

Complications

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The common complications are shown in Table 68.6 In sleeve gastrectomy, a staple line leak at the angle of His usually presents any time after discharge up to 30 days, and patients can also deteriorate rapidly with sepsis. Urgent - computed tomography (CT) scanning and relaparoscopy is indicated, with source control by drainage the major goal. Patients are typically in hospital for months and need multiple reinterventions, including any of: endoscopic interventions (stenting, endoscopic vacuum therapy), making a controlled fistula, conversion to gastric bypass and fistula enterostomy. Long-term nutritional support is needed as patients are severely catabolic after complications from both bypass and sleeve surgery. - Anastomotic leakage, bleeding and closed loop obstruction after Roux-en-Y or one-anastomosis gastric bypass can be life-threatening. If a bypass patient is not well after 24 hours urgent consideration should be given to oral contrast X-ray swallow or CT scanning and/or relaparoscopy. Other than a feeling of 'impending doom' patients may have few overt features of sepsis and abdominal examination can be very misleading. Deterioration after an anastomotic leak can be very - rapid and there is no time for delay. Very few patients with gastric bands develop early intra- - abdominal complications. Unfortunately a large number of patients have their bands removed later on if there is inadequate follow-up, a late complication or the patient is unable to tolerate the device. The incidence of late complications is difficult to estimate as so many patients are lost to follow-up. Internal hernias develop as weight is lost and hernia spaces open up after gastric bypass. CT scanning has a high rate of false negatives. for internal hernia, so anyone presenting with severe, cramping abdominal pain 2-3 years after surgery needs to be

Gastric pouch End-to-side duodenoileostomy Removed stomach Biliopancreatic limb Common channel 250-300 cm Figure 68.6 Single-anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S).

high priority for investigation by laparoscopy. Closure of the internal hernia spaces is now standard of care in Roux-en-Y gastric bypass. Summary box 68.5 Acute complications /uni25CF /uni25CF

anastomosis gastric bypass, and gastric banding, and late complications. Early Sleeve gastrectomy Leak at angle of His (1-2%) Intra-abdominal bleed (2-3%) DVT/PE (<1%) Gastric bypass Anastomotic leak (<1%) Intra-abdominal bleed (2-3%) Unspecified obstruction (1-2%) DVT/PE (<1%) Gastric band Access port infection (1%) DVT/PE (<0.1%) Anastomotic leak and staple line dehiscence can be rapidly fatal and require emergency laparoscopy Internal hernias developing after surgery are very difficult to diagnose other than by prompt laparoscopy; they require a high index of suspicion

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