

## Obstrucción gástrica secundaria a deslizamiento de la banda gástrica ajustable.

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**Resumen:** La cirugía de banda gástrica ajustable por laparoscopia (BGAL) es un procedimiento quirúrgico restrictivo, que tiene una tasa de morbilidad y mortalidad baja. Sin embargo, las complicaciones tales como deslizamiento de la banda gástrica no son infrecuentes. Presentamos un caso de una obstrucción de la salida gástrica debido a un deslizamiento BGA 3 años después de su colocación. La gastroscopia mostró la existencia de una estenosis extrínseca a nivel duodenal, el TEG mostró un paso filiforme del contraste en la primera porción del duodeno, y TAC abdominal con contraste oral, reveló la migración distal de la BGA en la primera porción del duodeno. Se decidió la retirada por laparoscopia. Se cortó la banda en la zona hinchable, y se redujo a su posición habitual. Aquello permitió la extracción de la banda, así como la cápsula circundante, además del Puerto de hinchado. En nuestro caso la retirada de la BGA fué un procedimiento laborioso y complejo, desmitificando así la idea de que es un procedimiento fácilmente reversible.

**Palabras clave:** Banda Gástrica Ajustable, deslizamiento, obstrucción gástrica.

**Abstract:** LAGB is a restrictive surgical procedure, which has a low morbidity and mortality rate, nevertheless, complications such as gastric band slippage are not uncommon. We report a case of a gastric outlet obstruction due to a LAGB slippage 3 years after its placement, which required surgical removal. Gastroscopy showed existence of an extrinsic stenosis of the duodenum, Upper GI series demonstrated a filiform progress of the contrast at the first duodenal portion and contrast abdominal CT scan revealed distal migration of the LAGB band at the first portion of the duodenum. The band was cut, reduced to its anatomical position allowing the removal of the band as well as the surrounding capsule. In our case the retrieval of the gastric band was a laborious procedure thus demystifying the idea that it is an easily reversible procedure.

### Introduction

Laparoscopic adjustable gastric banding (LAGB) is a commonly performed bariatric procedure. LAGB is a restrictive surgical procedure, which has a low morbidity and mortality rate in the immediate postoperative period along with a good weight loss. (1,2) Nevertheless, complications such as gastric band slippage are not uncommon leading to a surgical intervention that puts the patient at risk of further complications. We report a case of a gastric outlet obstruction due to a LAGB slippage 3 years after its placement, which required surgical removal.

### Material and Methods

A 37-year-old woman presented to our emergency department with progressive mesogastric pain, nausea and vomiting for four days. Relevant past history included LAGB placement three years earlier at a local clinic, with adequate postoperative weight loss. She had previously been to the ER, at the same center where the band was placed, with similar complaints, and the band was completely deflated, but her symptoms did not subside. Abdominal examination showed mild

tenderness in the epigastrium on palpation with no other positive signs. Blood tests revealed a slightly elevated C Reactive Protein with a normal hemogram. Plain films of the abdomen confirmed the presence of a LAGB in a horizontal position, attached to its external port as seen in Figure 1

Figure 1



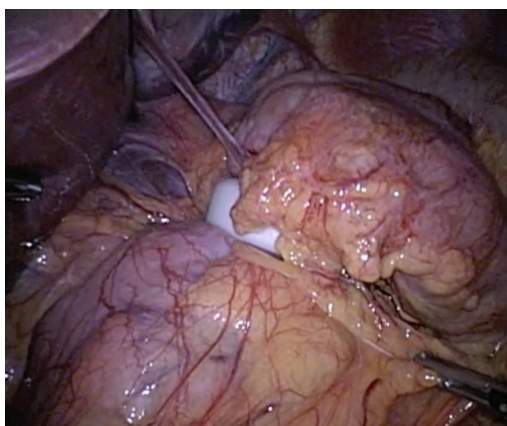
A gastroscopy was performed and concluded the existence of an extrinsic stenosis of the duodenum, and an Upper GI series demonstrated a filiform progress of the contrast at the first duodenal portion. A contrast enhanced abdominal CT scan revealed distal migration of the LAGB band at the first portion of the duodenum (Figure 2), thus confirming the band's slippage.

**Figure 2**



The patient was admitted for nutritional optimization prior to surgery and surgery was performed 2 weeks after admission. A laparoscopic approach was undertaken. Exploration of the abdominal cavity showed the slipped gastric band between the pylorus and first portion of the duodenum, with an enlarged gastric pouch (Figure 3).

**Figure 3**



Adhesions surrounding the anterior part of the band were dissected using scissors and electro cautery. The band was cut at its inflatable part just to the left of the buckle, and the slipped portion of the stomach was reduced to its anatomical position. Additional adhesions at the retrogastric tunnel and the gastric

fixation sutures were taken down, allowing the removal of the band as well as the surrounding capsule. Methylene blue was instilled via the nasogastric tube to rule out any leaks. The subcutaneous reservoir was extracted through a small skin incision. The patient had an uneventful postoperative course and was discharged on the third postoperative day.

## Discussion

Gastric band slippage is a frequent complication of this procedure with a rate varying from 2-24%. In many cases this complication requires another surgical intervention to remove the slipped band (4) that it's not exempt of further complications. Though considered a relatively easy procedure with a low learning curve, low morbidity and mortality rate, and easily reversible, the use of gastric banding is being questioned in Europe and the Middle East, where it is now, in certain centers, being replaced by the laparoscopic Roux-en-Y gastric bypass and, more recently, by gastric sleeve resection (3). In our case the retrieval of the gastric band was a laborious procedure thus demystifying the idea that it is an easily reversible procedure.

## Conclusion

A LAGB slippage can go as far the duodenum, causing a gastric outlet obstruction. In our case the laparoscopic approach proved to be a safe and adequate procedure, though the he dissection of the band from its capsule and restitution of the gastric anatomy proved to be arduous; nevertheless no complications were encountered during the intervention.

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