Acutely Incarcerated Jejunojejunostomy in Recurrent Umbilical Hernia in Patient with Remote Roux-en-Y Gastric Bypass

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Background

- Laparoscopic Roux-en-Y Gastric Bypass (LRYGB) is a safe and effective treatment for morbid obesity; however, obese patients often present with ventral hernias and their management has been a subject of debate for sometime [1].
- Early approaches to this have focused on a staged approach, where LRYGB is performed first with subsequent hernia repair following weight loss [2].
- Recently, there has been a push for synchronous repair with studies demonstrating its safety and effectiveness [3-5].
- However, there are also concerns for higher complication rates, including increased small bowel obstructions [5-8].
- With this in mind, the post-LRYGB patient with a history of synchronous hernia repair should be approached with particular attention.

Case Study

This is a 50-year old female with a history of laparoscopic Roux-en-Y gastric bypass (2005) complicated by recurrent jejunojejunostomy intussusception, requiring revision with concurrent repair of a known umbilical incisional hernia (2019). She presented to us with a recurrent umbilical incisional hernia with an acutely incarcerated jejunojejunostomy (JJ).

ED Presentation and Course

- She presented to the ED with four days of projectile emesis, constipation and mild abdominal pain.
- On exam, she was found to have an incarcerated umbilical hernia which was confirmed to be the JJ on CT.
- CT imaging showed an incarcerated JJ with significant Roux-limb and gastric pouch dilation.
- The hernia was successfully reduced at the bedside into a 1-cm supraumbilical defect.
- The patients symptoms immediately subsided.



Figure 1. CTAP: Incarcerated jejunojejunostomy within umbilical defect

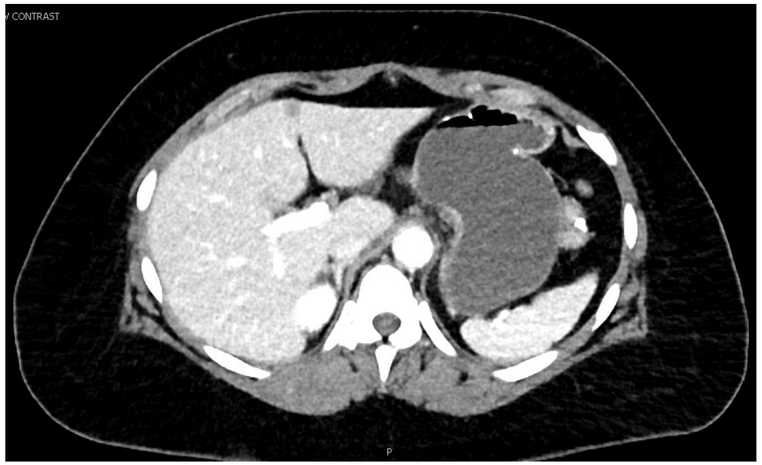


Figure 2. CTAP: Marked gastric pouch dilation

Operative Approach & Findings

After further discussion, the decision was made to take the patient for diagnostic laparoscopy:

- The patient was administered general anesthesia, prepped and draped, and the abdomen was entered at Palmer's point with an Optiview trocar.
- On entry, the patient was found to have a 1-cm supra-umbilical defect with an adhesive band to the JJ anastomosis.
- An additional 5 mm trocar was placed in the lower left quadrant and the adhesive band was lysed, completely freeing the JJ.
- The fascial defect was repaired from an anterior open approach and closed with a figure of eight 0-prolene stitch.

Discussion

We present a case of an acutely incarcerated jejunojejunostomy within a recurrent umbilical incisional hernia, the take-home points include:

1. This is an extremely rare complication of Roux-en-Y Gastric Bypass.
2. This mechanism of obstruction is particularly dangerous given obstruction of both the roux and biliopancreatic limbs, putting the patient at risk of jejunal/duodenal ischemia and gastric remnant blowout.
3. The decision here to proceed with urgent repair despite hernia reduction and complete resolution of symptoms was prudent given the intraoperative finding of a tethering adhesion between the JJ and the hernia sac, likely predisposing to recurrence.

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