



A Unique Presentation of COVID-19 in a Patient Post Sleeve Gastrectomy

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We present a case of a 35-year-old female who presented to the accident and emergency department of our university teaching hospital in London, one of the worst hit cities in Europe with the SARS-CoV-2 pandemic. She complained of a 6-day history of progressive vomiting and epigastric pain culminating in an inability to hold down any fluids. This was on a background of an uneventful laparoscopic sleeve gastrectomy for management of morbid obesity that was performed 6 weeks prior. Additional past medical history includes insulin-dependent type 2 diabetes, hypertension and hypercholesterolemia.

The operation was uneventful, and there were no immediate post-operative complications. The patient was discharged on day 2 post-operative. She then attended her routine follow-up appointment on day 10 where she was found to be in good health with no complaints or symptoms to report. Vital signs and observations were normal, and she was tolerating her liquid diet without vomiting or pain. Abdominal examination was unremarkable, and biochemical tests were all within normal range.

Other than her presenting symptoms, she denied any other symptoms, namely, cough, fevers, myalgia and diarrhoea. She had no recent travel history. She lives with her partner and two children who do not report any similar symptoms. She was triaged by the accident and emergency team who accordingly put her to the “green” non-COVID area. She was then referred

to the bariatric team for further management as a bariatric surgical emergency.

On examination there was mild abdominal tenderness around the port sites and in the epigastric region. The patient was normotensive, afebrile and mildly tachycardic at 102 beats per minute with oxygen saturations of 99% on room air. Laboratory tests showed a white cell count of $6.4 \times 10^9/L$, a lymphocyte count of $2.0 \times 10^9/L$ and a mildly elevated CRP of 39.7 mg/L. Renal function showed no electrolyte disturbance or evidence of dehydration.

Likely cause for this presentation was assumed to be a surgical complication, and our working diagnosis was a stricture within the sleeved stomach, a port site hernia or, far less likely, a possible leak. A CT scan of the abdomen with intravenous and oral contrast was performed.

The CT (Fig. 1) showed no evidence of surgical complications with free flow of contrast across the sleeved stomach and the small bowel. However, the scanned lung bases showed classic COVID-19 infection changes (Fig. 2). The formal



Fig. 1 A CT scan image showing free flow of contrast through the sleeved stomach and into the small bowel

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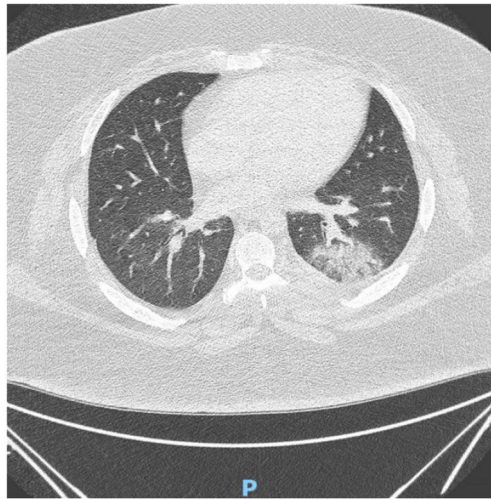


Fig. 2 A CT scan image showing perilobular consolidation with multiple reverse halo sign lesions and focal areas of ground-glass opacification bilaterally with a small left-sided pleural effusion

report concluded a moderate/severe infection on CT scoring [1]. Nasopharyngeal and oropharyngeal swabs were positive for COVID-19 infection.

Supportive care was initiated, and the patient received intravenous anti-emetics and fluids in order to symptomatically manage her ongoing vomiting. Observations remained stable with a mild pyrexia of 37.7 °C and the mild tachycardia normalised on day 2. No oxygen support was required throughout the admission. The patient was discharged on day 4 once she could tolerate oral fluids.

This case describes the novel presentation features of a COVID-19 infection in a post-bariatric surgical patient—persistent vomiting and epigastric pain. Gastrointestinal symptoms have been reported to be associated with COVID-19 infection but not as the sole presenting feature, and we were unable to find a similar presentation post bariatric surgery [2].

In these current unprecedented times, we feel that it is important to be aware of this possible presenting symptom of COVID-19 in this cohort of patients—particularly as they have an overall higher morbidity and mortality compared with

the general population [3, 4]. This case can be used to highlight as to whether, at least until the infection curve is flattened, we should be managing every emergency surgical patient presenting to the accident and emergency department as a suspected COVID-19 case until proven otherwise through testing. This should help prevent the unknown and unnecessary exposure to members of the healthcare team and patients in order to ultimately halt onward COVID-19 transmission. However, this may present a new burden of unnecessary and possible overuse of personal protective equipment in an already strained healthcare system.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Human and Animal Rights This article does not contain any studies with human participants or animals performed by any authors.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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