Laparoscopic revision of gastrojejunostomy stricture after roux en y gastric bypass

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Objectives

• To review strategies for managing gastrojejunostomy strictures after laparoscopic roux en y gastric bypass

• Review surgical technique used in the management of gastrojejunostomy stricture presented in this case
Gastrojejunostomy strictures

- Incidence ranges from 5-27% of cases
- Typically within 90 days from surgery
- Manifests as persistent postprandial vomiting with or without pain
- May be caused by ischemia, excessive scar formation, marginal ulceration, tension or malposition of the anastamosis and surgical technique.

Gastrojejunostomy strictures

- Endoscopic balloon dilation is preferred diagnostic and therapeutic procedure

- Up to 67% of cases will respond to first dilation
  - 3-8% will require three or more dilations

- Endoscopic stenting also a consideration
  - Limited experience
  - Stent migration may be an issue

- Intralesional injection with triamcinolone acetonide
  - Limited experience/efficacy

Gastrojejunostomy strictures

- Surgical management
  - Only required in 0.05% of cases
  - Reserved for persistent stenosis despite repeat dilations or complication of dilation

- Resection/revision of GJ anastomosis

- Restoration of original anatomy (OA)

Case Presentation

- 34 y.o. Female
- Laparoscopic roux en y gastric bypass one year previous
- Gastrojejunostomy stricture requiring serial dilations
Case Presentation

- Suffered perforation at gastrojejunostomy during dilation
- Laparoscopic lavage, drainage and insertion of gastrostomy
- Persistent nausea and need for parenteral nutrition
- Required laparoscopic revision of gastrojejunostomy anastomosis
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