A 43-year-old woman presented to our hospital with emesis and coffee-ground output from the gastrostomy tube that she had had placed by interventional radiology 1 year before. On arrival, her heart rate was 140 beats per minute and her systolic blood pressure was 50 mm Hg. Laboratory testing showed her white blood cell count to be $30 \times 10^9$/L and her lactate was 3.8 mmol/L. A gastrostomy was in place, without any external fixation device. Computed tomography showed a mass containing small bowel, which was thought to be a jejunogastric intussusception (Fig. 1, 2). Upper endoscopy revealed the gastrostomy, with its balloon inflated, approximately 10 cm from the gastric entry site (Fig. 3), and a large, purple, friable mass emanating from the pylorus (Fig. 4, 5). Because the intussusception could not be reduced endoscopically, an emergency laparotomy was performed and a retrograde jejunogastric intussusception with ischemia was found. The bowel was dusky but was not perforated (Fig. 6). We resected 20 cm of jejunum and pathological examination revealed hemorrhagic coagulative necrosis and acute inflammation. The patient made an uncomplicated recovery postoperatively.
Acknowledgment

We would like to thank Dr. Michael Hull from the Department of Pathology and Immunology at Washington University School of Medicine for his assistance with the pathology specimens.

Endoscopy_UCTN_Code_CPL_1AH_2AI

L. Pelosof1, D. A. Ringold2, E. Kuo1, S. Bhalla3, R. Whinney1, G. R. Zuckerman2

1 Department of Surgery, Washington University School of Medicine, St. Louis, Missouri, USA
2 Department of Medicine, Washington University School of Medicine, St. Louis, Missouri, USA
3 Department of Radiology, Washington University School of Medicine, St. Louis, Missouri, USA

References


Corresponding author

D. Ringold, MD
Department of Medicine
Division of Gastroenterology
Washington University School of Medicine
660, South Euclid Avenue
Campus Box 8124
St. Louis
Missouri 63110
USA
Fax: +1-314-454-5107
dringold@im.wustl.edu

Bibliography

Endoscopy 2007; 39: E262 – E263
© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

Fig. 5 A close-up endoscopic view of the friable, dusky, intussuscepted small bowel, which is covered with gelatinous exudate.

Fig. 6 A segment of jejunum is mobilized intraoperatively. Patches of pale, dusky serosa are widespread on the left, and focal, transmural necrosis was identified in the histologic sections of this portion of the intestinal segment.