Commentary

The transected banded vertical gastric bypass is one of the modifications of gastric bypass in which a Silastic ring is placed around the pouch to form the stoma. Intragastric band migration or erosion is an uncommon complication of both vertical banded gastroplasty and laparoscopic adjustable gastric banding, with a reported frequency for the former of 0.5% to 3.8% and a frequency of up to 11% for the latter. Suspect this occurrence when weight regain, abdominal pain, GI bleeding, or gastric obstruction develops postoperatively. Diagnosis usually is made by endoscopy, but upper GI series can show the pathognomonic appearance of contrast material flowing around the part of the band that has eroded into the stomach. Obviously, CT scanning is best if symptoms suggest intra-abdominal abscess or perforation. The appropriate treatment of intragastric band erosion is still controversial, but usually involves a decision between endoscopic and laparoscopic band removal. Recently, self-expanding plastic stents have been used to facilitate removal of partially migrated bands or in cases of refractory outlet stenosis; the therapeutic principle is that by causing ischemic damage to the gastric wall between the band and the stent, the band will gain free access to the gastric lumen.

Silastic is a trademark registered to the Dow Corning Corporation and is a portmanteau word resulting from the combination of silicon and plastic. It describes a widely used, flexible but inert material also referred to by another portmanteau word, elastomer (from elastic and polymer). Portemanteau originally referred to a large traveling bag with two compartments, but in its modern meaning, the word, along with its new spelling, was first used in 1871 by Lewis Carroll in Through the Looking Glass and What Alice Found There, in which Humpty Dumpty explains words from Jabberwocky to Alice: “Well, slithy means lithe and slimy...it’s like a portmanteau...” Well, intragastric band migration is not a portmanteau, although the band may simultaneously reside in two compartments that are best separated from one another.

Endoscopic treatment of a large gastric duplication cyst with hook-knife and snare (with video)

A 23-year-old woman presented with recurrent epigastric pain of several years’ duration. EGD revealed a large gastric subepithelial lesion (A) that on EUS was shown to be a 5.1 × 4.2-cm cyst with anechoic content that contained echogenic debris and 4 distinct walls, suggestive of a gastric duplication cyst. The decision to treat the lesion endoscopically was based on the patient’s chronic recurrent pain, which was nonresponsive to a variety of medications including proton pump inhibitors, antispasmodics, and prokinetic agents, as well as the risk of complications because of the lesion’s large size. The large size of the lesion prevented us from grasping it with a snare. We resected a small area of covering mucosa, observing a white glistening base that was believed to be muscle because of a repetitive pattern of parallel lines (B). We then made a large crosswise incision in the lesion with a hook-knife, after which there was an immediate outpouring of yellow viscous matter from the incision (C), followed by a dramatic decrease in the size of the lesion. After the collapse of the cyst, its wall was resected in piecemeal fashion by using a snare (Video 1, available online at www.giejournal.org). Histologic findings showed that the cyst was located in the muscle layer, which formed its outer wall; inflammatory cells infiltrated the inner aspect of the cyst wall (D). Even without cystic lining epithelium, the lesion would still be considered a gastric duplication cyst. The patient became asymptomatic after treatment.
Commentary
By definition, duplication cysts consist of a well-developed coat of smooth muscle with an epithelial lining that represents some portion of the alimentary tract. The small intestine is the most common site of duplication cysts, all other sites being relatively rare; gastric duplications account for less than 10% of all GI duplications. Duplications are believed to have their development in the gastrulation phase of embryology and result from persistence of an endomesenchymal tract between the yolk sac and the amnion or a partial twinning phenomenon. GI duplications are single, tubular, or cystic and are most often located on the mesenteric side of the native alimentary tract structure. Gastric duplications usually are cystic, located on the greater curvature and have no communication to the stomach. Symptoms are often related to the location of the duplication, and in this patient, pain may have resulted from its expansion or elevation of intracystic pressure. Traditionally, gastric duplication cysts are resected. In this case, because the patient is now asymptomatic, can we consider her cured? The answer is no because such cysts rarely may develop adenocarcinoma. How and when to reevaluate her is empirical and whether relieving the closed space nature of the cyst alters this dire development is, to me, unknown. It is sort of like conjoined twins. This woman’s stomach now has a partner for life.

Lawrence J. Brandt, MD
Associate Editor for Focal Points