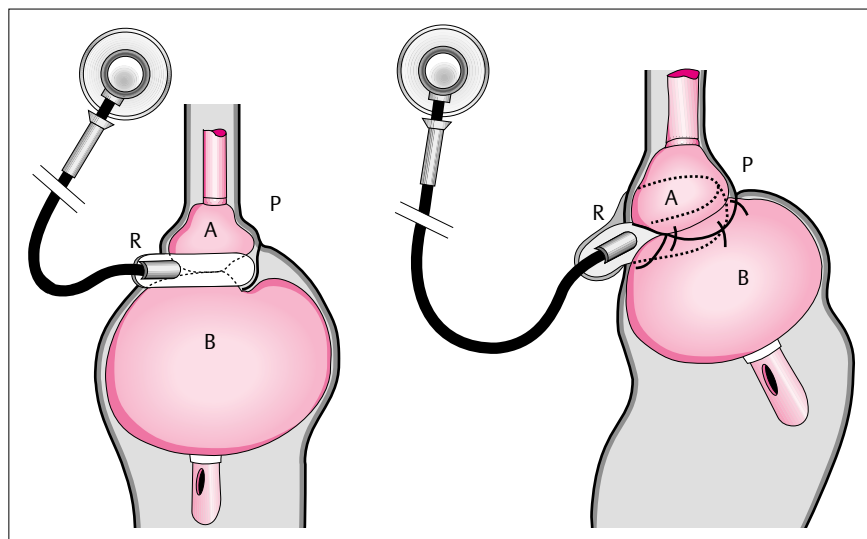


## Sengstaken Balloon Tamponade for Life-Threatening Pouch Hemorrhage after Laparoscopic Gastric Banding

Laparoscopic gastric banding is advocated as a minimally invasive procedure with a low risk profile and high efficacy in the treatment of morbid obesity.

A 34-year-old woman with a body mass index of 48 underwent a laparoscopic gastric banding operation (Swedish adjustable gastric banding, SAGB). The operative technique was performed according to the described and standardized technique [1–3]. A gastric tube was placed in the stomach during retrogastric tunnelling with the goldfinger (Obtech Medical AG, is a smooth tool recommended for dissecting and pulling of the band) and removed after closure of the band and before creation of the pouch. The small pouch was created and secured with five anterior gastrogastic nonabsorbable sutures. The intraoperative and immediate postoperative follow-up was uneventful, but during the first postoperative night the patient developed severe melena and hematemesis. At emergency endoscopy, brisk profound bleeding from the pouch was found with no additional bleeding source. Despite aggressive endoscopic sclerotherapy with injection of, in total, 32 ml of 1% Aethoxysclerol (Kreussler Pharma, Wiesbaden-Biebrich, Germany) over two occasions, hemostasis could not be achieved. Shock necessitated intensive care observation and the transfusion of 9 units of packed red cells. A Sengstaken-Blakemore tube was introduced (Figure 1) and blocked. The esophageal balloon was filled with 40 ml of water and the stomach balloon was inflated with 120 ml of air. After placement of the tube, immediate hemostasis was achieved. No further signs of bleeding occurred and a gastroscopy 1 day later confirmed hemostasis. The patient was subsequently discharged on the fifth postoperative day. At 1- and 2-month follow-up the patient had no complaints and had a total weight loss of 23 kg. All laboratory values were in the normal range.

We hypothesize that the bleeding was related either to the removal of the gastric tube by the anesthetist while applying suction to the tube or to one of the pouch sutures. Control of such bleeding using an endoscopic approach is nearly impossible because the pouch is too small to allow direct vision. In such a situation, we



**Figure 1** The Sengstaken-Blakemore tube. A, esophageal balloon; B, gastric balloon; P, pouch; R, adjustable band

recommend the use of the Sengstaken-Blakemore tube with the method described above.

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