Use of a Lumen-Apposing Metal Stent for Management of Pouch Outlet Stenosis After Vertical Banded Gastroplasty

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ABSTRACT
Lumen-apposing metal stents (LAMSs) offer a novel alternative for the treatment of anastomotic strictures or short, benign gastrointestinal strictures. In the bariatric realm, LAMSs provide a potentially safer, efficacious, and nonsurgical approach to surgical revision. Here, we present a case where a LAMS was successfully used to manage pouch outlet stenosis from a previous vertical banded gastroplasty.

INTRODUCTION
The need for bariatric surgery in the United States parallels the rising obesity epidemic, with current estimates suggesting that nearly 40% of the adult population is categorically overweight or obese.1 Bariatric surgery can have serious complications, including hemorrhage, obstruction, anastomotic leaks, internal hernias, or anastomotic stenoses, any of which may ultimately require surgical revision.2 Unfortunately, these revisions also present unique challenges and carry an even higher risk of perioperative and postoperative complications.3 One common complication is a anastomotic stricture or short, benign gastrointestinal stricture (SBGS). Current nonsurgical management for SBGS includes balloon dilation, steroid injection, incisional therapy, and placement of a fully covered self-expandable metal stent (FCSEMS).4 However, these therapies carry high recurrence rates and risks of stent migration.4 The emergence of lumen-apposing metal stents (LAMSs) have drastically changed the approach to SBGS.5 We present a case where a LAMS was successfully used to treat pouch outlet stenosis as a result from a previous vertical banded gastroplasty (VBG). This use of a LAMS offers a novel alternative to surgical revision for the management of pouch outlet stenosis in the setting of previous VBG.

CASE REPORT
A 69-year-old woman with history of VBG, performed in 1987, presented with long-standing nausea, vomiting, and decreased oral intake. An upper gastrointestinal series was performed which demonstrated an intact VBG with a normal-sized pouch, intact staple line, and pouch outlet stenosis at the banded channel (Figure 1). The stricture was visualized with an esophagogastroduodenoscopy (EGD) and subsequently dilated with a through-the-scope balloon dilator to 11 mm. The patient had a recurrence of symptoms shortly after dilatation. She was then referred to interventional gastroenterology for further management. Conversion to a Roux-en-Y gastric bypass (RYGB) was discussed with the patient; however, after discussion with the bariatric surgery team, a decision was made to pursue a step-up approach starting with the least invasive option (ie, placement of a LAMS) with consideration to conversion to an RYGB as a last resort. A repeat esophagogastroduodenoscopy was then performed identifying the stenosed VBG, and a contrast medium was injected to identify the length of the stricture (Figure 2). Next, a 20-mm × 10-mm LAMS was deployed across the 7-mm stricture under fluoroscopic guidance (Figure 3). The stent was then dilated under fluoroscopic guidance and secured in place with a single 2-0 polypropylene suture in an interrupted fashion with the use of the overstitch device (Figure 4). The patient was discharged home without any intraop or postop complications. At 6-week follow-up, she was able to tolerate a regular diet and remained...
symptom-free. The decision was made to keep the LAMS in place for 6 months to avoid recurrence of symptoms given extrinsic compression from the VBG. The stent was successfully removed at the 6-month follow-up visit, and she continues to remain symptom-free.

DISCUSSION

The literature reports that upward of 56% of bariatric surgery will require some revision, with VBG being among the most common. VBG, first described in 1978, is a restrictive procedure that involves creating a gastric pouch. The pouch is partitioned along the lesser curvature of the stomach by a vertical staple line and connected to the remainder of the stomach by a stoma, encircled with a band. VBG has fallen out of favor with the evolution of bariatric surgical techniques; however, bariatric surgeons and gastroenterologists still face late postoperative complications of VBG, which include stenosis of the banded channel, staple line dehiscence, pouch dilatations, and fistula formation. Given the clinical complexity of the disease and after considering the pros and cons of a second procedure, most surgeons favor revisional bariatric surgery or reoperation; yet, guidelines concerning the bariatric surgical standard for reoperation do not exist. However, several options do exist for VBG reoperation: a new restrictive procedure (re-VBG), conversion to an RYGB, or conversion to a biliopancreatic diversion. Revisional bariatric surgery, most commonly conversion to an RYGB, remains the mainstay of therapy but is often technically challenging and carries a high risk of complications such as anastomotic leak, strictures, and infection. However, reports do indicate that conversion to an RYGB to be more effective than a re-VBG. Nonsurgical management offers an alternative to revisional bariatric surgery for the management of complications such as SBGS in the setting of previous VBG.

The mainstay of therapy for nonsurgical management for SBGS in the setting of previous VBG includes balloon dilation, steroid injection, incisional therapy, and placement of an FCSEMS. Although through-the-scope balloon dilation is the initial recommended management in postbariatric strictures, dilatation carries a risk of perforation and high likelihood for recurrence.

**Figure 1.** Stenosed vertical banded gastroplasty as seen on an upper gastrointestinal series.

**Figure 2.** Stenosed vertical banded gastroplasty as seen on esophagogastroduodenoscopy.

**Figure 3.** Lumen-apposing metal stent deployed across stricture as seen on esophagogastroduodenoscopy.
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DISCLOSURES

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