Upper GI Surgery

Type I Distalisation.

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Bypass with malabsorption

JAMA Surg. 2016 Dec 1;151(12):1146-1155. doi: 10.1001/jamasurg.2016.2798.

Standard vs Distal Roux-en-Y Gastric Bypass in Patients With Body Mass Index 50 to 60: A Double-blind, Randomized Clinical Trial.

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Abstract

IMPORTANCE: Up to one-third of patients undergoing bariatric surgery have a body mass index (BMI) of more than 50. Following standard gastric bypass, many of these patients still have a BMI greater than 40 after peak weight loss.

OBJECTIVE: To assess the efficacy and safety of standard gastric bypass vs distal gastric bypass in patients with a BMI of 50 to 60.

DESIGN, SETTING, AND PARTICIPANTS: Double-blind, randomized clinical parallel-group trial at 2 tertiary care centers in Norway (Oslo University Hospital and Vestfold Hospital Trust) between May 2011 and April 2013. The study included 113 patients with a BMI of 50 to 60 aged 20 to 60 years. The 2-year follow-up was completed in May 2015.

INTERVENTIONS: Standard gastric bypass (alimentary limb, 150 cm) and distal gastric bypass (common channel, 150 cm), both with a biliopancreatic limb of 50 cm and a gastric pouch of about 25 mL.

Does ‘malabsorption’ actually help these patients?

What's going on with bypass's

- Attempts to distalise gastric bypasses by lengthening alimentary limb (with shortening of common channel) haven't led to increased weight-loss, just increased malsorption.
  - Clearly the therapeutic window for malabsorption for weight loss is narrow, and hampered by side effects and complications.
- There have been signals that lengthening the BP limb may help however, while this realisation has spawned a host of surgical procedures the take-up has been poor.
  - Its likely that surgical enthusiasm over-represents the +ve therapeutic effect and downplays side effects and late revisions.

Gut Hormones lecture

The microbiome

Small bowel ~~witchcraft~~ manipulation

Study	AL and BPL	Patient numbers	Duration	Weight or Metabolic difference
Inabnet 2005	100 and 50 v 150 and 100	48	1 yr	Nah
Pinheiro 2007	150 and 50 v 250 and 100	115	4 yrs	Better sugars
Nergaard 2014	60 and 200 v 150 and 60	187	7 yrs	5% incr TBWL
Homan 2018	75 and 150 v 150 and 75	146	4 yrs	Nah
Ruiz-Tovar 2019	150 and 70 v 150 and 120	506	5 yrs	Nah
AD Miras 2021	100 and 50 v 100 and 150	50	3 yrs	Nah

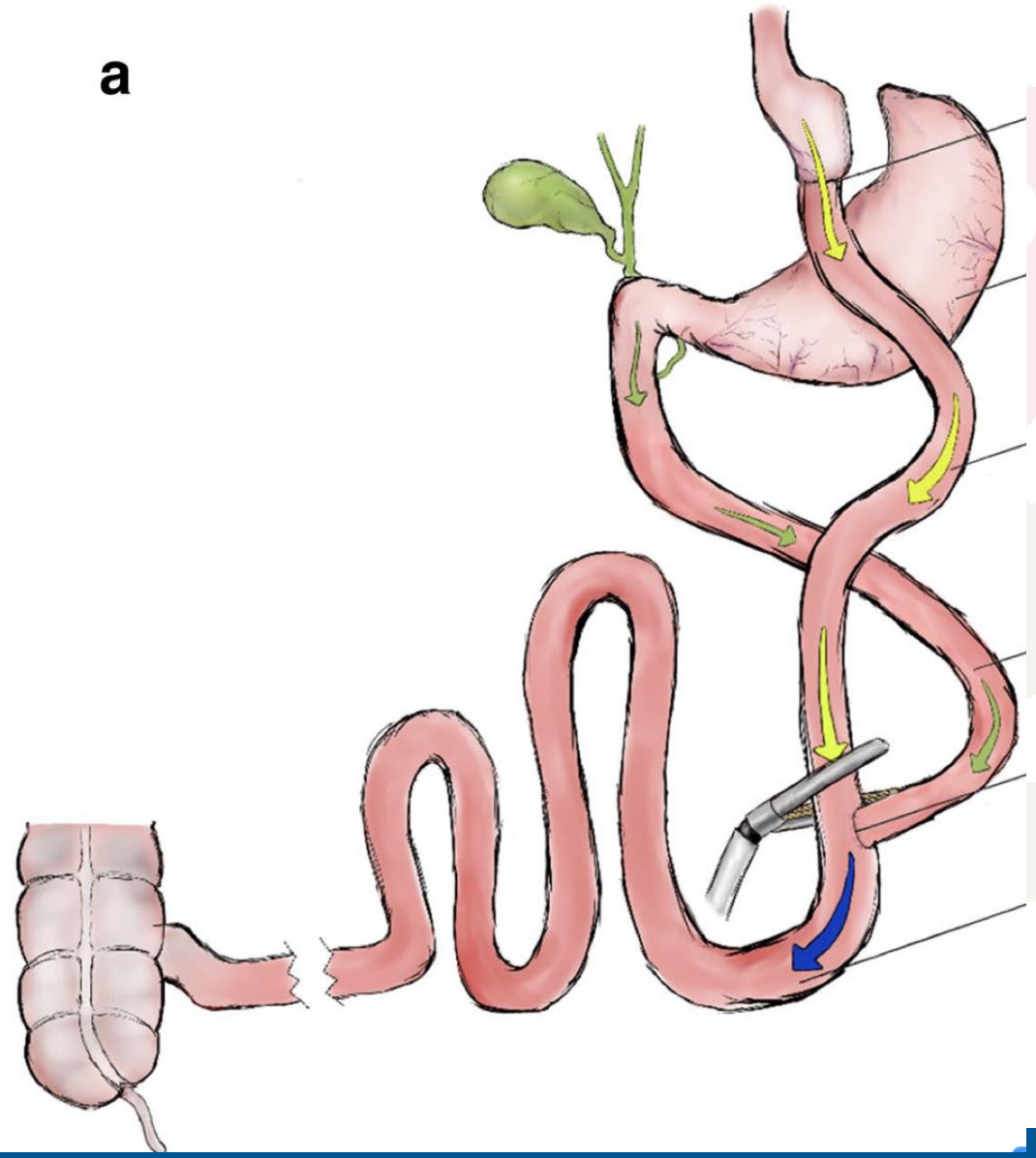
Study	AL and BPL	Patient numbers	Duration	Weight or Metabolic difference
Maude(YOMEGA) 2019	150 and 50 v 200 OAGB	253	2 yr	Nah. Just more malnutrition in OAGB
Bertrand 2022	150 OAGB v 200OAGB	784	5 yrs	Nah. More malnutrition in OAGB 200
Salte. BMI > 50	50 + 150 v 50 + a cc of 150	187	5 yrs	Nah, just malnutrition in distals
Lourensz 2022	Revision to DS or BPD	102	17 yrs (of pain)	22 then 17% TWL at 15 yrs. 80% deficiency, 10% TPN
Ghiassi (Higa) 2018	Distalisation of BP with 400 TAL	96	3	Weight loss 15% but malabsorption

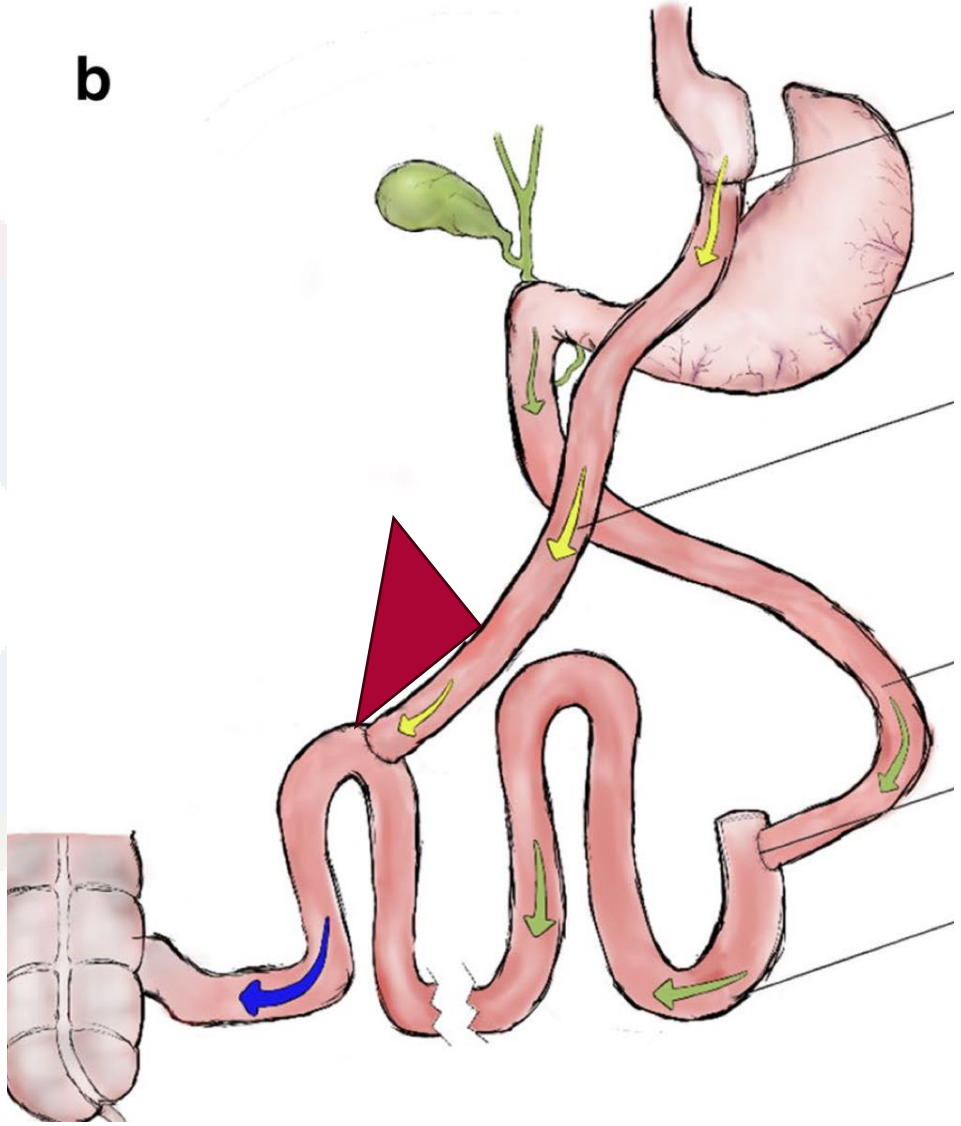
Law of diminishing returns

- I’m mostly against malabsorption. The things we want patients to malabsorb are easy to absorb, the things we want to keep we lose.
  - Lose minerals, then fats, then complex carbs, then protein, then simple sugars.
- Our patients are hooked on simple sugars and processed carbs…..
- All revisions have incremental effects.
- Recruit as many mechanisms as possible, and I generally go for pouch based therapies if possible as well.

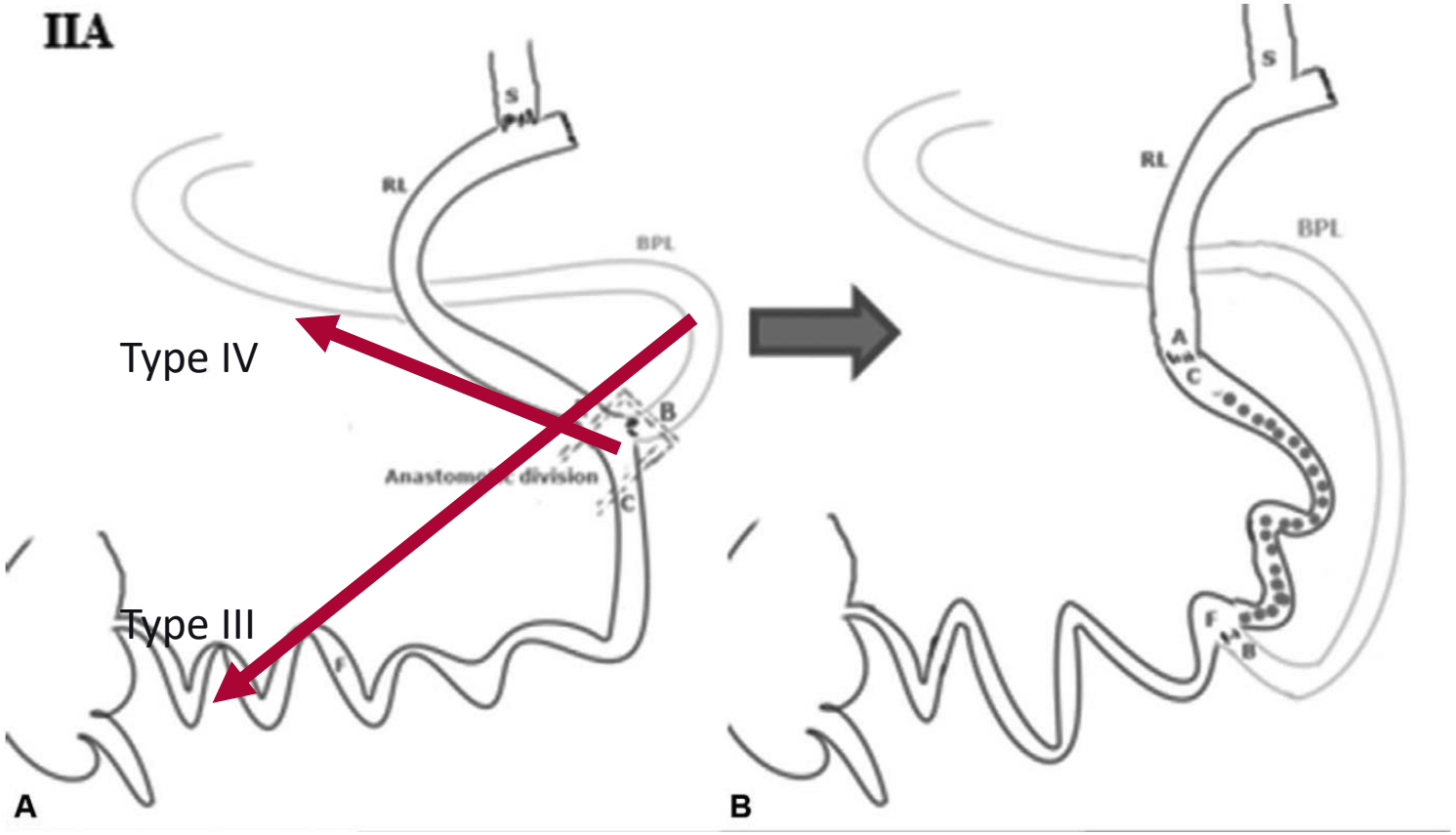

84, F, 31Y
SOMATOM Definition Fla
CT 2012
FIZZ

Type I, how does this look?

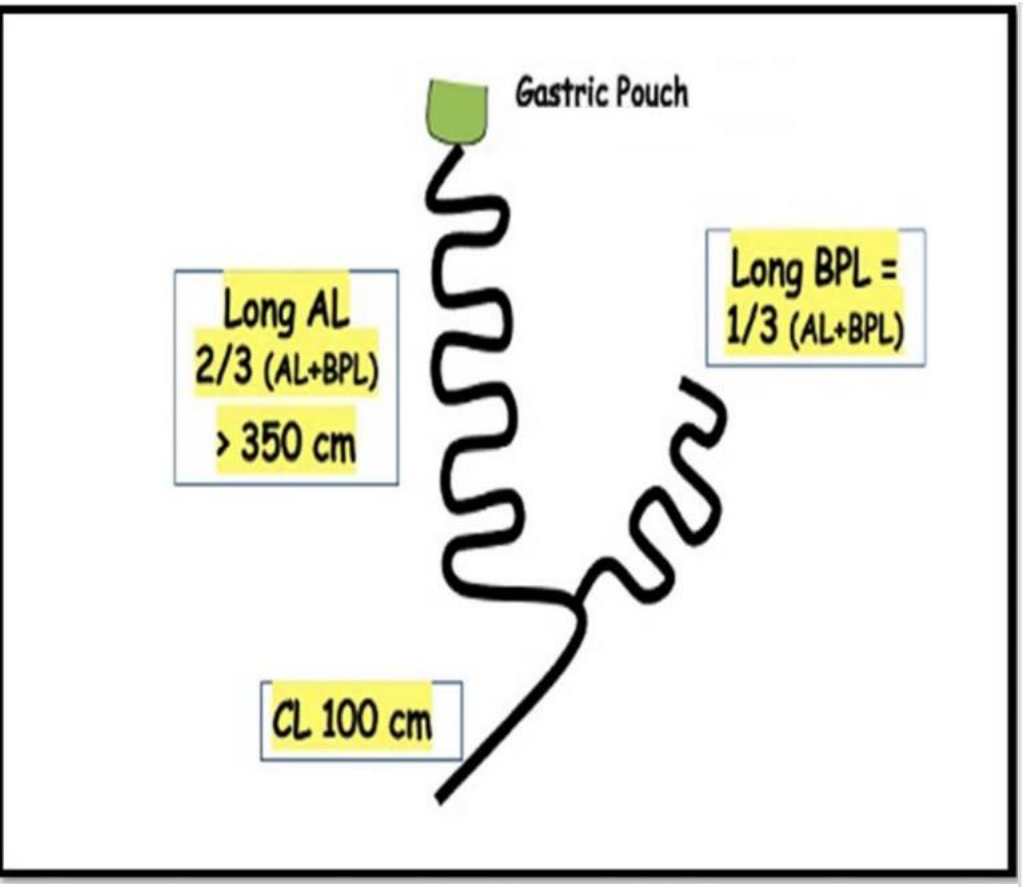


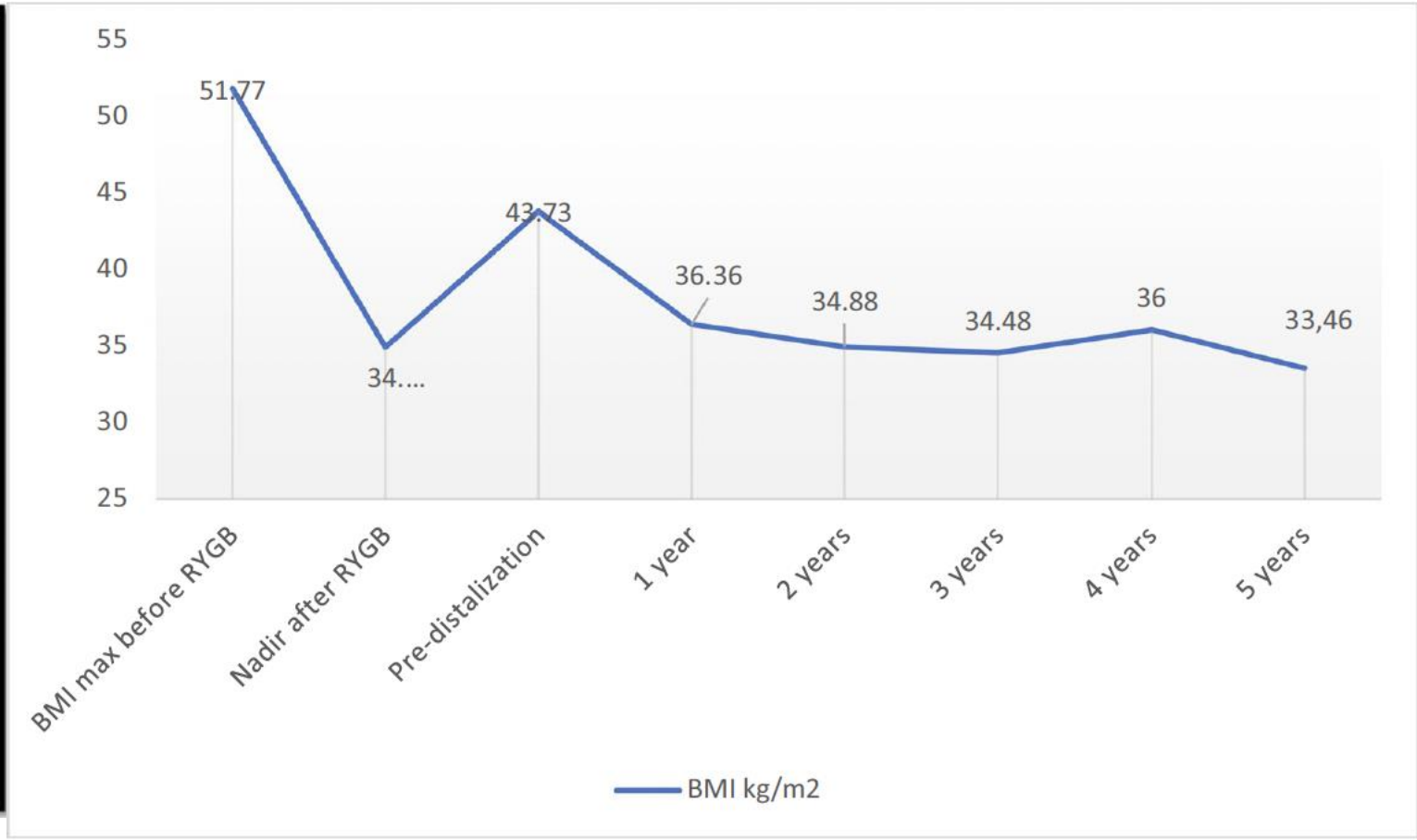


There's more.....



Using ratio's. *Obesity Surgery (2023) 33:1373–1381. https://doi.org/10.1007/s11695-023-06524-3*





TALL 400 favoured over 250 or 300. 20% TBWL

ELSEVIER

CrossMark

SURGERY FOR OBESITY AND RELATED DISEASES

Surgery for Obesity and Related Diseases 14 (2018) 554–561

Original article

Conversion of standard Roux-en-Y gastric bypass to distal bypass for weight loss failure and metabolic syndrome: 3-year follow-up and evolution of technique to reduce nutritional complications

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Weight loss.

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40% revision of
TALL 250 cm

	%TWL		
	TALL 250 ($n=48$)	TALL 300 ($n=42$)	P-value
6 months	17.0 ± 7.1	16.8 ± 5.8	0.8850
1 year	23.8 ± 9.9	21.9 ± 7.9	0.3217
2 years	25.5 ± 11.1	23.2 ± 8.9	0.5589
3 years	25.3 ± 11.2	23.8 ± 11.8	0.5990
4 years	24.0 ± 11.3	21.0 ± 12.9	0.3429
5 years	24.5 ± 10.9	20.1 ± 12.0	0.2034
6 years	22.5 ± 12.2	18.1 ± 9.9	0.2845
7 years	20.3 ± 11.4	18.0 ± 12.4	0.7010
8 years	17.8 ± 5.6	16.7 ± 7.3	0.7701

KISS

- The method of simple Type I distalisation is advantageous.
- Recruits what we want, eminently modifiable.
- Technically simple…..do close defects.
- TALL 300-400 without compromising common channel are reasonable depending on nutritional competency and level of trust you have with the patient.
- Type I destalinisation wins the race with regards to customisation, durability and safety.
  - Lasts longer than endoscopic treatments.
  - Limits role of BPDS to patients with neuroglycopenic symptoms.