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Endoscopy after Bariatric Surgery Case Series

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Morbid Obesity contributes to the constellation of medical comorbidities that comprise Metabolic Syndrome. As >2/3 of America is Overweight (BMI 25-29.9) or Obese (BMI 30+). There are many treatment modalities for Morbid Obesity, but none is more effective long term than Bariatric Surgery, not even the newest GLP-1 agonists can compete with the Laparoscopic Sleeve Gastrectomy (LSG) or the Roux-en-Y Gastric Bypass (RYGB). About 300,000 Metabolic and Bariatric Surgery (MBS) procedures were performed yearly (1/1000 population of the US per year).

As surgical treatment for Morbid Obesity becomes more common, we as Gastroenterologists must continue to learn about the topic and how to treat potential complications. Sleeve Gastrectomy continues to be the most performed procedure, RYGB continues to be 20-25% of the MBS volume yearly. RYGB complications that may require Endoscopic interventions may include: Leak (which is usually at the Gastro-Jejunostomy/GJ) and may require stenting, Stricture (which may require dilation with either an endoscopic balloon or with a bougie, Formation of Marginal Ulcers, Bleeding (which can require any number of methods to control endoscopically, owing to the stomach's rich blood supply), Perforation, Pouch or GJ enlargement.

The Gastrogastic Fistula (GGF) is a rare (1%) but complex problem that requires clinical insight and suspicion. GGF typically presents with: weight regain, pain, worsening GERD symptoms. It may occur because of a complication from surgery (leak, infection, bleed) where a fistula forms between the gastric pouch and the remnant stomach due to a staple line breakdown. Alternatively, it may result from iatrogenic methods.