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SURGICAL IMAGES

Internal hernia after omega loop gastric bypass: Beware of ischemic stenosis of small intestine!



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KEYWORDS

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At the outset of the 20th century, Petersen was the first to report the occurrence of an internal hernia (IH) following gastrectomy for ulcer with gastro-jejunal anastomosis on omega loops. A hundred years later, a variant of that intervention, the Mini Gastric Bypass (MGB), technique came into being as a means of treating severe obesity. While several cases of internal hernia subsequent to MGB have been described [1,2], the exact incidence and the consequences of the complication remain unknown. IH morbidity is directly associated with the existence of digestive distress complicating occlusion. Emergency surgical exploration is required in order to establish the diagnosis and to treat the complication and its consequences (Fig. 1). Treatment will be based on reduction of the strangled digestive segment and, in some cases, its resection in presence of massive necrosis and the closing of Petersen's mesenteric-mesocolic breach. However, even when macroscopic signs of suffering do not appear or when the vitality of the incarcerated digestive segment has been restored following IH reduction, ischemic stenosis can be formed secondarily and entail, during the weeks subsequent to the operation, mechanical occlusion of the small intestine (Fig. 2). As in Roux-en-Y gastric bypass surgery, systematic closing of the above-mentioned space should in the future reduce incidence of the complication and its consequences [3].

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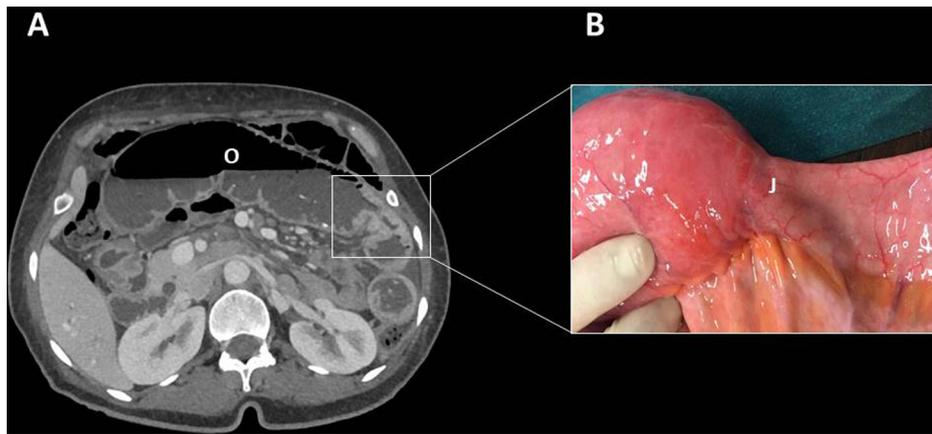


Figure 1. Abdominal tomodensitometry injected in axial section (A) and operative view (B) showing mechanical occlusion (O) of the small intestine with a junction zone (J) presenting a flat and distended intestine corresponding to the zone in the distal jejunum previously incarcerated in Petersen's space and reduced during the operation 5 weeks earlier.

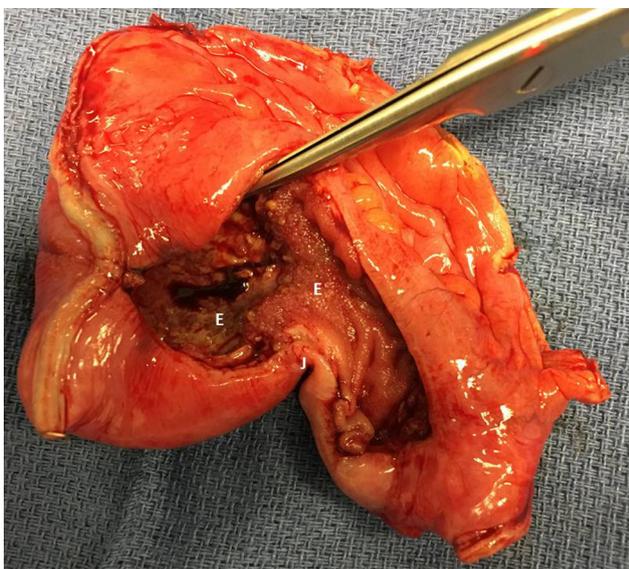


Figure 2. Intraluminal operative view of the surgical specimen (anastomotic resection of the small intestine) displaying at the level of the junction zone (J) a focal ulceronecrotic enteritis (E) of ischemic origin without tumor process or gigantocellular epithelioid granuloma.

Disclosure of interest

The authors declare that they have no competing interest.

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