Endoscopic approach to bariatric surgery.
The role of double-balloon enteroscopy

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CLINICAL CASE

In this paper we report the case of a 34-year-old woman who underwent laparoscopic bariatric surgery—a gastric bypass with antropyloric exclusion—8 years before, with no postoperative complications. She was admitted to our unit because of severe ferropenic anemia that required blood transfusion and the usual gastroscopy and colonoscopy procedures. DBE showed a normal mucosa of the small bowel up to the anastomosis, reaching the pylorum backwards without any injuries, and even exceeding the pylorum (Fig. 1) up to the gastric stump, where we could observe an ulcer that was the origin of the digestive hemorrhage. We could observe it with more precision with retroversion view in the same cavity (Fig. 2). We could see a normal papilla in situ.
COMMENTARY

Obesity surgery is, in the long term, the best and only therapeutic option to achieve weight loss and to improve comorbidity in cases of morbid obesity. Among surgical procedures, bypasses produce a gastric exclusion following intestinal anastomosis, with the result that the stomach is beyond the reach of conventional endoscopy. Roux-en-Y assemblies usually have about 100 centimeters anterogradely and 100 centimeters to the pylorus in retrograde sense.

Double-balloon enteroscopy (DBE) (1), described by Yamamoto, allows a total exploration of the small bowel by the oral route (2), hence it is an ideal technique for the exploration of this organ.

Increased recommendations for bariatric surgery due to increasing obesity among the population can create the problem of not having access to the excluded stomach via conventional endoscopy. The excluded stomach can be the origin of hemorrhage (in this case, although it would conceptually be a case of upper gastrointestinal hemorrhage) that would not be accessible by conventional therapeutic endoscopy. We still need to know the incidence of neoplasms and other injuries such as those induced by NSAIDs in the excluded stomach. In addition, in cases in which gastrostomy (PEG) feeding is required, the retrograde technique (RPEG) (3) could also allow, after fistula healing, an easy access to the papilla for ERCP.

DBE has proved a useful technique in this case for the analysis of the excluded stomach following bariatric surgery, while opening up new possibilities for complementary techniques.

REFERENCES