

# Hematemesis: A Rare Cause From Gangrenous Retrograde Jejuno gastric Intussusception

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## Abstract

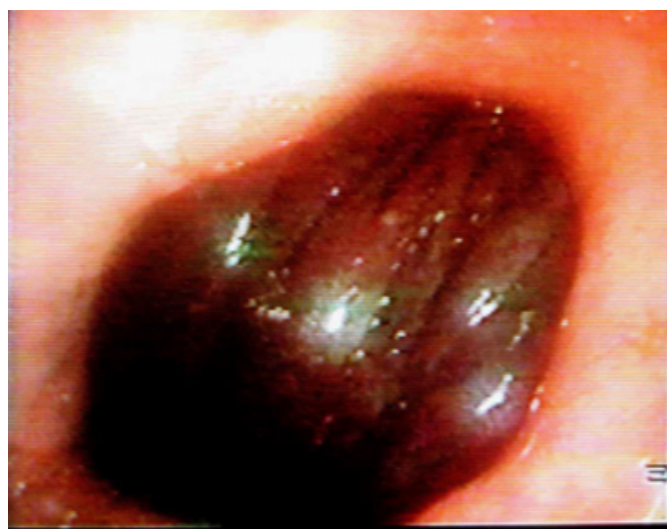
A case of retrograde intussusception (acute type) of efferent limb into the stomach through the stoma of gastrojejunostomy (GJ) is rare and life threatening complication. We report a case of intussusception of efferent of GJ with gangrene that occurred in an adult 12 years after truncal vagotomy and posterior GJ. Emergency laparotomy and resection of gangrenous jejunum after reduction was done. Patient had uneventful recovery.

## CASE REPORT

A 42-year-old man presented to the emergency department with history of multiple episodes of vomiting blood for 2 days. He also gave history of surgery for peptic ulcer disease 12 years earlier. On examination, he was hemodynamically stable. He had upper abdominal midline scar and an ill-defined resonant mass felt in the epigastric region, which was moving with respiration. Ryle's tube showed altered blood. Ultrasonography of the abdomen showed small bowel loops inside the stomach. Gastroscopy revealed gangrenous small bowel in the stomach (Figure 1 and Figure 2).

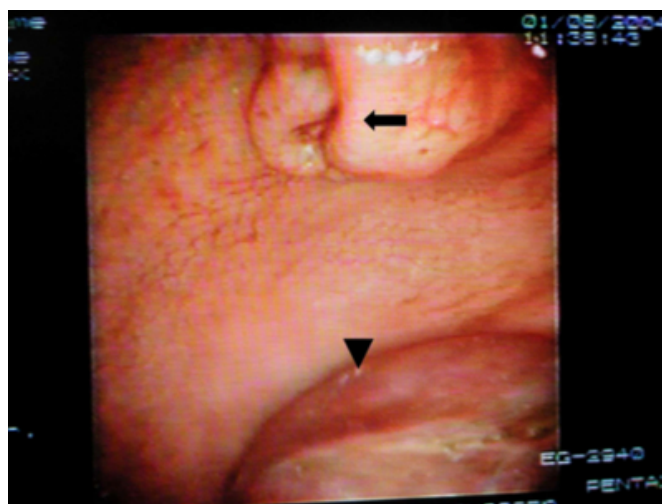
### Figure 1

Figure 1: Endoscopic picture showing gangrenous jejunum with adjacent normal stomach.



### Figure 2

Figure 2: Endoscopic picture showing stenosed pylorus (arrow) and gangrenous jejunum (arrow head).



At laparotomy, there was retrocolic posterior gastrojejunostomy (GJ) and the efferent loop of GJ had intussuscepted into the stomach through the stoma (type II jejuno gastric intussusception). The efferent loop of jejunum was reduced and about 2 feet of jejunum 15 cms from the stoma was found to be gangrenous. The gangrenous jejunum was resected and end-to-end to anastomosis done in two layers. Postoperative period was uneventful.

## DISCUSSION

Retrograde jejuno gastric intussusception (RJGI) is a rare acute abdominal condition (1,2). It usually presents as chronic recurrent epigastric pain and vomiting in patients after various types of gastrointestinal surgery (3). Rarely the small

bowel loops get incarcerated and strangulated inside stomach and present in acute form with severe colicky epigastric pain and GI bleeding – hematemesis and hematochezia. Diagnosis of RJGI is based on clinical suspicion especially in patients who has undergone previous gastric surgery (1). Ultrasonography will show small bowel loops inside the lumen of the stomach. CT scan or water-soluble upper GI study may reveal a coiled-spring appearance and is avoided in acute cases and in sick patients, as urgent surgery will be delayed. Gastoscopy is diagnostic and also therapeutic in the cases without gangrene. Laparotomy is required when endoscopic reduction fails or the vascularity of the bowel is compromised. Manual reduction followed by resection of the gangrenous segment is the treatment when efferent loop is gangrenous (4,5). Various other surgical options when bowel is viable include reduction, resection, revision of the anastomosis and the takedown of the anastomosis, depending on the conditions found during the operation (1). The best way to prevent recurrence, if any, has not been identified yet but anchoring the efferent loop to abdominal wall is done commonly (5).

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