Acute dysphagia: an unusual treatable cause

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Bariatric surgery is a rapidly expanding surgical sub-speciality, with a large proportion of the relevant surgical procedures being performed in the private sector. Acute complications of newer surgical procedures can lead to emergency department presentation, with which the staff may be unfamiliar. A 34-year-old woman was seen in the emergency department with acute total dysphagia following laparoscopic adjustable gastric banding, which was treated successfully by a simple bedside procedure.

A 34-year-old woman attended the emergency department with an acute onset of difficulty in swallowing both liquids and solids, of 3 days' duration. She had attended two other emergency departments on two occasions, each with the same complaint during this period, and had been diagnosed as having viral gastritis.

When seen in our department, she also complained of burning retrosternal chest pain and constipation, both of the same duration. On further questioning, it was noted that she had laparoscopic gastric banding performed 2 years previously. She was also noted to be on citalopram for depression and propranolol for anxiety.

On examination, she was clinically dehydrated. Her vital signs were within normal limits. Apart from this, examination of the chest, cardiovascular system and abdomen did not reveal any abnormality. The Portacath, overlying the xiphisternum, was palpable, and its location was confirmed on radiographic findings (fig 1).

Her surgeon, based in another city, was contacted over the phone and, following discussion of her presenting complaint, it was concluded that the band might be malfunctioning leading to obstruction at the gastro-oesophageal junction. The Portacath was aspirated aseptically using a green needle (21 gauge) attached to a 10 ml syringe; 6 ml of clear fluid was aspirated with immediate and complete relief of her symptoms. She was then admitted under the care of the on-call general surgical team for 24 h of observation. Venous blood tests were within normal limits. She was able to tolerate oral

fluids and was discharged home the following day.

DISCUSSION

The prevalence of morbid obesity is steadily rising in the industrialised world. Surgical methods of treatment are associated with sustained long-term weight reduction, and this has led to an explosion in bariatric surgical techniques, along with their attendant complications. These techniques are currently mainly performed in the UK, primarily in the private sector.

Laparoscopic adjustable gastric banding was introduced as a mode of surgical therapy¹ for morbid obesity in 1993, and since then has become

increasingly popular for its minimally invasive nature as a potentially first choice surgical treatment. It involves placement of an inflatable silicone band around the cardiac (proximal) portion of the stomach, which is tightened or adjusted by injecting fluid into a subcutaneous reservoir port connected to it. Gradual adjustment of the inflation is achieved over a period of time, guided by a feeling of satiety, allowing for gradual weight loss. Several complications of this procedure have been described, but most can be overcome without compromising the possibility for alternative surgical treatments.³

Acute total dysphagia can be a potentially life threatening complication, associated with slippage of the gastric band. Emergency department medical staff may encounter this complication and may have to act urgently in order to decompress the band, which can be achieved by a simple procedure, involving percutaneous aspiration of fluid. An attempt should always be made to contact the patient's surgeon in the first instance, but this may not always be possible as anecdotally many of these procedures are currently being performed abroad on medical tourists from Britain.

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Figure 1 Radiograph showing position of banding.