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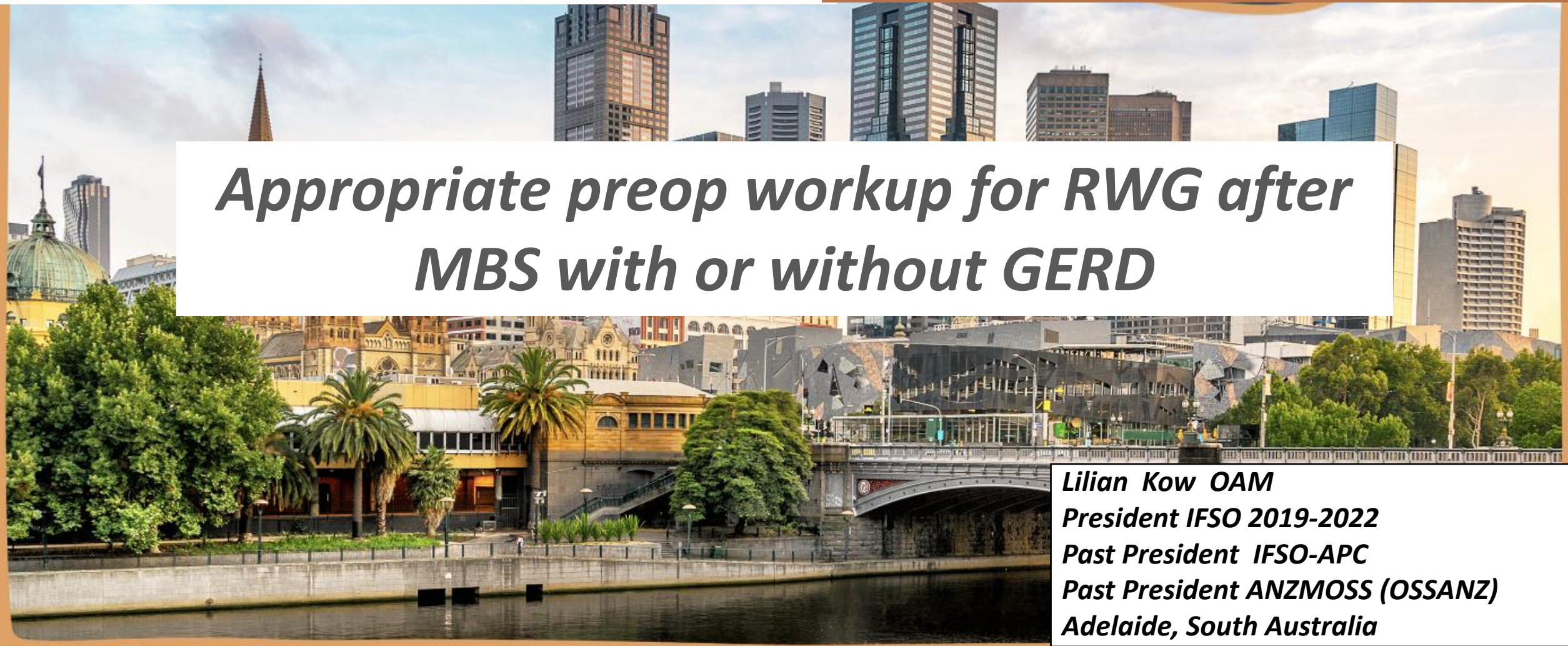

Appropriate preop workup for RWG after MBS with or without GERD

Lilian Kow OAM
President IFSO 2019-2022
Past President IFSO-APC
Past President ANZMOSS (OSSANZ)
Adelaide, South Australia

CONFLICT OF INTEREST DISCLOSURE

I have no potential conflict of interest to report

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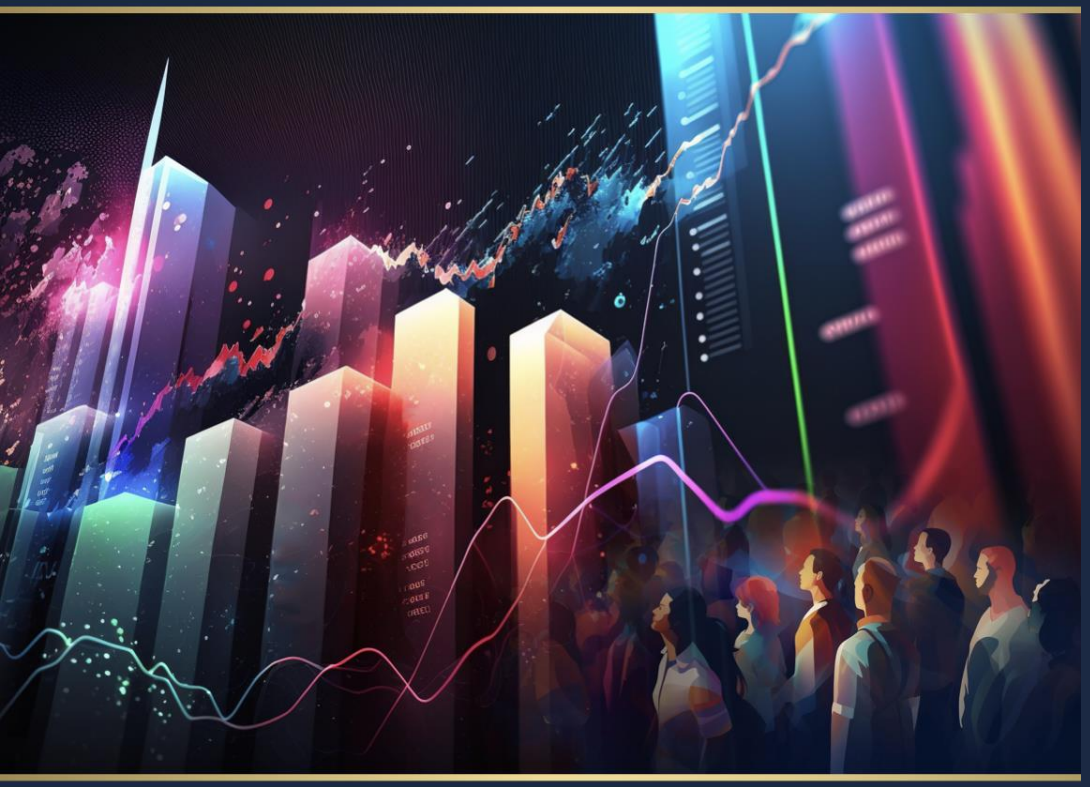
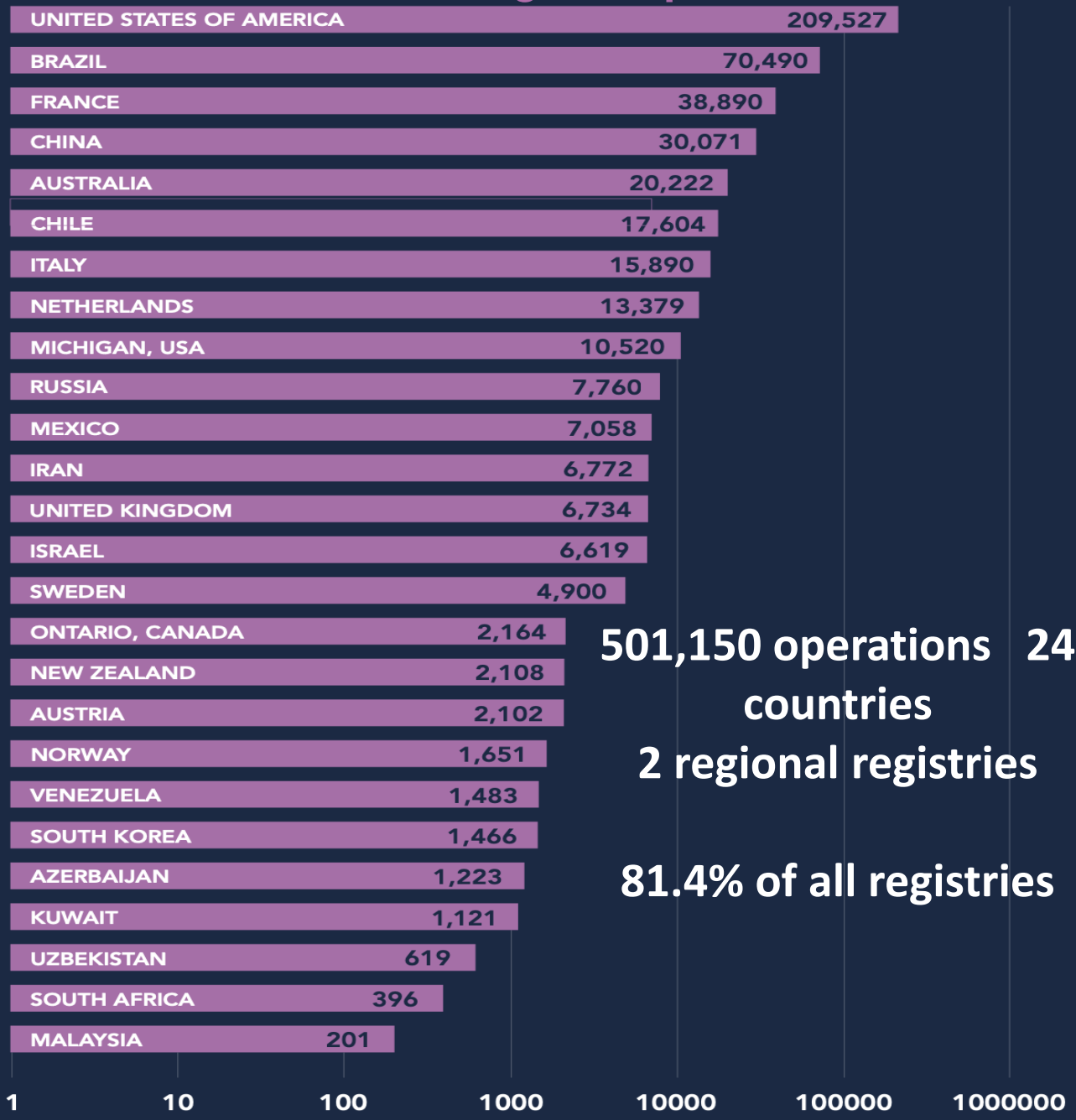
8TH GLOBAL REGISTRY REPORT



International Federation for Surgery for Obesity and Metabolic Disorders

2024

Contributors to the eighth report



501,150 operations 24 countries

2 regional registries

81.4% of all registries

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8TH GLOBAL REGISTRY REPORT

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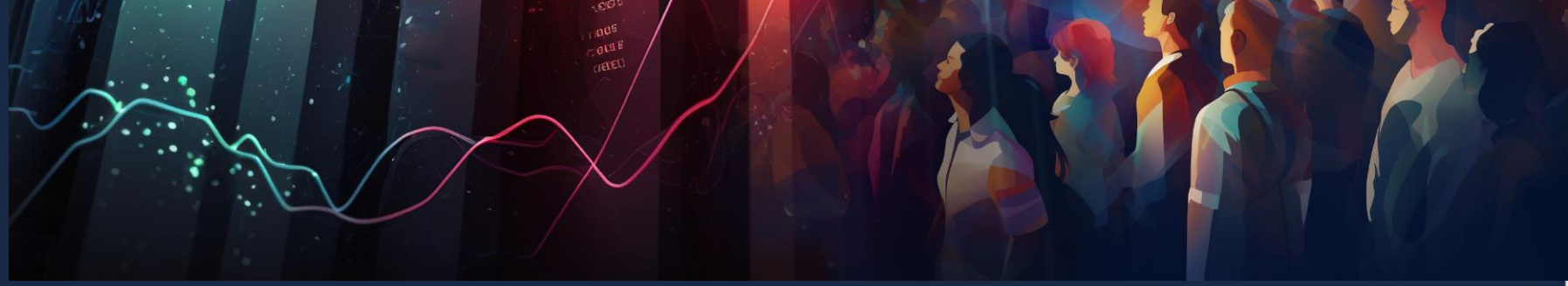
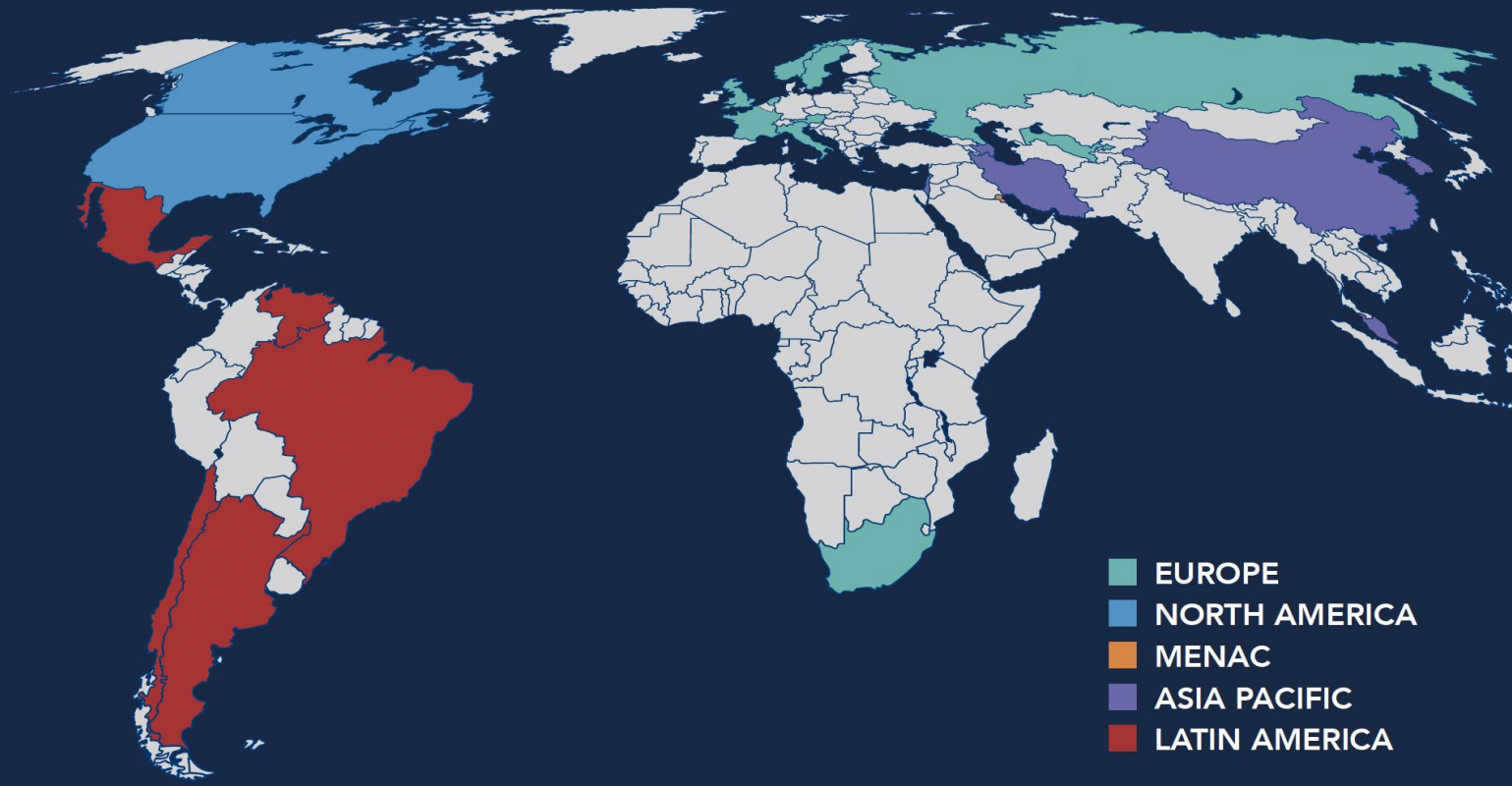


Contributors to the eighth report



501,150 operations 24 countries

2 regional registries

81.4% of all registries

Geographic distribution of contributors to the eight IFSO global registry report - seen on the map above.
Each of the IFSO Chapters is represented. A list of key contacts can be found in Appendix 1

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8TH GLOBAL REGISTRY REPORT

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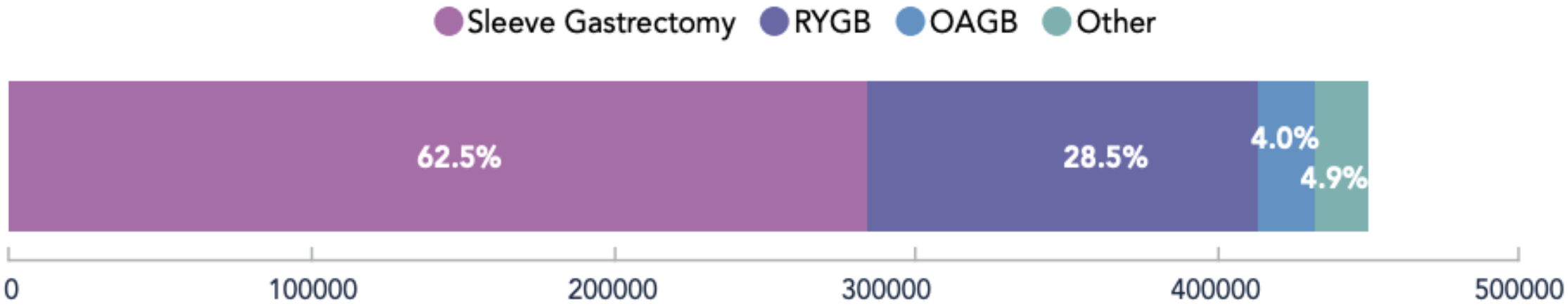
Primary procedures



Primary procedure types (n=449,815).

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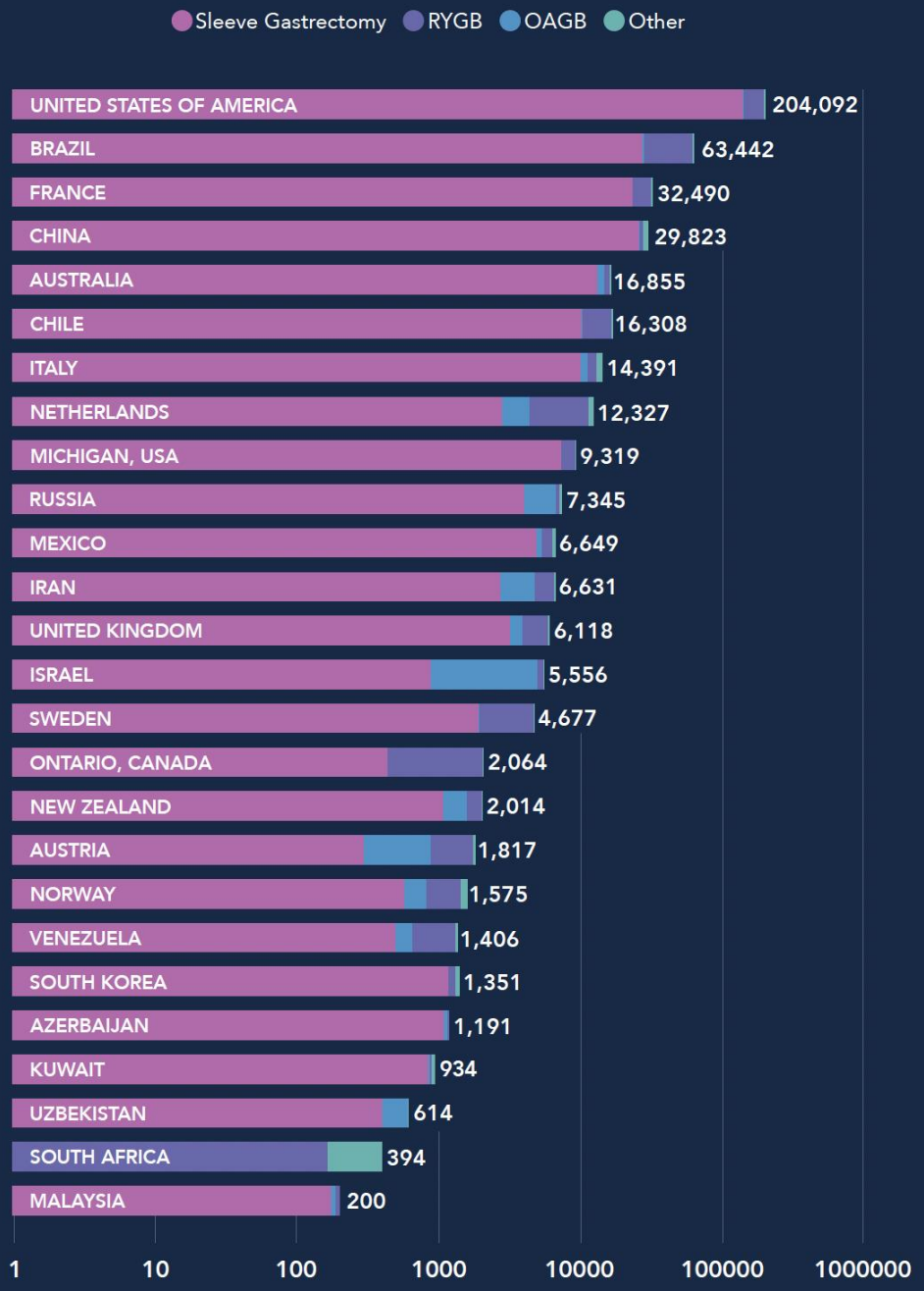
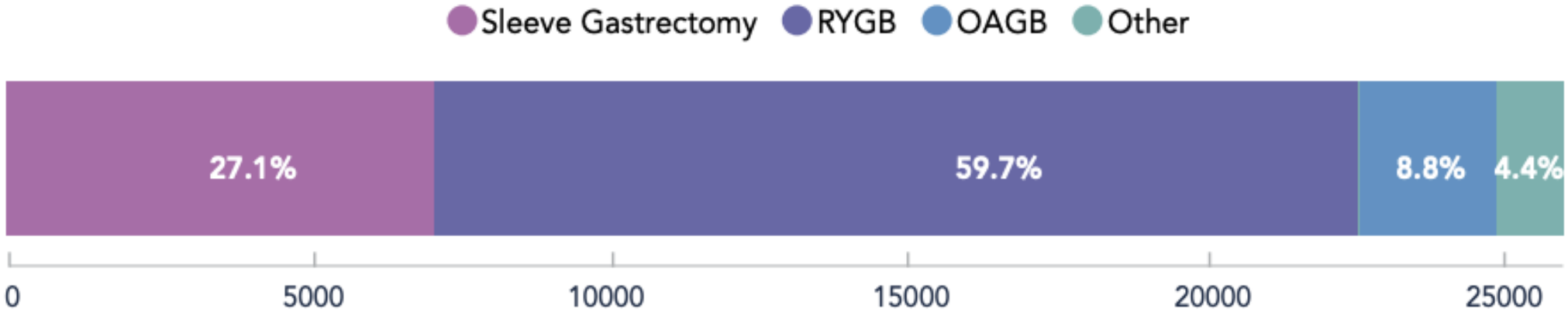
Primary procedures



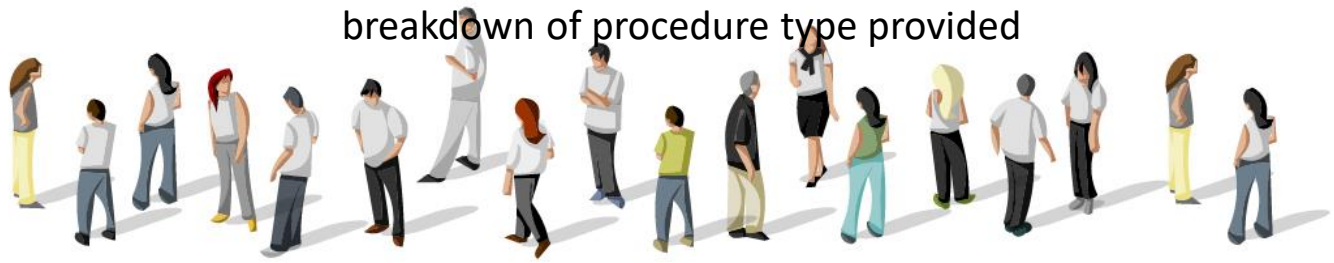
Types of primary procedures by country or region.

Revisional procedures



Revisional procedures (n= 25,938).

21,057 conversion procedures from USA excluded from analysis as no breakdown of procedure type provided



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8TH GLOBAL REGISTRY REPORT
2024

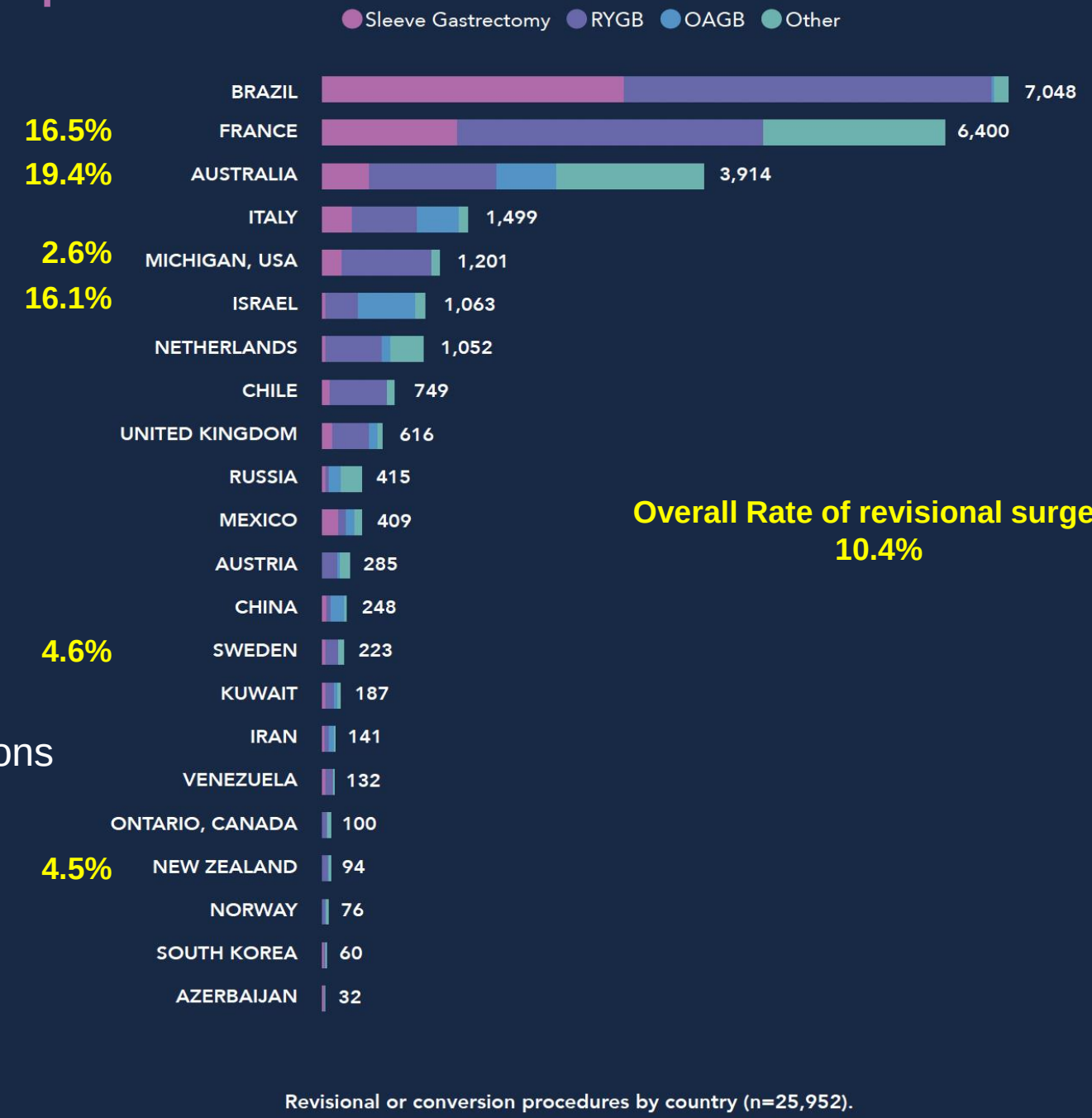
Revisional procedures

Revisional MB procedures

- defined as procedures to change one type of MBS → a different MBS

- ***conversion*** → revise index procedure → another
  - required for - weight ↑
    - SE initial procedure or
    - recurrence metabolic disorders
- ***corrective*** → revise index to - change anatomy
  - address complications
  - reduction internal hernia
  - dilatation of a stricture

All acceptable reflecting the chronic nature of the disease of obesity.



Overall Rate of revisional surgery 10.4%

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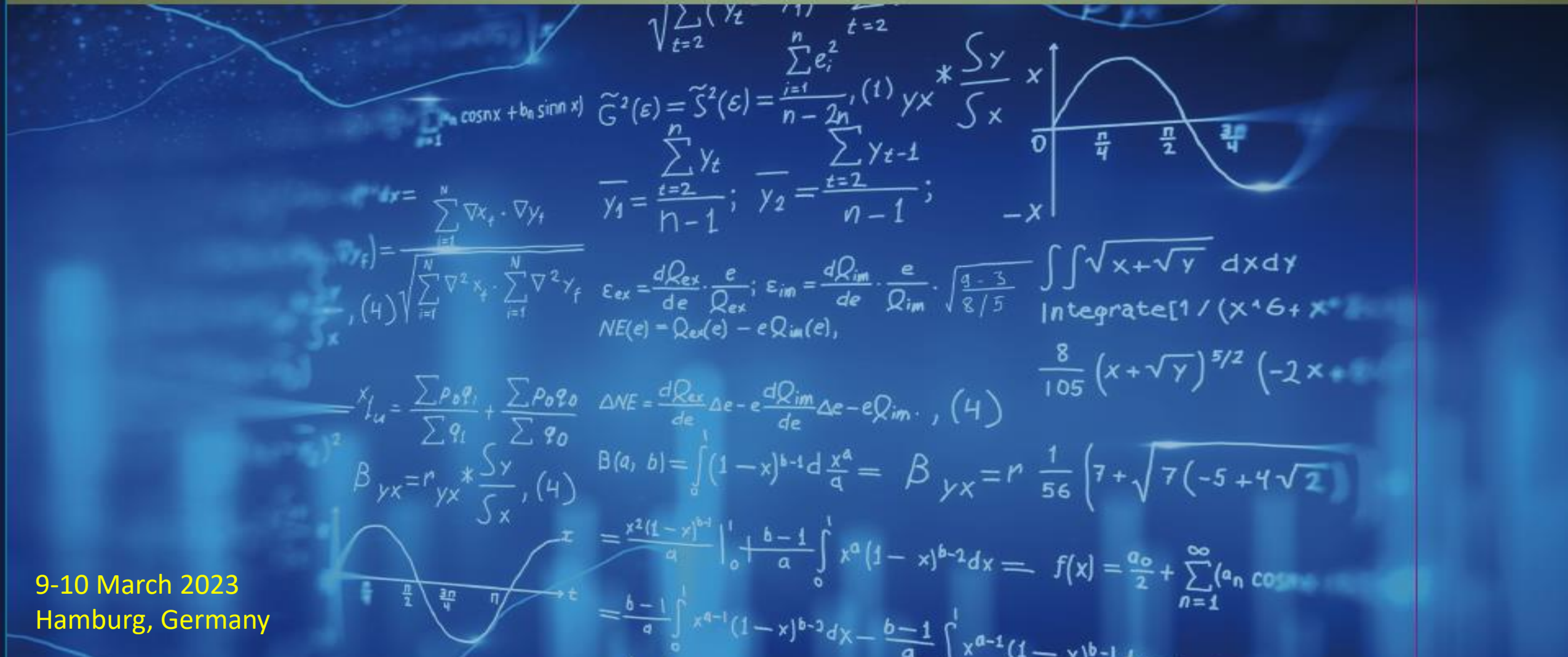
CONSENSUS ON DEFINITIONS AND CLINICAL PRACTICE GUIDELINES FOR PATIENTS CONSIDERING METABOLIC-BARIATRIC SURGERY



9-10 March 2023
Hamburg, Germany

IFSO

CONSENSUS ON DEFINITIONS AND CLINICAL PRACTICE GUIDELINES FOR PATIENTS CONSIDERING METABOLIC-BARIATRIC SURGERY

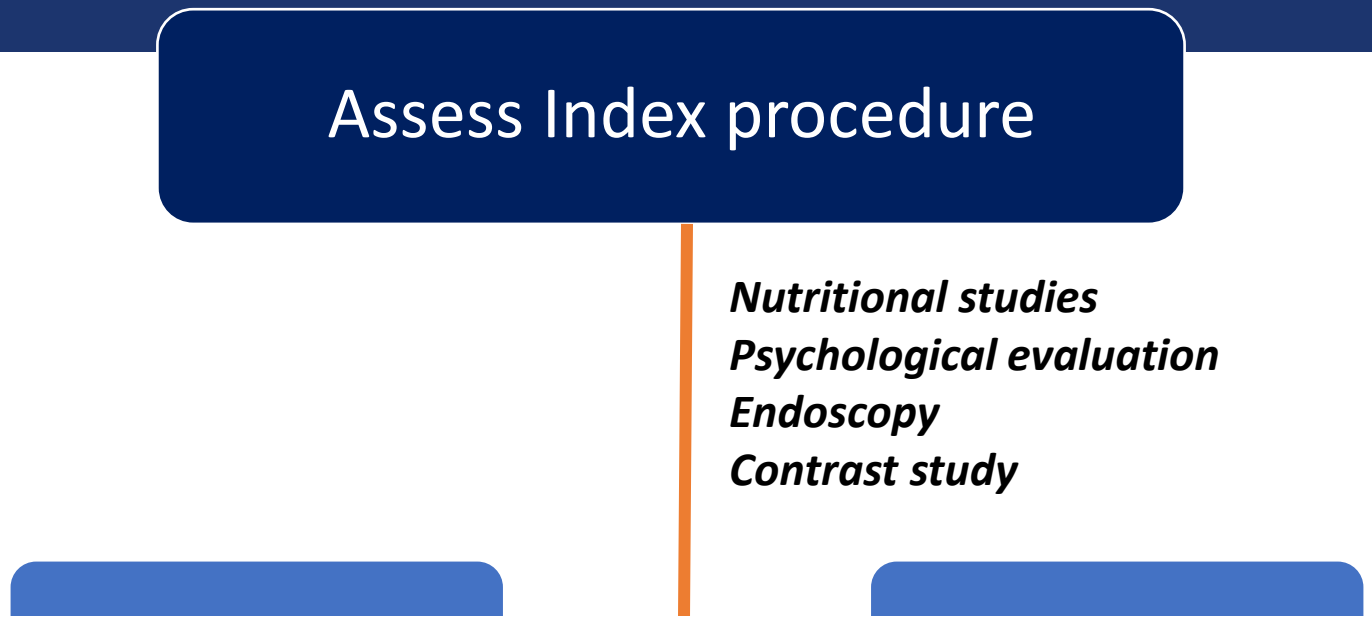
REPORTING STANDARDS : RECURRENT WEIGHT GAIN	Percentage Consensus
In general, a suboptimal initial clinical response to MBS is demonstrated either by a total body weight or BMI loss of less than 20% OR by an inadequate improvement in an obesity complication that was a significant indication for surgery.	100%
In general, a late post-operative clinical deterioration after MBS is demonstrated either by recurrent weight gain of more than 30% of the initial surgical weight loss OR by worsening of an obesity complication that was a significant indication for surgery.	85%

Evidence regarding therapeutic weight loss for complications of obesity

Obesity complication	Weight loss for substantial improvement (%)	Benefits increase with increasing weight loss
Type 2 diabetes	5-15	✓
Hypertension	15	✓
Dyslipidemia	10-15	✓
Fatty liver disease (NAFLD)	10	✓
Sleep apnea	10	✓
Osteoarthritis	5-15	✓
Stress incontinence	5-10	✓
Gastroesophageal reflux	10-15	✓
Polycystic ovary syndrome	10-15	✓

Adapted from Cefalu WT et al., Diab Care 2015

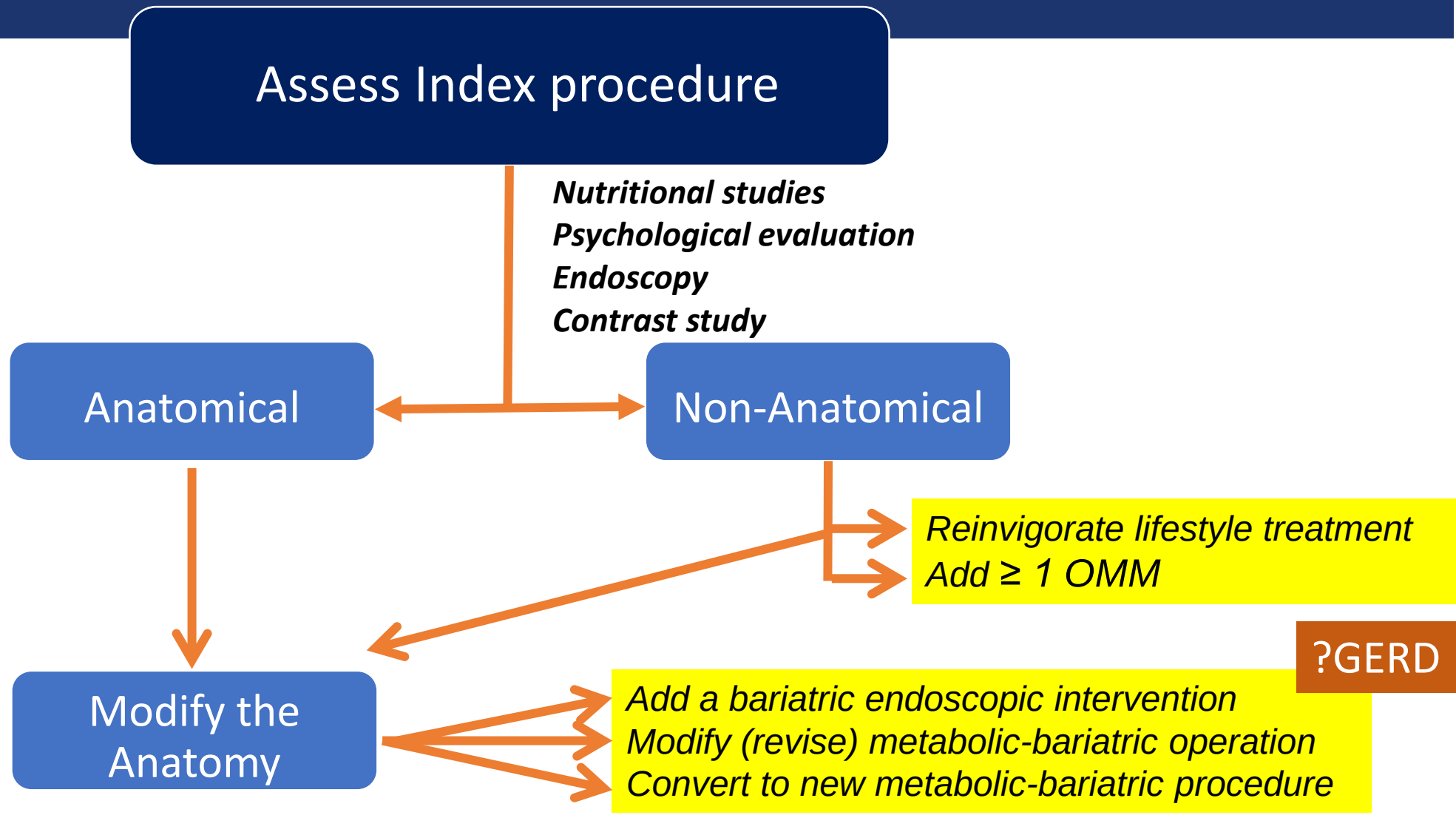
Appropriate preop workup for RWG after MBS with or without GERD



- **endoscopy**
  - Volume of LSG or Proximal pouch of GB
  - Esophagitis
  - Hiatus Hernia +/- reflux : LSG → RYGB
  - BE - ↑ Prevalence BE after LSG - ↑ year by year. Not ↑ after RYGB (level 1:Qumseya et al.)
  - Assess anastomosis (Gastro-Jejenostomy/ Duo-Ileal)
- **H Pylori** must be evaluated before any MBS with gastric exclusion
  - HP may →gastric Ca, atrophy, ulceration or GIST (level 1: Wang et al)
  - HP should be eradicated before MBS to ↓ the risk of gastric Ca
  - HP protects however against esophageal adenoCa (level 1:Xie et al)

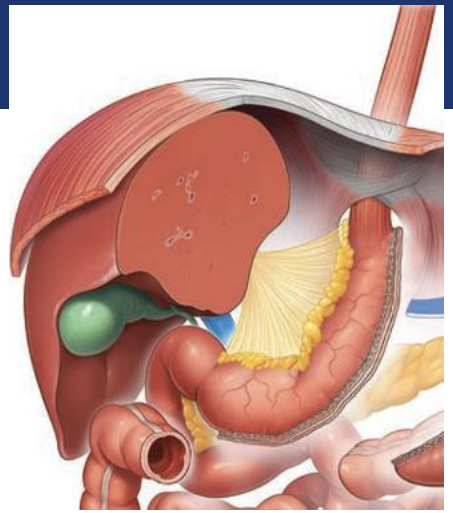
Wang et al Obesity surgery. 2021;31:337-42
Qumseya et al Obesity surgery. 2022;32:3513-22
Lewis et al SOARD 2021;17:72-80
Xie et al World J Gastroenterology. 2013;19:6098-107

Appropriate preop workup for RWG after MBS with or without GERD



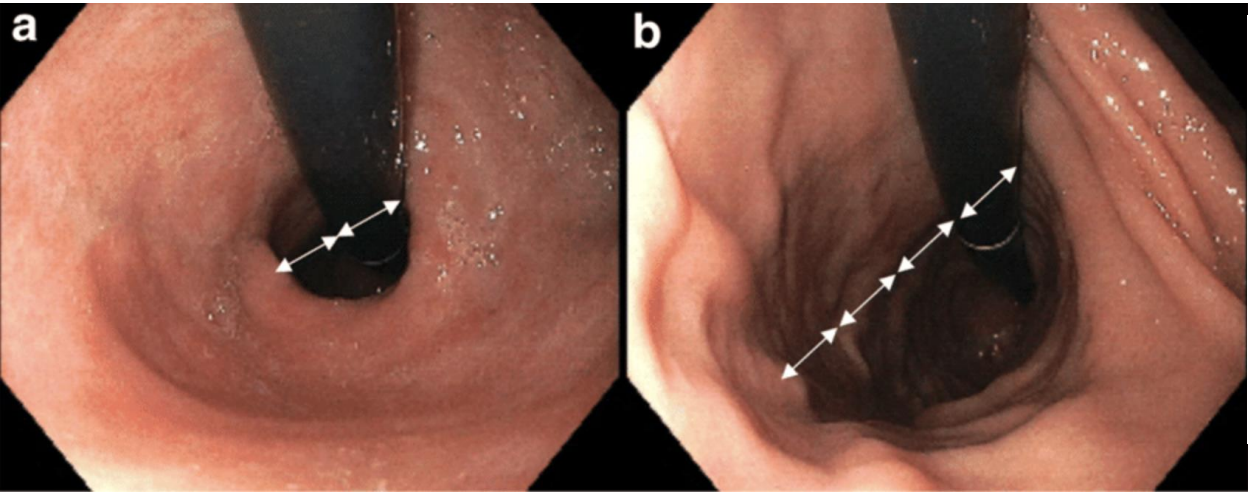
Each option has different benefit, risk and cost characteristics

Appropriate preop workup for RWG after MBS with or without GERD

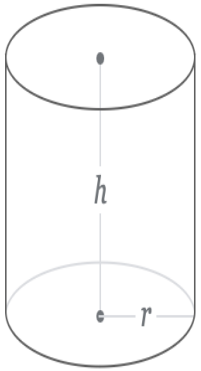


Assess Index procedure: SG

Volume
Sleeved Stomach



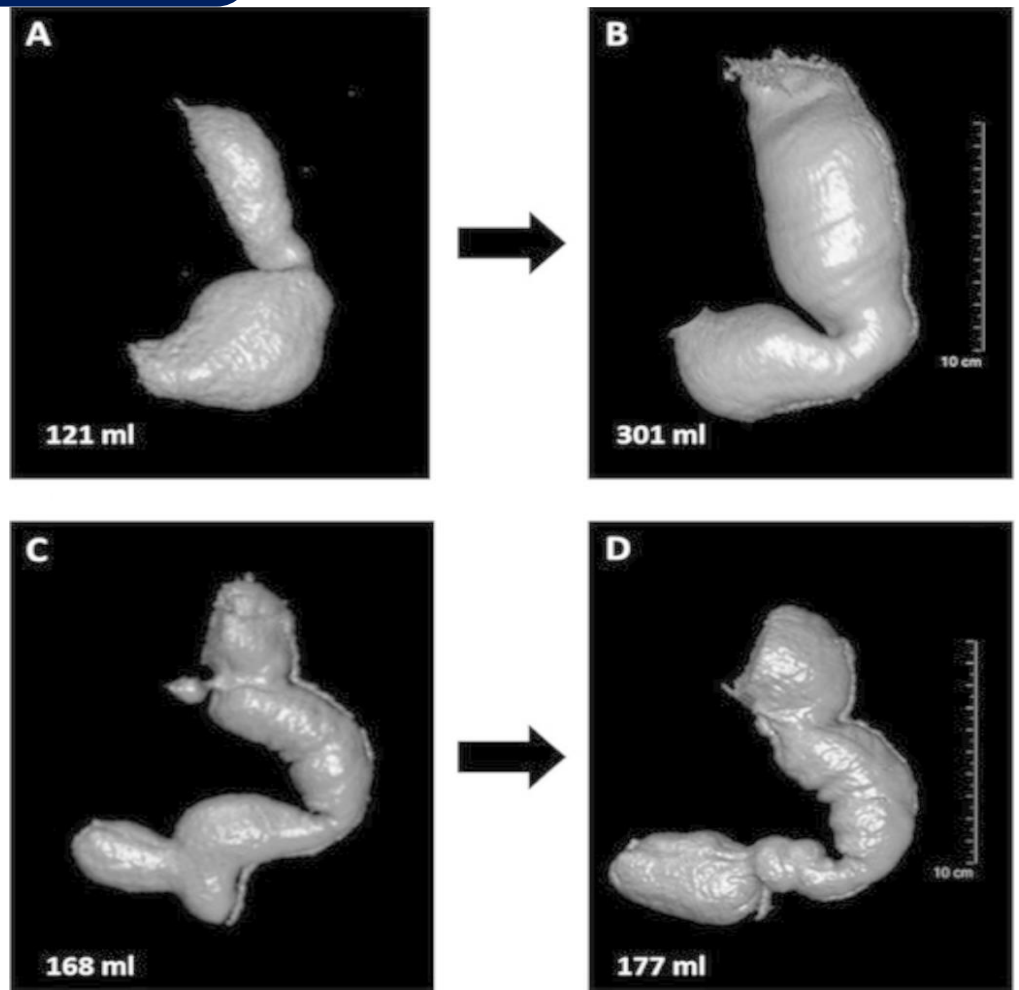
endoscopy



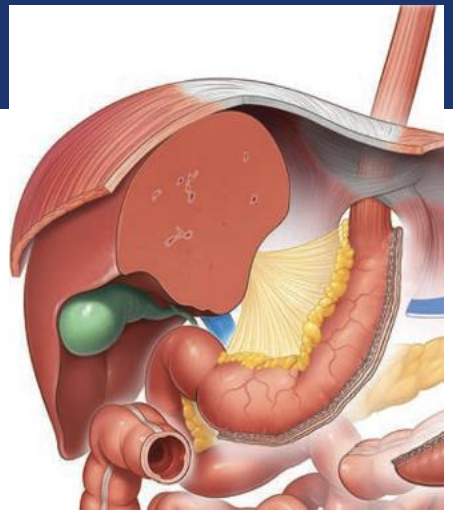
$$V = \pi \left(\frac{d}{2}\right)^2 h = \pi \cdot \left(\frac{2.5}{2}\right)^2 \cdot 30 \approx 147.26216$$

Lim et al Obesity Surgery (2019) 29:207–214
Disse et al: Obesity Surgery (2017) 27(1)

3D gastric CT fizzogram



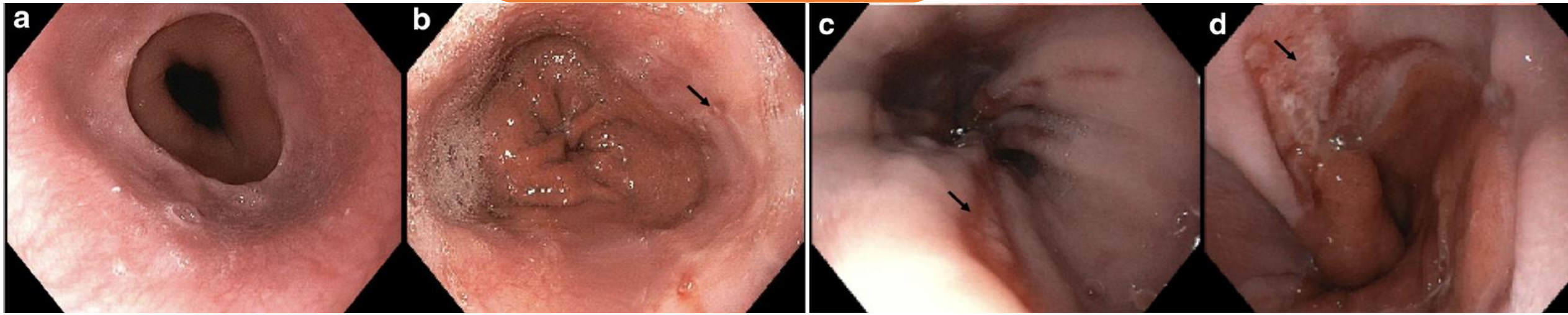
Appropriate preop workup for RWG after MBS with or without GERD



Assess Index procedure: SG

Endoscopy Sleeved Stomach
- Volume
- Esophagitis
- BE

DEN Open. 2022;2:e94 https://doi.org/10.1002/deo2.94

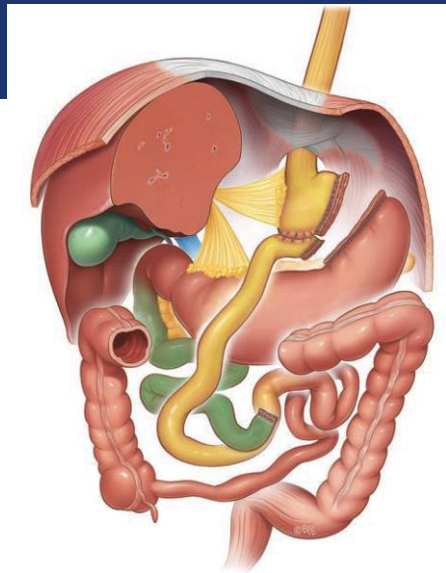


A Hiatal hernia *B grade A esophagitis* *C grade B esophagitis* *D grade C esophagitis*

Los Angeles (LA) classification of erosive esophagitis.

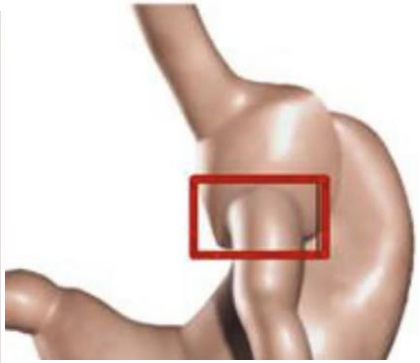
Lim et al Obesity Surgery (2019) 29:207–214

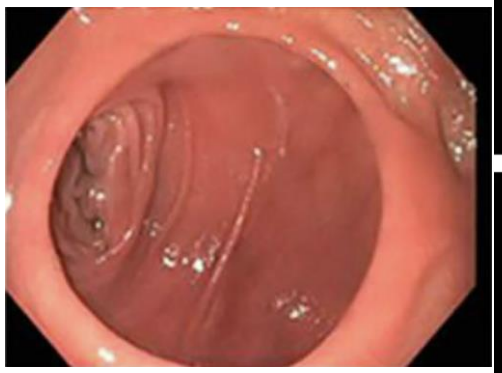
Appropriate preop workup for RWG after MBS with or without GERD



Assess Index procedure:RYGB

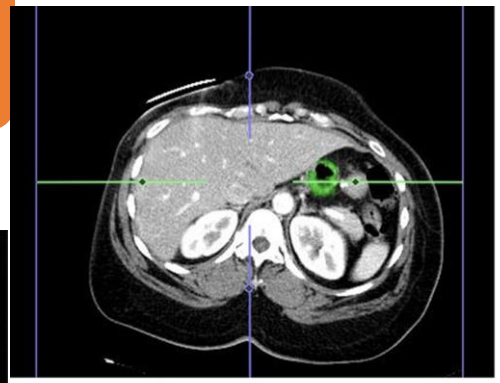
Volume gastric pouch
Diameter Gastro-Jejunostomy Stoma

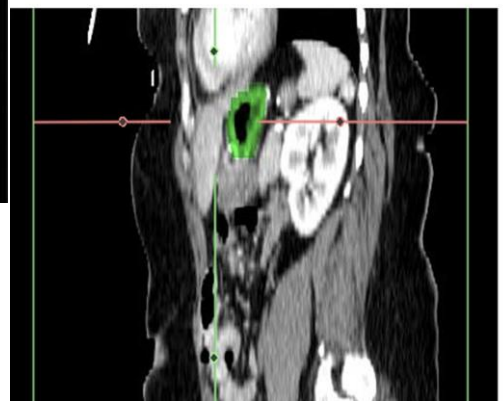




endoscopy

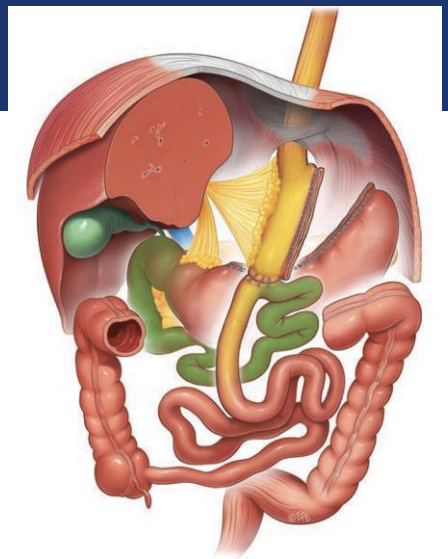
CT volumetric analysis





Barham Abu Dayyeh et al Frontiers Endocrinology 2022 (13) doi: 10.3389/fendo.2022.946870
Nimeri et al Obesity Surgery (2022) 32:587–592
The SAGES Manual of Physiologic Evaluation of Foregut Diseases. Endoscopic Evaluation of the Bariatric Surgery Patient 2023: 215-233

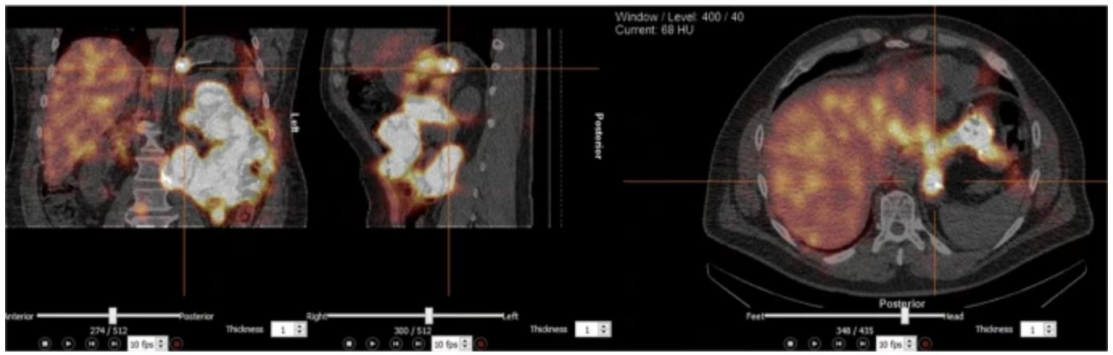
Appropriate preop workup for RWG after MBS with or without GERD



Assess Index procedure: OAGB

6 RCTs/Prosp/retrosp cohort studies n=134

- Bile Reflux 47% asso RWG
- Inadequate Weight loss 8%
- Malnutrition 31 %



SPECT–CT scan at the end of bile reflux scintigraphy of a representative patient. Bile tracer activity in the gastric pouch and esophagus are shown

endoscopy

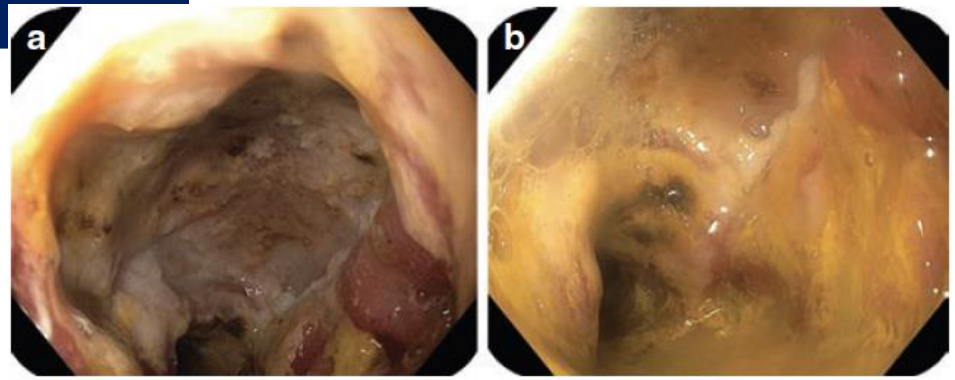


Fig. 42.7 (**a**, **b**) Bile reflux in a patient who underwent OAGB one year prior, complaining of severe abdominal pain, bilious vomiting and poor appetite. (**a**) Extensive and deep GJ ulcer. (**b**) Bile noted in the gastric pouch and esophagus

Sargsyan N et al. Outcomes of OAGB Conversion to RYGB for Severe Obesity: A Systematic Review and Meta-analysis Obesity Surgery 2024 (34): 976–984.

Del Gobo & Kroh M. The SAGES Manual of Physiologic Evaluation of Foregut Diseases:Reflux After RYGB and OAGB. P573-590

Saarinen T et al Bile Reflux is a Common Finding in the Gastric Pouch After One Anastomosis Gastric Bypass Obesity Surgery 32020(30) 875–881,

Options for RWG after MBS with or without GERD

LAGB (level 3 and 4)
- conversion to SG
- conversion to RYGB
- conversion to OAGB
- conversion to BPD/DS or SADI-s

Sleeve Gastrectomy (level 3 and 4)
- conversion to RYGB
- conversion to OAGB
- conversion to BPD/DS or SADI-s
- Endoscopic gastroplasty/TORe

RYGB (level 4 and 5)
- Lengthening of BP limb
- conversion to BPD/DS?
- Endoscopic gastroplasty/TORe

VBG (level 4 and 5)
- conversion to RYGB
- conversion to BPD/DS (high complication rate)

SADI-S (level 4)
- conversion to BPD/DS

OAGB (level 4 and 5)
- Conversion to RYGB
- conversion to BPD/DS?
- Endoscopic gastroplasty/TORe

BPD/DS (level 5)
- conversion to ……..

Kermansaravi et al. Best Practice approach for redo surgeries after sleeve gastrectomies, an expert modified Delphi consensus Surgical Endoscopy (2023) 37:1617–1628
Barham Abu Dayyeh et al Frontiers Endocrinology 2022 (13) doi: 10.3389/fendo.2022.946870
Brethauuer Set al. Systematic Review on reoperative BS. ASMBS Revision Task Force SOARD, 2014-09-01, Volume 10, Issue 5, Pages 952-972,
Mahawar K et al. The first consensus statement on revisional bariatric surgery a modified Delhi approach. Surgical endoscopy, 04/2020, Volume 34, Issue 4

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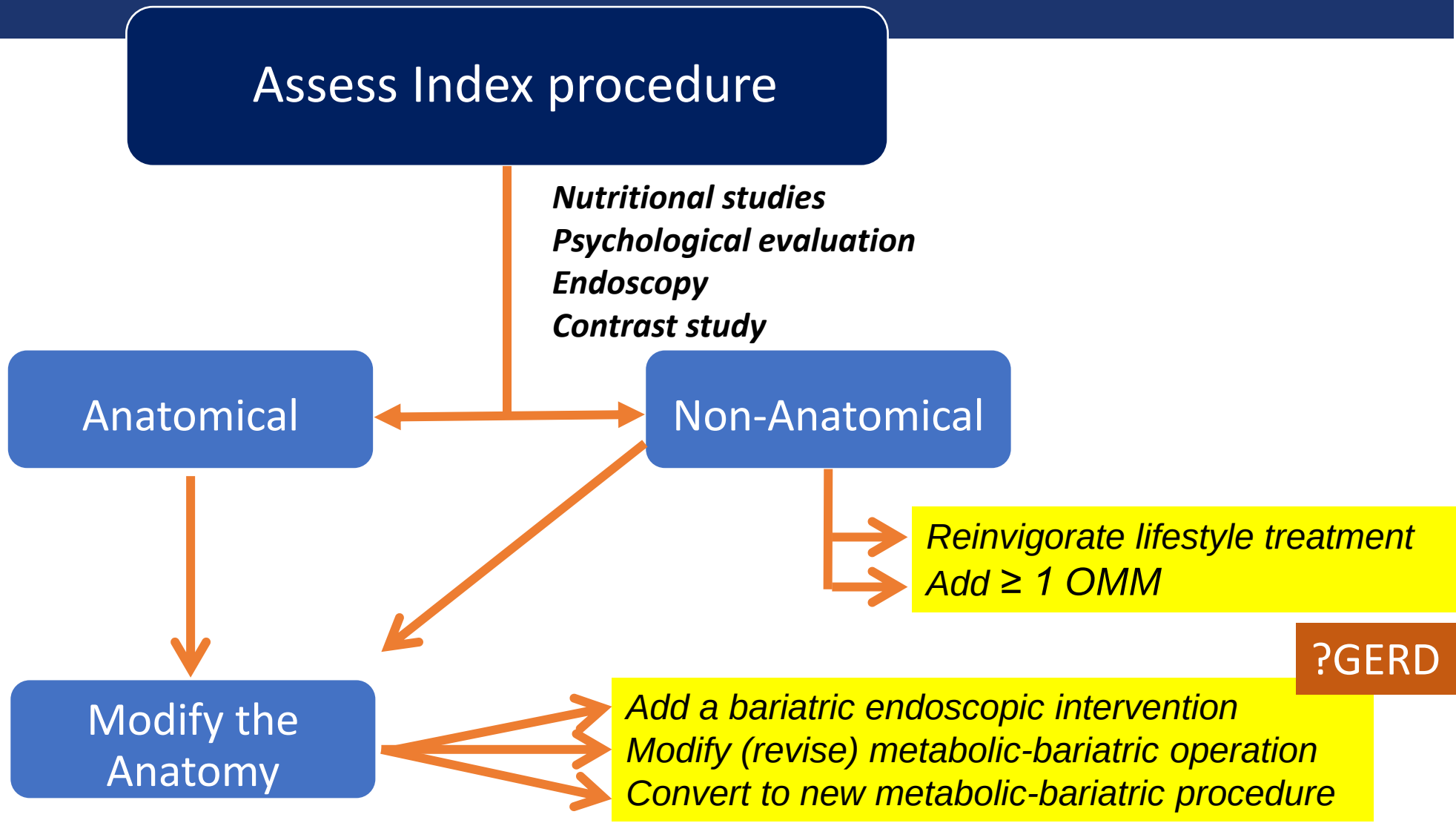

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