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Image in Medicine

Megaesophagus after gastric band placement for the treatment of morbid obesity

Megaesôfago pós-colocação de banda gástrica para tratamento de obesidade mórbida

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Introduction

Gastric band is considered a less efficient treatment when compared to Roux-en-Y gastric bypass, although it is still used due to ease of implementation and low rate of perioperative mortality. At long term, the complications have been high, making this surgery almost prohibitive.¹

This paper presents a case of megaesophagus grade IV after gastric band placement to treat morbid obesity.

Case presentation

Patient was 53-years, male, and, undergone a gastric band placement to treat morbid obesity for 9 years. One year ago he started presenting dysphagia, reflux, choking, coughing and wheezing.

Upper endoscopy was performed, showing erosive esophagitis, esophageal dilation and constriction in the gastric body with difficulty passage. Constriction was found at 3 cm from esophagogastric transition.

Contrastive X-ray of esophagus, stomach and duodenum showed dilated esophagus (grade IV) and dilation of stomach

to the proximal portion where is the already deflated gastric band, at 3 cm from the esophagogastric transition (Figs. 1 and 2).

Discussion

Stomach and esophagus dilation are rare, occasional descriptions of complications of gastric band. There are cases described of bronchoaspiration in late postoperative of gastric band placement. Bronchoaspiration is a serious complication that should be prevented by immediate deflation of the gastric band.²

A trial with 167 patients treated with gastric band showed disturbances of esophageal motility in 68% patients, and esophageal dilation in 25.5% patients. Six patients developed megaesophagus grade IV needing to remove the band.³

The gastric band can result in disturbances of esophageal motility and relaxation of the lower esophageal sphincter, allowing the expansion of the esophagus. Pre-surgery manometry is not able to predict these events, and in most dilation cases, removing the band is the only possible treatment.⁴

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Fig. 1 – Dolichos megaesophagus and dilatation of the stomach proximal to the band with esophagogastric stasis of the contrast.



Fig. 2 – Overview showing the band preventing adequate passage of the contrast to the distal stomach.

Some patients lacking proper instructions regarding food use the esophageal dilation as food reservoir, with consequent reflux and insufficient weight loss.⁵

Conclusion

What we have seen in daily medical care is that the gastric band has poor results in weight loss and high complication rates. These results have inhibited the indication of gastric bands worldwide, with failure rates reaching 60% in some studies. Several complications have been reported, the most common are insufficient weight loss, ischemic ulcers in the stomach in the band region, stomach dilation proximal to the band, and dysphagia. Now it is known that at long term megaesophagus with important dysphagia can occur, leading to the need for removal of the band and conversion to another type of surgery more efficiently and with fewer complications to treat morbid obesity.

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