



INTERFACE OF ENDOSCOPY X ADJUSTABLE GASTRIC BAND (AGB). 356 ENDOSCOPIES IN 1111 BANDS

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BACKGROUND: The Adjustable Gastric Band (AGB) is one of the approved options in terms of bariatric surgery with is less invasive with lower mortality rate, but the reports inform more complications and re-operation rate that the so-called golden standard in bariatric surgery, the gastric bypass. Endoscopic evaluation and surveillance on the follow-up of AGB band is an important tool with its interface will be described. **AIM:** Evaluate upper endoscopies and endoscopic procedures in a series patients submitted to laparoscopic AGB in a 4 year period. **CASUISTIC:** Between December of 1999 and July of 2004, 1111 patients were submitted to AGB under NIH indications for bariatric surgery. Among those AGB patients, 356 were submitted to upper endoscopies and procedures by endoscopists of reffer centers with proper training in dealing with endoscopy in AGB. 217 were female (61%) with a follow-up between 45d e 4y (M=20months) and had their data retrospectively analyzed. **METHODS:** The endoscopic evaluation of the AGB consists in analyze the esophagus looking for dilatations and esophagitis. In the gastric pouch, the endoscopists had to look for its extension, mucosal damage, contents, centralization and shape. The stoma was evaluated in terms of its axis and if it is easy to pass trough. In the stomach the band fundoplication was analyzed by its shape and integrity. The rest of the stomach and duodenum were analyzed on routine manner. **RESULTS:** From 356 (32% of 1111 AGB) patients submitted to endoscopies in this AGB series, 259 (72,7%) were considered as normal (compatible with the endoscopic expectations of AGB), with a gastric pouch in between 5cm (M = 2cm), stoma centered and easy to pass and a compatible fundoplication on u-turn maneuver. 53 (14,8% of endoscopies) presents with any grade of erosive esophagitis . Esophageal dilatation - achalasia like occurred in 2 (0,56%), Food impaction in 1(0,28%). The main complications found on the AGB endoscopies were; slippage in 31 (8,7%) and band migration in 10 (2,8%) patients .The patients with esophageal dilatation had their band deflated, the food impaction was removed, patients with slippage had their band repositioned by laparoscopy and 5 of the migrated bands were removed by endoscopy. **CONCLUSION:** By the numbers presented above it is clear that the interface between AGB and endoscopy plays an important rule on the follow-up of these patients and should be stimulated on bariatric surgery service that performs this technique.