

A Complication in Gastric Bypass: Gastro-Jejunal Twisting

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Abstract

The gastric bypass operation is an effective procedure to achieve weight loss in overweight patients

Keywords: gastric bypas; gastro-jejunal twisting; surgical approach

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).

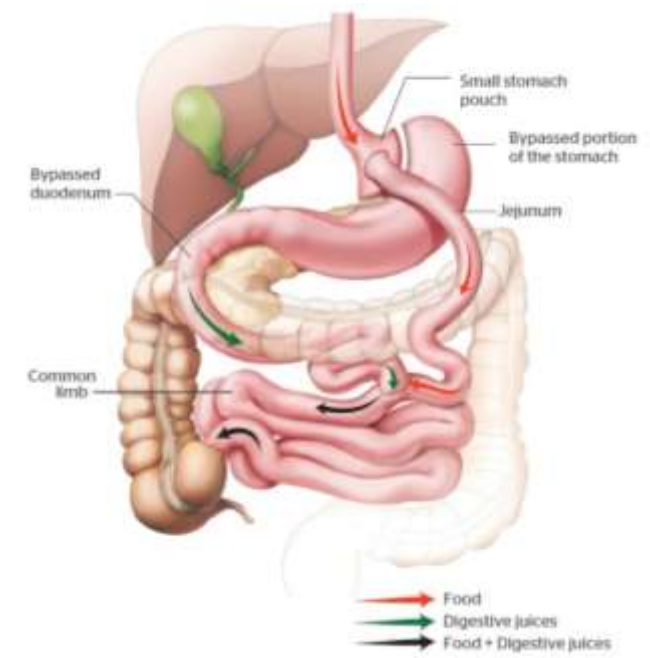


Figure 1: Bariatric surgery anatomy (3).

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 gastrojejunosomy, i. e. candy cane syndrome (**Figure 2**).



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

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/m² was submitted for a Roux-en-Y gastric bypass. At the 3-year follow-up, BMI was 22.4 kg/m² 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**),



Figure 3: The integrity of the distal duodeno-jejunal anastomosis.

the presence of a twisted candy cane (**Figure 4**)

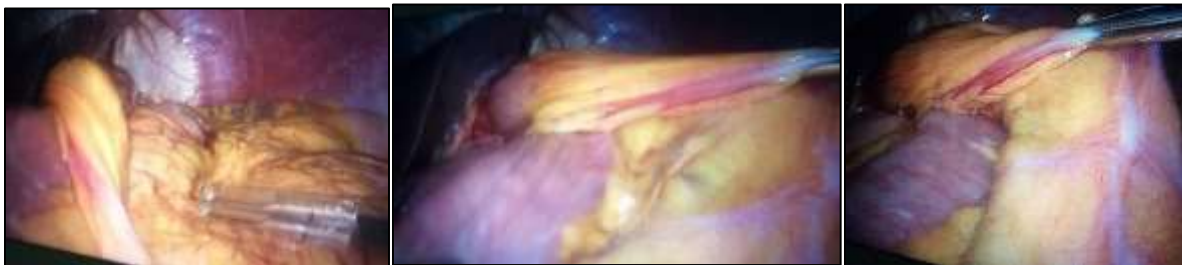


Figure 4: The twisted gastric-jejunal anastomosis.

and multiple adhesences between gastric reservoir (**Figure 5**),



Figure 5: *Gastric reservoir fibrotic adhesences with the proximal anastomosis.*

liver (**Figure 6**) and proximal anastomosis; identification and resection (**Figure 7**)

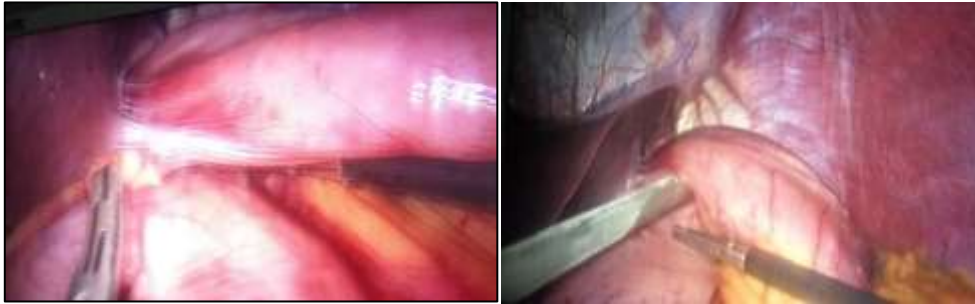


Figure 6: *Hepatic fibrotic adhesences with the proximal anastomosis.*



Figure 7: *Resection of proximal anastomosis and hepatic fibrotic adhesences.*

of proximal anastomosis with isolation of gastric reservoir (**Figure 8**)



Figure 8: *Gastric reservoir after resection of proximal anastomosis.*

untwisting, right repositioning, lifting and re-anastomosis of proximal bypass with gastric reservoir (**Figure 9**).



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

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.

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