Adding Duodenal Switch to Your Practice

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Why Add a Duodenal Switch to Your Practice?

- Very effective for weight loss
- Management of Diabetes
- Hyperlipidemias
- Pylorus preserving
- Revision from other cases
Starting point

- Your interest
- Your level of expertise
  - In bariatric surgery
  - In robotics
Information gathering

- Procedure specific information
  - Articles
  - Videos
  - Who are the experts
  - National meetings
  - See live cases with an expert
  - da Vinci/device makers can be a resource
Introducing the concept

- Partners
- Chairs
  - Surgery
  - Anesthesiology
  - Chief medical officer
- Hospital administration
  - Business development
  - Perioperative services / Operating room manager
  - Chief financial officer
- Marketing
- Clinic staff
Information gathering

- Credentialing requirements (Medical Staff Office)
  - For Bariatric Surgery
  - For Robotic Surgery
Create a core group

- Surgeon (Console, bedside)
- Scrub and circulator
- Anesthetist
- Robotic and bariatric co-coordinators
Implementation phases

- Phase 1 - FDA mandated training if using the robot
- Phase 2 - inanimate, animate and cadaveric models
- Phase 3 – Site visit and observation of procedure
- Phase 4 – Mock up and Initiation of live procedure with proctors and preceptors
- Phase 5 – Quality and outcomes improvement
Training nurses – phase 1 and 2

- Competency of nursing and scrubs techs with
  - Robotics
  - Procedure
    - Laparoscopy
    - open
Create Pathways and Protocols

- Team meetings to develop
  - Care plans (pre op, post op)
  - Insurance authorization and billing issues
  - Marketing
  - Block time
  - Anesthesia
Core team - phase 3

- Site visit with experts
  - Notes
  - Digital pictures of room and equipment, patient and port placements
  - Procedure videos
  - Flow of the case
Positioning
Tape mattress to frame of split-leg OR bed to prevent sliding when in Trendelenburg position.
Place patient supine on OR bed.
Tuck patient’s arms at his or her sides.
Place temperature-regulating blanket on patient’s upper body.
Place bed in reverse Trendelenburg; lower bed before bringing in robotic arms.
After prepping and draping, move Mayo stand over patient’s head to protect from camera arm.

Suture
0-polyglactin with a medium-sized cutting-taper needle for ligating the dorsal vein complex; cut 6 inches long and flatten needle; have ready for emergency use during stapling of dorsal vein complex.
3-0 polyglactin with small-medium taper needle; cut 5 inches long for oversewing bulldog clamps on pedicles.
3-0 poliglecaprone with small taper needle (ie, one each dyed and undyed), which are tied together with tissue bolster.

Port sites
Port #1: 5-mm accessory port
**Port sites**

Port #1: 5-mm accessory port

Port #2: 12-mm port centered above the patient's umbilicus a minimum of 18 cm from the pubis for the telescope

Port #3: 5-mm accessory port, if needed, for extra retraction

Port #4: 12-mm port with 5-mm reducer cap to accommodate laparoscopic stapler

Port #5: 8-mm robotic port

Port #6: 8-mm robotic port

(ie, one each dyed and undyed), which are tied together with tissue bolster.

**Robotic instruments**

0-degree and 30-degree endoscopes

Bipolar electrocautery

Basic robotic instrument tray

Stapler with special port

Robotic accessory tray

Starts with 30-degree endoscope, robotic bipolar forceps, monopolar spatula electrocautery, round-tip scissors, and two large needle drivers.

**Notes**

Open the following items.

- Extra-long laparoscopy suction/irrigation tip
- Bulldog clamps andappers

Put 1,000 units (ie, 1 mL of 1:1,000) heparin in 1,000 mL bag of normal saline (NS) (ie, 1 unit heparin/1 mL NS).

Have suture boots ready to place on a curved grasper or fine dissector for retraction during urethral anastomosis.

Have the following available in the room.

- Hemostatic agent and applicator
- Endoscopic-laparoscopic pouch
- Ligature clips/appliers for nonnerve-sparing procedures.
Initiate live procedures - phase 4

- Mock up (Operating table, anesthesia cart, monitors, electrocautery, gas tubing and supply, instruments, monitors, recording devices)
- Anesthesia
  - Positioning (Patient, Anesthetic cart, Padding)
  - Lines and tubes, patient warmers
  - Access to patient’s face
Initiate live procedures - phase 4

- Appropriate patient selection and consents
- Let entire team know dates in advance
- Arrange for proctors or preceptors and device representative
- Videotape
- Aim for one - two cases a month
Initiate program…….

- Debrief with team to thank and to encourage
- Be prepared for glitches and inefficiencies, but be the cheer leader for the staff
Quality improvement – Phase 5

- Record outcomes
- Periodic meetings to optimize process
- Addition of team members
- Marketing to grow the program
Formula for success - Phase 5

- Patience
- Persistence
- Good planning, preparation and execution
- Take the highs and the lows with humility and grace
Post Operative Management

- Nutritional issues
- Unique complications