IFSO-EC WEBINAR INTERNATIONAL FEDERATION FOR THE SURGERY OF OBESITY AND METABOLIC DISORDERS

CONTROVERSIES IN BARIATRIC SURGERY: CAN WE FINALLY SOLVE THE DILEMMA?

Exclusive partner of the webinar Medtronic

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CONTROVERSIES IN BARIATRIC SURGERY: CAN WE FINALLY SOLVE THE DILEMMA?

Q&A

Q: Does the hiatal hernia repair include fundoplication, or only cruroplasty?

A: Cruroplasty

Q: Should not we go for a by-pass in case of proved HH?

A: Yes

Q: What is your definition of hiatal hernia?

A: In individuals with obesity hiatal hernia most frequently is of type I: when there is a separation of the LES and the oesophageal defect at the hiatus (sliding hernia). The consequence is that the actual distance between LES and hiatus impression (as seen during UGI endoscopy) creates a "Pocket of acid" that is submitted to the pressure changes induced by respiration

Q: So, what's the final conclusion? Should we do it concomitant?

A: Posterior hiatus dissection

Q: What about mobilisation of the distal oesophagus in a larger hernia??

A: Yes, obviously. In case of large hernia, absolutely

Q: Should we perform systematically an upeerGI XRay before a sleeve gastrectomy?

A: Endoscopy

Q: Which is the minimum length for Alimentary limb + BPL limb in gastric bypass to be safe?

A: In my opinion: alimentary at least 70 cm to prevent reflux, I never used BL more than 200 cm (since 2004) Rudolf Weiner
sorry, I mean alimentary limb + CL
There is one RCT from Spain that found no effect of the BPL..

Q: What is the diarrhoea incidence in longer bpl? What revisions you did?

A: 5-10%

Q: How far can we go in % of TBL of the BPL elongation with a distalisation of the RYGB in revisional surgeries (as of weight regain)?

A: Be sure that total AL is 260-300cm, in other words keep a CL of 150 plus

Q: Is the SLIM trial started yet?

A: Yes, we are at 200 pts

Q: Can we come to the conclusion that the AL length is no longer important?

A: Important to prevent reflux= at least 60-70 cm, no real influence on weight loss… (if shorter than 200)

Q: Have we given up on the restrictive mechanism of gastric bypass?

A: In the classic proximal bypass not, in malabsorptive variations: yes

Q: What is dr Himpens opinion on dissecting the hiatus in RYGB / OAGB?

A: He is not doing this

Q: But even with the same TOTAL bowel length among different patients, and the same length derivations (BPL and CL), the results will vary. Absorption is not a linear phenomenon. Overall we should insure that the CL is always superior to a minima length..

A: In my opinion YES

Q: What is the best method to measure the length?

A: 10cm steps with acruler

Q: Have you ever find a lipoma inside the crura, which doesn't allow to recognize a hiatal hernia endoscopically, and when you remove it you find a huge hiatal hernia?

A: In my experiences: yes

Q: When a patient with a bypass technique weighs a fixed loop of 150 and the GLP loop is fixed at 100 cm. common channel not known. What should we do?

A: The risks are low, but not more (f.e. 150 plus 150), Avoid mistakes during measuring. Since 2004 with 270 cm (200 plus 70) 3 cases with malnutrition and surgical revision only (1400 cases), Rudolf Weiner

Q: If long BL is better for WL and metabolic effects, why not performing a MBG instead of a RY bypass?

A: Not a standard procedure in Switzerland, no advantage in my opinion, EE anastomosis does not take long, so what is the benefit?

Q: Can you explain why a 150 cm OAGB is as good or better than the elegancy RYGB 75 alimentary 150 biliary??

A: Thanks. OAGB 150 gives similar weight loss outcomes as OAGB 200 (Boyle and Mahawar, Obesity Surgery) which has been shown to be non-inferior to RYGB in YOMEGA trial. However, we should also look at metabolic effectiveness, and early/late safety. Absence of Roux limb makes OAGB metabolically more effective (in terms of diabetes resolution rates). Early complication rate of OAGB is lower than that of RYGB. In long-term, risk of internal hernia and chronic, unexplained abdominal pain is probably lower than RYGB but this comes at the cost of higher risk of GORD.

Q: What do you think about SAGIS?

A: Thanks. I personally do not think SAGIS offers any particular advantage over OAGB and may be associated with higher risk of nutritional issues. With our bypass our aim should to be bypass as little small bowel as possible.

Q: One of the reasons why the BPL was 200 cm in the original OAGB was that bile gets diluted/reabsorbed before reaching the anastomosis. Shortening the BPL to 100 cm could increase bile reflux and its possible deleterious effects. Comments?

A: Thanks. Anecdotally, risk of GORD does not seem to be higher with OAGB 150 compared to OAGB 200 but this needs to be formally examined. I would expect bile to become more concentrated as it goes distally not diluted. My understand was that bile salts are absorbed in terminal ileum through enterohepatic circulation not in proximal jejunum.

Q: Has bile reflux been studied in those cases of shorter BPL in OAGB?

A: Thanks. I would not expect bile reflux to be higher in those with shorter BPL. It is the same bile and more dilute if anything.

Q: 150 CMS OF BPL IN HIGH IMC PATIENTS?

A: We don't know now, we need more evidence

Q: Have you any opinions to use mesh to repair HHO?

A: Mesh repair should be avoided in HH repair because of the risk of erosion, a dreadful complication. What I commonly do, though, is to us pledges of cellulose acetate (surgical) to prevent the (posterior) stitches from cutting through the hiatal muscle fibres.
If one elicits to use mesh anyway, it should be biodegradable in my opinion.

Q: How do you think about tailoring the BP-limb length based on total small bowel length in OAGB?

A: Thanks. I think it is unnecessary and a risky strategy. Measuring the entire small bowel is not without its risks. Outcomes of a gastric bypass are not dependent on the length of the small bowel bypassed.

Q: Using OAGB with 100cm is official method?

A: Thanks. There is one published study with OAGB from Russia where a BPL of 50-60 cm was used. But Mason's Bypass also had a short BP limb. So, though there is no published study with OAGB 100 yet, I think we have data to suggest that OAGB even with a BPL of 50-60 cm would be an effective procedure. We need to formally study a BPL of 100 cm with OAGB now.

Q: Does keeping the patients on micronutrient supplements help avoid some of the malabsorptive drawbacks? and is that considered in comparative studies?

A: Better compliance of supplement intake helps but does no avoid 100% deficiencies