**Near fatal intussusception and perforation of stomach in first-trimester pregnancy: eight year after laparoscopic Roux-en-Y gastric bypass**Rajarshi Bhadra1, Kamran Adibi 1, Keyvan Ravakhah1, Mukul Pandit1, Michael Nowak2  
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Introduction

The increasing demand and popularity of bariatric surgery is not only to curb the ever-increasing obesity epidemic but also to curb obesity-related illnesses like diabetes and hypertension, often resulting in near complete remission.

One rare and late complication after laparoscopic Roux-n-Y bypass surgery is intussusception. The most common site is jejunojejunal anastomosis. It happens when the alimentary limb telescopes into the jejunal anastomosis creating obstruction of both the alimentary and biliopancreatic limbs.

Clinical case:

40-year-old Caucasian female with past medical history significant for bariatric surgery 2009 ( laparoscopic gastric bypass with Roux-en-Y anastomosis), Rh incompatibility and pregnant 10 weeks came to the hospital complaining of severe tearing epigastric and peri-umbilical abdominal pain and vomiting frank blood. Ultrasound abdomen done in the local hospital showed 9.6 cm lobulated mostly solid mass versus an abnormal segment of bowel located in the left lower quadrant. MRI done in the same hospital visit showed intussusception of small bowel involving the jejunum with obstruction and dilated small bowel loops up to 5 cm diameter along the duodenal sweep and proximal jejunum. On physical examination, there was marked abdominal distension, with guarding and rebound tenderness and hypoactive bowel sounds. Lab results were remarkable for neutrophilic leukocytosis and a Hb 12.7gm%. Intravenous fluids were administered, two units of PRBC were kept on hold. The pain was severe and uncontrolled even by maximum permissible doses of dilaudid. Immediate exploratory laparotomy was performed. Immediately upon entering the abdomen, there was a gush of bilious fluid. Around 2 liters of bilious fluid was suctioned. There was jejuno-jejunal intussusception with extensive ischemic necrosis of the small bowel and the jejunostomy site. The proximal biliopancreatic limb was markedly distended but viable. The jejuno-jejunal intussusception was resected. The Roux limb along with the gastric pouch was viable and intact. Proximal fundus of the stomach showed ischemic perforation and necrosis and was partially resected. Re-anastomosis was done to maintain GI continuity. Post surgery, the patient got transferred to the surgical intensive care unit on mechanical ventilation, started on meropenem. Later she became stable and was extubated. Subsequently, she was transferred to a center with high risk neonatal unit for overall including her pregnancy. She made a complete recovery with an intact, viable fetus.

DISCUSSION

Most cases of intussusception in medical literature occur between one and three years post surgery. There is single case report of intussusception after seven years post surgery. With growing demand of bariatric surgery, occurrences of intussusception might see an increase. Diagnosis necessitates a high index of clinical suspicion and appropriate imaging studies. CT scanning or MRI is the imaging procedure of choice.  There should be a very low threshold for surgical exploration even if the diagnosis is equivocal. A delay in diagnosis might be fatal.