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Gastrojejunal-Colic Fistula of Ulcerative Origin: A Case Report

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Abstract **Case Report**

Gastrojejunocolic fistula was a frequent complication of surgery for peptic ulcer disease. Currently, it has become exceptional since the rarity of ulcer gastrectomies. Only 37 cases have been reported in the literature. The treatment of gastrojejunocolic fistula is surgical. It consists of a triple resection, gastric, jejunal and colonic, including the fistula. We report a case of gastrojejunocolic fistula, previously operated for perforated ulcer treated by simple suture with gastro-entero-anastomosis.

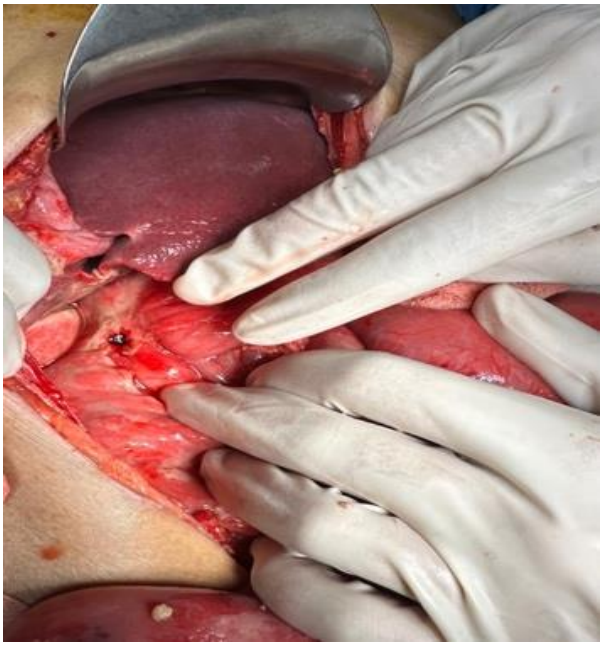
Keywords: gastrojejunocolic fistula, ulcer, anastomosis.

INTRODUCTION

Gastrojejunal-colic fistulas: the ultimate course of anastomotic ulcers after gastrojejunal anastomoses, have become exceptional since the rarity of gastrectomies for ulcers. Only 37 cases have been reported in the literature. The severity of this complication lies in the creation of a digestive bypass which is often responsible for severe malnutrition requiring rapid management. We report a recent observation illustrating the diagnostic and therapeutic difficulties of gastrojejunal-colic fistulas of ulcerative origin.

CASE REPORT

A 59-year-old patient was hospitalized for chronic diarrhea associated with a high intestinal stenosis syndrome with fecaloid vomiting, which had progressed in a context of deterioration of the general condition. The interview revealed a significant surgical history, in fact, the patient had been operated on 13 years previously for a perforated ulcer treated by simple suture with gastrojejunostomy. Upper digestive endoscopy and TOGD revealed gastric stasis with an impassable pyloric stenosis. The patient underwent surgery with intraoperative discovery of a fistula between the old gastrojejunal anastomosis and the transverse colon (figure). The patient underwent a subtotal gastrectomy with gastrojejunal anastomosis on a Y-loop and a segmental resection of the transverse colon followed by a termino-terminal colocolic anastomosis. The postoperative course was simple with a good evolution of the patient's general condition after a 6-month follow-up.



Gastrojejunal-colic fistula of ulcerative origin

DISCUSSION

In the past, gastrojejunal-colic fistula was a common complication of surgery for gastroduodenal ulcer disease [1, 2]. Currently, with the advent of triple therapy, it is exceptional [3]. Thus, the formation of a gastrojejunal-colic fistula implies a recurrence of ulcer disease [4]. This recurrence is preferentially located at

the level of the gastrojejunal anastomosis. This anastomotic ulcer gradually excavates into the adjacent mesocolon until it comes into contact with the colonic wall before opening into it, thus creating a gastrojejunal-colic fistula [5, 6]. The clinical symptomatology is typical, called post-GEA syndrome (weight loss, AEG, fecaloid vomiting, epigastralgia, early postprandial diarrhea, fetid breath) [7]. The diagnosis of certainty is based on barium enema; esophagogastroduodenal transit is often negative [8]. The treatment of gastrojejunal-colic fistula is surgical [9, 10]. It requires general preparation (nutritional status and electrolyte disorders) and local preparation (colonic preparation). It consists of a triple resection, gastric, jejunal and colonic, removing the fistula followed by immediate restoration of continuity [11].

CONCLUSION

Gastrojejunal-colic fistula of ulcerative origin has become a historical complication since the generalization of triple therapy. Management is surgical after correction of nutritional and ionic disorders.

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