

CASE REPORT

Laparoscopic removal of gastric band after laparoscopic gastric bypass and following placement of adjustable gastric band

Andrea Lanaia*, Maurizio Zizzo, Concetto M. Cartelli, Matteo Fumagalli, and Stefano Bonilauri

Department of General Surgery, S.C. General and Emergency Surgery, Arcispedale Santa Maria Nuova, IRCCS, Reggio Emilia, Italy

*Correspondence address. Department of General Surgery, S.C. General and Emergency Surgery, Arcispedale Santa Maria Nuova, IRCCS, Reggio Emilia 42100, Italy. Tel: +39-3470450660; Fax: +39-0522-296191; E-mail: andrealn1@yahoo.it

Abstract

Banded gastric bypass is a bariatric surgical intervention that has been regularly performed in many centers. According to some series, banded gastric bypass is safe and feasible. We describe the case of a 42-year-old woman undergoing laparoscopic gastric bypass in 2008. Subsequently, she underwent surgery in order to place adjustable gastric banding on previous bypass because of gastric pouch dilatation. Five months later, patient showed anorexia and signs of malnutrition. For this reason, she underwent laparoscopic removal of gastric banding. In our opinion, placing a device to restrict an already dilated gastric pouch must be avoided.

INTRODUCTION

Banded gastric bypass is a bariatric surgical intervention that has been regularly performed in many centers. The theoretical advantage is that of reducing the rate of drawbacks occurring after gastric bypass, namely gastric pouch dilatation [1–3]. According to some series, banded gastric bypass is safe and feasible, because it has a low risk of complications such as band displacement or gastric pouch erosion [2, 3]. We describe the case of a 42-year-old woman undergoing laparoscopic gastric bypass in 2008, because of morbid obesity. After an initial weight loss, the patient started to regain weight because of gastric pouch dilatation. For this reason, in 2013, she underwent surgery in order to place adjustable gastric banding on previous bypass. Five months later, patient showed symptoms such as anorexia, dysphagia for

solids and fluids, nausea, vomiting, signs of malnutrition with dysproteinemia, hypoalbuminemia and ankle swelling.

CASE REPORT

On the first day of admission, gastric banding was completely deflated. Rx abdomen showed posterior slippage of the ring (Fig. 1). Subsequently, the patient underwent rehydration therapy, 20-day total parenteral nutrition and infusion of human albumin. During that period, we examined her upper digestive tract with oral water-soluble contrast (Fig. 2) with the result of a thin liquid passage downstream of the ring and marked gastric pouch distension. Esofagogastroscopy was performed, which was negative for erosion or gastric perforation; however, it

Received: March 29, 2015. Accepted: July 7, 2015

Published by Oxford University Press and JSCR Publishing Ltd. All rights reserved. © The Author 2015.

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited. For commercial re-use, please contact journals.permissions@oup.com



Figure 1: Posterior slippage of the ring.

revealed a 1-cm-diameter passage through the gastric band. Despite an improvement in symptoms with partial resumption of semi-liquid intake, the patient continued to experience nausea and vomiting. For this reason, she underwent laparoscopic removal of gastric banding. In the operating room, she was placed in the lithotomy position; we placed a 10-mm optical trocar in supraumbilical region, a 5-mm one in the right upper quadrant and a 10-mm one in left upper quadrant near the subcutaneous tank. After lysis of adhesions between liver and stomach, the intraoperative picture showed a banding displacement, confirming posterior slippage of the banding and its sliding back to the level of previous gastro-jejunal anastomosis. Ascitic effusion due to dysproteinemia was reported. A methylene blue test showed no gastric perforation. After this procedure, the patient started to resume liquid intake in the first postoperative day and food intake in the second postoperative day, with complete resolution of vomiting and nausea. Then, she was discharged with the advice of an appropriate diet and invited to attend a recall visit 10 days later. In subsequent follow-up, the complete resolution of clinical symptoms was confirmed together with an improvement of the biochemical picture.

DISCUSSION

Many case studies universally acknowledge banded gastric bypass as a safe and effective procedure. However, complications can be very serious [4–6]. There is no doubt that patient must be made aware of the risks of such intervention and, last but not least, patient must undergo a close postoperative follow-up. In our opinion, however, placing a device to restrict an already dilated gastric pouch must be avoided; rather, it would be useful to prevent this occurrence by educating patients to follow a correct diet.

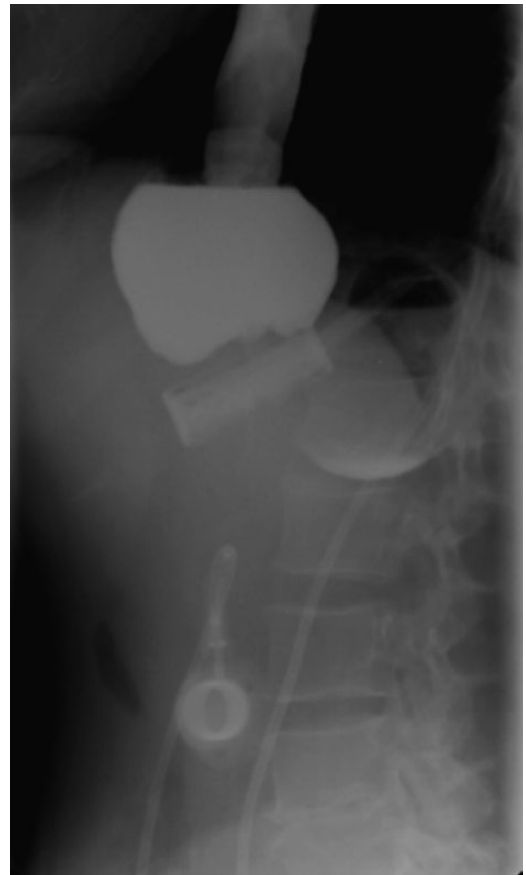


Figure 2: Water-soluble contrast shows a thin liquid passage downstream of the ring and marked gastric pouch distension.

CONFLICT OF INTEREST STATEMENT

None declared.

REFERENCES

1. Kyzer S, Raziel A, Landau O, Matz A, Charuzi I. Use of adjustable silicone gastric banding for revision of failed gastric bariatric operations. *Obes Surg* 2001;11:66–9.
2. Lemmens L, Karcz WK, Bukhari W, Fink J, Kuesters S. Banded gastric bypass—four years follow up in a prospective multi-center analysis. *BMC Surg* 2014;14:88.
3. Bessler M, Daud A, Di Giorgi MF, Olivero-Rivera L, Davis D. Adjustable gastric banding as a revisional bariatric procedure after failed gastric bypass. *Obes Surg* Nov 2005;15:1443–8.
4. Capella JF, Capella RF. An assessment of vertical banded gastroplasty-Roux-en-Y gastric bypass for the treatment of morbid obesity. *Am J Surg* 2002;183:117–23.
5. Fobi M, Lee H, Igwe D, Felahy B, James E, Stanczyk M, et al. Band erosion: incidence, etiology, management and outcome after banded vertical gastric bypass. *Obes Surg* 2001;11:699–707.
6. Taddeucci RJ, Madan AK, Ternovits CA, Tichansky DS. Laparoscopic re-operations for band removal after open banded gastric bypass. *Obes Surg* 2007;17:35–8.