A rare complication and proper management in cholangioenteric Roux-en-Y anastomosis

Cholangioenteric Roux-en-Y anastomosis is a classic surgical approach for bile duct reconstruction. The common postoperative complications include anastomotic leakage and stenosis, cholangitis, and recurrent stone formation [1]. However, the occlusion of the manually created side-to-side anastomosis between the proximal jejunum and the jejunum at a distance of 40 cm from the cholangioenteric anastomosis is rare [2].

A 77-year-old woman was admitted for intermittent upper abdominal pain with hypoalbuminemia and severe electrolyte disturbance. The patient had undergone radical resection of cholangiocarcinoma and cholangioenteric Roux-en-Y anastomosis 2 weeks previously (Fig. 1). Abdominal computed tomography (CT) after admission revealed dilation of upper gastrointestinal tract (Fig. 2, Fig. 3). All possible treatments were administered, but her general condition worsened. Digital subtraction angiography (DSA) showed an increased frequency of intestinal peristalsis, and the contrast agent could not pass through the jejunal side-to-side anastomosis. DSA-guided placement of the enteral feeding tube failed. Based on the patient’s age and physical condition, a laparoscopic exploration was urgently performed. During the operation, it was found that the blind loop (Fig. 1, A) was adhered to the mesocolon, along with anastomotic angulation, which may have been the main cause of the rare anastomotic occlusion. In addition, the suture at the anastomosis was completely loosened and detached (Video 1). However, whether the complete detachment of the anastomotic suture was involved in the occlusion or was just an isolated event remains unclear.

There are a variety of treatment methods for anastomotic occlusion, and an endoscopic technique should be one of the important options [3]. Our case had poor anastomosis healing that was found during the operation (Video 1). If endoscopic balloon dilation was used, it might have had more serious or even catastrophic consequences (e.g., intestinal fistula). Fortunately, our patient underwent laparoscopic surgery, which proved to be proper and feasible.
Competing interests

The authors declare that they have no conflict of interest.

The authors

Junjing Zhang, Junjie Lu, Ang Li, Huijun Wang, Weihua Zheng
Department of General Surgery, Hohhot First Hospital, Hohhot, China

Corresponding author

Junjing Zhang, MD
Department of General Surgery, Hohhot First Hospital, No. 150 Nan'erhuan Road, Yuquan District, Hohhot 010030, Inner Mongolia, China
zhang.jj@vip.163.com

References


Bibliography

Endoscopy
DOI 10.1055/a-1886-3464
ISSN 0013-726X
published online 2022
© 2022. The Author(s).
This is an open access article published by Thieme under the terms of the Creative Commons Attribution-NonDerivative-NonCommercial License, permitting copying and reproduction so long as the original work is given appropriate credit. Contents may not be used for commercial purposes, or adapted, remixed, transformed or built upon. (https://creativecommons.org/licenses/by-nc-nd/4.0/)
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany

ENDOSCOPY E-VIDEOS
https://erev.thieme.de/e-videos
Endoscopy E-Videos is an open access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online. Processing charges apply (currently EUR 375), discounts and waivers acc. to HINARI are available.
This section has its own submission website at https://mc.manuscriptcentral.com/e-videos