When sleeve gastrectomy fails: adding a laparoscopic adjustable gastric band to increase restriction

Alexander J. Greenstein · Anthony J. Vine ·
Brian P. Jacob

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Abstract The use of laparoscopic sleeve gastrectomy (LSG) as a procedure for morbid obesity has recently increased. The LSG procedure is used most often as a part of a biliopancreatic diversion with duodenal switch (BPDDS) or as a first stage that can be converted to a BPDDS or Roux-en-Y gastric bypass (RYGB) [1, 2]. However, the surgical indications for LSG have rapidly expanded, and some centers use the sleeve as the primary operation for morbid obesity [3, 4].

The utility of LSG as a primary procedure is controversial, with consensus lacking in the literature. Whether the etiology of failed sufficient weight loss is the result of an inadequate sleeve or attributable to dilation or hypertrophy of the sleeve, the incidence of failed sleeve gastrectomies may be significant.

In the treatment of a patient with a failed LSG, the options typically include creation of a tighter sleeve or conversion to biliopancreatic diversion or RYGB [5]. These procedures, however, are complex and can carry significant morbidity.

The authors report a case of a morbidly obese 42-year-old man who failed to lose sufficient weight after an LSG. Because the patient was dependent on several oral antipsychotic medications, he refused any malabsorptive

procedure, and a decision was made to proceed with laparoscopic adjustable gastric banding (LAGB). The case proceeded successfully, and at this writing, 9 months after surgery, the patient has achieved a 57% excess weight loss from an original weight of 390 lb.

The insertion of an LAGB into its normal anatomic position is feasible after a sleeve gastrectomy, and its use can induce sufficient restriction and weight loss results equivalent to those of a sleeve or band alone and possibly better.

Keywords Band · Gastrectomy · Laparoscopic · Obesity · Revision · Sleeve

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A. J. Greenstein · A. J. Vine · B. P. Jacob (✉)
Department of Surgery, The Mount Sinai Medical Center,
1010 Fifth Avenue, New York, NY 10028, USA
e-mail: Brian.Jacob@mssm.edu