An 80-year-old woman who had undergone hemigastrectomy and Billroth’s operation II gastrojejunostomy because of a perforated peptic ulcer 3 years previously presented to the emergency department with crampy epigastric pain, which had been followed by coffee-ground vomitus. Her vital signs were normal, and her physical examination demonstrated mild epigastric tenderness without peritoneal signs. Blood test results were negative. Abdominal radiograph (Figure 1) was performed, and computed tomography (CT) was subsequently obtained (Figures 2 and 3).

[Ann Emerg Med. 2017;70:300.]

For the diagnosis and teaching points, see page 322.

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DIAGNOSIS:

*Retrograde jejunogastric intussusception.* The incidence of retrograde jejunogastric intussusception is reported to be 0.1% after gastric surgery, including Billroth’s operation I and II reconstruction and total gastrectomy with Roux-en-Y anastomosis.1-4 Sudden epigastric pain, vomiting with or without hematemesis, and a palpable abdominal mass are the classic triad of retrograde jejunogastric intussusception.5 The mortality rate ranges from 10% when treated within the first 48 hours to more than 50% with a 96-hour delay.6 The diagnosis can be determined with a range of imaging studies, including endoscopy, ultrasonography or endoscopic ultrasonography, barium series studies, and abdominal CT. Immediate surgical intervention is usually necessary but successful endoscopic reduction has been reported.7 Although rare, retrograde jejunogastric intussusception is a potentially life-threatening disease if the diagnosis and treatment are delayed. It can sometimes be observed on abdominal radiographs.

The patient underwent emergency laparotomy for segmental resection of the jejunum with Roux-en-Y anastomosis without complications.

AUTHOR AFFILIATIONS

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REFERENCES