



Unforeseen Postoperative Complication in a Bariatric Patient: The Rare Case of a Large Phytobezoar Causing Gastric Outlet Obstruction.



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Introduction

Bariatric surgery has become increasingly popular in the treatment of obesity to achieve sustainable weight loss. Despite its numerous benefits, complications can arise due to postoperative gastric hypoacidity and motility disorders. Phytobezoars are an infrequent complication of bariatric surgery that arise from impacted aggregates of indigestible fruit and vegetables. Rarely, bezoars can cause gastric outlet obstruction and/or perforation. The following case highlights the presentation, diagnosis and treatment of phytobezoars and the importance of diet compliance in bariatric patients.

Case Presentation

- 60-year-old Hispanic woman with chronic isolated thrombocytopenia and hyperlipidemia was admitted due to progressive epigastric fullness and postprandial emesis of 2-week duration. She could not tolerate liquids nor solids. Moreover, nausea was constant associated with abdominal bloating and 7-pound weight loss. She reported a sensation of food getting stuck at epigastric area. Famotidine did not alleviate symptoms.
- She denied fever, chills, chest pain, shortness of breath, diarrhea, constipation, hematochezia nor hematemesis.
- Her past surgical history was pertinent for sleeve gastrectomy in 2017. She denied toxic habits.
- Laboratories were unremarkable except for isolated thrombocytopenia ($40 \times 10^3 /\mu\text{L}$). No electrolyte disturbances nor renal impairment. Liver and pancreatic enzymes were normal.
- BMI 34. Physical exam was pertinent for positive bowel sounds, abdomen was soft and depressible with moderate epigastric tenderness. No abdominal rigidity nor guarding present. No palpable masses on epigastric area.
- Imaging: Abdominopelvic CT revealed a gastric fundus dilation, but an upper GI series was the study that diagnosed a large lobular filling defect compatible with a 7.2 cm phytobezoar.
- Upon questioning about eating habits in the past weeks, the patient reported that she arrived from a cruise vacation before onset of symptoms. She recalled consuming large amounts of vegetables, nuts and fruits.
- Management: Initial intervention consisted of papain meat tenderizer to help dissolve bezoar. Nevertheless, symptoms persisted due to oral medication intolerance. Upper endoscopy was performed and phytobezoar was removed with Roth Net device.
- Follow up: After procedure, patient was able to progressively tolerate diet and was discharged home with resolution of symptoms.

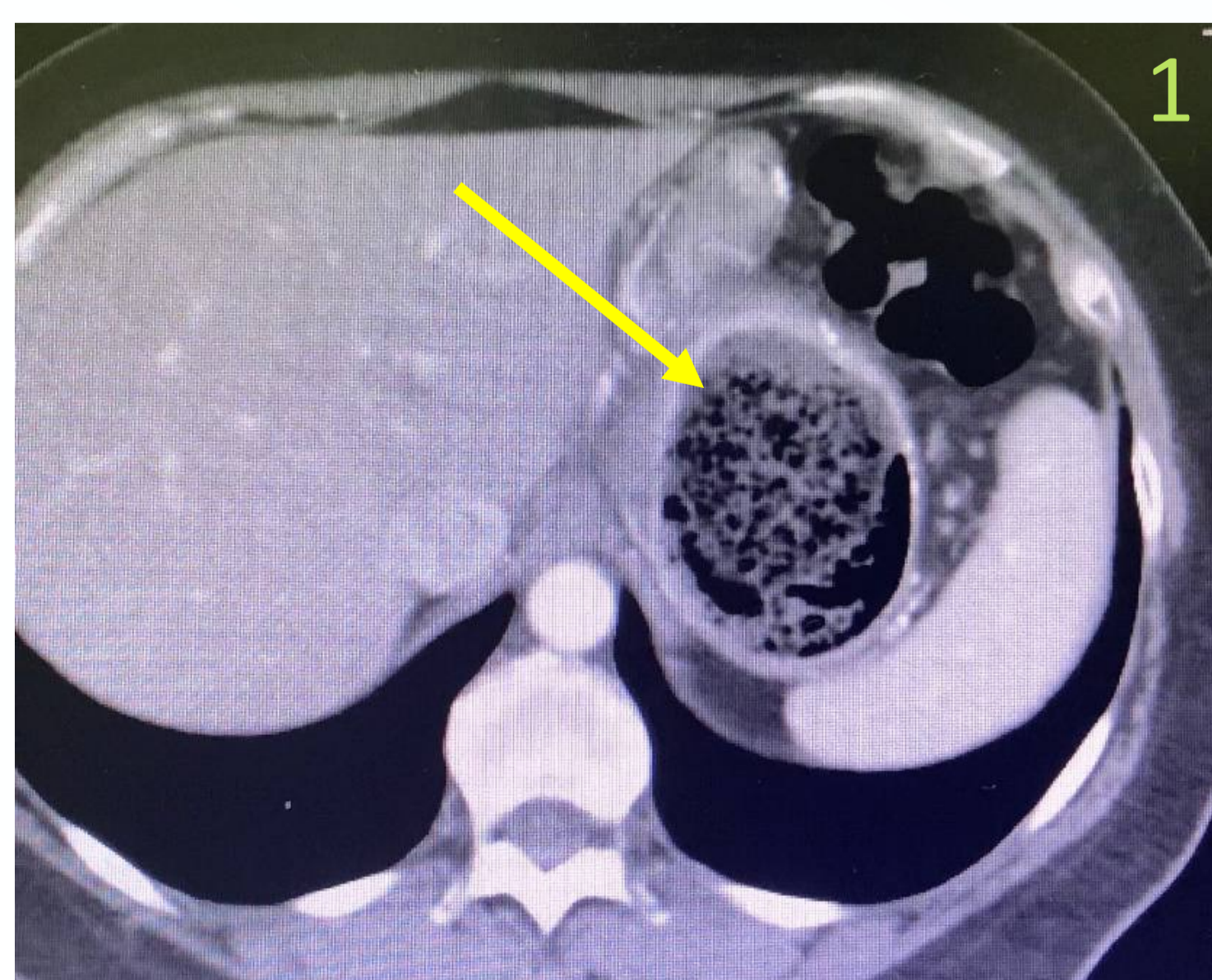


Figure 1: Abdominopelvic Computed Tomography with IV contrast showing gastric fundus dilation.

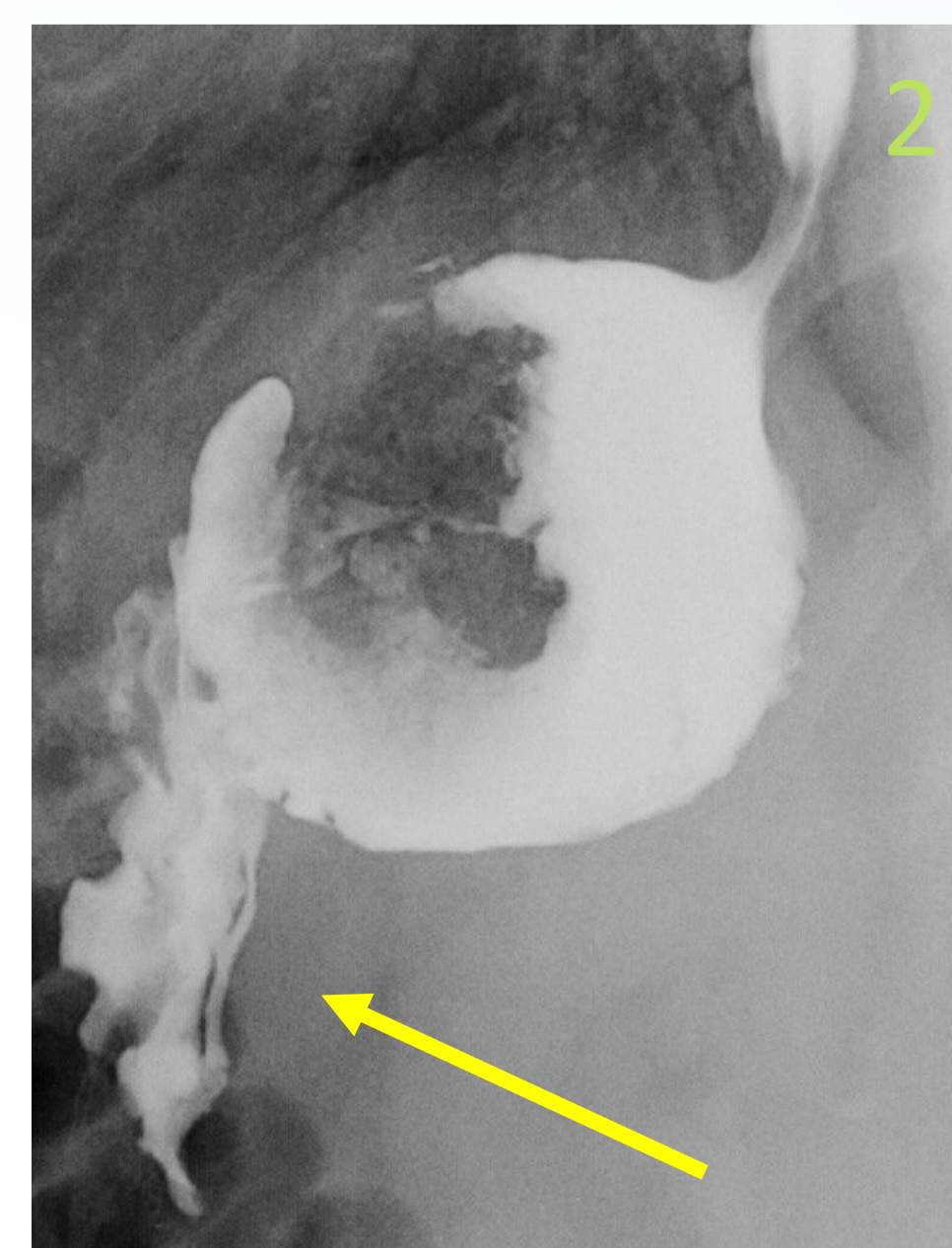


Figure 2: XR UGI with KUB. Phytobezoar causing slow intermittent emptying of the gastric remnant into distal stomach.

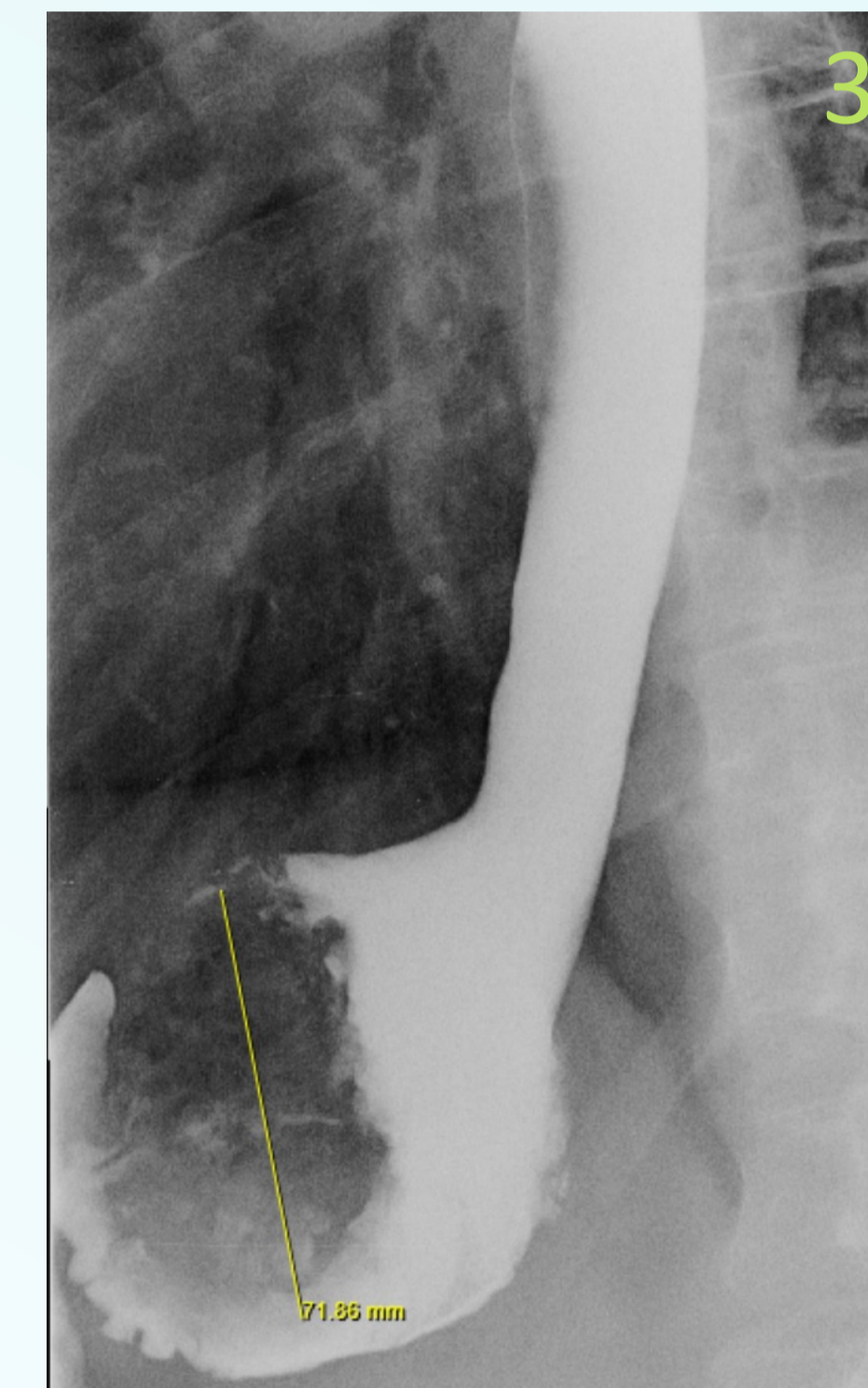


Figure 3: XR UGI with KUB. Status post sleeve gastrectomy with dilated fundus containing large lobular filling defect compatible with phytobezoar. It measures 7.2 cm in its greater dimension.



Figure 4: Imaging taken during upper endoscopy. We can see a large phytobezoar at fundus of stomach causing almost complete gastric obstruction.

Discussion and Conclusion

- The incidence of large phytobezoars has been reported as low as 0.3% in the general population, and therefore, its identification is a diagnostic challenge.
- Even though most of the patients remain asymptomatic, large bezoars can cause gastric outlet obstruction that could end in perforation if not treated promptly.
- Best imaging modality to diagnose a phytobezoar and identify delay in gastrointestinal emptying is an upper gastrointestinal series.
- Avoidance of excessive high fiber diet is recommended in bariatric patients with sleeve gastrectomy to prevent bezoar formations.
- This case emphasizes the importance of considering phytobezoars as a cause of gastrointestinal symptoms in bariatric patients with sleeve gastrectomy and the importance of diet education in bariatric patients.

References

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