Options for Weight Gain after Sleeve Gastrectomy

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Sleeve is part of BPD/DS

- BPD/DS is a modification of the Scopinaro BPD first described in 1979
- First BPD/DS performed in 1988 by Hess
- First published by Marceau in 1993
Role of Pylorus Preservation

- Reduced marginal ulceration
- Increased sense of satiety
- Reduced dumping symptoms
Laparoscopic Sleeve Operation

- Ren described first laparoscopic series of BPD/DS in 2000
- Sudan performed first robotic BPD/DS in 2000
- Anthone described open sleeve
- Gagner described initially as staged and then stand alone procedure
- Ayloo described first primary robotic sleeve
Sleeve Gastrectomy

- Tubular stomach
- Stomach capacity reduced from 250cc (60 French bougie) to ≈ 100 mL (34 French Bougie)
- Many patients were not returning for second stage and concept of Sleeve as primary bariatic operation was born
Incidence of Sleeve Gastrectomy

- Gaining popularity worldwide
- In Europe, succeeding adjustable band as restrictive operation of choice.
- Emerging 5 year outcomes that appear to be superior to adjustable band.
Indications

- Anyone in whom malabsorption is undesirable or contraindicated
- Patients who do not want to deal with the device related issues of the adjustable band or in whom the band is contraindicated
- High risk candidates for staging purposes
Current Indications for LSG

- **Primary**
  - Transplant candidate
  - Continued NSAID/Steroid use
  - Crohn’s Disease
  - Multiple bowel resections
  - Average risk patient as stand-alone procedure

- **Staged Approach**
  - Severe cardiac/pulmonary disease
  - High anesthetic risk
  - Super super-obese
  - Advanced age, multiple comorbidities
Expected Weight Loss

- %EWL is about 50% at 1 year.

- Results for Diabetes are intermediate between Band and Bypass (Hutter 2011)
Failure of Sleeve

- Inadequate weight loss
- Inadequate resolution of comorbid conditions
- Complications
  - Technical
  - New onset comorbid conditions (GERD)
Evaluation

- May benefit from additional surgical therapy
- Should be thoroughly evaluated by a multidisciplinary program to determine the potential causes for their poor response.
- Includes nutritional and behavioral health assessment, and anatomic evaluation (EGD, UGI, Manometry, Gastric emptying studies, pH studies.
- The decision to proceed with additional medical or surgical therapy should be based on this multidisciplinary assessment and the patient’s specific risk/benefit profile for a reoperative procedure.
Management of Sleeve Related Problems

- Acute Complications
  - Bleeds (non-operative, endoscopic, surgical, interventional)
  -Leaks (Stents, endoscopic suturing, surgical)
  -Stricture (strictureplasty, RYGB)
- Development of de novo Reflux (sleeveplasty, RYGB)
- Chronic vomiting
- Nutritional
- Inadequate weight loss
Inadequate Weight Loss

- Conversion to RYGB
- Conversion to BPD/DS
- Re-Sleeve
- Band over sleeve
- Plication
Conversion to RYGB

- Straightforward
- Most surgeons are familiar with RYGB
Conversion to BPD/DS

- Technically more difficult than RYGB conversion
- Add more malabsorption
- Potentially higher risk and higher reward
- Preserves pylorus
- Many patients for whom a sleeve is a good option will also benefit from BPD/DS
Summary

- SG is gaining worldwide popularity.
- %EWL is about 50% at 1 year.
- Weight loss outcomes appear to be superior to adjustable gastric band.
- However long term results are not fully understood.
- For those who fail, conversion to RYGB or BPD/DS are options.
- Surgeon comfort and patient characteristics may determine best choice.
Thank You

- Questions?