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Large internal hernia with simultaneous marginal ulcer in Roux-en-Y gastric bypass (RYGB) patient

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Number of Reviewers: **4**
Total Score: **22**
Mean Score: **5.5**

Score	Reviewer	Reject Comment	Overall Comment
5	Dan Herron		Nice demonstration of a big internal hernia. Good teaching points.
5	Denise Gee		always good to review internal hernia locations and how to reduce/close defects. there is a lot of good information and good diagrams in video, but it gets rushed through and becomes a little confusing. narration also seems rushed in the end. if podium
6	Racquel Bueno		Outstanding presentation. Comprehensive narration of steps, complete with diagrammatic supporting slides and clear labeling of live video. Very well executed. Excellent for the expert as well as one ascending their learning curve.
6	Andrew Wu		nice organized diagrams

Background: In a recent review of nearly 10,000 laparoscopic gastric bypasses, Martin et al. reported an overall incidence of small bowel obstruction (SBO) of 3.6%. Unlike open bariatric procedures where adhesive disease is the most common cause of obstruction, small bowel obstruction after Laparoscopic RYGB is caused primarily by non-adhesive disease as internal hernia (> 50%) and abdominal wall hernia. Retrospective studies report an internal hernia incidence of 0.3-6.2%. We would like to present the interesting case of large internal hernia with volvulus in the pseudo Petersen space with simultaneous marginal ulcer in RYGB patient.

Method: A 57yo, F with past medical history of fibromyalgia, osteoarthritis on Celebrex for long time, depression, hypothyroidism, neuropathy, pituitary tumor, Morbid obesity who underwent laparoscopic RYGB in 2003 without follow up. Now her BMI is 26 (BW = 152 lbs). She has never smoker. She was admitted in the hospital with a central, epigastric, and postprandial abdominal pain. She initially presented for this acute event at an outside hospital and in the Emergency Department. They performed a CT scan with p.o. and IV contrast. CT abdominal scan showed no free air or free fluid, mild dilatation of Roux limb, no gastric remnant dilation and possible swirl sign that suspicious internal hernia. She underwent urgency diagnostic laparoscopy. We found large internal hernia with volvulus in the pseudo Petersen space. We also performed intraoperative upper endoscopy and found marginal ulcer at the gastrojejunal anastomosis (jejunum side). as well.

Result: Patient was doing well postoperatively. She was discharge home on postoperative day 3. We treated her marginal ulcer with Protonix 40 mg bid, Carafate liquid 1 gm x 4 times per day and stop celecoxib and NSAIDs Patient was doing well at 1 month follow up, denied abdominal pain.

Conclusion: Internal hernia is a serious and potentially life-threatening complication of LRYGB. One must maintain a high index of clinical suspicion for internal hernia in any patient status post LRYGB who presents with intermittent or acute sign or symptoms of SBO. Negative CT scan may be found in 20%.

https://youtu.be/ECO1w_zHNhc