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Gastric Hernia After Tubular Gastroplasty☆

Hernia gástrica secundaria a gastroplastia tubular plicada

Dear Editor,

We have read with interest the original article published in your journal by Dr. Pujol Gebelli et al.,[1] which reviewed the cases of patients treated at their hospital with laparoscopic gastric plication. We have recently treated a patient with a gastric hernia that resulted as a complication of this technique.

The patient is a 51-year-old patient who had undergone gastric plication for obesity (BMI: 36) and also presented arterial hypertension treated with valsartan. The postoperative period transpired without incident. In the first month, the patient's blood pressure levels had normalised and antihypertensive treatment was suspended. Five months after surgery, the patient presented a weight loss of 32 kg.

Also five months post-op, and after having been asymptomatic previously, the patient came to the emergency room of our hospital with abdominal pain and vomiting that had been progressing for several hours. During the examination, the abdomen was soft, painful in the epigastrium, with no guarding or signs of peritoneal irritation. Abdominal CT showed evidence of a herniated stomach through the gastroplasty suture (Fig. 1).

Given these radiological findings, urgent surgery was indicated, at which time we observed the gastric fundus herniated through the gastroplasty in the greater curvature. We released the herniated tissue, completely disassembled the gastroplasty, and were able to clearly observe the area of the fundus that presented vascular compromise. We performed a sleeve gastrectomy with mechanical sutures (Fig. 2) and reinforced the staple line with Prolene® 3/0. The postoperative period was uneventful and the patient was discharged on the 5th day post-op.

Gastric plication is one of the new restrictive techniques within the arsenal of bariatric surgery that is still in the validation period and the process of defining its indications as well as perioperative management.[2–4] It is a variation of vertical sleeve gastrectomy with the theoretical advantage of presenting a lower possibility for complications as it does not require resection[3,4] and thus avoids the much-feared leakage in the proximal gastric suture. It is also a potentially reversible technique. Complications, if they appear, are usually early-onset and can include sialorrhea, nausea and vomiting, which generally recede in the first few days.

In our case, we were faced with a severe late-onset complication that required urgent reoperation that was resolved with a reconversion to sleeve gastrectomy.

The particularity of this case, unlike the case published by Dr. Pujol and other publications reviewed in the literature, is that the complication occurred 5 months after surgery, and the patient had experienced a postoperative period with no

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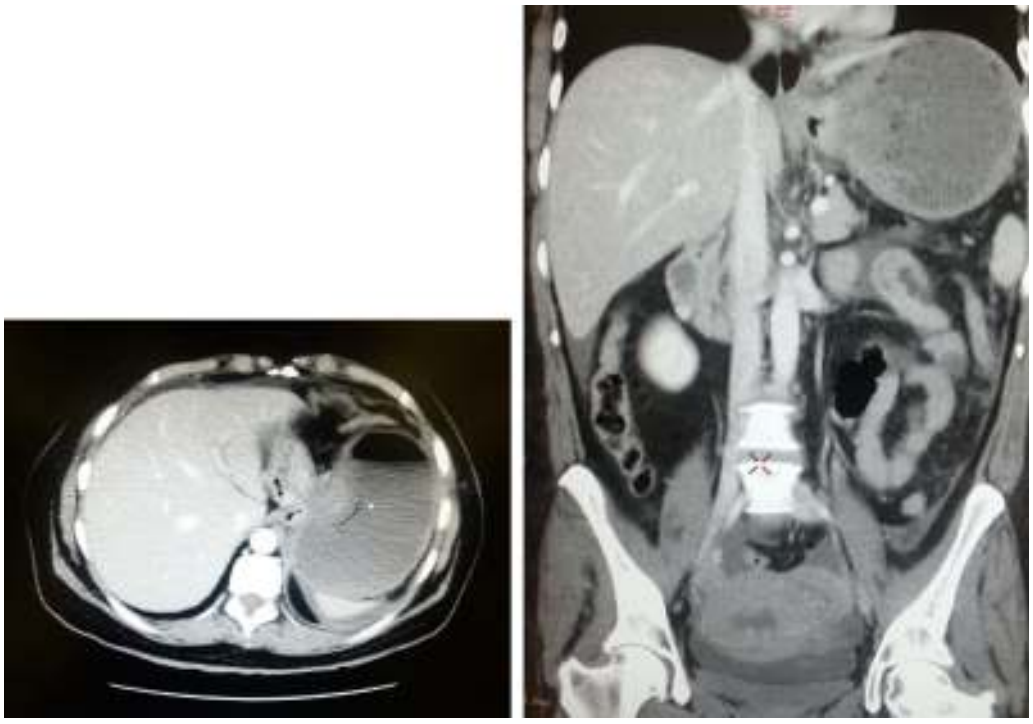

Fig. 1 – Abdominal computed tomography in the ER showing gastric hernia.

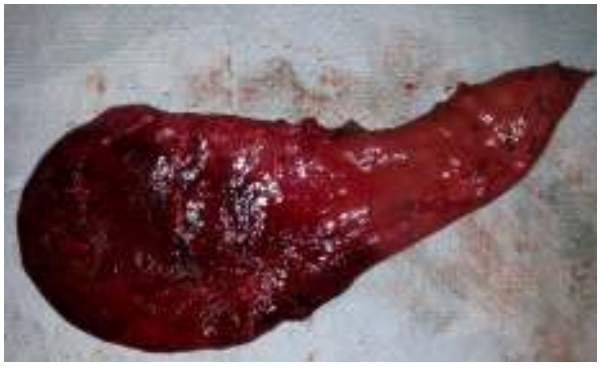

Fig. 2 – Surgical piece after vertical sleeve gastrectomy.

incidents, good weight loss, resolution of comorbidities, and several months of a normal diet.

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