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Letter to the Editor

Gastric Plication for Repeated Gastric Band Prolapse after Endoscopic Treatment: A Case Report

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Laparoscopic Adjustable Gastric Banding (LAGB) is a simple, safe and effective procedure for treating morbid obesity. However, several complications after LAGB have been reported, such as band erosion, prolapse, gastric perforation, abscess, tube disconnection, port flip down and infection.

These complications could be the main cause of failure after LAGB. For this reason, revisional weight-loss surgery after failed LAGB might be considered [1].

Band prolapse is a significant and common late complication after LAGB [2]. We have performed endoscopic treatment of band prolapse as we reported [3].

However, band prolapse occurred repeatedly in two cases. We present a patient with repeated prolapses after endoscopic treatment that required gastric plication treatment. A 35-year-old woman with BMI (Body Mass Index) 40 underwent LAGB procedure to treat her obesity using the pars flaccida technique with no implication suture, and port placement under the anterior sheath of the rectus abdominis muscle. The patient presented a history of onset of band prolapse 22 months after the LAGB procedure. The symptoms of prolapse were sudden abdominal pain and repeated vomiting. An endoscopic procedure was performed after deflation of the band under intravenous anesthesia. Band prolapse was diagnosed and treated by endoscopy.

After a prolapsed stomach pouch was found, we inflated it with air. The prolapsed stomach pouch was gradually reduced as the stomach was inflated with air. The stomach was fully reduced and finally the band returned to its normal position. After reduction, the entire lumen of the stomach was examined to check its normality. However, the patient had the second episode of band prolapse that required endoscopic treatment five months after the first one. We treated it with the same endoscopic technique as above. The patient had recurrence that was treated by the endoscopic reduction technique 13 months after the second episode. The third endoscopic treatment of band prolapse was performed for an hour resulting in failure. She was sent to operating room and underwent laparoscopic reduction with two-row gastric plication. The gastric greater curvature was plicated using 2/0 prolen from fundus at the level of diaphragm preserving the His angle to 10cm proximal to the pylorus. It took 70min for the whole procedure with 3 trocars under general anesthesia. The patient was discharged in good condition 3 days after surgery. Fifteen months later, there was no evidence of recurrence.

Not all anterior band prolapses have reduced by band deflation and endoscopic approach. When we found any sign of infection or perforation inside the stomach, we fixed it operatively. Otherwise, almost all the band prolapses after such sutureless LAGB without delay in diagnosis can be fixed easily with an endoscopic procedure. Those patients with repeated band prolapses could be treated by one-row or two-row plication technique. The gastric greater curvature was plicated using 2/0 prolen from fundus at the level of diaphragm preserving the His angle to 10cm proximal to the pylorus. The aim of the plication was restriction of the prolapsed portion of the stomach via folds from its own wall [4]. However, we need long term follow-up to evaluate the efficacy of the gastric plication and endoscopic treatment of the band prolapse.

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