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Retrograde Jejunogastric Intussusceptio: A case Report

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INTRODUCTION

Jejunogastric intussusception (JGI) is a rare, very serious complication of gastrojejunostomy or Billroth – II reconstruction. Since gastrojejunostomy with vagotomy are on a declining trend, it is extremely rare to come across such a complication. Only about 250 cases have been reported in literature to date. The condition is not difficult to diagnose, if an endoscopy is performed by someone familiar with this complication. The condition can be acute and life threatening or chronic and disabling. We report such a case with review of literature.

CASE REPORT:

65 year old female presented to emergency department with pain abdomen and hemetemesis.

Clinical examination revealed that patient was in hypotension with BP of 90/60; she was dehydrated and looked in distress. Systemic examination revealed epigastric tenderness, guarding and a vague fullness. Baseline investigations revealed anemia, leukocytosis, and pre-renal azotemia. Upper Gastrointestinal endoscopy [Fig.1] showed a large loop of edematous, erythematous and bluish red jejunal loop intussuscepting into stomach via anastamosis. An emergency CT scan confirmed the diagnosis [Fig.2]. An emergency laprotomy was performed and patient was managed for Retrograde-Jejunogastric intussusceptions.

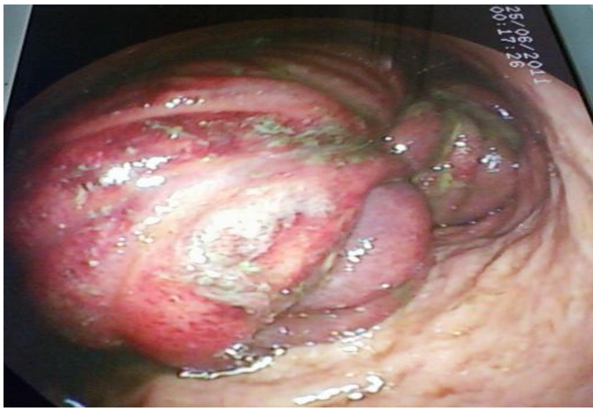

Figure 1. Endoscopic Image showing Inflamed and Edematous Jejunal loops

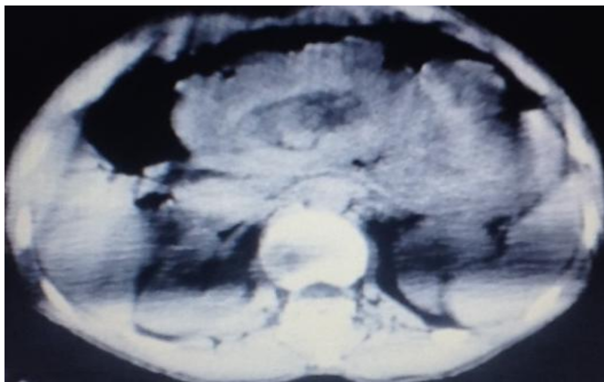

Figure 2. CT scan showing small bowel loops in Stomach

DISCUSSION:

It was Bozzi in 1914 who reported the first case of retrograde jejunogastric intussusception(JGI) following gatrojejunostomy[1]. It is pertinent to mention that first gastroenterostomy was done as early as 1881 by Wolfler. First review appeared in New England Journal of Medicine in 1929[2] and many case reports have been published since then. Approximately 200 cases have been reported in the literature till date[3]. Retrograde JGI is a rare complication following gastrectomy or Billroth II gatro jejunostomy.

There are three anatomical types of JGI. Type I involves intussusception of afferent loop and occurs in 15% of patients. Type II in which efferent loop of jejunum prolapses into stomach is the commonest type of JGI (75%). In 10% both afferent and efferent loops are involved (type III)[3]. There are two clinical types of JGI; acute and chronic. Acute type has two clinical varities[4]. In first variety patient develops sudden onset epigastric pain followed by sensation of severe constriction of abdomen. There are visible peristalsis and an abdominal mass may be palpable. Early surgical intervention is life saving. Second clinical variety resembling bleeding anastamotic ulcer, dumping syndrome or obstruction due to adhesions. Vomitting followed by haemetemesis is main presentation. As these patients are managed conservatively for sometime, delay in surgery causes more morbidity and mortality[5]. Chronic type of retrograde JGI is characterised by recurrent bouts of pain abdomen, nausea and vomitting and sometimes upper abdominal discomfort only. Occasionaly patient has intermittent intractible vomitting. Upper Gastrointestinal endoscopy during the attack is diagnostic[3,6]. What causes Retrograde Jejunogasric Intussusception is not known, however possible factors include: hyperacidity, long afferent loop, jejunal spasm, increased intraabdominal pressure and retrograde peristalsis. The presentation of JGI varies according to the type and clinical variant of JGI, ranging from asymptomatic, incidental finding on upper GI endoscopy to massive gut gangrene[7-11]. Sudden onset epigastic pain, vomitting and subsquent haemetemesis and a papable epigastic mass in a

patient with previous gastric surgery is a classical traid of symptoms of JGI[12]. There is wide variation in lapse time between gastric surgery and JGI ranging from 6 days to 20 years in Gastroenteric anastamosis and 8 days to 19 years in patients with partial gastrectomy[7].

Diagnosis of JGI may be easy in some cases, if the presentation is typical and physician is sensitized about the condition. In acute cases a standing and decupetus x-ray series followed by water soluble upper GI contrast (coiled spring in stomach) may be of help. Upper GI endoscopy is diagnostic and visualizes jejunal loops in stomach.

Conclusion: Retrograde jejunogastric intussusception is a rare complication of gastric surgery. Approximately 200 cases have been reported till now. Clinical suspicion in a case of previous gastric surgery and an early Upper GI endoscopy is important. An early referal to surgery decreases both morbidity and mortality. As gastrojejunostomies were frequently done two decades back in our set up, we still come across such complications and should be sensitized about the condition.

Treatment of JGI is surgical. There is no medical management for this condition

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