Gangrenous Jejunogastric Intussusception: Is Reduction advisable?

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We have read the article *Jejunogastric intussusception with internal herniation in the stomach* by Khanna S, Kumar D, Khanna R, and Gupta SK [1] with interest. The authors have described a case, wherein a gangrenous jejunogastric intussusceptions (JGI) was reduced by gentle traction and about 30 cm of gangrenous bowel was subsequently resected. Presence of gangrene in the intussusceptions is an important consideration in deciding the operative procedure in individual patient and it also affects prognosis. Reduction of gangrenous JGI is difficult, often impossible, and even inadvisable. Rupture of the jejunal wall may occur at the site of necrotic areas [2] and cause peritoneal contamination.

A gangrenous JGI is required to be resected expeditiously. Various techniques for resection of irreducible gangrenous JGI have been described: division of stoma, taking down the gastrojejunostomy, or a higher gastrectomy. We wish to draw attention of the esteemed readers to a simple technique for in situ resection of irreducible, gangrenous JGI [2, 3]. The

gangrene is confined to the distal part of intussusception which can be resected just distal to gastroenterostomy stoma, through an anterior gastrostomy. Both the outer tube (the intussusceptient) and the inner tube (the intussusceptum) are divided circumferentially at the same level, about 2 cm away from the gastroenterostomy stoma, followed by piecemeal division of the mesentery. The two segments of the jejunum can be easily dis-invaginated following the resection of distal gangrenous part. Continuity of the jejunum can be restored by primary end-to-end anastomosis after confirming the viability of the ends of the jejunum. The anterior gastrostomy is closed in two layers. In situ resection obviates the need for applying traction to gangrenous bowel; it furthermore avoids division and dismantling of gastroenterostomy stoma or higher gastric resection.

References

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