Obesity, a major public health issue of the 21st century, is increasingly common in adults and children. It is also considered, as the easiest to prevent death cause worldwide.

Excessive body weight is associated with well-known adverse effects, particularly cardiovascular disease, type 2 diabetes mellitus, obstructive sleep apnea, some cancers, osteoarthritis (1). Obesity significantly reduces life expectancy, by six to seven years on average (1, 2). BMI 30-35 reduces life expectancy by two to four years, whereas severe obesity (BMI> 40) reduces life expectancy by 10 years (3).

Non-surgical treatment for obesity includes dietary changes and exercise that can help by 5% -10% reduction in weight. Unfortunately, once patients stop exercise and diet, it comes to re-gain weight. Pharmacological treatment of obesity does not give much better results. No good results of pharmacological treatment of obesity results in rapid development of bariatric surgery, which treats obesity and comorbidities associated. There are many surgical options for treating obesity. Options for surgical management of morbid obesity include restrictive (adjustable gastric banding, vertical band gastroplasty), restrictive/resective (sleeve gastrectomy), restrictive/malabsorptive (Roux-en-Y gastric by-pass, bilipancreatic diversion with duodenal switch) and purely malabsorptive procedures (duodenal switch). Among them, swedish adjustable gastric banding (SAGB) or laparoscopic adjustable gastric banding (LAGB) have been more frequently performed. SAGB is considered to be safe and effective method of weight loss and elimination of diseases associated with obesity. Laparoscopic gastric banding offers the advantages of minimally invasive surgery, adjustability, and reversibility. Despite fewer number of complications than other bariatric operations, patients after SAGB may have unique complications that are characteristic of the SAGB and require special management and treatment. This paper presents a rare case of complete migration of the band into the gastric lumen.

Key words: obesity, SAGB, band migration
versibility. Despite fewer number of complications than other bariatric operations, patients after SAGB may have unique complications that are characteristic of the SAGB and require special management and treatment (8, 9).

Gastric pouch enlargement, band slippage, band migration, port-site infections and port leakage are the most common complications associated with SAGB. This paper presents a rare case of complete migration of the band into the gastric lumen.

CASE REPORT

62 years old diabetic female with arterial hypertension was qualified to laparoscopic adjustable gastric banding in 2007. Her BMI was 51.47 kg/m² (weight 140 kg, height 165 cm). Before the surgery she was consulted by a clinical psychologist, endocrinologist and bariatric surgeon and she had a preoperative gastroscopy. The operation was performed in a routine manner, using the pars flaccida technique. The band created a small upper stomach pouch of about 30 ml and was secured in place with three non-absorbable sero-serosal sutures. The sutures created a tunnel that covered anterior band surface and should help in prevention of band slippage. Postoperative course was uneventful and the patient was discharged home on the third day after the operation.

In 2009 the patient weighted 75 kg, her diabetes and hypertension subsided. With her weight stable over 6 months she received abdominoplasty and repair of a port site hernia. Also in 2009 she was diagnosed with symptomatic gallstones and underwent laparoscopic cholecystectomy. In 2010 the contact with the patient had been lost and it was not until February 2011 when she asked for an appointment. During the visit in January 2011 she had a barium swallow X-ray of the abdomen to check the position of the band and its lumen. The study detected a complete migration of the band into the stomach (fig.1 and 2). Gastroscopy was immediately performed and confirmed the diagnosis. The patient was informed about the findings and the need for intervention was explained. At that time the patient admitted that she had been overeating and vomiting many times in the past year.

The patient was admitted to the hospital under general anesthesia following the disconnection of the tubing system. Subcutaneous port was also removed through a separate incision under left costal margin. There was no damage to the stomach wall and no signs of perforation. On the first day after band removal, stomach X-ray with gastrografin was performed showing no leakage. Postoperative period was uneventful. She was consulted by psychologist, who recognized problems with patient’s compliance and difficulties in adjusting the lifestyle. The patient was discharged home in good condition and on solid food on the fourth day after the procedure. The patient was followed up in 2012 and she kept on gaining weight. She was offered another type of bariatric procedure, but she refused and the contact with her has been lost again.

Fig. 1. Barium swallow X-ray of the abdomen. Complete migration of the band into the stomach

Fig. 2. Barium swallow X-ray of the abdomen. Complete migration of the band into the stomach
DISCUSSION

LAGB or SABG are very common bariatric procedures. These safe procedures, with a little risk of complications, in some centers are performed as a “one-day surgery”. Proper patient’s qualification and selection to this operation along with nutritional education is a must in the clinical success. Our case is an example of a late complication, which might be ignored by doctors and in emergency situations, be dangerous for the patient. Band erosion occurs in 1-9% of patients after LAGB, but almost 50% of patients did not reveal any symptoms (10-13). The risk for complete migration is apparently lesser in larger series, Dargent reported 3 patients with band erosion in the group of 500 patients after LAGB (14). It seems that early erosion cause severe inflammation and may result in a serious consequences including infection of the mediastinum. Late erosion is associated with less severe inflammation and often is asymptomatic. A band erosion should be suspected in a symptom free patient who is gaining weight and feels no restriction. Important contributing factors in band erosion include: overfilling of the band (ischaemia of the stomach wall), an injury to the stomach during the operation (sutures, clipses, electrocautery). Lack of compliance with dietary restrictions and overeating causing extremely high pressures in the upper stomach, may contribute to ischaemic lesions and band erosion.

Both symptomatic band erosion and complete band migration to the stomach, should always be treated by endoscopic removal and laparoscopic suturing of gastric wall if necessary. The reported case confirms the need of treatment for bariatric patients in highly experienced centers. In conclusion, such cases of complete band erosion should always be treated by band removal, but there are no clear guidelines on whether to ligate the stomach again and if so, when to do this. Some other bariatric procedures as sleeve resection or gastric bypass may be also considered.

REFERENCES


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