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Qpost Roux-En-Y Gastric Bypass Chronic Abdominal Pain with Multiple Intra-Operative Causes: Video Case- Report

Alwahhaj Khoǵeer[2], Marco Adamo[3] and Mohammed Elkalaawy[3]

[2]*King abdullah Medical City, Makkah, Saudi Arabia*
[3]*University college london hospital, London, UK*

Abstract

Post-Roux-en-Y (RY) gastric bypass abdominal pain can be due to a diversity of reasons. This complication is under-reported and sometimes hard to diagnose. We present a video case with possible causes and their management.

Keywords: Roux-en-Y gastric bypass; Chronic abdominal pain; Internal hernia; Cabdy cane syndrome

Introduction

Roux-en-Y gastric bypass (RYGB) is the gold standard in bariatric surgery [1]. Post- operative weight loss, co-morbidity resolution and quality of life (QoL) factors following RYGB have been thoroughly reported [2]. However, postoperative chronic abdominal pain is under-researched in the literature [3]. A large study of 1429 patients showed thatabdominal pain is the most common symptom (34%) for patients who contact their treating bariatric teams for assistance [2,4]. Possible causes are cholelithiasis, anastomotic ulcers, internal hernia and candy cane syndrome [5–8].

We present a video case of post-RYGB chronic abdominal pain where we found someof these causes intra-operatively. Furthermore, we conducted surgical management toensure the complete resolution of symptoms afterwards.

Case Report

A 49-year-old woman who had a RYGB in 2011 with a biliopancreatic limb of 60 cm andan alimentary limb of 120 cm. Her initial body mass index (BMI) on the day of surgery was 43.2 kg/m^2, and her BMI upon examination in this study was 32 kg/m^2. She has had regular follow-ups after surgery. Two years ago, her left-upper-quadrant and central abdominal pain became intolerable. The pain was colicky in nature, was associated withbloating and was aggravated by eating. She denied any symptoms of reflux or diarrhoeabut had always complained of some dyspepsia.

She underwent esophagogastroduodenoscopy, which showed a small pouch about 6 cm in length, a wide gastrojejunostomy with no ulceration and a 5 cm hockey stick. A gastrografin study and computed tomography (CT) scan of the abdomen with oral andIV contrast revealed no clear abnormalities.

A diagnostic laparoscopy was performed, and the finding was a 6 cm candy cane at the gastrojejunostomy which was amputate using linear stapler. A 5 cm blind end found at the jejunojejunostomy resected using linear stapler. A wide-open Petersen's and a smallmesenteric defect found during the jejunojejunostomy were present with no internal herniation. Both defects were closed using 0-0 non-absorbable sutures. In addition, the omental adhesion band in the lower abdomen was taken down, and there was about a 2cm defect in the anterior abdominal that was closed with a 0-0 non-absorbable sutureintracorporeally and using the transfascial closing device.

Recovery was uneventful, and she was discharged on postoperative day 1. She wasfollowed up with at the clinic 4 months later, and her abdominal pains had resolved.

Conclusion

Post-RYGB non-specific chronic abdominal pain might be difficult to diagnose [9]. The deferential diagnoses include candy cane syndrome, open mesenteric defects with intermittent internal hernia and blind syndrome [5,7,8]. We believe the surgical techniqueduring primary surgery plays a role in the prevention of such causes. Diagnostic laparoscopy should be considered, especially if investigations show no abnormalities.

Approvals

IRB approval was obtained.

Consent from the patient was obtained.

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Conflicts of interest

There are no conflicts of interest.

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