Acute “balloon pancreatitis”

Fig. 1 Computed tomography image, showing compression of the pancreas body by the inflated balloon, with necrosis in the left pararenal fascia.

Intragastric balloon (IGB) placement is an endoscopic treatment for obesity, which offers a less invasive alternative to bariatric surgery. Severe complications, which occur in less than 1 % of cases, relate mostly to gastric perforation and intestinal obstruction. Two cases of pancreatitis have been reported to date [1,2].

A 47-year-old woman was admitted to the emergency room with epigastric pain, vomiting, and recent weight loss (6 kg). Symptoms had started 15 days earlier, following placement of an IGB (Orbera; Allergan Inc., Santa Barbara, California, USA). Medical history included cholecystectomy in 2003, obesity (body mass index 31.8 kg/m²), and associated co-morbidities (hypercholesterolemia, type II diabetes, and nonalcoholic steatohepatitis). Blood analysis showed an increased lipase serum level (1100 UI/mL; normal level <52 UI/mL), and a minor liver enzyme elevation with normal bilirubin levels. Abdominal computed tomography scan showed a Balthazar C pancreatitis (fat stranding around its tail and pararenal located necrosis) (● **Fig. 1**). The liver and biliary tract were unremarkable. The IGB was compressing the pancreas through the gastric wall. Urgent endoscopic removal of the IGB was warranted.

The procedure time was >2 hours as, in the emergency room, we did not have the appropriate manufacturer's instruments for efficient removal. The balloon was progressively deflated by siphoning the water it contained using a 20-mL syringe without Luer lock tip (BD, Discardit; Franklin Lakes, New York, USA), which was connected to a sclerosing needle (22 gauge, 0.7 mm diameter; Prince Medical, Ercuis, France) and introduced through the silicone wall. The balloon was then extracted using a bipod grasping forceps (Fujinon Corp., Saitama, Japan), which allowed a strong grip of the silicone surface.

Within 48 hours after the procedure, the pain and vomiting had disappeared and lipase levels returned to normal, allowing oral intake to resume and the patient to be discharged 4 days later.

An endoscopic ultrasonography performed 2 months later was unremarkable, and thus excluded other causes of pancreatitis.

Two other cases of pancreatitis have been described with IGB. In one case, the IGB had a noncollapsible catheter, which impacted in the ampulla and caused severe pancreatitis that required intensive care and surgical treatment. The present case presented with radiological criteria of se-

verity, and an endoscopic course of treatment was possible. In such cases, we suggest early endoscopic treatment, and use of instruments designed for extraction procedures provided by the balloon manufacturer to facilitate the extraction.

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Competing interests: Dr. Duboc is a scientific consultant for Ipsen Pharma.

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