



RETROGRADE JEJUNOGASTRIC INTUSSUSCEPTION – REPORTING A RARE CASE.

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ABSTRACT

Background- Retro grade jejunogastric intussusception is a rare condition, that follows after any sort of gastrojejunal anastomosis, where the loop of jejunum intussuscepts into the cavity of stomach through the anastomotic stoma. It is so rare that less than 200 cases have been reported till now in literature since it was first reported in 1914.

Patient and Method-A patient was referred to our endoscopy centre for Upper GI endoscopy on 2nd day of hospital admission with a H/O pain abdomen and haematemesis. diagnostic endoscopy spotted the condition rapidly.

Result-A non gangrenous but contused retrograde jejunogastric intussusception (RJGI) was possible to diagnose within a short time of hospital admission by UGI endoscopy. A delayed diagnosis always carries high mortality in these cases.

Conclusion- Patients with H/O previous stomach operation presenting with upper abdominal pain and With or without haematemesis should rise the clinical suspicion of Retrograde jejunogastric intussusception and diagnostic UGI endoscopy should be done as soon as possible .It is most rapid diagnostic method for RJGI and thus saving the patient from delayed intervention and high mortality.

KEY WORDS- retrograde jejunogastric intussusception, clinical suspicion , early



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INTRODUCTION

Any gastrojejunostomy operation, though rarely, is liable to get retrograde jejuno gastric intussusception (RJGI). Though first gastrojejunostomy was done in 1881, first RJGI was reported by Bozi (1914) (1). According to Baumann (2), as quoted by Drummond (1923) (3), intussusceptions are mostly of descending variety, and the ratio between Ascending : Descending is 1:200. Hence is the rarity of retrograde or ascending intussusception. Charterman (1934) (4) cautioned about sensitizing the clinicians about the presence of RJGI and also about hopeless prognosis without early surgical intervention. Till now, only about 200 cases reported in literature. (Vhora P et al) (5) Athanios et al (6) McNamara (1947) (7) first reported RJGI after subtotal gastrectomy. Though haematological and biochemical investigation will say something about the clinical status of the patient it will not suggest about diagnosis. Straight X-Ray abdomen is not of help conclusively. Ba-meal X-ray stomach duodenum and then CT-Scan with contrast go along way to diagnose the condition. After introduction of UGI endoscopy, it has become the most important diagnostic tool.

CASE REPORT

It was a male patient, 50 yrs, was referred to our endoscopy centre for diagnostic upper GI endoscopy with H/O haematemesis. About 15 yr back he was operated for peptic ulcer disease. No definite paper was available. He was recently having pain upper abdomen, vomiting and finally developed haematemesis. He was admitted in a hospital on previous day. After going through initial resuscitation; he was referred for diagnostic UGI endoscopy to our unit. 10% Lidocaine spray was applied on his pharynx. Continuous pulse oxymetry was done. Nasal oxygen was running. Endoscopy was done in left lateral position with an Olympus scope. Incidentally it was an older model. A convoluted hemorrhagic mass with clearly apparent characteristic small intestinal mucosal folds or *valvulae conniventes* was apparent. The mass was detected inside stomach and sitting on the gastrojejunostomy stoma through posterior wall. Stomach cavity contained blood mixed fluid which was sucked out via endoscope. Pt co-operated well and the procedure ended smoothly. The diagnosis was now confirmed and pt was sent back to referring hospital. We performed only the UGI endoscopy and unable to comment about treatment outcome.

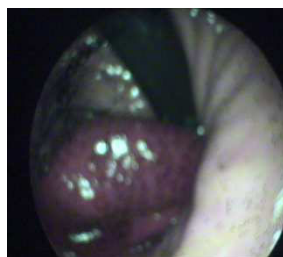


Figure 1
Endoscopic view

DISCUSSION

Jejunogastric intussusception following Gastrojejunal anastomosis was first reported by Bozi(1914)(1). Condition was also reported to occur after Billroth II operation(Lundberg1922)(8) and after Billroth I operation (Shifman1966)(9) There are three anatomical types of retrograde jejunogastric intussusception(Shackman1940)(10). Type I - Afferent loop intussusception (10%), Type II- Efferent loop intussusception(80%), and Type III- combined efferent and afferent loop intussusception (Reylet W. P, 1964)(11). It is difficult to predict pre operatively about the type of intussusception-it is rather classified peroperatively. Time of occurrence of RJGI after gastric operation reported to vary between 6 days and 20 yrs.(Conklin1965)(12). Our patient presented after 15 years of operation Causes that induce retrograde jejunogastric intussusception are various. To mention a few are - long afferent loop, jejunal spasm, abnormal motility, raised intraabdominal pressure(Waits J .O 1980)(13), Irons H S 1965 (14) Clinically there are two forms of RJGI-i) Acute fulminating and ii) Chronic relapsing (Gupta SS 1986)(15). Five characteristic findings are taken to be important in diagnosing acute cases- acute onset of pain, vomiting, haematemesis, sudden appearance of epigastric mass, H/o previous gastric operation and presenting as high intestinal obstruction. A complete full bloom picture is seen only in 1/3 of the cases(Olsen A K 1978)(16). Our pt was an acute case without any palpable lump. In chronic form, presentation is varied and be diagnosed even as neurosis or recurrent

ulcer.(Gupta SS 1986)(15). It can also present as a subdued form of acute variety and resolving spontaneously (Olsen AK 1978)(16).

Clinical suspicion is the stepping platform for guiding the diagnostic algorithm. UGI endoscopy with a bit of expertise is the cheapest and quickest form of diagnostic tool(Hassan m 2009)(17). Ba-meal X-ray shows striated filling defect inside stomach caused by pooling of contrast media in the folds of jejunum(Vhora P)(5). In computed tomography with contrast ,the classical "Target Sign" with mesenteric vessels pulled up inside stomach is seen(Vhora P)(5) Another importance of UGI endoscopy is its ability to bring about a Jejunogastric intussusception by flushing water jet onto Gastro-jejunostomy stoma. This may guide towards diagnosing unexplained pain after peptic ulcer operation(Czeriak A et al1987)(18) Surgery is the only effective treatment. But we have not done the treatment as the patient belonged to some other hospital.

CONCLUSION

In a patient with a history of Gastro jejunal anastomosis, having sudden pain and features of high intestinal obstruction or having a dumping like symptom, should be assessed by UGI endoscopy to exclude RJGI at the earliest. Alertness of the clinician can avert high mortality in a undiagnosed case of retrograde jejunogastric intussusception.

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