

Rare Intraluminal Migration of an Adjustable Gastric Band into the Ileum 17 Years Post Insertion: Case Report and Literature Review

Hamzah El Baba

HEIbaba@hamad.qa

Hamad Medical Corporation

Asaad Salama

Hamad Medical Corporation

Mohammed Al Kuwari

Hamad Medical Corporation

Case Report

Keywords: gastric band migration, laparoscopic adjustable gastric banding complications, bariatric surgery complications

Posted Date: October 7th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10629121/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License. [Read Full License](#)

Additional Declarations: No competing interests reported.

Abstract

Introduction:

Gastric band erosion is a recognized long-term complication of laparoscopic adjustable gastric banding, with reported incidence between 0.6% and 3%. Distal migration of the eroded band is rare and may present with nonspecific symptoms or acute obstruction.

Presentation of case:

A 33-year-old man with a history of LAGB performed 17 years prior presented following a road traffic accident. He later developed abdominal pain with a seatbelt sign and mild tenderness but no peritonitis. Contrast-enhanced computed tomography revealed an intraluminal gastric band within the small bowel without obstruction. Laparoscopic exploration confirmed migration of the band into the ileum, which was removed through a small enterotomy. The postoperative recovery was uneventful, and the patient was discharged on postoperative day four.

Discussion:

Complete intraluminal migration of a gastric band may remain asymptomatic for years until incidental discovery or triggered by unrelated events. Early recognition through imaging and timely laparoscopic removal can prevent severe complications such as small bowel obstruction or perforation.

Conclusions:

This case highlights that complete intraluminal migration of a gastric band may remain clinically silent for years and may be discovered incidentally. Prompt surgical intervention allows safe removal and prevents potentially life-threatening complications such as obstruction or perforation.

1. Introduction

Laparoscopic adjustable gastric banding (LAGB) has been widely used as a surgical treatment for morbid obesity since its introduction in the 1990s (1). While initially considered safe and reversible, long-term follow-up has revealed significant complications, with up to 50% of patients requiring reoperation, and gastric band erosion representing a serious late complication with a reported incidence ranging from 0.6% to 3% (2, 3). Band erosion occurs when the gastric band gradually migrates through the gastric wall into the stomach lumen, a process that can take several years to develop and may remain asymptomatic for extended periods (4).

Following complete erosion, the band can migrate distally through the gastrointestinal tract into the small bowel, colon, or rectum, presenting with varied clinical manifestations ranging from asymptomatic findings to life-threatening complications such as bowel obstruction and perforation (5). We present a case of delayed gastric band erosion and distal migration to the small bowel occurring 17 years after the gastric band insertion procedure, incidentally, discovered following a road traffic accident. We report this case in line with the updated consensus-based surgical case report (SCARE) guidelines (6).

2. Case presentation

A 33-year-old male with a history of laparoscopic gastric banding done seventeen years prior presented to the Emergency Department at Hamad General Hospital, a tertiary care center, following a road traffic accident on October 2025. He was the driver of the vehicle and was wearing a seatbelt at the time of the collision. The patient reported experiencing a sudden episode of dizziness with a near-syncope sensation immediately before the accident, which resulted in the crash. Importantly, there was no documented abdominal pain, loss of consciousness, vomiting, or evidence of nasal bleeding. Past medical, social, environmental, family and employment history were unremarkable. He did not smoke, never consumed alcohol and was not on long-term medications.

The patient was initially evaluated in the Emergency Department on the same day of the accident; he was discharged home with medication for symptomatic management. However, later the same day, the patient returned to the Emergency Department with new onset abdominal pain. He denied associated symptoms such as nausea, vomiting, fever, or changes in bowel habits, including difficulty passing stool or flatus. His past surgical history was significant for gastric banding performed in Syria with no subsequent follow-up care. At presentation, his body mass index was 35.98 kg/m². There was no other significant medical history, and he reported no known allergies.

On examination, the patient was alert and oriented, with stable vital signs: temperature ranged between 36.8°C, heart rate was 66 beats per minute, respiratory rate 18 breaths per minute, blood pressure 108/71 mmHg, and oxygen saturation was 98% on room air. Physical examination revealed a seatbelt sign (Fig. 1). There was superficial tenderness over the lower abdomen, but no deep abdominal tenderness, guarding, or rigidity. Laboratory investigations revealed a hemoglobin level of 13.3 gm/dL, white blood cell count of 10.9 x10³/uL, platelet count of 359 x10³/uL, whereas electrolytes, liver and renal function panels were within normal.

Table 1
Timeline of the Patient's Clinical Course

Time	Clinical encounter	Event
2008	Surgical history	Laparoscopic gastric banding
30 October 2025	Day of road traffic accident	Sudden episode of dizziness with a near-syncope sensation immediately before the accident, which resulted in Motor vehicle accident.
30 October 2025	First Emergency Visit	No documented abdominal pain, loss of consciousness, vomiting, or evidence of nasal bleeding.
30 October 2025	2nd Emergency visit	Developed new-onset abdominal pain after the initial discharge, denies any other symptoms.

A contrast-enhanced computed tomography scan of the abdomen and pelvis identified fat stranding in the lower abdominal wall and, notably, demonstrated an intraluminal device within the small bowel which is disconnected to the previously placed abdominal catheter (Fig. 2A and B). Mild dilatation of the proximal bowel was observed (Fig. 2C). There were no free fluid, pneumoperitoneum, solid organ injury, or pelvic fractures. The differential diagnoses considered included traumatic bowel injury, gastric band erosion with migration, and small bowel obstruction. Given the imaging findings demonstrating an intraluminal gastric band with bowel dilatation and the possibility of a disconnected tube (Fig. 3A), along with the patient's persistent abdominal symptoms, the decision was made to proceed with surgical intervention to prevent potential complications such as bowel perforation or complete obstruction.

The patient was scheduled for laparoscopic exploration the following day. Intraoperatively, diffuse erythema was noted on the small bowel and abdominal wall, which were attributed to recent trauma. Dense adhesions were present at the former gastric band site, with a well-healed serosal scar. The gastric band was identified as having completely eroded through the stomach and migrated intraluminally to an ileal bowel loop (Fig. 4A); the band tube was disconnected at this time. The disconnected tube was removed, and an enterotomy was created distal to the intraluminal band in healthy bowel to extract the device (Fig. 4B). The enterotomy was closed primarily with a v-lock 4 – 0 suture (Fig. 4C). The gastric band port was also removed through the old skin incision, with closure of the anterior sheath and subcutaneous tissue in a double layer. Estimated blood loss was minimal at approximately 10 mL, and dressing was applied. The patient was smoothly extubated in the operating room and sent to the recovery suite in a stable condition.

The patient's postoperative course was uneventful, with no complications recorded (Clavien-Dindo Grade 0). He remained hemodynamically stable throughout his four-day hospital stay, tolerated advancement to a full diet without difficulty, and exhibited no postoperative complications. The surgical wounds stayed clean and dry, and all laboratory parameters remained within normal limits during recovery. The patient was subsequently discharged in good condition. At follow-up two weeks postoperatively, he was clinically well, reported no issues, and there were no concerns noted on examination. Written informed consent was obtained from the patient for both the surgical intervention and for publication of this case report.

3. Discussion

The current case is an exceptionally late case of distal gastric band migration, reported 17 years after LAGB. Late complications of LAGB include gastric band erosion and distal migration, which are known but infrequent (with the erosion rate of 0.6 to 3% and the distal migration rate of less than 1%) and are rarely reported (1–3). In addition to previously reported series, a further review identified 23 more published cases of distal migration with complete case details (Table 2).

Table 2
Summary of 23 previously reported cases of distal gastric band migration with complete demographic and clinical details

AUTOR	AGE	SEX	BMI PRE/POST	TIME SINCE INSERTION	PRESENTATION	DIAGNOSTIC	TREATMENT	LOS	TYPE OF OBSTRUCTION
(5) Abeysekera 2017	43	F	45/31	16 y	Colicky abdominal pain, nausea, vomiting, abdominal distension, obstipation	CT scan, Chest X-ray	Laparotomy, ileal resection 150mm, side-to-side anastomosis	7 d	Mid-ileal - band in lumen protruding through intestinal wall
(7) Shah 2011	45	F	NA	15 y	Epigastric abdominal pain, nausea, emesis	Ultrasound, MRCP, CT scan	Laparotomy	7 d	Gastric erosion and migration into the Jejunum with bowel obstruction
(8) Egbear 2008	49	M	NA	3 m	Upper abdominal pain, bilious vomiting	Abdominal X-ray, CT scan	Laparotomy	8 d	Jejunal obstruction
(9) Reche 2017	36	F	NA	11 y	Abdominal pain, fever, jaundice	CT scan	Laparotomy	29 d	Intrajejunal migration of the gastric band, peritonitis due to perforation of the stomach, duodenojejunal flexure and jejunum
(10) Lemaire 2017	42	F	NA/38	10 y	Acute abdominal pain located in the left flank, nausea, vomiting, ileus	CT scan	Endoscopy, laparoscopy	7 d	Jejunal obstruction due to the migration of the LAGB
(11) Bueter 2006	65	M	43/27	13 m	Recurrent vomiting, epigastric pain	Gastrografen swallow, X-ray, Gastroscopy, CT scan	Laparoscopy, jejunotomy, band removal, port removal	7 d	Jejunal with walled-off perforation
(12) Parmar 2016	43	F	45.8/44.3	6 y	Abdominal pain, vomiting	CT scan, EGD	Endoscopic band removal (per oral), port removal	2 d	Band erosion and migration into proximal jejunum - removed endoscopically
(13) Sleiman A. 2020	69	F	NA/31	10 y	Epigastric pain, no nausea, no vomiting	CT scan	EGD	1 d	Migration up to the proximal jejunum
(14) Aili A. 2023	56	M	NA	10 y	Right lower abdominal pain, nausea, vomiting	Abdominal Xray, CT scan, intraoperative gastroscopy	Laparoscopy	NA	Erosion of the gastric wall, intestinal obstruction, and jejunal perforation
(15) Offodile 2010	30	M	60/51.7	4 y	Several postprandial epigastric pain, nausea, non-bilious emesis	CT scan	Laparoscopy and EGD	2 d	Partial duodenal obstruction
(16) Bassam 2012	54	F	41.2 / NA	8 y	Colicky abdominal pain, distension	CT, X-ray	Port removal, per-rectal band removal	Few days	Distal small bowel; band passed per rectum

AUTOR	AGE	SEX	BMI PRE/POST	TIME SINCE INSERTION	PRESENTATION	DIAGNOSTIC	TREATMENT	LOS	TYPE OF OBSTRUCTION
(17) Oppliger 2015	51	F	NA / -25 kg	1 y	Diffuse abdominal pain, bilious vomiting, acute pancreatitis	CT, UGI series, EGD, fluoroscopy	Laparoscopy → laparotomy, ileal resection 40 cm with end-to-end anastomosis, band removal	NA	Distal ileal obstruction with multiple perforations; band 20 cm from ileocecal valve
(18) Gonzalez-Urquijo 2022	50	F	55/40	19 y	Epigastric pain, nausea, vomiting, colicky abdominal pain	CT scan	Laparotomy, jejunal resection 90cm, side-to-side anastomosis	7 d	Small bowel- band at 40cm from Treitz ligament with 4 jejunal perforations
(19) Reyes 2018	58	F	46/NA	7 y	Epigastric pain, vomiting, hypertension	EGD, Abdominal X-ray, CT scan, Colonoscopy	Spontaneous excretion per rectum	NA	Band migrated to sigmoid colon
(20) Lattuada 2008	52	F	41.3/31.6	7 y	Biliary colic, acute pancreatitis, fever, upper abdominal pain, vomiting	X-ray, Gastrografin swallow, Gastroscopy, CT scan, MRCP	Laparoscopy, jejunotomy, cholecystectomy, band removal, port removal	10 d	Band in jejunal loop - tube entered and exited stomach through greater curvature
(21) Lantsberg 2008	58	F	41/29	63 m	Nausea, abdominal discomfort, abdominal pain, vomiting, weight gain	Abdominal X-ray, CT scan	Laparoscopy converted to laparotomy, jejunal extraction, port removal	5 d	Upper jejunal with multiple pressure ulcerations along migration pathway
(22) Taskin 2001	56	F	50/29	4 y	Nausea, bilious vomiting, epigastric pain	EGD, UGI series	Laparotomy	5 d	Duodenal obstruction
(23) Salar 2013	46	F	NA	5 y	Nausea, colicky upper abdominal pain, fever, bilious vomiting	Abdominal X-ray, CT scan	Laparoscopy	NA	Intraluminal band migration and proximal jejunal obstruction with prominent gastric dilatation
(24) Creedon 2014	41	F	NA	3 y	Colicky right upper quadrant pain extending into back	Abdominal X-ray, ultrasound scan, CT scan	Laparoscopy	10 d	The presence of the gastric band within the proximal jejunum with some dilated loops in the small bowel proximal to the band
(25) Sapalidis 2013	45	M	NA	4 y	NA	NA	EGD	NA	Fixing of the gastric band into the jejunum lumen, causing obstruction, symphysis, and jejuno-jejunal fistulae
(26) Widmer 2018	51	F	41/36.3	13 y	Abdominal pain, nausea	CT scan	Mini laparotomy (enterotomy + intestinal resection)	NA	terminal jejunum migration of the gastric band
(27) Ferris 2018	53	F	NA	10 y	Epigastric pain, nausea, vomiting	Ultrasound, MRCP	Laparoscopy	NA	Intraluminal migration of the gastric band, causing obstruction in the ampulla of Vater
(28)	43	M	48.8/44.5	7 y	Abdominal pain, vomiting	Ultrasound, ERCP	Laparoscopy, intraoperative	8 d	Acute cholecystitis, choledocholithiasis,

AUTOR	AGE	SEX	BMI PRE/POST	TIME SINCE INSERTION	PRESENTATION	DIAGNOSTIC	TREATMENT	LOS	TYPE OF OBSTRUCTION
Nasser 2019							EGDS, laparotomy		erosion of the gastric band tubing into the stomach and duodenum with secondary distortion of the major papilla

BMI: body mass index; CT: computed tomography; d: days; EGD: esophagogastroduodenoscopy; F: female; iv: intravenous; LOS: length of stay; m: month; M: male; MRCP: magnetic resonance cholangiopancreatography; NA: not available; NPO: nil per os; UGI series: upper gastrointestinal series; y: years.

The long latency in this case, as well as its accidental discovery after the trauma, reflects the unpredictable natural history of this condition and the need to monitor it over a long period of time. This is consistent with our review of the literature (Table 2), which demonstrated a median time of 7 years from insertion to diagnosis.

The majority of gastric band migrations manifest themselves in the form of nausea or abdominal pain, but this was incidentally detected in the course of a road traffic accident, a manifestation that is hardly mentioned in literature. The incidental occurrence suggests that distal migration may remain silent for years. Absence of long-term follow-up is one of the leading contributing factors; Chapman and colleagues found that less than one in ten patients continue to follow up after a decade. Likewise, we did not have any follow-up of our patient in seventeen years (4). Regular endoscopic follow-up would have detected erosion in time, and it may have avoided migration. The case supports the argument for lifelong and structured follow-up, particularly in patients who relocate to other countries and lose continuity of care. The pathophysiology of gastric band erosion and gastric band migration is compounded. As stated by Shah et al., mechanical pressure of overinflation, gastric wall ischemic chronic process, infection, and gastric wall trauma during primary placement can result in a progressive erosion process (7).

The band can then be propelled distally through the gastrointestinal tube by the peristaltic forces once the band has been totally eroded. The abdominal trauma in this case, caused by the road traffic accident, might have caused either the accelerated distal migration or accidental finding of the migrated band already. Distant migration is commonly characterized by nonspecific manifestations in a clinical picture. According to Egbeare et al. and Reche et al. the patients usually manifest with abdominal pain, nausea, and vomiting, with the most frequent complication being the obstruction of the small bowel (8, 9). Conversely, our patient did not show any major signs of peritonitis and only some slight abdominal tenderness, which highlights the fact that distal migration may not show any symptoms until being accidentally identified. Imaging is also a significant element of diagnosis; Lemaire et al. considered computed tomography (CT) valuable to outline the intraluminal location of the band, bowel expansion, and port disconnection (10). In our example, CT results validated the presence of an intraluminal band in the small bowel and eliminated the possibility of traumatic injury, which facilitates a timely surgical intervention. Distal migration has varying complications. Reche et al. noted that in approximately 70 per cent of cases, a small bowel obstruction was observed, and in 20–25 per cent, there was perforation or peritonitis. There are rare spontaneous expulsions observed (9).

Our patient was partially obstructed and was treated before perforation, which is also associated with the superior results of early surgical intervention (11). The therapy is based on the location of migration and the severity of the symptoms. According to Parmar et al. and Sleiman et al. endoscopy is effective in cases of proximal migration and laparoscopic enterotomy in cases of the small bowel, which is at the end (12, 13). In this case, laparoscopy worked, the bleeding was minimal, and recovery was fast, indicating its safety and efficiency. Laparoscopy enables them to spend less time in the hospital and experience fewer problems as compared to open surgery, as reported in Abeysekera et al. and Reche et al. (5, 9). According to Aili et al., laparoscopy is also effective in early jejunal perforation (14). Recent developments have diversified minimally invasive procedures, including endoscopic cutters, electrocautery, and hybrid laparoscopic/endoscopic procedures (15).

4. Conclusion

This case illustrates an unusually delayed presentation of distal gastric band migration occurring 17 years after LAGB—among the longest reported intervals in the literature. Unlike most previously described cases, which occurred in middle-aged women with symptomatic presentations, this patient remained asymptomatic until the incidental discovery following trauma. Laparoscopic removal provided a safe and effective approach, consistent with current evidence supporting laparoscopy as the preferred treatment for stable patients with distal band migration; incorporating periodic endoscopic or imaging surveillance into long-term postoperative care, particularly for patients lost to follow-up, may help prevent severe, undiagnosed sequelae.

5. Patient's perspective

I'm very happy with the treatment I received. After the accident, the doctors quickly found the problem with my old gastric band and removed it safely with laparoscopic surgery. I recovered quickly, and now I'm back to my normal life with no symptoms at all.

Declarations

Ethics and consent to participate

The procedures followed were in accordance with the ethical standards and with the 1964 Helsinki Declaration and its later amendments. The patient was informed of the aim of the study and signed a consent form.

Consent to publish

Written informed consent was obtained from the patient for publication of this case report and any accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

Competing interests

The authors declare no competing interests.

Funding

Open Access funding provided by the Qatar National Library.

Author Contribution

Hamzah El Baba conceived and designed the case report, conducted the literature review, and drafted the manuscript. Asaad Salama contributed to the conception and design of the case report, participated in the literature review, and manuscript review. Mohammed Al Kuwari contributed to the clinical management of the patient, acquisition of clinical data, and manuscript review. All authors reviewed and approved the final manuscript and agree to be accountable for all aspects of the work.

Acknowledgements

The authors gratefully acknowledge the patient who agreed to participate in this study.

Availability of data and materials

No datasets were generated or analysed during the current study.

Associated Data

This section collects any data citations, data availability statements, or supplementary materials included in this article.

Data Availability Statement

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

References

1. Kodner C, Hartman DR. Complications of adjustable gastric banding surgery for obesity. *Am Fam Physician*. 2014;89(10):813–8.
2. Mehanna MJ, Birjawi G, Moukaddam HA, Khoury G, Hussein M, Al-Kutoubi A. Complications of adjustable gastric banding, a radiological pictorial review. *AJR Am J Roentgenol*. 2006;186(2):522–34. 10.2214/AJR.04.0655.
3. Aarts EO, van Wageningen B, Berends F, Janssen I, Wahab P, Groenen M. Intra-gastric band erosion: experiences with gastrointestinal endoscopic removal. *World J Gastroenterol*. 2015;21(5):1567. 10.3748/wjg.v21.i5.1567.
4. Chapman AE, Kiroff G, Game P, Foster B, O'Brien P, Ham J, et al. Laparoscopic adjustable gastric banding in the treatment of obesity: a systematic literature review. *Surgery*. 2004;135(3):326–51. 10.1016/S0039-6060(03)00392-1.
5. Abeysekera A, Lee J, Ghosh S, Hacking C. Migration of eroded laparoscopic adjustable gastric band causing small bowel obstruction and perforation. *BMJ Case Rep*. 2017;2017:bcr-2017-219954. 10.1136/bcr-2017-219954

6. Sohrabi C, Mathew G, Maria N, Kerwan A, Franchi T, Agha RA. The SCARE 2023 guideline: updating consensus Surgical CAse REport (SCARE) guidelines. *Int J Surg.* 2023;109(5):1136–40. 10.1097/JS9.0000000000000313.
7. Shah KG, Molmenti EP, Nicastro J. Gastric band erosion and intraluminal migration leading to biliary and small bowel obstruction: case report and discussion. *Surg Obes Relat Dis.* 2011;7(1):117–8. 10.1016/j.soard.2010.01.008.
8. Egbeare D, Myers A, Lawrance R. Small bowel obstruction secondary to intragastric erosion and migration of a gastric band. *J Gastrointest Surg.* 2008;12(5):983–4. 10.1007/s11605-007-0304-y.
9. Reche F, Mancini A, Faucheron J–L. Gastric band migration causing jejunal obstruction: a life–threatening complication. *J Gastrointest Surg.* 2017;21(12):2122–3. 10.1007/s11605-017-3493-z.
10. Lemaire J, Dewit O, Navez B. Management of a jejunal obstruction caused by the migration of a laparoscopic adjustable gastric banding. A case report. *Int J Surg Case Rep.* 2017;30:6–8. 10.1016/j.ijscr.2016.11.026.
11. Bueter M, Thalheimer A, Meyer D, Fein M. Band erosion and passage, causing small bowel obstruction. *Obes Surg.* 2006;16(12):1679–82. 10.1381/096089206779319446.
12. Parmar C, Mamtara S, Balupuri S. Endoscopic removal of intrajejunal migrated gastric band. *Surg Obes Relat Dis.* 2016;12(9):e75–6. 10.1016/j.soard.2016.08.021.
13. Sleiman A, Studer AS, Garneau PY, Denis R, Magdy M, Alanazi M, et al. Case report: endoscopic removal of an eroded gastric band causing small bowel obstruction upon migration into the proximal jejunum. *Obes Surg.* 2020;30(12):5153–6. 10.1007/s11695-020-04906-5.
14. Aili A, Li X, Abudureyimu K. Intra-jejunal migration with intestinal obstruction and perforation after gastric banding: a case report. *Heliyon.* 2023;9(10):e20703. 10.1016/j.heliyon.2023.e20703.
15. Offodile AC, Okafor P, Shaikh SN, Lautz D, Thompson CC. Duodenal obstruction due to erosion and migration of an adjustable gastric band: a novel endoscopic approach to management. *Surg Obes Relat Dis.* 2010;6(2):206–8. 10.1016/j.soard.2009.12.003.
16. Bassam A. Unusual gastric band migration outcome: distal small bowel obstruction and coming out per–rectum. *Pan Afr Med J.* 2012;13:59.
17. Oppliger F, Ríos H, Manríquez L. Migración y perforación de una banda gástrica en el intestino delgado [Migration and perforation of a gastric band in the small bowel]. *Cir Esp.* 2015;93(9):601–3. 10.1016/j.ciresp.2014.07.008.
18. Gonzalez–Urquijo M, Frias–Molina I, Lozano–González E, Rojas–Mendez J. Unusual gastric band migration causing multiple perforations on the jejunum. *Cir Esp.* 2022;100(10):659–62. 10.1016/j.ciresp.2021.08.002.
19. Reyes MA, Hernández Y, Méndez JR, Avila M, Núñez–Sánchez A, González AA, Romero LP, Reyes HA. Migration of the gastric band to the colon and excretion seven years after placement. *Bariatric Surg Pract Patient Care.* 2018;13(4):191–4. 10.1089/bari.2018.0024.
20. Lattuada E, Zappa MA, Mozzi E, Antonini I, Boati P, Badiali S, et al. Concurrent band and tube migration following acute pancreatitis. *Obes Surg.* 2008;18(3):329–31. 10.1007/s11695-007-9299-4.
21. Lantsberg L, Kirshtein B, Leytzin A, Makarov V. Jejunal obstruction caused by migrated gastric band. *Obes Surg.* 2008;18(2):225–7. 10.1007/s11695-007–9380–z.
22. Taskin M, Zengin K, Unal E. Intraluminal duodenal obstruction by a gastric band following erosion. *Obes Surg.* 2001;11(1):90–2. 10.1381/096089201321454178.
23. Salar O, Waraich N, Singh R, Awan A. Gastric band erosion, infection and migration causing jejunal obstruction. *BMJ Case Rep.* 2013;2013:bcr2012007737. 10.1136/bcr-2012–<background-color:#D279AA;>007737</background-color:#D279AA;>.
24. Creedon L, Leeder P, Awan A. Laparoscopic adjustable gastric band erosion and migration into the proximal jejunum. *Surg Obes Relat Dis.* 2014;10(2): e19–21. 10.1016/j.soard.2013.06.013.
25. Sapalidis K, Liavas L, Panteli N, Kosmatopoulos E, Anastasiadis I, Charalambides S, et al. Intrajejunal migration of adjustable gastric band: a case report. *Curr Health Sci J.* 2013;39(2):118–20.
26. Widmer JD, Schade S, Muller MK. A 13–year journey of a gastric band–ultimate destination terminal jejunum: a case report. *J Med Case Rep.* 2018;12(1):297. 10.1186/s13256-018-1850-5.
27. Ferris BWC, Isaacs A. Biliary obstruction secondary to migrated intra–duodenal gastric band: a case report. *J Surg Case Rep.* 2018;2018(9):rjy260. 10.1093/jscr/rjy260.
28. Nasser H, Ivanics T, Leonard–Murali S, Genaw J. A case report of an adjustable gastric band erosion and migration into the jejunum resulting in biliary obstruction. *Int J Surg Case Rep.* 2019;64:139–42. 10.1016/j.ijscr.2019.10.025.

Figures

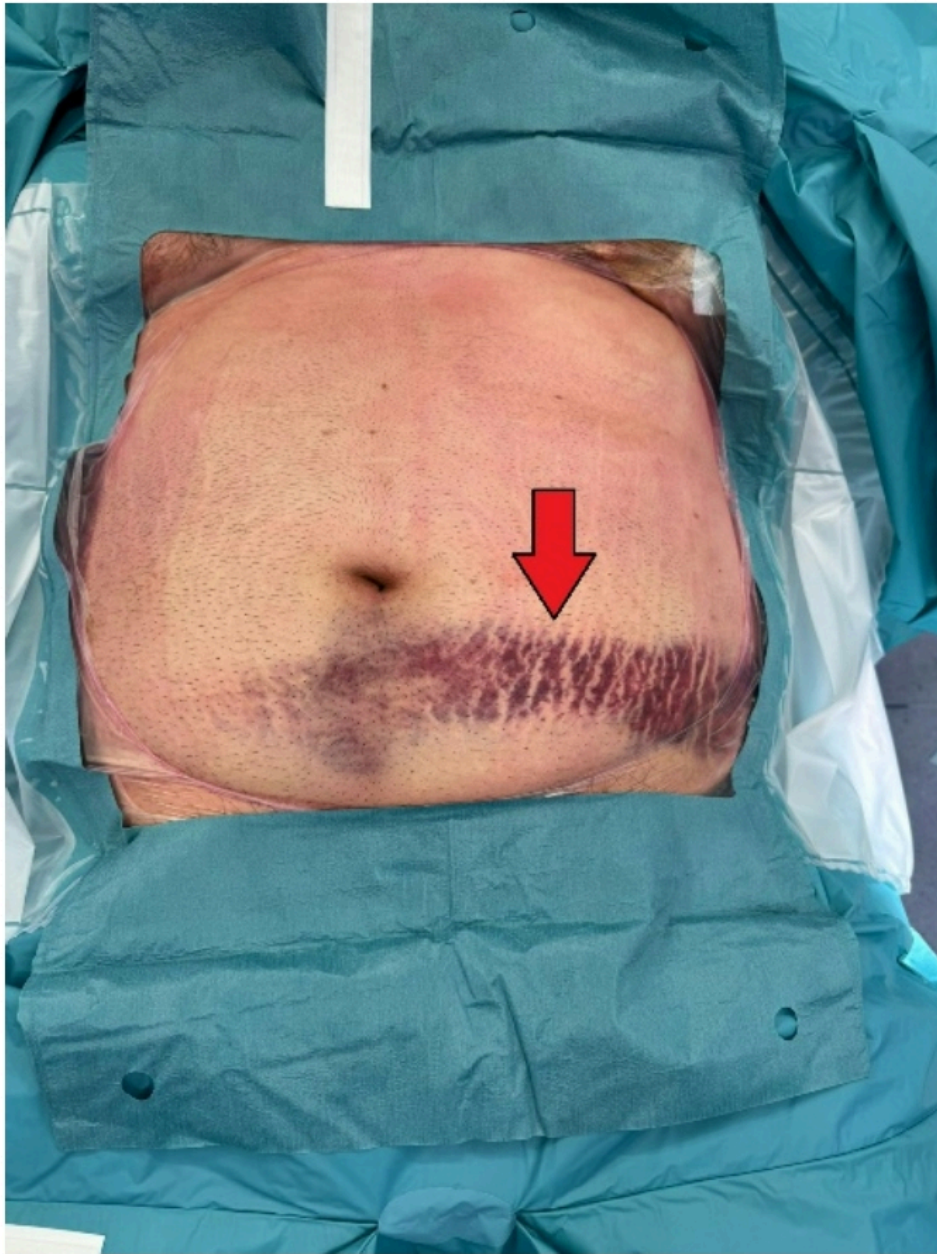


Figure 1

Seatbelt sign indicated by the red arrow

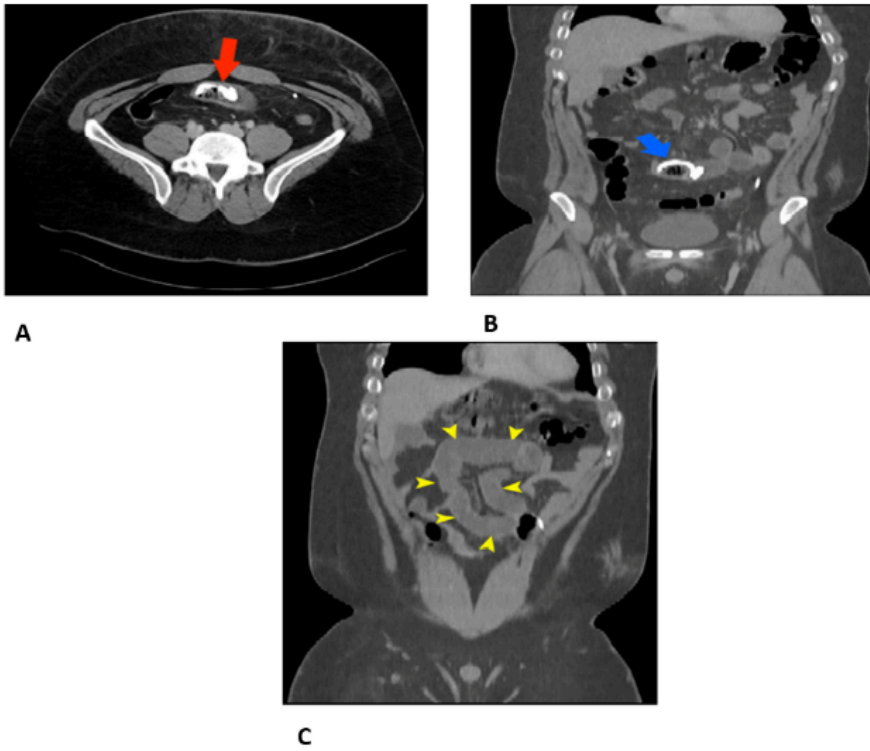
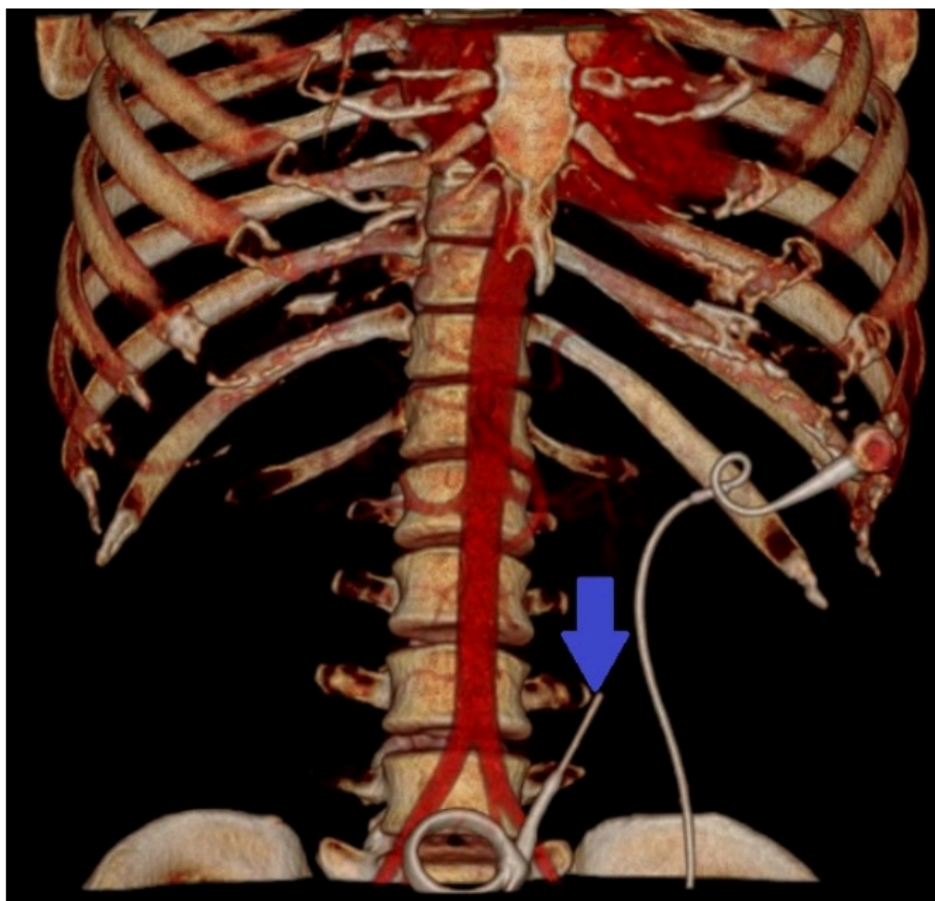


Figure 2

Whole body CT showing: A) intraluminal device within the small bowel pointed by the red arrow (coronal view); B) intraluminal device within the small bowel pointed by the blue arrow (axial view); and C) Mild dilatation of the proximal small bowel point



A

Figure 3

CT scan of the abdomen and pelvis - coronal plane - 3D Volume Rendering technique showing: A) Disconnected tube pointed by blue arrow

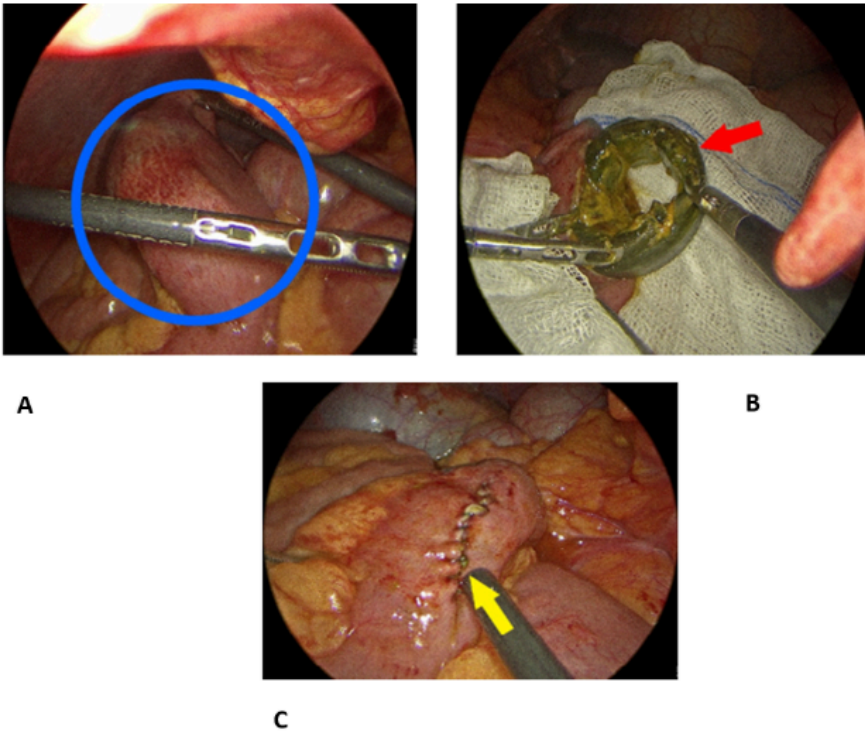


Figure 4

Laparoscopic views showing: A) Intraluminal gastric band within the small bowel (blue circle); B) Extraction of the gastric band through a distal enterotomy (red arrow); and C) Enterotomy closure with adequate bowel diameter (yellow arrow)