Hemorrhagic gastritis at the excluded stomach after Roux-en-Y gastric bypass

Anemia frequently occurs in patients after Roux-en-Y gastric bypass. The causes are usually related to surgery, anastomotic site lesions, or malabsorption of nutrients caused by altered anatomy and physiology [1]. A 57-year-old man underwent an uncomplicated laparoscopic Roux-en-Y gastric bypass for morbid obesity and experienced melena and anemia 10 years after surgery. His medical history included hypertension and insulin-dependent diabetes mellitus that disappeared after surgery. Laboratory findings revealed a hemoglobin level of 5.9 g/dL and iron deficiency (iron, 47 µg/dL; ferritin 11 ng/mL; iron saturation, 8.6%). His medications included vitamin B12 and omeprazole (20 mg/day). Endoscopy, colonoscopy, and abdominal computed tomography showed no abnormalities apart from anatomical changes related to surgery.

Double-balloon enteroscopy showed the pylorus and hemorrhagic erosive pangastritis at the excluded stomach (Fig. 1 and Fig. 2, Video 1). Biopsy specimens were negative for Helicobacter pylori and demonstrated chronic active gastritis, regenerative activity, and foveolar hyperplasia. The omeprazole dosage was increased to 40 mg/day. The patient progressed without melena, and with a continuing increase in the hemoglobin level. After 3 months of treatment, double-balloon enteroscopy revealed atrophic pangastritis, but no bleeding focus. Laboratory tests exhibited a normal iron profile with a hemoglobin level of 15.5 g/dL, iron 155 µg/dL, ferritin 44.7 ng/mL, and iron saturation, 29.5%.

This case shows the importance of double-balloon enteroscopy for examining the excluded stomach in patients with Roux-en-Y gastric bypass. In addition, double-balloon enteroscopy has proven useful for the evaluation and therapy of obscure gastrointestinal bleeding in patients with a surgically altered upper gastrointestinal anatomy [2].

Competing interests: None

Adriana Vaz Safatle-Ribeiro1, Emanuele Lima Villela1, Eduardo Guimarães Hourneaux de Moura1, Paulo Sakai1, Klaus Mönkemüller2

1 Endoscopy Unit of the Hospital das Clínicas, Department of Gastroenterology, University of São Paulo School of Medicine, São Paulo, Brazil
2 Hirschowitz Endoscopic Center of Excellence, Division of Gastroenterology and Hepatology, University of Alabama at Birmingham, Birmingham, USA

References


Corresponding author
Adriana Vaz Safatle-Ribeiro, MD, PhD
University of São Paulo School of Medicine
Department of Gastroenterology
Endoscopy Unit of the Hospital das Clínicas
Av. Dr. Enéas de Carvalho Aguiar, 255 – Cerqueira César
São Paulo – SP
Brazil
Fax: +55-11-32849885
adrisafatleribeiro@terra.com.br

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