

Dilation of a Post-Roux-En-Y Gastric Bypass Stricture

CRE™ WIREGUIDED BALLOON DILATOR Technique Spotlight



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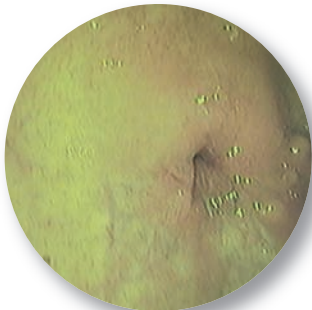


Figure 1

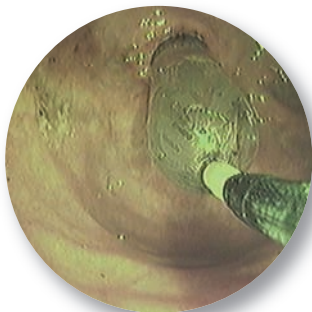


Figure 2

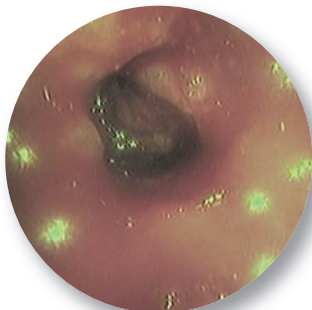


Figure 3

HISTORY

A 22-year-old female presented to The Bariatric Institute at Cleveland Clinic Florida for evaluation for potential bariatric surgery. Her past medical history was significant for morbid obesity (body mass index 42 kg/m²), obstructive sleep apnea, and GERD. Of note, her parents were also both morbidly obese and had undergone bariatric surgery.

The patient underwent a laparoscopic Roux-en-Y gastric bypass with a combined linear stapler and hand-sewn gastrojejunal anastomosis. The surgery and postoperative stay were uneventful and she was discharged home on postoperative day three. Three weeks after surgery, the patient complained of difficulty with a pureed diet and progressive dysphagia to liquids, with concomitant nausea and vomiting. She presented with a weight loss of 30 lbs during that time and was mildly dehydrated.

PROCEDURE

The patient was admitted for IV hydration, multivitamin and mineral supplementation, and an esophagogastrojejunoscopy (EGJ) with possible dilatation. During the endoscopy, performed the following day, the endoscope was advanced to the level of the gastrojejunostomy and revealed a narrow anastomosis of approximately 4 mm in diameter (Figure 1) due to the recent surgical procedure. In order to facilitate the passage of the catheter through the anastomosis and minimize trauma as well as any risk of perforation, a CRE™ Wireguided Balloon Dilator was employed. A 6-7-8 mm CRE Balloon was advanced through the channel of the endoscope. The floppy tip was positioned across the stricture, under direct vision. Once in place, the CRE Balloon was advanced over the guidewire, leaving approximately one third of the balloon beyond the stricture. The CRE Balloon was then inflated to 6, 7, and then 8 mm (Figure 2), for 3 minutes at each diameter. The 6-7-8 mm CRE Balloon was then removed and replaced with a 8-9-10 mm CRE Balloon. Adequate dilation was noted with minimal bleeding (Figure 3). The patient tolerated the procedure well and was discharged home the following day, tolerating liquids comfortably.

POST PROCEDURE

Since it is my personal choice not to use more than two catheters (6 balloon sizes) during a single session, the patient was scheduled for a planned repeat dilatation in two weeks time, to achieve a desirable sized anastomosis of approximately 12-15 mm. The procedure was successfully repeated two weeks later using 8-9-10 mm and 10-12-13.5 mm CRE Balloons. Four months post surgery the patient was tolerating all foods well, with a total weight loss of 56 lbs since her surgery and was very pleased with her quality of life. After one year, she has lost 77 pounds and her current BMI is 25 with excellent quality of life.

SUMMARY OF CLINICAL EXPERIENCE

At The Bariatric Institute at Cleveland Clinic Florida, our stricture rate in over 2300 cases is 6.7%. The time from surgery to diagnosis is 17 to 163 days (mean 47), with 1 to 5 dilatations per patient (mean 1.6), and only one perforation. It is my personal preference to use the CRE Wireguided Balloons for dilatation when the anastomosis measures less than 5 mm. The use of a guidewire is a much easier option of safely and accurately passing the catheter through the anastomosis, prior to inflation of the balloon for dilatation.

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