P241

Three unique presentations of jejunojejunostomy intussusception after roux-en-y gastric bypass

Thanh-Tin Nguyen[1], Ethan Benning[1], Ramses Saavedra[1], Anna Lise Koenig[1]

[1]School of Medicine, Department of Surgery, University of New Mexico, Albuquerque, New Mexico

THE UNIVERSITY OF NEW MEXICO

INTRODUCTION

Jejunojejunostomy (JJ) anastomosis intussusception is a rare complication following Roux-en-Y gastric bypass (RYGB) surgery with an incidence that ranges between 0.4% to 4.7% in post-RYGB patients [1]. The pathophysiology involves telescoping of the common channel limb into the JJ, often without a clear lead point [2]. The rarity of this clinical entity, range of clinical presentations, and lack of evidence-based guidelines for management leaves room for further analysis [3]. Here, we present a series of three unique cases of JJ intussusception and their respective clinical courses.

METHODS AND PROCEDURES

The electronic health records of three patients who presented to Sandoval Regional Medical Center in Rio Rancho, New Mexico and the University of New Mexico Hospital in Albuquerque, New Mexico between the years of 2020 and 2025 were analyzed. Patient demographics, clinical presentation, and operative management were obtained. Literature review was performed and analyzed to synthesize current recommendations.

CASE 1

A 69-year-old woman with a history of laparoscopic RYGB 17 years earlier and 250-lb weight loss presented with nausea, emesis, hematochezia, and epigastric pain. Five years prior, she had experienced left lower quadrant pain and hematochezia with CT demonstrating transient short-segment intussusception at the JJ anastomosis without obstruction, which resolved on repeat imaging 24 hours later. She was subsequently treated empirically for small intestinal bacterial overgrowth and experienced only intermittent vague abdominal pain over the next four years. On current presentation, CT again demonstrated intussusception at the JJ anastomosis. Diagnostic laparoscopy was offered but the patient chose observation. Repeat CT 24 hours later showed spontaneous resolution. At follow-up, she reported intermittent abdominal pain without recurrent nausea, emesis, or hematochezia and elected continued conservative management.

CASE 2

A 48-year-old woman with a history of RYGB 22 years prior and prior exploratory laparotomy for incarcerated ventral hernia repair presented with severe diffuse abdominal pain. CT demonstrated a long segment of jejunum telescoping into the jejunojejunal (JJ) anastomosis without obstruction. Her symptoms resolved with nasogastric decompression, and she was discharged after 48 hours. Five days later, she returned with recurrent nausea and severe colicky periumbilical pain. CT again demonstrated small bowel intussusception at the JJ anastomosis. At surgery, a significant portion of the common channel was intussuscepted into the JJ with vascular compromise. After reduction, approximately 10 cm of ischemic bowel was identified. The JJ anastomosis and ischemic segment were resected, and a 75-mm enteroenteric anastomosis was created between the distal Roux limb and proximal common channel. The biliopancreatic limb was anastomosed 20 cm proximally to avoid short gut syndrome. Aside from a postoperative surgical site infection, recovery was uneventful.

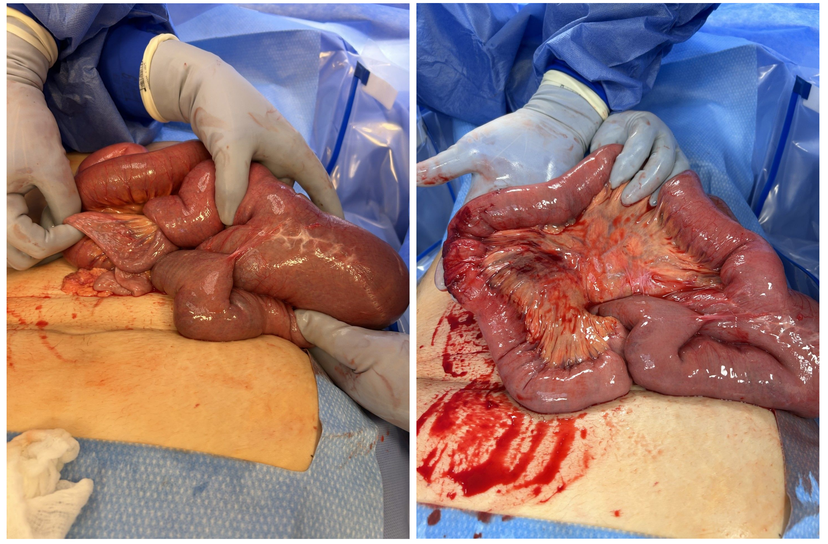

Figure 1. Left image: large segment intussusception of the common channel into the jejunojejunal anastomosis. Right image: demonstrates serosal injury and ecchymosis concerning for bowel ischemia after reduction of the intussusception.

CASE 3

A 35-year-old woman who underwent sleeve gastrectomy conversion to RYGB six years prior presented with worsening abdominal pain, nausea, and emesis. Her postoperative course had been complicated by chronic abdominal pain and oral intolerance requiring total parenteral nutrition for four years, during which serial CT scans demonstrated intermittent self-resolving JJ intussusception. Her symptoms did not improve after 24 hours of nasogastric decompression. CT showed enteritis without other abnormalities. Diagnostic laparoscopy revealed no mechanical obstruction. Given her history of recurrent JJ intussusception, small-bowel enteropexy was performed between the Roux limb and the blind loop of the biliopancreatic limb and between the biliopancreatic limb and common channel over approximately 4 cm. She recovered well and was discharged with improved pain and nausea control.

CONCLUSION

More data is needed to assess what clinical and diagnostic criteria warrant surgical exploration and intervention in JJ intussusception. These cases demonstrate the often nonspecific presentations, the variance in intervention, and the many considerations taken into account during operative management for JJ anastomosis intussusception.

References

1. *Fry, B. T., & Finks, J. F. (2023). Abdominal pain after Roux-en-Y gastric bypass: a review. JAMA surgery, 158(10), 1096-1102.*
2. *Angrisani, L., Santonicola, A., Iovino, P., Formisano, G., Buchwald, H., & Scopinaro, N. (2015). Bariatric surgery worldwide 2013. Obesity surgery, 25(10), 1822-1832.*
3. *Orthopoulos, G., Grant, H. M., Sharma, P., Thompson, E., & Romanelli, J. R. (2020). S054: incidence and management of jejunojejunal intussusception after Roux-en-Y gastric bypass: a large case series. Surgical Endoscopy, 34(5), 2204-2210.*