Internal Hernias May Follow Gastric Bypass

BY DAMIAN MCMANAMA
Miami Bureau

ORLANDO — Although internal hernias occur infrequently, they are a potential complication of bariatric surgery that can develop long after gastric bypass surgery, according to a study presented by Brennan J. Carmody, M.D., at the annual meeting of the American Society for Bariatric Surgery.

“Internal hernia can be a devastating postoperative complication that leads to intestinal obstruction,” he said. With an overall incidence of 2.9%, clinical suspicion for internal hernia needs to be high.

Consider internal hernia when a bariatric surgery patient presents with abdominal pain. If more than a year has passed since the procedure was done, Dr. Carmody suggested. In his study, all 20 patients who required surgery to correct an internal hernia initially presented with abdominal pain. Nausea, vomiting, and bowel obstruction are other clinical clues.

Dr. Carmody and his associates reviewed 785 laparoscopic gastric bypass procedures performed between 1998 and 2003 at Virginia Commonwealth University Medical Center in Richmond. The mean preoperative body mass index was 47 kg/m², and BMI was a mean 31.2003 at Virginia Commonwealth University.

There might be a reluctance to re-examine patients with vague symptomatology, Dr. Carmody said.

But that is not the only challenge. A mean of 303 days elapsed between bypass and development of symptoms in his study. The patient with a late complication may not see the same bariatric surgeon who performed the procedure, he said.

“Internal hernia may not be obvious on routine chest and abdominal X-rays,” Dr. Carmody concluded.

“An uneventful course following surgery does not eliminate the possibility of an internal hernia. Symptoms may develop days or even years after surgery,” Dr. Carmody said.

“Internal hernia can occur long after gastric bypass with variable presentation,” Dr. Carmody said. Such patients are now offered repair of the hernia or crural defect. Of those who presented with severe reflux at a mean of 44 months following LAGB, all were on proton pump inhibitor therapy. After considering band removal, four had severe dysphagia, nine had hiatal hernia/concentric dilatation, and six had slipped bands.

Crural Defect Repair Can Salvage Many ‘Failed’ LAGB Procedures

BY SHARON WORCESTER
Tallahassee Bureau

HOLLYWOOD, Fla. — Undiagnosed hiatal hernias or large hiatal crural defects account for many failed laparoscopic adjustable gastric banding procedures, and correcting these defects can obviate band removal, George A. Fielding, M.B., reported at the annual meeting of the Society of American Gastrointestinal and Endoscopic Surgeons.

In one series of 2,450 patients who underwent laparoscopic adjustable gastric banding (LAGB), 5% experienced symptomatic failure. Most of these failures were a result of reflux or dysphagia, and many of the patients were found to have a hiatal hernia or large hiatal crural defect, Dr. Fielding wrote in the “poster of distinction” that he presented at the society meeting.

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Among 2,450 patients who underwent LAGB, 5% experienced symptomatic failure; most of these failures were a result of reflux or dysphagia. Dr. Fielding concluded. Such patients are now offered repair of the hernia or crural defect. Of those who presented with severe reflux at a mean of 44 months following LAGB, all were on proton pump inhibitor therapy. After considering band removal, four had severe dysphagia, nine had hiatal hernia/concentric dilatation, and six had slipped bands.

Gallstone Prophylaxis Is Called Costly And Unwarranted After Gastric Bypass

ORLANDO — Cholecystectomy or 6 months of prophylactic medication to prevent gallstones after gastric bypass surgery is unwarranted for most patients and is expensive, according to results of a study presented by Joseph A. Caruana, M.D., at the annual meeting of the American Society for Bariatric Surgery.

Dr. Caruana and his associates studied 100 women and 25 men after open Roux-en-Y gastric bypass. None of the participants received ursodeoxycholic acid, a medication often used to prevent gallstones during rapid loss of weight. The procedures were performed at the Sisters of Charity Hospital in Buffalo, N.Y., from June 2000 to July 2002. Participants did not have palpable gallstones at the time of surgery, and required at least 16 months of follow-up for inclusion in the study.

A total of 10 patients (8%) developed symptomatic gallstones that required cholecystectomy. Nine of these 10 women had laparoscopic cholecystectomy, and 1 had an open procedure. There were no serious complications from the gallstones or cholecystectomies, said Dr. Caruana, a laparoscopic fellow at the Sisters of Charity Hospital.

“Prophylactic cholecystectomy would have been unnecessary in 115 patients,” Dr. Caruana said. “The risk and cost of prophylactic cholecystectomy outweigh the benefits. Concomitant cholecystectomy is indicated only when stones are detected pre- or intraoperatively.”

The incidence of symptomatic stones in the first two postoperative years was about 6% per year, Dr. Caruana said. “Most newly formed stones after gastric bypass are asymptomatic.” He added that most patients with asymptomatic stones will remain asymptomatic during their lifetimes.

Many surgeons have proposed prevention with a cholecystectomy at the time of gastric bypass surgery. (Ochsner Surg. 2004;14:763-5). However, “most general surgeons would not remove the gallbladder during other procedures without the presence of stones,” Dr. Caruana said.

Rapid weight loss after gastric bypass surgery can cause gallstones to form in up to 10% of patients, Dr. Caruana noted. For this reason, some experts recommend 6 months of ursodeoxycholic acid. A 6-month course of ursodeoxycholic acid for all 125 participants in the study would have cost $56,250, he said.

A better use of ursodeoxycholic acid might be for symptomatic patients who refuse surgery, he suggested.

—Damian McNamara