

## **Management of Persistent Vomiting Following Gastric Restrictive Procedures**

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### **ABSTRACT:**

Persistent vomiting following gastric restrictive procedures for weight management is a well described event. The initial focus of the evaluation is to exclude mechanical outlet obstruction. In the absence of mechanical problems, antiemetics are employed with dietary counseling. Management, when these actions fail to resolve the problem, is the focus of this case report.

### **CASE:**

ND is a 52-year-old Caucasian female who underwent vertical banded gastroplasty (VBG) for morbid obesity in 1984. She initially had a good weight loss, but had regained weight beginning two years after the initial procedure continuing over the subsequent 15 years. Additionally she has had persistent daily vomiting in spite of outlet dilations. She had undergone repeated extensive workups with upper GI contrast imaging studies, CT scans, motility evaluations, none of which identified a mechanical cause for the vomiting. She reported the only things she did not vomit were milkshakes and tuna salad.

She was evaluated by a clinical psychologist with an extensive experience in eating disorders, who identified no characteristics compatible with bulimia. Her weight is 198 pounds and height is 65 inches (BMI 33 Kg/m<sup>2</sup>). Her obesity-related comorbid conditions include asthma, venous insufficiency, gastroesophageal reflux disease, type 2 diabetes, joint and back pain, and depression. She had undergone cholecystectomy in the past.

Insurance approval for conversion to relieve outlet obstruction took about 11 months to obtain. A surgery converted a divided roux en Y gastric bypass (RYGB). The roux limb was brought up in a retrocolic position and a gastrostomy (G) tube was placed in the distal pouch (Figure 1). An upper GI was obtained on day 2 post operative, and the nasogastric tube was removed. She was started on a clear liquid diet. The G tube was clamped on day 3 and she was discharged to home on day 4 post operative with her G tube in place.

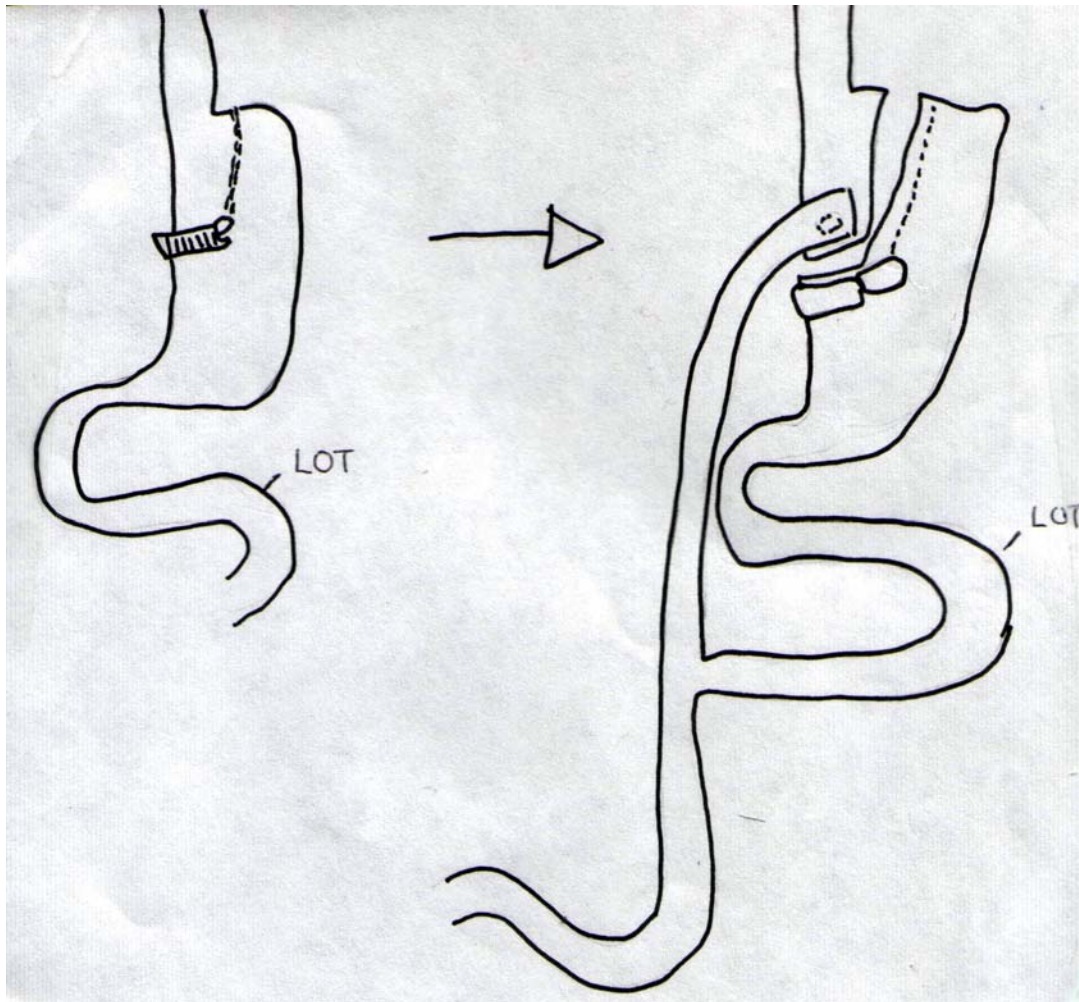
She was seen at 2 week, 6 weeks and 3 months for routine follow-up. She had some additional visits because of inflammation at the G tube site. This has nearly resolved with G tube removal, though this tract still has occasional drainage. She has had no vomiting since her surgery. At her three month visit her weight was 165 lbs (BMI 27.5).

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**FIGURE 1**



**DISCUSSION**

Vomiting is one of the most common side effects or complication of gastric surgery. It is usually associated with poor food choices or eating too fast. Vomiting that does not resolve with dietary counseling and antiemetics, warrants evaluation to determine if a mechanical outlet obstruction is present. Anastomotic strictures occur in about 1-10% of the cases with the incidence being procedure specific. Most strictures can be eliminated with endoscopic dilations.

Patients with strictures following banded

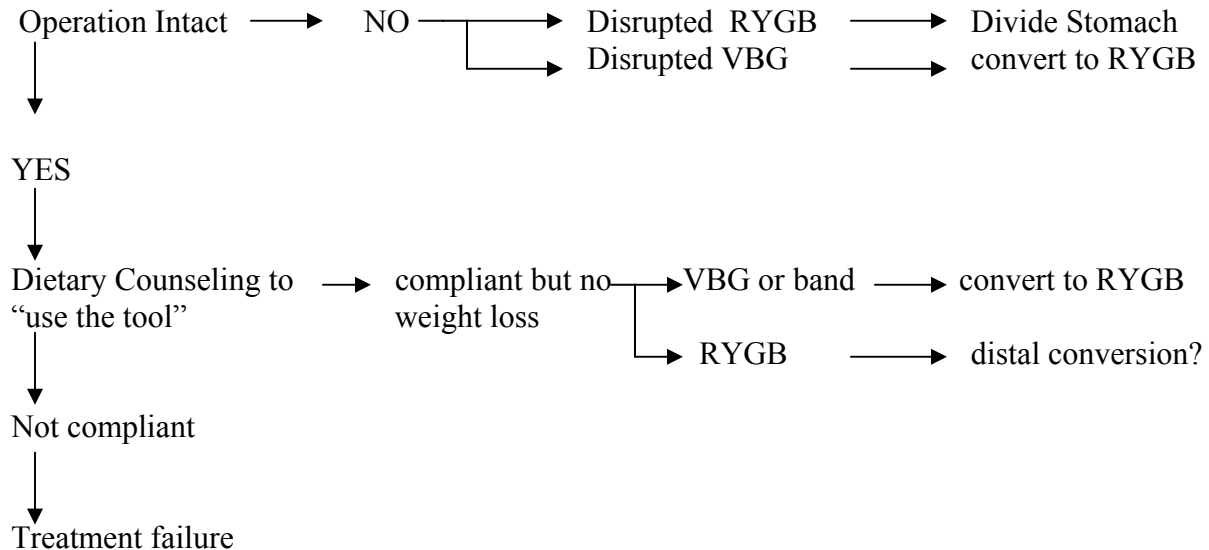
restrictive procedures are more likely to fail dilation treatments. Some will have persistent vomiting in spite of what appears to be an adequate outlet. Surgical revision is then considered. Treating the obstruction without compromising the weight reduction effects becomes the challenge.

Gastrogastrostomy, reconnecting the little pouch to the native stomach, will resolve the obstruction and vomiting, but weight regain will nearly always occur. Whereas, conversion of the procedure to a non-banded gastric bypass will usually resolve the

vomiting and maintain or improve weight loss.

It is not uncommon for the vomiting to still be associated with weight gain. Patients report “only the bad stuff stays down”, bad

stuff generally being calorie dense liquids and highly processed calorie dense foods. The surgical options for weight gain depend what procedure is currently “in place” for that patient and if it is anatomically intact.



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