



Reply to: Inclusion of Orogastric Tube in the Staple Line During Laparoscopic Roux-en-Y Gastric Bypass: an Avoidable Complication

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We thank the authors for their encouraging comments on our video case report [1] and congratulate them for the exhaustive review of foreign body entrapment in staple line during bariatric surgery [2]. We would certainly have liked to quote some of the previous reports; however, the prescribed format and word limit of video case reports in obesity surgery did not allow much room for discussion of literature. Instead, our focus was on the laparoscopic management of this complication when detected intraoperatively. This correspondence gives us an opportunity for further discussion on this topic.

We agree with the authors' (and Dr. Champion's) suggestion of a strict protocol before stapler firing [3]. After this complication [1], we have formulated a similar policy. In our practice, the anaesthetist inserts an orogastric tube (OGT) after induction. After placement of all ports, the OGT is removed. Dissection of greater or lesser curvature (depending on the procedure) is commenced only after confirmation of OGT removal. We now routinely take a time out before the stapler is opened. During this time, we ensure that there is no orogastric/nasogastric tube or thermal probe in the oesophagus. In case of sleeve gastrectomy, the bougie is inserted at this point. In RYGB or OAGB, the bougie is inserted after the first staple fire. Before each subsequent staple fire, once the stapler jaws have been closed, the anaesthetist is asked to move the bougie to and fro to confirm that there is no

entrapment. The stapler is fired only if there is free movement of the bougie. After methylene blue dye test, the bougie is removed.

The systematic review by Calikoglu et al. [2] proves emphatically that this complication is not as rare as we may think it to be. In fact, the actual incidence is possibly higher, as few cases are reported [3]. Measures like a dedicated bariatric team including anaesthetists are definitely helpful for better communication, but may not be feasible everywhere. Incompressible bougies and transparent drapes have also been suggested but may not be available at all centres. However, we believe that with the simple protocol mentioned above, it is possible to avoid this complication.

As pointed out by Calikoglu et al., double impaction of the OGT in the staple line is also possible, if the tube is coiled within the stomach. This can easily go unnoticed because only one of the two parts of the tube in the stomach will be amenable to pulling by the anaesthetist. According to the authors, to prevent double entrapment, whenever an entrapment is detected, further stapling should not ensue until the transected ends of the tube are retrieved.

In case of gastric bypass, the two parts of the tube from the gastric pouch and remnant stomach should be retrieved, and the total length of the two parts measured, to check if the whole of the tube has been retrieved. Sanchez et al. have listed some pointers to this complication – improper stapler fire, deformity of the stapler jaws, need of undue force for stapler firing or excessive staple line bleeding. Indeed, they managed to immediately detect six out of their seven OGT entrapments [4]. However, this may not be always possible. The fact that, in our patient it was detected only at the time of extubation, shows that stapler firing can occur without the surgeon feeling any resistance at all. Others have also reported delayed detection of this complication [5, 6].

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