



## Infective Esophagitis and Gastric Balloon Case Study

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### Abstract

The primary reason for early removal of intra-gastric balloon is nausea, vomiting, stomach cramps and gastro-esophageal reflux which is caused by the defense mechanism of the stomach, as balloon is considered as a foreign body. However, it will subside by the conventional treatments such as PPIs. Another reason for balloon removal is *Candida* esophagitis. Even though, it is a rare side effect, it is very serious. This is due to the long term use of PPIs after balloon insertion for reducing the primary side effects.

**Keywords:** Gastro-Esophageal Reflux; *Candida* Esophagitis; Proton Pump Inhibitors (PPIs)

### Introduction and Case Study

Gastric balloon is an inflatable medical device which is temporarily placed in stomach to reduce weight. Different types of intra-gastric balloons are used for weight reduction. Common side effects of intra-gastric balloon insertion are intolerance, nausea, vomiting, gastroesophageal reflux etc. In some cases, it is identified that *Candida* esophagitis is also associated with intra-gastric balloon insertion after the conventional treatment.

Patients who were infected *Candida* esophagitis after balloon insertion are presented in this study. It is mainly associated with long term intake Proton Pump Inhibitors (PPIs) after the balloon insertion procedure. However, some predisposing factors such as gastric stasis, antacid drugs and smoking, DM a may also cause infective esophagitis in patients with intra-gastric balloons.

#### Acid suppressing therapy as a risk factor for *Candida* esophagitis

Patients under long term PPIs are symptomized with oral thrush, nausea, vomiting and abdominal pain which are caused by *Candida* esophagitis. PPI-induced elimination of the gastric acid barrier is a major mechanism leading to oro-pharyngeal and esophageal *Candida* colonization.

The documented observation revealed that patients who had done intra-gastric balloon insertion were developed oral thrush, nausea, vomiting and abdominal pain due to esophagitis.

The table below shown the patient who were diagnosed with infective esophagitis after balloon insertion.

Ballon type	Total cases	Esophagitis	<i>Candida</i> esophagitis
Orbera	200	(56) 28%	(24)12%
Elipse	150	(7.5) 5%	(6)4%
Spatz	35	(1.75)5%	(1.4) 4%
Obalon	35	(0.35) 1%	(1.05) 3%

It is identified that the above mentioned patients with candidiasis esophagitis, nausea and vomiting were not subsided with conventional treatment such as Omeprazole (40 mg), inj. Metoclopramide (10 mg), Ondansetron (4 mg). It is also observed that they had developed oral thrush after the procedure. In contrast, the patients who received antifungal treatment were improved from above symptoms.

The documented observation revealed that nausea, vomiting and abdominal pain which are the predominant side effects of in-

tra-gastric balloon cannot be relieved in patients with Candidiasis esophagitis. Because it is due to long term suppression of gastric acid barrier by PPIs. So, it can be considered as the main cause of early balloon removal.

We evaluated rates of nausea and vomiting of four subtypes of IGB systems: Elipse, Orbera, obalon and Spatz and calculated meta-analytic rates based on adverse events' sample size. In 420 patients total 65.6 (39%) patients reported experiencing esophagitis and 32.45 (23%) patients reported with candidiasis esophagus. The ORBERA balloon system had the highest rates of esophagitis and *Candida* esophagus compared to other balloon systems [1-5].

### Conclusion

Based on the findings it can be scrutinized that the unrelieved symptoms of *Candida* esophagitis is the main cause of intolerance to intra-gastric balloon insertion.

### Bibliography

1. Laine L and Bonacini M. "Esophageal disease in human immunodeficiency virus infection". *Archives of Internal Medicine* 154 (1994): 1577-1582.
2. Wilcox CM and Karowe MW. "Esophageal infections: etiology, diagnosis, and management". *Gastroenterologist* 2 (1994): 188-206.
3. Schwartz DA and Wilcox CM. "Atypical cytomegalovirus inclusions in gastrointestinal biopsy specimens from patients with the acquired immunodeficiency syndrome: diagnostic role of in situ nucleic acid hybridization". *Human Pathology* 23 (1992): 1019-1026.
4. Connolly GM., *et al.* "Oesophageal symptoms, their causes, treatment, and prognosis in patients with the acquired immunodeficiency syndrome". *Gut* 30 (1989): 1033-1039.
5. Hyder AA and Khan OA. "HIV/AIDS in Pakistan: the context and magnitude of an emerging threat". *Journal of Epidemiology and Community Health* 52 (1998): 579-585.

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