Pooja M. Jotwani, MBBS; Anish V. Patel, MD

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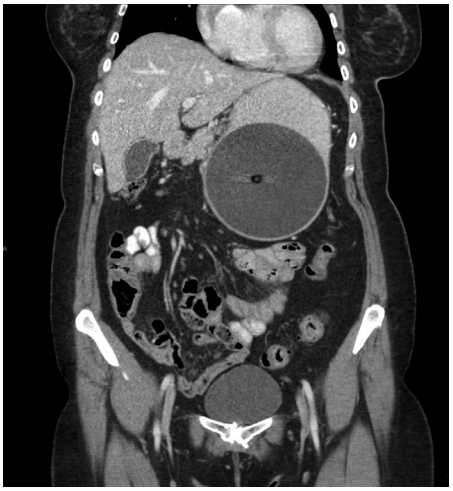

Figure 1. CT of the abdomen and pelvis with oral contrast (coronal view), showing an air- and fluid-filled intragastric balloon in the proximal midstomach, measuring 12 cm and occluding much of the gastric lumen.

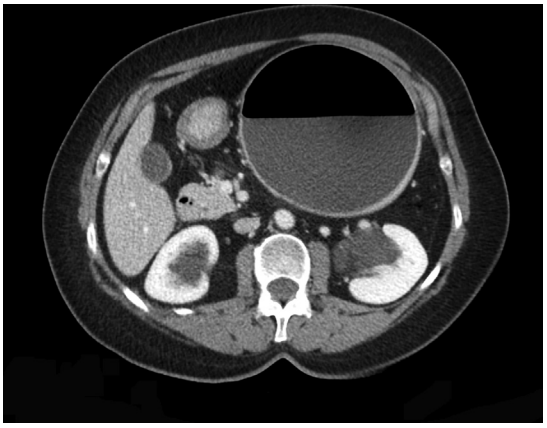

Figure 2. CT of the abdomen and pelvis with oral contrast (axial view), showing an air- and fluid-filled intragastric balloon in the proximal midstomach, measuring 12 cm and occluding much of the gastric lumen.

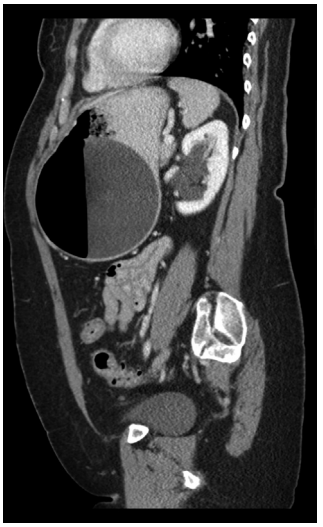

Figure 3. CT of the abdomen and pelvis with oral contrast (sagittal view), showing an air- and fluid-filled intragastric balloon in the proximal midstomach, measuring 12 cm and occluding much of the gastric lumen.

Figure 4. Upper endoscopy revealed the intragastric balloon in the proximal midstomach. The intragastric balloon was punctured with a Carr-Locke needle, with visualized deflation.

[Ann Emerg Med. 2019;73:18.]

A 53-year-old woman with obesity (body mass index 39 kg/m^2) presented to the emergency department with nausea, vomiting, and inability to tolerate oral intake for 5 days. She had had an intragastric balloon placed 1 week ago for weight loss. She was in mild distress but hemodynamically stable. Physical examination revealed mild epigastric tenderness. Laboratory studies showed normal WBC count, as well as normal liver enzyme, lipase, and lactate levels. Computed tomography (CT) of the abdomen was performed.

For the diagnosis and teaching points, see page 39.
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(continued from p. 18)

DIAGNOSIS:

Gastric outlet obstruction caused by intragastric balloon. The CT revealed an air- and fluid-filled intragastric balloon in the proximal midstomach, measuring 12 cm and occluding much of the gastric lumen, with minimal passage of oral contrast into the small bowel (Figures 1 to 3). An upper endoscopy was performed. The balloon was punctured multiple times with a Carr-Locke needle and biopsy forceps (Figure 4). This caused deflation of the balloon and allowed its endoscopic extraction. The patient tolerated oral intake postprocedure, with resolution of her symptoms.

Gastric outlet obstruction after intragastric balloon placement occurs primarily because of spontaneous deflation and distal migration of the balloon. However, balloon overinflation may also cause obstructive gastrointestinal symptoms, as in our patient. These complications may occur in the first few days after placement. It is a diagnostic challenge because patients can have nonpathologic nausea and vomiting during the first week after balloon insertion.[1] Urgent CT of the abdomen on presentation is essential for early diagnosis. If left untreated, the obstruction may result in gastric wall ischemia, necrosis, and perforation, requiring emergency surgery. Early endoscopic balloon deflation by puncture and extraction is recommended to prevent further complications.[2,3]

Author affiliations: From the Byramjee Jeejeebhoy Government Medical College, Pune, India (Jotwani); and the Department of Gastroenterology, Zucker School of Medicine at Hofstra/Northwell, New Hyde Park, NY (Patel).

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