Hemorrhagic gastritis at the excluded stomach after Roux-en-Y gastric bypass

Anemia frequently occurs in patients after Roux-en-Y gastric bypass. The causes are usually related to surgery, anastomotic site lesions, or malabsorption of nutrients caused by altered anatomy and physiology [1]. A 57-year-old man underwent an uncomplicated laparoscopic Roux-en-Y gastric bypass for morbid obesity and experienced melena and anemia 10 years after surgery. His medical history included hypertension and insulin-dependent diabetes mellitus that disappeared after surgery. Laboratory findings revealed a hemoglobin level of 5.9 g/dL and iron deficiency (iron, 47 µg/dL; ferritin 11 ng/mL; iron saturation, 8.6%). His medications included vitamin B12 and omeprazole (20 mg/day). Endoscopy, colonoscopy, and abdominal computed tomography showed no abnormalities apart from anatomical changes related to surgery. Double-balloon enteroscopy showed the pylorus and hemorrhagic erosive pangastritis at the excluded stomach (● Fig. 1 and ● Fig. 2, ● Video 1). Biopsy specimens were negative for *Helicobacter pylori* and demonstrated chronic active gastritis, regenerative activity, and foveolar hyperplasia. The omeprazole dosage was increased to 40 mg/day. The patient progressed without melena, and with a continuing increase in the hemoglobin level. After 3 months of treatment, double-balloon enteroscopy revealed atrophic pangastritis, but no bleeding focus. Laboratory tests exhibited a normal iron profile with a hemoglobin level of 15.5 g/dL, iron 155 µg/dL, ferritin 44.7 ng/mL, and iron saturation, 29.5%.

Video 1

Double-balloon enteroscopy showing hemorrhagic erosive pangastritis at the excluded stomach.

This case shows the importance of double-balloon enteroscopy for examining the excluded stomach in patients with Roux-en-Y gastric bypass. In addition, double-balloon enteroscopy has proven useful for the evaluation and therapy of obscure gastrointestinal bleeding in patients with a surgically altered upper gastrointestinal anatomy [2].

Endoscopy_UCTN_Code_CCL_1AB_2AD_3AC

Competing interests: None

**Adriana Vaz Safatle-Ribeiro¹,
Emanuele Lima Villela¹, Eduardo
Guimarães Hourneaux de Moura¹,
Paulo Sakai¹, Klaus Mönkemüller²**

¹ Endoscopy Unit of the Hospital das Clínicas, Department of Gastroenterology, University of São Paulo School of Medicine, São Paulo, Brazil

² Hirschowitz Endoscopic Center of Excellence, Division of Gastroenterology and Hepatology, University of Alabama at Birmingham, Birmingham, USA

References

- 1 Obinwanne KM, Fredrickson KA, Mathiason MA et al. Incidence, treatment, and outcomes of iron deficiency after laparoscopic Roux-en-Y gastric bypass: a 10-year analysis. *J Am Coll Surg* 2014; 218: 246–252
- 2 Safatle-Ribeiro AV, Kuga R, Iriya K et al. What to expect in the excluded stomach mucosa after vertical banded Roux-en-Y gastric bypass for morbid obesity. *J Gastrointest Surg* 2007; 11: 133–137

Bibliography

DOI <http://dx.doi.org/10.1055/s-0034-1390778>
Endoscopy 2014; 46: E630
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Fig. 1 Endoscopic view of the pylorus from the duodenum in a 57-year-old man who had undergone an uncomplicated laparoscopic Roux-en-Y gastric bypass for morbid obesity 10 years earlier and who was experiencing melena and anemia.

Fig. 2 Endoscopic image of hemorrhagic erosive gastritis at the excluded stomach 10 years after Roux-en-Y gastric bypass for morbid obesity.

Corresponding author

Adriana Vaz Safatle-Ribeiro, MD, PhD
University of São Paulo School of Medicine
Department of Gastroenterology
Endoscopy Unit of the Hospital das Clínicas
Av. Dr. Enéas de Carvalho Aguiar,
255 – Cerqueira César
São Paulo – SP
Brazil
Fax: +55-11-32849885
adrisafatleribeiro@terra.com.br