Case Report

Retrograde jejunogastric intussusception presenting as upper gastrointestinal bleed.

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Introduction

Bozzi described first case of Jejunogastric Intussusceptions (JGI) as complication of Gastrojejunostomy in 1914 and it is less reported[1,2]. It has mortality of 50% if operation is delayed beyond 48 h of severe symptoms. Here we emphasize the rare presentation of intussusception as hematemesis and usefulness of endoscopy in early diagnosis and management.

The first gastro-enterostomy was performed by Wolfer in 1881. Early diagnosis and prompt surgical intervention is mandatory. We describe an elderly patient with JGI, admitted to the hospital for upper gastrointestinal (GI) bleeding. JGI was diagnosed by an emergency upper GI endoscopy.

A 65 year old patient was admitted with complaint of epigastric pain and 3 bouts of hematemesis. There was a past history of gastrojejunostomy, done 30 yrs back for peptic ulcer disease. On examination mild epigastric tenderness was present. Lab investigations revealed mild leukocytosis with prerenal azotemia.

After resuscitation, Emergency Gastroduodenoscopy (Fig 1) was done which showed lobulated congested mass with superficial ulceration entering into gastric lumen from efferent limb of Gastrojejunostomy

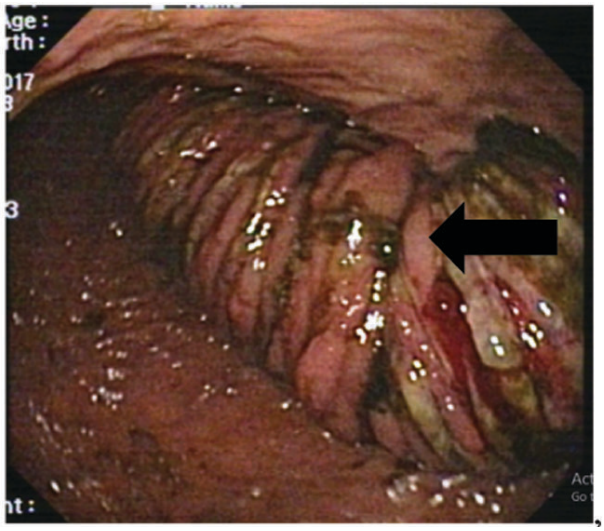

Figure **1**: Endoscopy image showing JejunoGastric intussusception into stomach

Afferent loop was normal. There was dark blood in stomach and duodenum was normal. Plain CT abdomen (Fig 2) was done as contrast was contraindicated due to high creatinine.

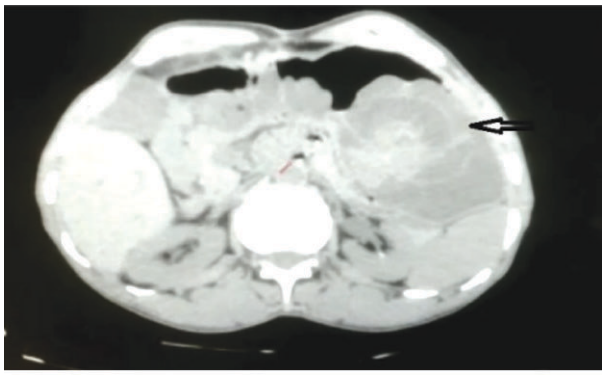

Figure **2**: CT Abdomen image showing Jejuno-Gastric intussusception

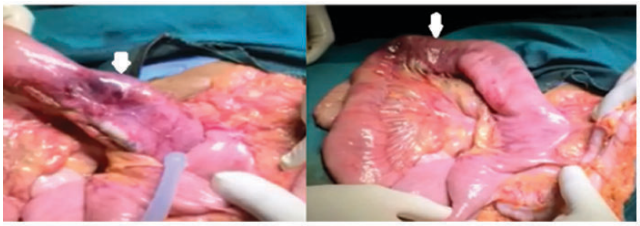

Figure **3, 4 :** Intraop pictures showing retrograde efferent loop intussusception and nonviable jejunum. On exploration (Fig 3& 4) retrograde efferent jejunal loop intussusception was found. It was reduced and 10 cms

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of jejunal loop was gangrenous. Resection and end to end anastomosis with duodenum was done . Post surgery was uneventful and patient recovered from renal failure and was discharged.

Discussion: Jejuno Gastric intussusception can present as acute or chronic form. Acute form presents with epigastric pain, vomiting and hematemesis. On examination there may be tender epigastric mass in about 50% [5,6], as in our case. The picture was absolutely typical in the case described here. Chronic form presents with mild symptoms which may subside spontaneously. [7].

There are three anatomic types of JGI proposed by Shackman : Type I intussusception involves the afferent loop (antegrade), Type II intussusception involves the efferent loop (retrograde) and type III intussusception involves both the efferent and afferent loop [8].Type II or retrograde efferent loop intussusception is the most common and occurs in around 80% of cases [9]. There are cases reported symptomatic post operatively from 2 days to 30 years with an average of 6 years. In our case it presented 30 years after surgery.

The definite treatment of acute variety of JGI is surgery. If the intussuscepted jejunum is reducible and viable, then simple reduction should be performed, and the reduced jejunum should be fixed either to the afferent limb of gastro-jejunal anastomosis or to the transverse mesocolon to prevent recurrence. If the bowel is nonviable, it should be resected. In our case intraop picture shows non viability of bowel and so resection was done and end to end anastamosis done with normal duodenum. Surgery beyond 48 hours of symptoms is associated with an approximately 50% mortality

Conclusion: Retrograde jejunogastric intussusception is a well-recognised, but rare and potentially fatal, long-term complication of gastro-jejunostomy. Endoscopy is diagnostic. In case of acute fulminant presentation, early and prompt surgery can reduce mortality.

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