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A good lesson on lap bands in pregnancy – A slipped gastric band in a 33-year-old pregnant woman presenting with gastric outlet obstruction: A case report

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Introduction

The number of women of reproductive age undergoing metabolic surgery is on the rise, resulting in an increase in pregnancies after restrictive weight loss surgery techniques such as Laparoscopic Adjustable Gastric Band (LAGB). While bariatric surgery may help protect obese women and their babies from obesity related complications during pregnancy, the potential risks and complications associated with restrictive weight loss surgery techniques (such as LAGB) during pregnancy are not fully understood.

Case presentation

A 33-year-old 1+0 at 22 weeks' gestation was referred from a maternity unit with intractable vomiting, nausea and malnourishment. This was on a background of a LAGB insertion 6 years previously. She had persistent weight loss, nausea and epigastric pain despite deflation of the gastric band earlier in pregnancy. MRI and subsequent gastroscopy demonstrated slippage of the band to the level of the gastric antrum and erosion into the stomach without perforation. There was an endoscopically impassable obstruction at the gastric outlet and significant proximal gastric dilatation. A nasojejunal feeding tube could not be passed. Given degree of stomach dilatation and complete obstruction, decision was made to proceed to surgery for removal of the LAGB.

At surgery, the band was found to encircle the gastric antrum causing a complete obstruction. There was a thick fibrous capsule around the band, and the proximal stomach appeared dilated, injected and atonic. The band was removed successfully in the usual fashion. The patient required a return to theatre in the early post-operative period due to bleeding from a superficial epigastric vessel damaged at the time of port placement.

The patient was monitored postoperatively in the hospital, started on a clear liquid diet and gradually progressed to soft foods as tolerated. Foetal monitoring was maintained throughout the procedure and recovery. The patient's tolerated diet

and began to meet calorific requirements after the surgical removal of the gastric band. She was transferred on postoperative day 4 in stable condition to her referring maternity hospital. The pregnancy remains ongoing without further complications.

Discussion

Slipped gastric band is a rare but serious complication of restrictive bariatric surgery, occurring in approximately 5% of patients with adjustable gastric bands [1]. The mechanism typically involves a misplacement of the band around the stomach, leading to gastric outlet obstruction.

In terms of the management of uncomplicated LAGB in pregnancy (and the potential avoidance of complications of LAGB) there remains no consensus. A 2013 Cochrane review found no evidence to favor either elective deflation or maintaining gastric band balloon inflation in pregnancy [2].

Symptoms of band slippage can include nausea, vomiting, and epigastric pain, which may mimic pregnancy-related gastrointestinal symptoms. In pregnant women, delayed diagnosis may occur due to overlapping symptoms with common pregnancy complaints such as morning sickness and gastroesophageal reflux [3]. In severe cases, gastric perforation and foetal demise can occur [4].

There is a paucity of literature on the management of slipped bands in pregnancy. Conservative management [5] and postpartum surgical removal [3,6] have been described but this is the first report of a surgical intervention to manage a slipped band (although removal of LAGB in a patient in her first trimester with tubing related complications has been reported [7]). While non-surgical interventions, such as band adjustment or conservative management, may be appropriate in some cases, surgical removal is required when the slippage causes significant obstruction or other complications, as seen in this case. This patient underwent timely surgical intervention, which resulted in complete resolution of her symptoms and an uncomplicated pregnancy outcome.

Although this case highlights issues with LAGB in pregnant patients, the safety of pregnancy post metabolic surgery and reduction of obesity related complications in pregnancy such as gestational diabetes and maternal hypertension have previously been elucidated [8,9] and warrant mentioning. A distinction should be drawn between the difference between restrictive bariatric surgery, such as LAGB and other more clinically effective surgeries [10] such as sleeve gastrectomy and gastric bypass which would confer the above benefits without the tubing and band related risk profile.

Conclusion

This case demonstrates the importance of considering gastric band slippage in the differential diagnosis of gastric outlet obstruction in pregnant women as well as the potential risks associated with the continued use of LAGBs. In stark contrast to the literature, surgical removal of the LAGBs can be a safe and effective treatment, leading to improved maternal outcomes. A multidisciplinary approach is recommended for optimal management of such cases and a transition away from LAGB use to other, more effective, bariatric surgery techniques would prevent its occurrence in the first place.

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