



AN OLD GASTROJEJUNAL ANASTOMOTIC SITE PERFORATION PRESENTING AS ACUTE ABDOMEN: A CASE REPORT

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ABSTRACT Complications most frequently encountered with GastroJejunal anastomosis after a bypass procedure are Marginal ulcer, GI bleeding and strictures. Marginal ulceration (MU) at the anastomotic site after gastric bypass is a well-recognized complication. Its incidence varies between 1% and 16%. Direct exposure of gastric acid is the important cause of ulcer formation which may get further complicated by the use of NSAID's, alcohol intake and smoking. But perforation secondary to ulceration at anastomotic site is very rare and seldom reported. We report a case of 37 year old male patient who developed perforation at the gastrojejunal anastomotic site of old gastrojejunostomy for peptic ulcer disease.

KEYWORDS :

INTRODUCTION

A gastrojejunal anastomosis refers to a surgical connection between stomach and jejunum typically created to restore or establish gastrointestinal discontinuity. This procedure is generally performed in the context of certain gastrointestinal surgeries such as gastric bypass procedures for weight loss or as a part of the treatment for specific conditions like refractory peptic ulcers. The indication for surgical intervention in patients with peptic ulcer are obstruction, bleeding, perforation and intractability. Pyloroplasty and gastrojejunostomy were the most frequently performed procedures for obstruction. Anastomotic stenosis and marginal ulcer are by far the most common complications with incidence rates of 1-9% and 1-16% respectively.

Case Report

A 37-year-old male patient presented to the casualty with complaints of pain abdomen for 1 day associated with several episodes of bilious vomiting, fever and obstipation for 1 day. Patient had a past history of Truncal vagotomy and Gastrojejunostomy done 3 years back for peptic ulcer disease. He is a chronic smoker and alcoholic since 20 years. On clinical examination abdomen was firm with diffuse tenderness and absent bowel sounds suggesting diffuse peritonitis. On per rectal examination, hard impacted stools were present. X-ray erect abdomen showed air under the diaphragm and CT abdomen confirmed free intraperitoneal air-suggestive of hollow viscus perforation and fluid collection present.

Emergency laparotomy was done and transverse colon was found to be adherent to stomach with thick omental fat stranding. Adhesions released, and small bowel traced from DJ flexure to caecum. No abnormality detected.



Fig 1. Perforation Noted At Old GJA

On careful examination of stomach, an anterior gastrojejunostomy (GJ) was found and a perforation was found at the stoma site.

A perforation of approximately 1.5×1.5 cm was found, biopsy was taken from edges of perforation site, primary closure of the perforation was done in two layers. Later the site is closed with rose graham's

omental patch. Following closure stomach was filled with 1 litre of normal saline and no leak was found. Two abdominal drains placed one in the peritoneal cavity and one in the pelvis. Abdomen is closed in layers. Post-operative period was uneventful. Patient started taking orals on 3rd post-operative day.

Histopathology report was suggestive of Chronic Gastric ulcer and negative for malignancy. Patient was started on anti-Pylori treatment and discharged. Patient was followed up every month with strict advice of cessation of smoking and alcohol. Endoscopy was done in the third month post operatively which showed no abnormality with patent GJ stoma without ulceration.

DISCUSSION

The surgical treatment of peptic ulcer disease is generally considered when conservative measures fail or in cases of complications such as perforation, bleeding or obstruction. Initially in 1920's vagotomy was done for PUD. In 1940's and 1950's the most common operation performed for peptic ulcer disease were truncal vagotomy with pyloroplasty and antrectomies. In the 1960s, recognition of complications such as post vagotomy diarrhoea led to development of proximal gastric vagotomy and the need for gastric emptying procedure. In India, Gastrojejunostomy is still the most commonly performed drainage procedure following vagotomy. Anastomotic stenosis and marginal ulcer are the most common complications after gastrojejunostomy with incidence rates of 1-9% and 1-16% respectively. The presence of Helicobacter Pylori may additionally play a role in the development of ulceration and subsequently leading to perforation.

The Majority of these Ulcers can be Treated Medically.

However, a subset of patients will have intractable disease requiring surgery for definitive management as last resort. Patients with marginal ulcer are primarily treated with H2 blockers or proton pump inhibitors with strict advice of cessation of smoking. A minority of these patients will present with acute abdomen and free perforation of ulcer must be ruled out. Perforation of GJA ulcers is uncommon and is associated with high morbidity, the incidence ranges from 0.25 to 1%. The management of old gastrojejunal anastomosis perforation necessitates a multidisciplinary approach. It should be based on the context of prior surgical procedure. It includes thorough clinical assessment, time between prior GJA as it influence the choice of intervention, diagnostic imaging, stabilization and resuscitation of the patient, antibiotic therapy and surgical options for treatment of the condition, post operative care and follow up imaging.

CONCLUSION

Perforation of previous gastrojejunostomy site is a very rare condition. A careful examination must be made intra operatively with release of adhesions to arrive at a diagnosis and locate the Anterior perforation. When perforation is due to chronic ulceration freshening the edges of perforation and taking tissue for histopathological examination with primary omental patch closure is ideal method of choice in an emergency sitting.

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