Gastrojejunocolic fistula: A case report

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ABSTRACT

Benign gastrojejunocolic fistula is mostly due to Bilroth II operations. It typically presents with a triad of feculent vomiting, weight loss and chronic diarrhoea but sometimes the diagnosis is not straightforward. We discuss a case that presented and was investigated as intestinal obstruction however diagnosed with gastrojejunocolic fistula during surgery.

KEYWORDS: Gastrojejunocolic fistula, Bilroth II

INTRODUCTION

Gastrojejunocolic fistula (GJCF) can be benign or malignant. Most of the malignant fistulas are due to tumour infiltration or tumour recurrence. Benign GJCF is rare nowadays due to a reduction in peptic ulcer operations. However, clinicians should be alert to this condition especially in patients with previous history of Bilroth II operation.

CASE REPORT

A 53 year-old gentleman presented with a one-week episode of post-prandial feculent projectile vomiting, associated with generalized abdominal pain and distension. He was able to pass flatus but had no bowel motion during admission. He also complained of passing loose stools for four months prior to the admission. There were constitutional symptoms of losing weight and appetite. He had undergone gastrojejunostomy and truncal vagotomy for gastric outlet obstruction in 1999. On examination he was cachexic, peripherally oedematous with a tinge of jaundice. The abdomen was distended, mildly tender with ascites and hyperactive bowel sounds.

His blood investigation showed severe malnutrition; he was anaemic with hemoglobin of 6.2g/dl, hypokalaemic with potassium of 2.7 mmol/l, hypoalbuminaemic with albumin 15 g/l and several documented episodes of hypoglycaemia whilst in the ward. Abdominal radiography showed dilated large bowels (Figure 1).

He had upper and lower endoscopy performed. Oesophagastroduodenoscopy (OGDS) showed stomach filled with food particles. Colonoscopy was normal but the physician was unable to advance beyond the splenic flexure. CT scan showed dilated stomach and small bowels, and mildly dilated ascending colon (Figure 2). The contrast study does not reveal any fistula. There was no abnormal mass noted.

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With provisional diagnosis of obstruction secondary to adhesion, laparotomy was performed. There were 1500mls of ascitic fluid. Stomach and small bowel were dilated. The stomach, jejunum and transverse colon were locked at one point. Upon further dissection, gastrojejunal fistula was revealed. This patient had a short retrocolic proximal limb to gastrojejunostomy done in the previous surgery. There was a stomal ulcer and histopathology showed a chronic ulcer. Staged procedure was planned on table. Fistula at the stomach and jejunum were closed primarily (Figure 3). The colonic fistula was brought out as loop colostomy. New gastrojejunostomy was created.

Most fistulas are diagnosed pre-operatively. Pre-operative optimization is crucial for these patients as a majority of them are malnourished. Mortality following surgical repair has been reported to be as high as 40% especially for single stage operations. Staged operations are one of the important management steps in most cases especially for those diagnosed during laparotomy. Staged repair of GJCF is considered as damage-control surgery and requires preliminary diversion colostomy. Combination of proper pre-operative optimization and staged operation has reduced the mortality to 5%. In selected cases proper pre-operative optimization and nutrition will also allow a single stage operation.

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REFERENCES
