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Case Report

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A Complication in Gastric Bypass: Gastro-Jejunal Twist

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Case Study

The gastric bypass operation is an effective procedure to achieve weight loss in overweight patients. But long-term chronic complications after Roux-en-Y gastric bypass (Figure 1) are possible, such as König's syndrome (i. e. abdominal pain related to meals with diarrhea, constipation, meteorism, and abdominal distension) or candy cane syndrome (i. e. chronic abdominal pain, vomiting, dysphagia, and nausea). Best long-term follow-up diagnostic exams are barium swallow, oesophago-gastro-duodenoscopy, and, in our case, explorative laparoscopy after computed tomography (CT) with oral contrast showing the presence of a blind and twisted afferent Roux limb at the gastrojejunostomy, i. e. candy cane syndrome (**Figure 2**). There are little data about the efficacy of surgical revision (1, 2) that seems to be the best treatment with symptomatic relief. In our case study, a 40-year-old female patient with an initial body mass index (BMI) of 36.5 kg/m^2 was submitted for a Roux-en-Y gastric bypass. At the 3-year follow-up, BMI was 22.4 kg/m^2 with a significant weight loss. In the last 2 months, there was a further weight loss of 6 kg with the presence of chronic abdominal pain, dyspepsia, dysphagia, abdominal distension, and vasomotor problems (hot flushing, sweating, palpitations, and diarrhea). So, consequently to CT, the patient was submitted for:

- diagnostic laparoscopy showing the integrity of distal anastomosis (Figure 3), the presence of a 180 degrees twisted candy cane (Figure 4) and multiple adherences between gastric reservoir (Figure 5), liver (Figure 6) and proximal anastomosis;
- identification and resection (Figure 7) of proximal anastomosis with isolation of gastric reservoir (Figure 8);
- untwisting, right repositioning, lifting and re-anastomosis of proximal bypass with gastric reservoir (Figure 9).

The postoperative stages were uneventful and the patient was discharged on the third postoperative day. Finally, our lifting surgical approach led us to conclude that this complication could be avoided by not making such a long loop in gastric bypass surgery.

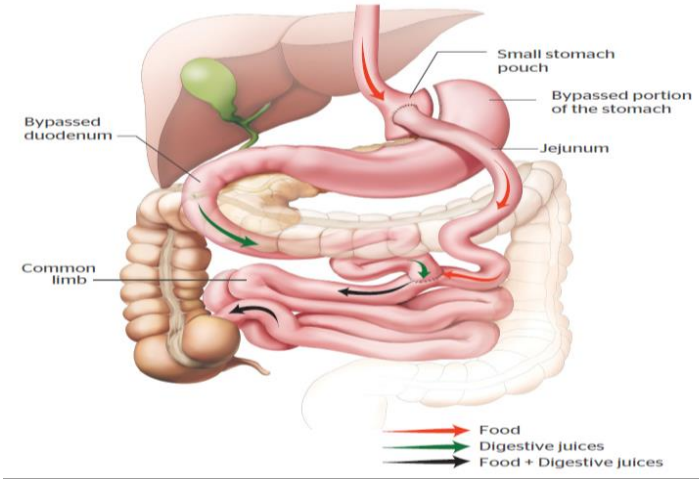

Figure 1. Bariatric surgery anatomy (3).

Figure 2. CT showing proximal gastro-jejunal lumen occlusion (indicated by the arrow).

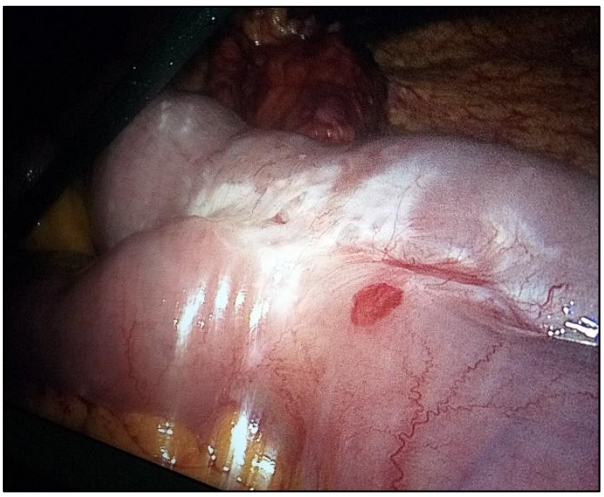

Figure 3. The integrity of the distal jejuno-jejunal anastomosis.

Figure 4. The 180 degrees twisted gastric-jejunal anastomosis.

Figure 5. Gastric reservoir fibrotic adherences with the proximal anastomosis.

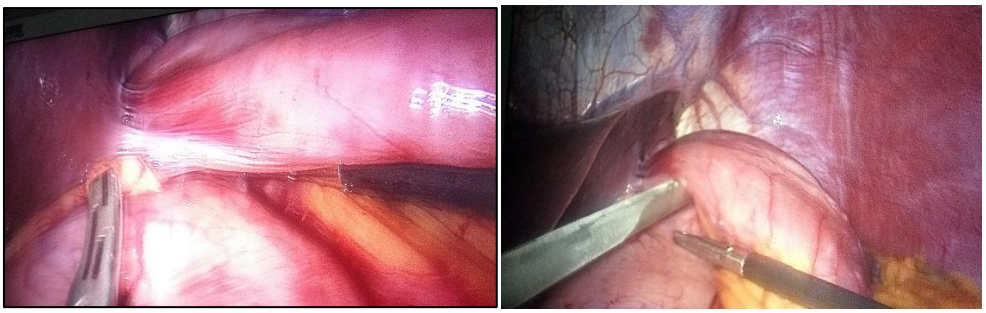

Figure 6. Hepatic fibrotic adherences with the proximal anastomosis.

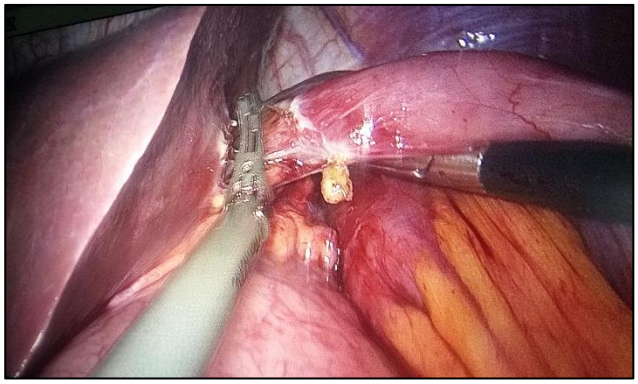

Figure 7. Resection of proximal anastomosis and hepatic fibrotic adherences.

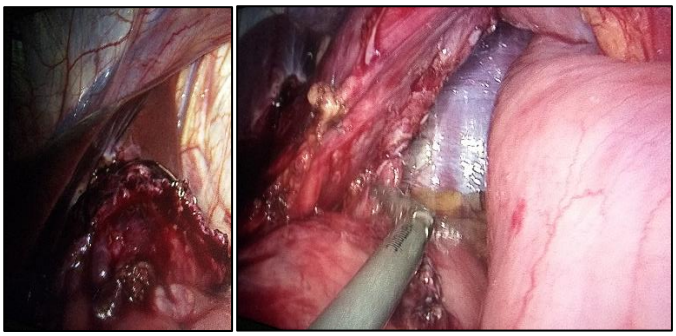

Figure 8. Gastric reservoir after resection of proximal anastomosis.

Figure 9. Right repositioning and re-anastomosis of proximal bypass with gastric reservoir.

References

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