Acute pancreatitis from closed loop of obstruction of incarcerated Biliopancreatic limb in a port site hernia following Gastric Bypass Surgery

Dr J Thomson, Mr SK Bandyopadhyay, Mr R Chaparala
Salford Royal NHS Foundation Trust, Salford, United Kingdom

Salford Royal NHS Foundation Trust
University Teaching Trust
safe • clean • personal

Introduction

The benefits of bariatric surgery are well established,[1] however, with the development of new techniques discussions of rare complications aid learning and quality improvement. Late incisional hernias have been reported as a rare complication of Laparoscopic Roux-en-y Gastric Bypass surgery (LRYGB).[2] This case report discusses a combination of rare complications of LRYGB 6 years after the original surgery.

Case presentation

- 63-year-old lady presented to the emergency department with abdominal pain and vomiting.
- Bowels not open and not passing flatus.
- On examination – Tender abdomen, non reducible LUQ incisional hernia, no peritonism
- Blood tests: amylase 1042, lactate < 2 and CRP 11 with normal haematology studies.
- Past surgical history - LRYGB 6 years previously, indication high BMI. Complicated by an incisional Hernia 5 years after operation.

CT scan on admission showed
1.) Closed loop bowel obstruction of the BP limb – figure 1
2.) Incisional hernia containing JJ anastomosis of RYGB – figure 2
3.) acute pancreatitis – figure 1

Intraoperatively

- Incisional hernia self reduced likely secondary to anesthetic and abdominal insufflation
- Hernia orifice visible 4 x 5 cm left of midline, secondary to previous laparoscopic port site. Antecolic RYGB
- Entire small bowel run, dilation visible but healthy JJ anastomosis intact
- NG tube drain 600 ml of bilious fluid after hernia self reduced
- Hernia repaired with 12 cm Parietex mesh
- Post operatively required redo mesh repair, due to re-herniation. Falciform ligament taken down and 4 x 2 cm defect visible. Symbotex composite mesh 15 cm placed.

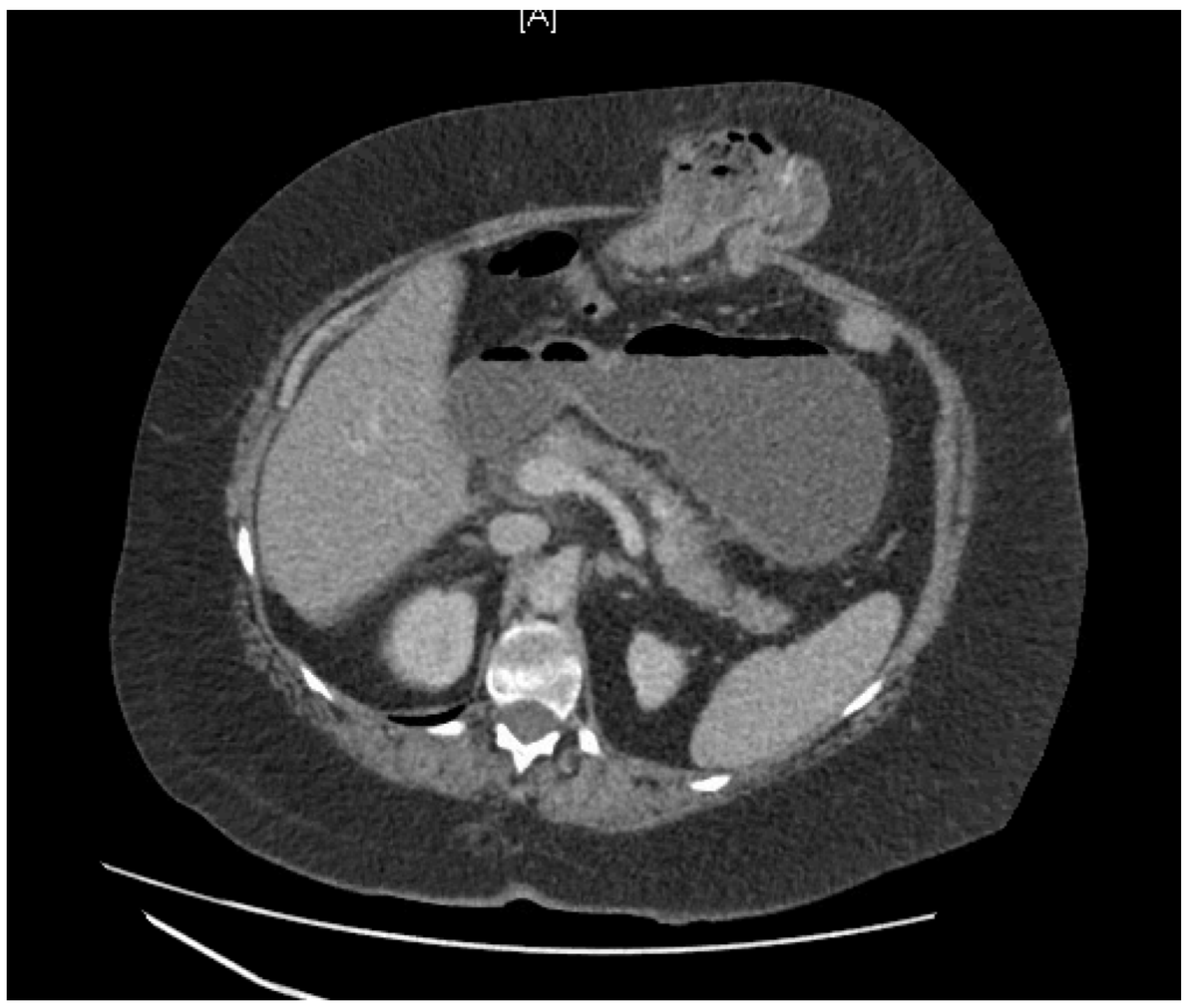

Figure 1: CT scan showing 1.) intestinal obstruction within the hernia sac. 2.) the incisional hernia contains the JJ anastomosis of the Biliopancreatic limb. 3.) There is a closed loop bowel obstruction of the Biliopancreatic limb. 4.) There is evidence of acute pancreatitis

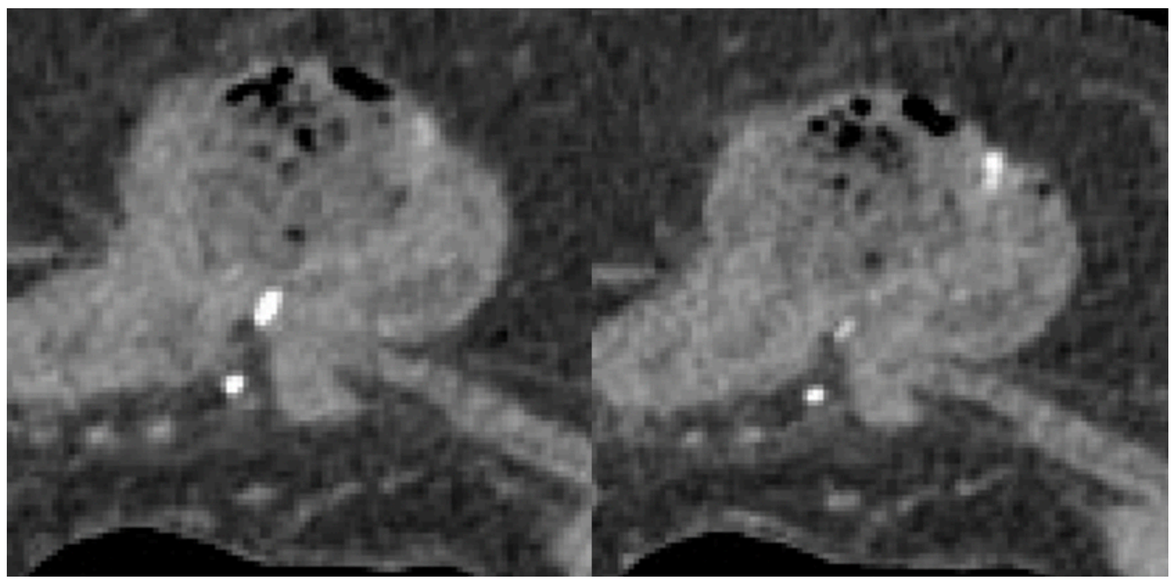

Figure 2 – CT image showing the JJ anastomosis within the incisional hernia sac

Conclusion

Acute pancreatitis after bariatric surgery is known and reported, with a large majority of cases seen as a result of increased rates of cholelithiasis and choledocholithasis.[3] However, port site herniation of the biliopancreatic limb can occur after a laparoscopic Roux en Y gastric bypass. If this herniation becomes incarcerated a closed loop bowel obstruction can occur. This subsequently can cause dilation of the biliary limb through distal obstruction of the passage of bile, pancreatic enzymes and gastric secretions from the stomach remnant. In rare circumstances this backflow may cause acute pancreatitis possible due to an acute obstruction of the ampulla of vater or refluxation of intestinal fluid. In this patient the pancreatitis was a symptom of the primary issue, which once addressed was resolved and required no further treatment.

Patient has consented for the above images and use for this presentation

References: 1) Colquitt JL, Pickett K, Loveman E, Frampton GK. Surgery forweight loss in adults. Cochrane Database Syst Rev 2014;(8):CD003641. 2) Mehaffey JH, LaPar DJ, Clement KC, Turrentine FE, Miller MS, Hallowell PT, Schirmer BD. 10-Year Outcomes After Roux-en-Y Gastric Bypass. Ann Surg. 2016 Jul;264(1):121-6. doi: 10.1097/SLA.0000000000001544. PMID: 26720434. 3.) Villegas L, Schneider B, Provost D, Chang C, Scott D, Sims T, Hill L, Hynan L, Jones D. Is routine cholecystectomy required during laparoscopic gastric bypass? Obes Surg. 2004 Feb;14(2):206-11.