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INTESTINAL OBSTRUCTION AFTER ROUX-Y BYPASS BARIATRIC SURGERY: A CASE REPORT

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INTRODUCTION

Bariatric surgery performed using the Roux-en-Y Bypass technique is a surgery performed to improve grade 3 obesity, also called morbid obesity. Thus, according to GERMINI (2019):

> " [...] patients undergoing gastroplasty by RYGB seem to achieve better weight reduction and management of comorbidities associated with obesity, in addition to improvement in reflux disease."

In turn, intestinal obstruction is a possible complicating factor related to bariatric surgery, leading to an expansive worsening of the case, as will be shown subsequently. Thus, intestinal blockage often presents with abdominal pain, inhibition of bowel sounds, in addition to being able to contain phytobezoar, lactobezoar or trichobezoar accumulated in places close to the gastric correction surgery. In fact, performing gastric surgery is one of the risk factors, as ABREU JUNIOR (2019) says: "Previous gastric surgery is also a risk factor, as it reduces the area of stomach digestion and acid secretion, causing poor digestion and passage bulkier, agglomerated materials into the small intestine."

In the case report presented here, an intestinal obstruction due to complications of a bariatric surgery performed using the Roux-en-Y technique will be discussed, which is the gold standard surgical method for patients with grade 3 obesity or morbid obesity.

OBJECTIVE

The objective of this study was to present a case considered atypical, considering that it does not correspond to the epidemiological characteristics presented in the literature, in addition to a clinical picture after bariatric surgery by Roux-en-Y bypass, with symptoms

of prolonged abdominal pain until arrival at the hospital. São Raimundo Emergency Service, where a lowering of the level of consciousness and a globular abdomen, tympanic and painful on palpation, were found, and he was promptly referred to Dr. João Lúcio Pereira Machado, both in Manaus-AM.

METHODOLOGY

Case study of a female patient, 27 years old, with a history of bariatric surgery by Roux-en-Y bypass, who presented symptoms of abdominal pain, vomiting, skin paleness and sweating. Upon admission to the São Raimundo Emergency Service, the patient was identified as having abdominal distension, lowering of the level of consciousness, in addition to a globular abdomen, distended and painful on palpation, and was promptly transferred to Dr. Joao Lucio Pereira Machado. The patient was evaluated by the General Surgeon, who found a hyperextended abdomen, tachydyspnea and cyanosis of the extremities. The patient underwent urgent exploratory laparotomy due to an acute abdomen.

The emergency surgery in question was performed, in which a cavity with fetid liquid and hyperextended intestinal loops was found in the ascending and transverse colon, requiring a colectomy of the two segments mentioned here and, finally, it was decided to for performing an ileostomy in the right iliac fossa for passage of the fecal bolus. The material removed was sent for histopathological examination. After the end of the surgery, the patient was admitted to the Intensive Care Unit, receiving care for a good postoperative period.

After medical evaluation, it was noticed that the patient evolved negatively, presenting hemoperitoneum and compartment syndrome, requiring a new surgery laparotomy type. In fact, a cavity was found with a serohematic collection, distention of intestinal loops, rotation of the ileostomized loop and decreased intestinal perfusion. Thus, the cavity was aspirated and the rotated loop was repositioned, requiring its internal fixation to the peritoneal wall in order to avoid new internal herniations. At the end of the surgery, the patient remained in the ICU bed.

As previously mentioned, a decrease in intestinal perfusion was observed, a problem that persisted, causing necrosis of the ileostomy, requiring a new surgery. The performed laparotomy followed satisfactorily, finding a cavity with serous collections and necrotic areas in the ileostomy. Thus, resection of the ileostomy and replacement and fixation of the loop were performed, in addition to enterectomy of the necrotic segment followed by end-to-end enteroanastomosis. It is important to mention that the patient was not completely sutured due to possible new surgeries to be performed, given that the patient was in a very critical condition. The patient was kept in the ICU postoperatively.

In fact, another exploratory surgery of the laparotomy type was necessary in order to revise the abdominal cavity. Upon opening the cavity, a large amount of enteric secretion was found, in addition to the presence of perforation in the jejunal segment close to the angle of Treitz. Intercurrences of ischemia in multiple intestinal segments remained, which shows an aggravation in this case. Thus, enterectomy of the margins of the perforated segment was performed, enterorrhaphy of the segment in question and, finally, peritoniostomy with inorganic mesh. The patient was taken to the ICU bed postoperatively.

Concomitant to this, a revision surgery was performed to evaluate the continuation of the case. Once again, enteric secretion was found in the abdominal cavity, in addition to, once

again, areas of ischemia in the small intestine. Dehiscence of jejunal enterorrhaphy was also found, requiring reinforcement. Patient returned to ICU bed.

A new revision surgery was performed. Again, an exploratory laparotomy, finding serous secretion in the cavity, ischemic areas in the intestine with probability of future perforations. Multiple adhesions were also noted. The patient left the surgery with a schedule for relaparotomy in 48 hours, but unfortunately the patient died.

RESULT

Patient with abdominal pain prior to bariatric surgery presenting anamnesis and physical examination with alarm signs, an emergency surgery was requested in which intestinal obstruction was found due to volvulus of the ascending and transverse colon. The patient had a negative evolution, and six exploratory laparotomies were performed in order to correct the different situations of rotations, ischemia and loop perforations. The patient died in the postoperative period of the sixth laparotomy.

CONCLUSION

The presented case does not escape the symptomatological variation characteristic of patients with intestinal obstruction after bariatric surgery. The peculiarity concerns the acute, catastrophic and disabling clinical onset of the symptoms found, in addition to a case in which the patient is a young adult, which is quite unusual given that such patients have a greater chance of healing more quickly. effective.

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