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Aspiration in a Patient with Bowel Obstruction s/p Gastric Bypass Surgery

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INTRODUCTION
Patient with a history of gastric bypass surgery with acute small bowel obstruction presented for exploratory laparotomy. The attending surgeon requested that a Nasogastric (NG) tube not be placed prior to the induction of anesthesia, secondary to the prior Roux-en-Y procedure. Pulmonary aspiration occurred during rapid sequence induction with cricoid pressure.

CASE DESCRIPTION
50 year old female with history of Roux-en-Y gastric bypass surgery ten years ago, presented with acute small bowel obstruction. Contrast-enhanced CT scan showed extensive bowel distension with air fluid levels (yellow arrow). The patient was not vomiting. She was taken to the OR for emergent exploratory laparotomy. The NG tube was not placed prior to induction due to concerns of injury to the anastomosis and the inability to effectively decompress the bowel. The patient aspirated during rapid sequence induction with cricoid pressure. The airway was secured with an endotracheal tube. Cricoid pressure was maintained. Aspirate was suctioned from the oropharynx and endotracheal tube prior to ventilation, using a fiberoptic bronchoscope. The patient subsequently developed aspiration pneumonitis and acute respiratory distress syndrome.

REFERENCES

DISCUSSION
Aspiration of gastric contents is a risk during the induction of general anesthesia particularly in patients with a history of gastric bypass surgery. There is also an increase in the incidence of bowel obstruction and internal hernias in these patients.1,2 Our patient was at risk both because of prior Roux-en-Y Gastric Bypass surgery and current bowel obstruction. Methods of decreasing the incidence of aspiration include appropriate preoperative fasting, decompression with a nasogastric tube and cricoid pressure. At this time there is insufficient evidence to determine the effectiveness of cricoid pressure in the prevention of passive regurgitation.3 In patients s/p gastric bypass surgery surgical concerns include potential disruption of anastomosis as well as failure to effectively decompress the bowel. However, no case reports of NG tube disruption of anastomosis in a gastric bypass patient were identified in our literature search. In fresh postoperative gastric bypass patients an NG tube may be placed safely with direct vision using an endoscope or via-fluoroscopic guidance.4

CONCLUSION
Prevention of aspiration is important during the induction of anesthesia especially in the patient population presented here. The conflicting concerns of injury to anastomosis and failure to decompress the bowel should be contrasted with the benefit of risk reduction.4 We advocate for further study of this issue and the identification of a strategy to reduce aspiration in this patient population.