a BMI of 32 kg/m2, she had been presenting episodes of postprandial epigastric pain, associated with nausea and stuffiness. Computed tomography (CT) showed 2 points of intestinal intussusception, one of which was intermittent. The patient was taken to laparoscopy, where the presence of an internal hernia was observed through the mesenteric breccia (with no signs of suffering or obstruction of intestinal loops). At the site where the CT scan showed intussusception, there was the presence of a large candy cane next to the entero-enteroanastomosis. The intestine at this site was thickened and fibrotic in appearance. The mesenteric breccia was closed with 3.0 prolene suture in continuous suture and the candy cane was resected with a stapler. The patient progressed well and remained asymptomatic after the procedure. Currently, she has returned to multidisciplinary follow-up with our team.

DISCUSSION

Intussusception is one of the possible complications after Roux-en-Y gastric bypass, which can appear between 5 months and 24 years, especially in female patients. However, despite its high morbidity and mortality, it has a low prevalence and is considered rare and very underreported. The patterns of intussusception found are anterograde and retrograde, with a predominance of 3⁄4 retrograde patterns. Generally, intussusception occurs in the jejunojejunal anastomosis, where the common distal limb extends into the proximal jejunal limb. The symptoms present as a consequence of occlusion of the small intestine, and may be intermittent, acute or chronic, depending on the degree of intussusception and are therefore considered nonspecific, and may present abdominal pain, nausea, vomiting, abdominal distension and absence of flatus and feces. CT imaging is the diagnostic modality of choice, which can show the classic "target sign", which will not appear in the picture of internal hernia, characterized by alternating areas of echogenicity and hypoechogenicity. The initial mode of surgical treatment is mainly laparoscopic reduction, with possible conversion to laparotomy; Some alternatives include resection with revision of the anastomosis or reduction and enteropexia. In addition, urgent surgery can decrease the risk of imminent intestinal necrosis and the need for bowel

resection, so it is important that in post-bariatric patients there is suspicion and early surgical intervention.

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