Postoperative upper gastrointestinal bleeding, though rare, is a potentially fatal complication of gastric bypass surgery that usually occurs a few months postoperation. The current report describes a 57-year-old man with a bleeding duodenal ulcer who underwent Roux-en-Y gastric bypass surgery 12 years earlier. With an increasing number of gastric bypass surgeries performed each year, physicians must be aware of their patients’ altered gastrointestinal anatomy and physiology—as well as the potential for pathophysiology.

**Report of Case**

A 57-year-old man presented to the emergency department complaining of weakness, light-headedness, and melena. On admission, the patient was hypotensive (blood pressure, 84/44 mm Hg), tachycardic (heart rate, 126 beats per minute), and tachypneic (respiratory rate, 34 breaths per minute). His medical history included chronic renal insufficiency, coronary artery disease, hypertension, micronodular cirrhosis, and peptic ulceration. The patient also had Roux-en-Y gastric bypass surgery 12 years prior. The patient was a nonsmoker and was not on nonsteroidal anti-inflammatory medications (NSAIDs). It was unknown whether he had a history of *Helicobacter pylori* infection.

Laboratory results revealed a hemoglobin level of 7.6 g/dL and no coagulopathy. Despite multiple blood transfusions—2 units of packed red blood cells administered the day of admission and the day after admission—the patient’s anemia persisted. Peroral endoscopy exposed a typical postgastric bypass anatomy without a source of bleeding. Subsequent celiac angiography revealed active bleeding in the duodenal area, and Gelfilm embolization was performed. However, as a result of ongoing hemorrhage, a surgical exploration was undertaken. An intraoperative upper endoscopy was performed through an anterior gastrotomy (Figure 1). A 1-cm bleeding ulcer was identified in the posterolateral wall of the duodenum (Figure 2).

The patient was taken immediately to the operating room. The endoscopy was then performed directly through a hole made in the stomach. The endoscope was withdrawn, and an anterior transverse duodenotomy was performed. After the duodenal ulcer was oversewn with interrupted 3-0 silk sutures, the duodenotomy and gastrotomy were closed in two layers. The patient had an unremarkable recovery and was discharged 5 days postoperation with a lifelong prescription for a proton pump inhibitor.

**Comment**

The most common etiology of upper gastrointestinal bleeding in patients who have undergone Roux-en-Y gastric bypasses is marginal ulceration at the gastrojejunal anastomosis. The overall incidence of marginal ulceration after such procedures may be as high as 7%. As demonstrated in animal experiments and evidenced in humans, the gastric pouch created during gastric bypass procedures is associated with decreased...
acid production. However, both Mason et al.9 and Flickinger et al.11 have demonstrated the bypassed segment’s ability to maintain an acidic—and therefore ulcer-friendly—environment. Although gastrin levels have been shown to decrease after gastric bypass, the vagus nerves are generally preserved and the excluded gastric mucosa retains its ability to respond to vagal and hormonal stimuli, again maintaining an acidic environment in the bypassed stomach and duodenum. Patient history of smoking, NSAID use, and Helicobactor pylori infection—though the former two were absent and the latter was unknown in the patient described in the current study—can also increase the incidence of ulcers.

The diagnosis of duodenal and antral ulcers in patients who have had Roux-en-Y gastric bypass surgery is difficult because altered anatomy denies endoscopic access to the distal stomach and duodenum. For this reason, and to prevent ulceration, some surgeons advocate lifelong proton-pump inhibitors for all patients undergoing gastric bypass surgery.12

In cases where upper gastrointestinal hemorrhage is suspected, peroral endoscopy should be performed to exclude marginal ulceration at the gastrojejunal anastomosis. Bleeding may be localized using technetium Tc 99m red blood cells, a celiac angiogram, or a combination of both. Once bleeding is identified, angiographic techniques can be used to attempt to stop the bleeding. However, if the patient requires transfusion or becomes hemodynamically unstable, operative exploration is mandatory. In our experience, it has been impossible to visualize the duodenum using transcolonic endoscopy—even with longer pediatric colonoscopes—because Roux limbs are commonly longer than 100 cm.

Conclusion

As more and more Americans become obese each year and as nonoperative options fail to bring these adults to a healthy weight, the explosion of bariatric surgery as witnessed in recent years will likely continue.3,13,14 These procedures, particularly Roux-en-Y gastric bypass surgery, present primary care physicians with new diagnostic and therapeutic challenges. However, an improved understanding of patients’ altered anatomy and subsequent comorbidities will ensure physician competence and improved patient care.

References


