Revision of Failed Sleeve. A lesson learned

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IFSO NAPLES 2023

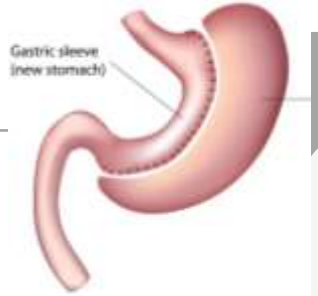
PRESENT STUDY

Single surgeon experience on Sleeve Revision

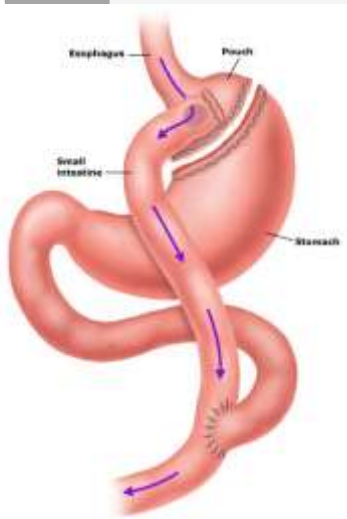
- 2 Private Hospitals UAE
- 614 pts underwent bariatric surgery between April 2017 and February 2023*
- 112pts (18.2%) were revisions of failed bariatric procedures
- 62 pts underwent **Revision of sleeve gastrectomy to OAGB and RYGB**

*IFSO REGISTRY - **Dendrite** Clinical Systems

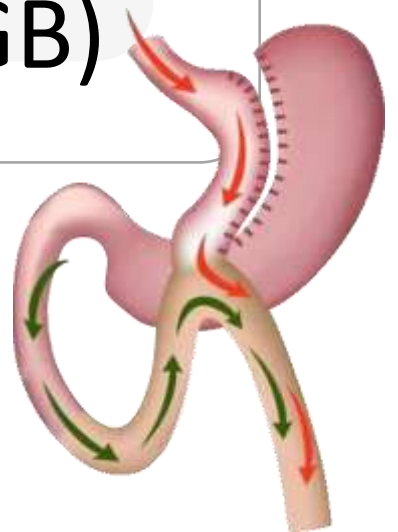
RETROSPECTIVE REVIEW
62 pts with failed Sleeve



25/62 Sleeves converted to Roux-en-Y Gastric bypass (RYGB)



37/62 Sleeves converted to One anastomosis gastric bypass (OAGB)

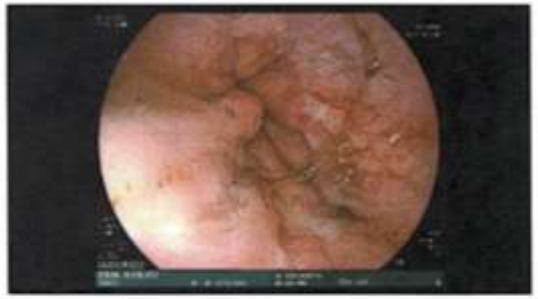


INDICATIONS FOR SLEEVE REVISION

	All patients (62)	Revised to OAGB (37)	Revised to RYGB (25)
Weight regain (WR) Inadequate weight loss (IWL)	26pts (42%)	24pts (65%)	2pts (8%)
Upper gastrointestinal symptoms/GERD/Vomiting	9pts (14.5%)	3pts (8%)	6pts(24%)
Both	27pts (43.5%)	10pts (27%)	17pts (68%)

PREOPERATIVE WORK-UP

- All patients had a Gastroscopy prior to surgery
- 23 (37%) were diagnosed with hiatal hernia (intrathoracic migration of the sleeve)
- Most of the patients had Sleeve dilatation of some degree and often Hourglass shaped stomach
- No patient was diagnosed with Barrett's epithelium in the current series
- All Patients with H.Pylori infection had eradication therapy prior to surgery



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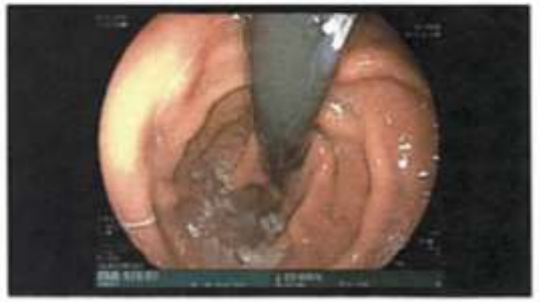
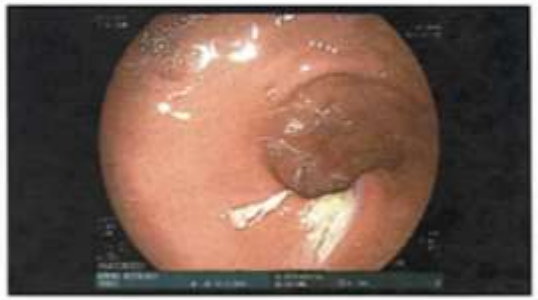


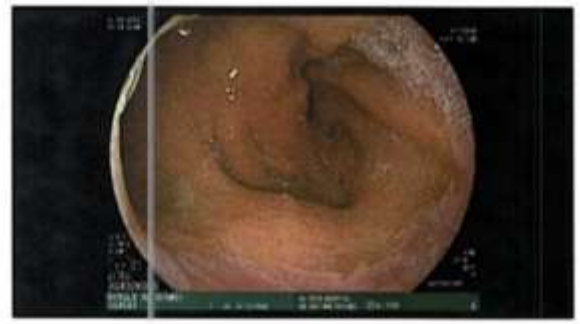
dilated sleeveStomach - Body



IncisuraStomach - Body

PREOPERATIVE WORK-UP

- All Patients had a Barium STUDY
- 25 patients Had a WIRELESS pH Monitoring with Bravo capsule
- Psychologist/psychiatrist/dietician/cardiology/endocrinologist/pulmonologist/gastroenterologist
- BARIATRIC MDT



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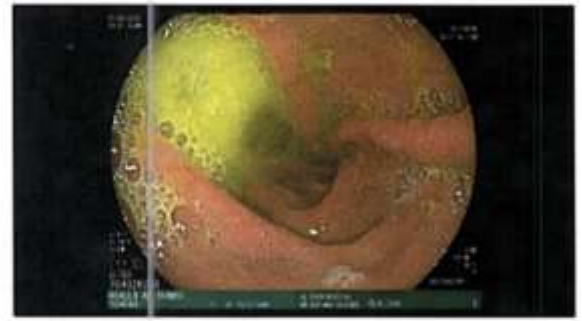
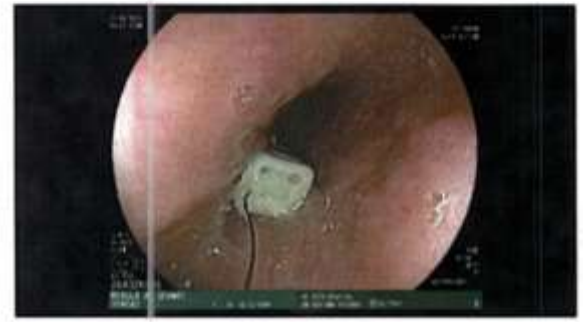


Severe bile reflux gastritis



wireless pH capsule

RESULTS

	SLEEVE TO RYGB 25/62	SLEEVE TO OAGB 37/62
M/F	11/14	7/30
age	40yrs	37.6yrs
BMI before revision	35.11kg/m2 (95.3kg)	37.6 kg/m2 (98.5kg)
BMI after revision (6months)	32.43 kg/m2 (90.2kg)	31.02 kg/m2 (82.6kg)
Length of stay	1-2 days	1-2 days
Length of surgery	126min (55min-284min)	96min (44min-194min)

RESULTS

- There was no morbidity or mortality in both revisional groups at 30 days.
- Hospital stay was 1-2 nights only in both groups
- Length of surgery was shorter in the sleeves converted to OAGB versus RYGB, average of 96min vs 126 min respectively.
- All patients with hiatal hernia had a suture repair at the same time of surgery (16 in the OAGB and 7 in the RYGB group).

Long term Complication/Reoperation rate

Sleeve to OAGB

9/37 Pts were reoperated in the **Sleeve to OAGB** group: 24%

6 converted to RY configuration for persistent bile reflux

2 excision of anastomosis and RY reconstruction for refractory MU

1 had an emergency lap washout for a perforated MU (in another facility)

RESULTS – Reoperation Sleeve to OAGB

	SLEEVE TO OAGB 37/62	Hiatal hernia repair 16/37	Reoperation
WR/IWL	24/37	5/24	1 RY configuration
UGI symptoms/GERD	3/27	3/3	3 (2 excision of anastomosis and 1 RY configuration)
Both	10/37	8/10	5 (4 RY configuration 1 lap washout)

Long term Complication/Reoperation rate Sleeve to RYGB

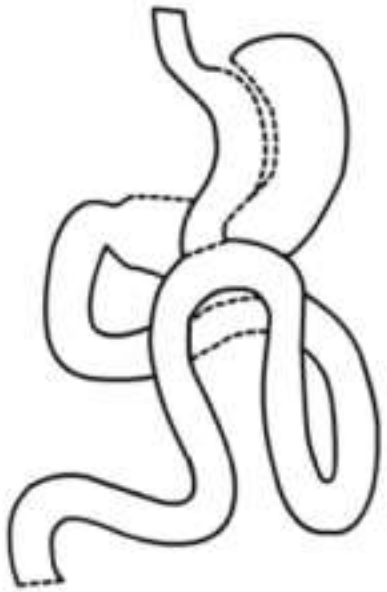
1/25 patient was reoperated in the Sleeve to RYGB group (4% reoperation rate)

For a very complex **recurrence of hiatal hernia** containing the gastric pouch and the

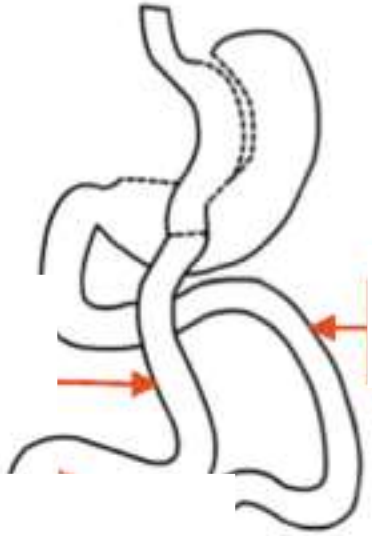
gastro-jejunal anastomosis – this was the only hernia recurred to the date (1/23)

Surgical technique

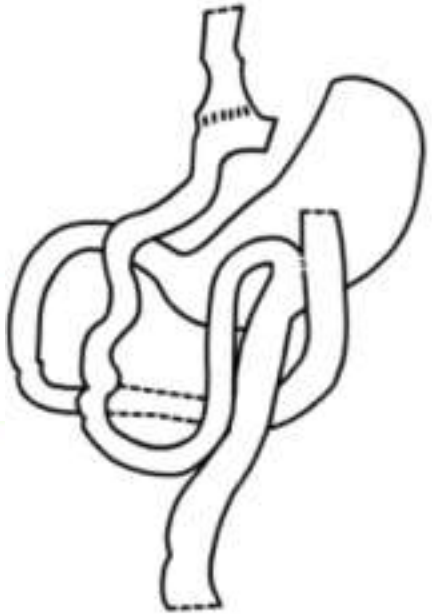
OAGB



EXTENDED POUCH RYGB

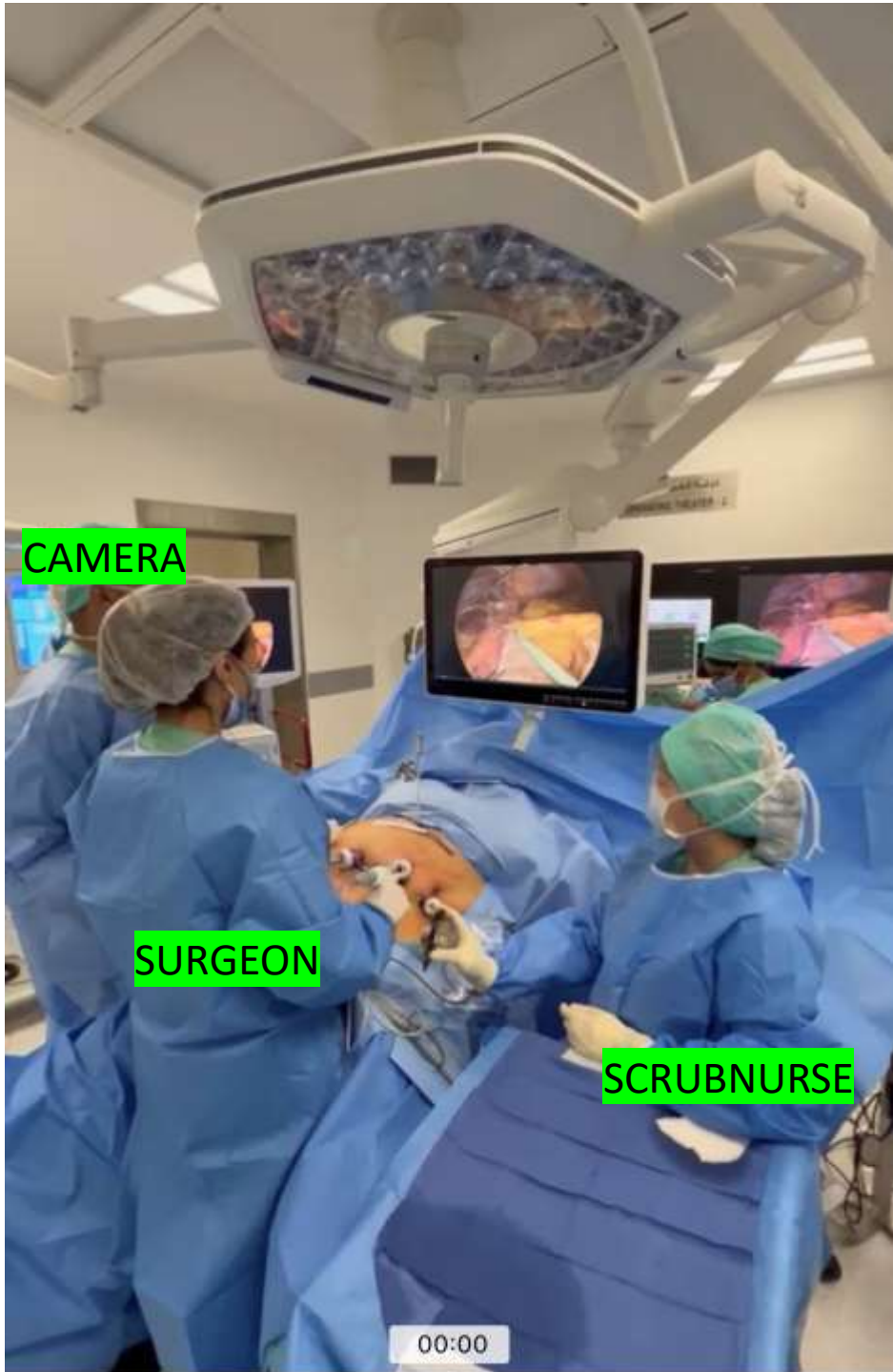


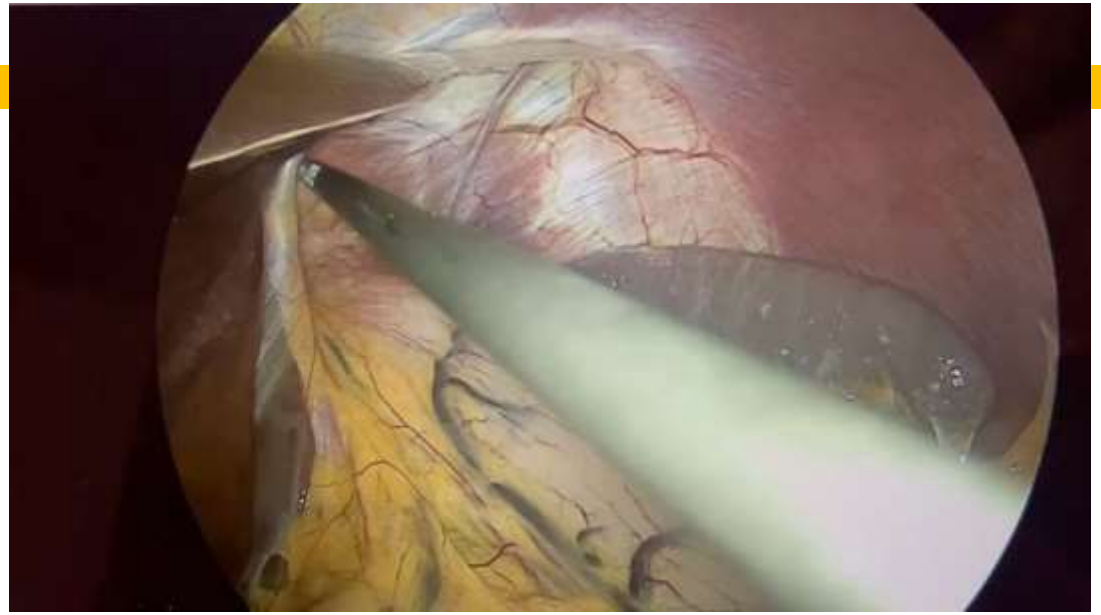
RYGB

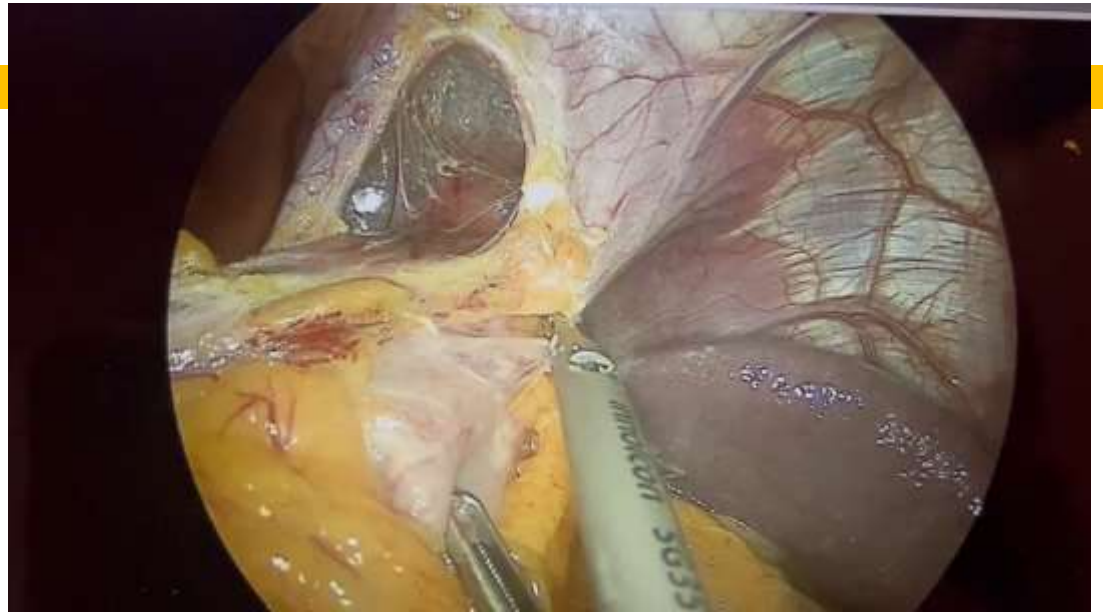


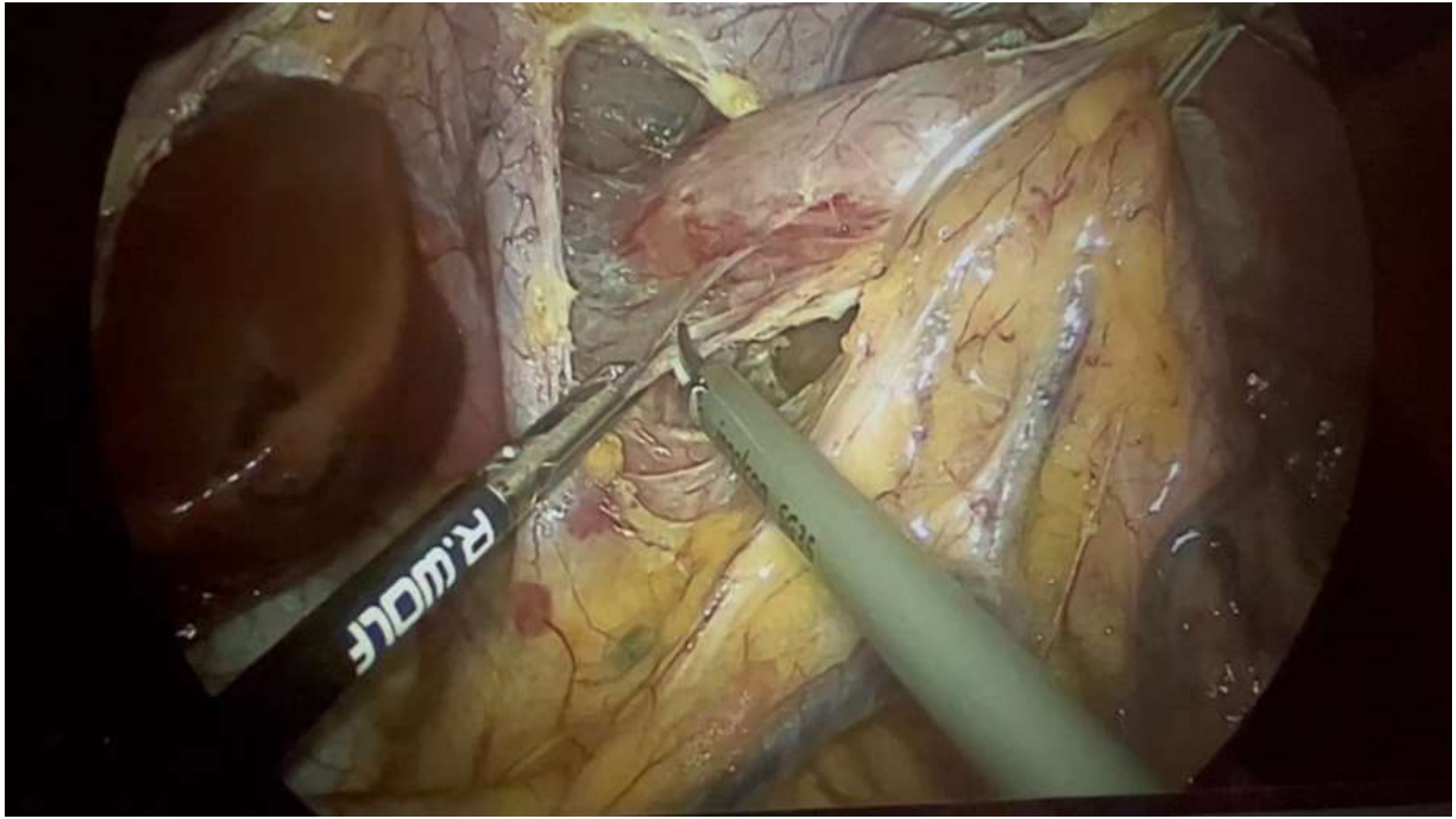
Surgical technique

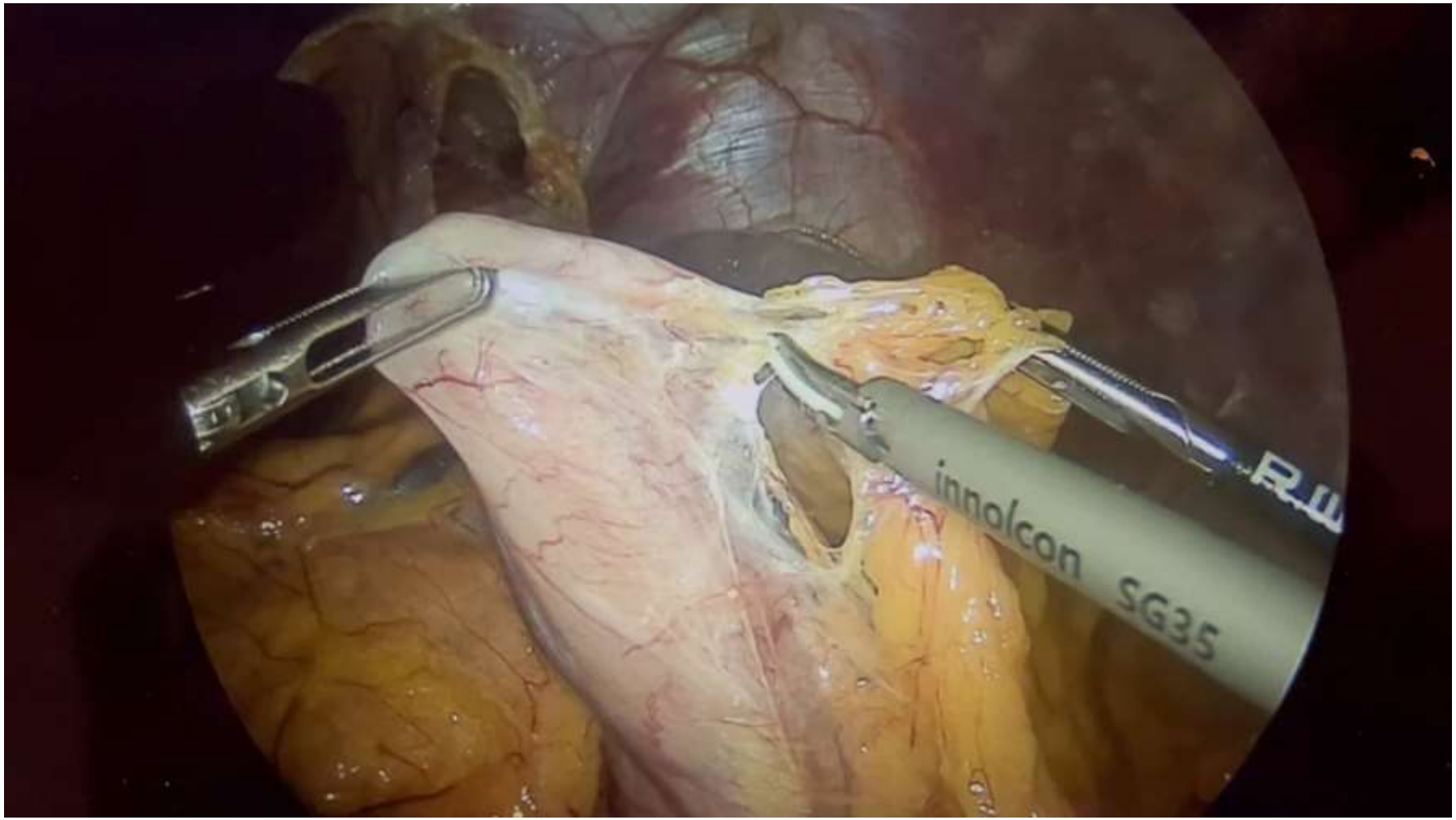
- 4/5 trocars
- Hiatal hernia repair is the first step
- 36Fr bougie
- Long gastric pouch
- Resizing of the gastric pouch
- BP lenght varied 50 to 150
- Closure of the spaces







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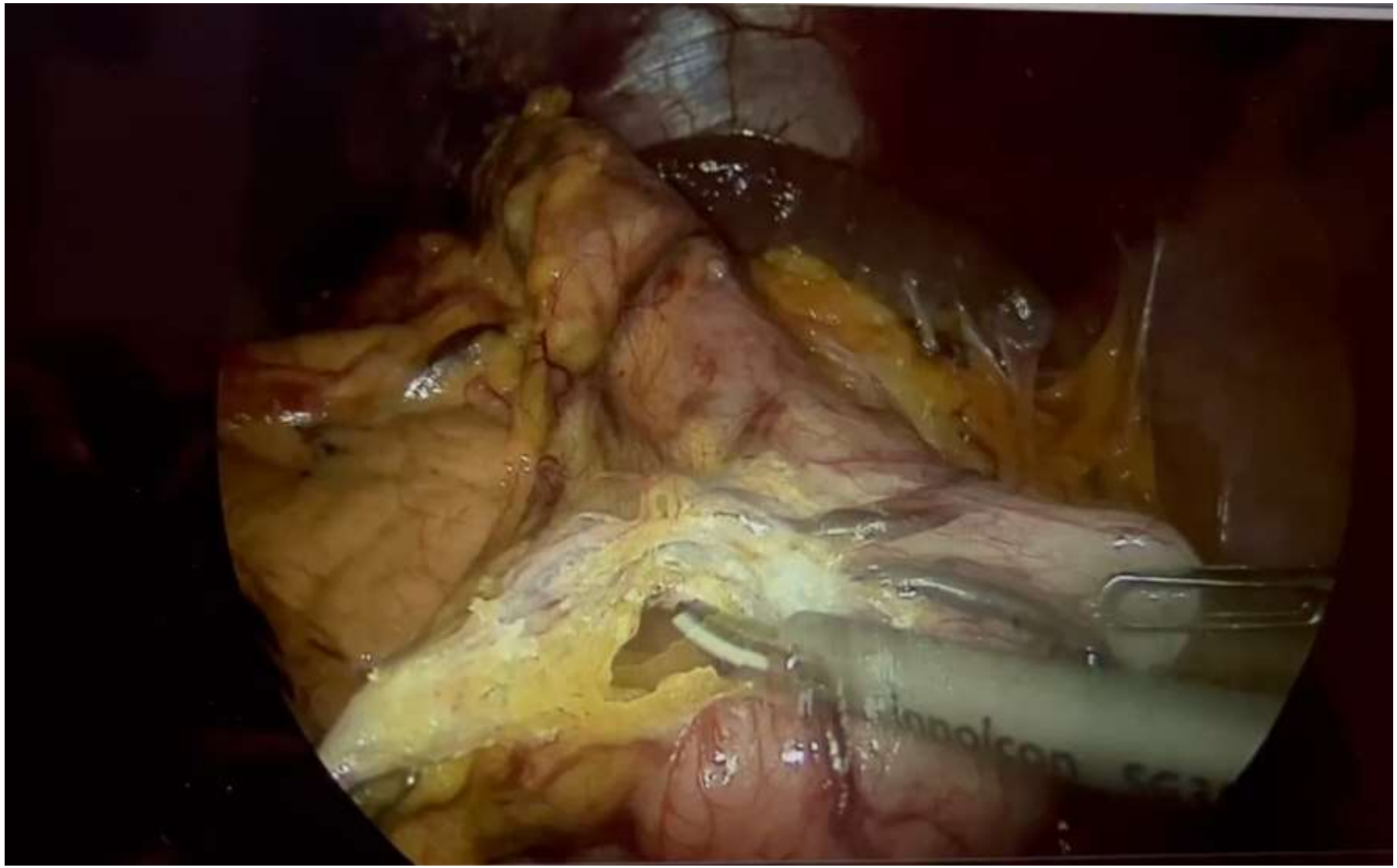

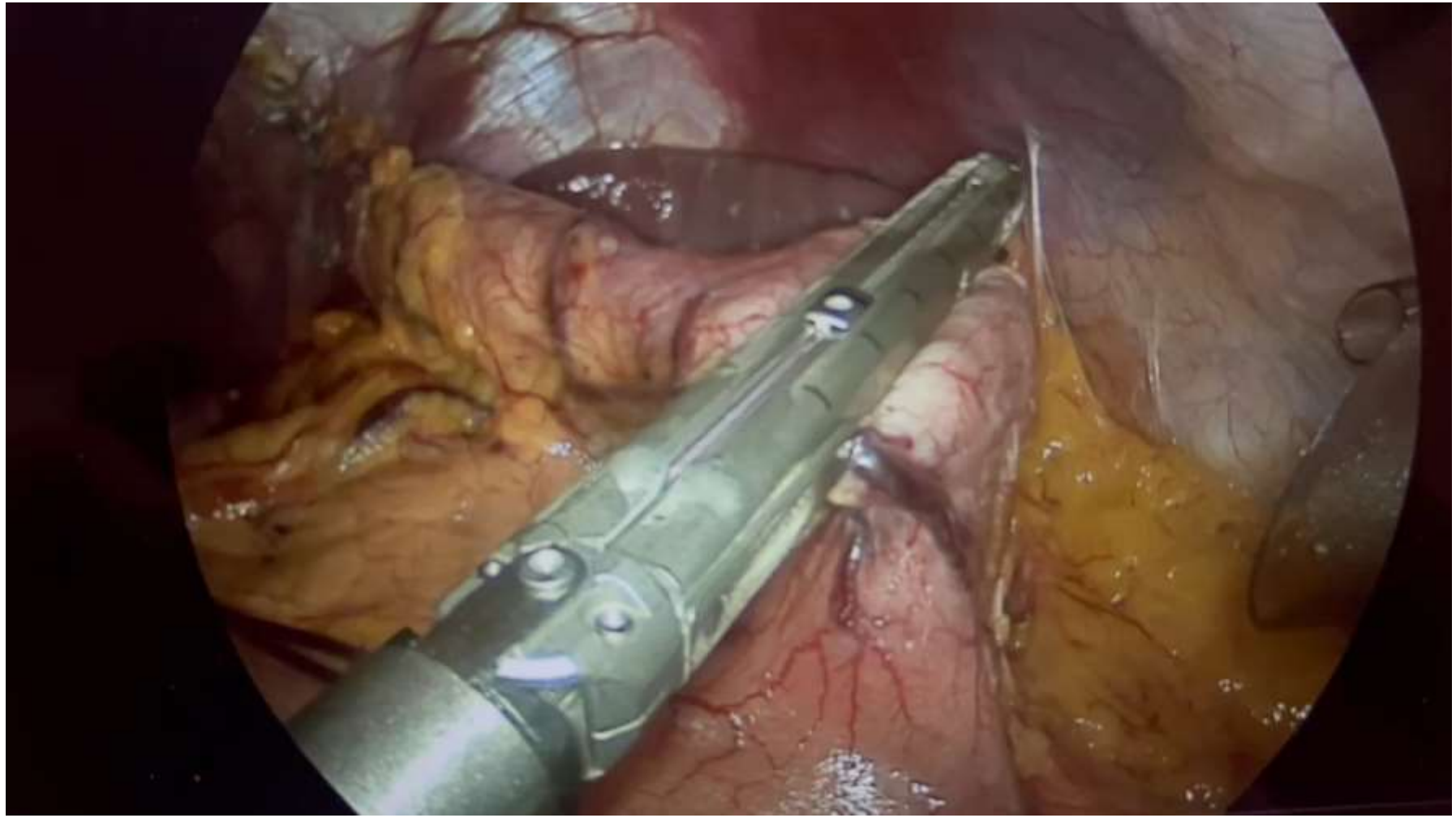

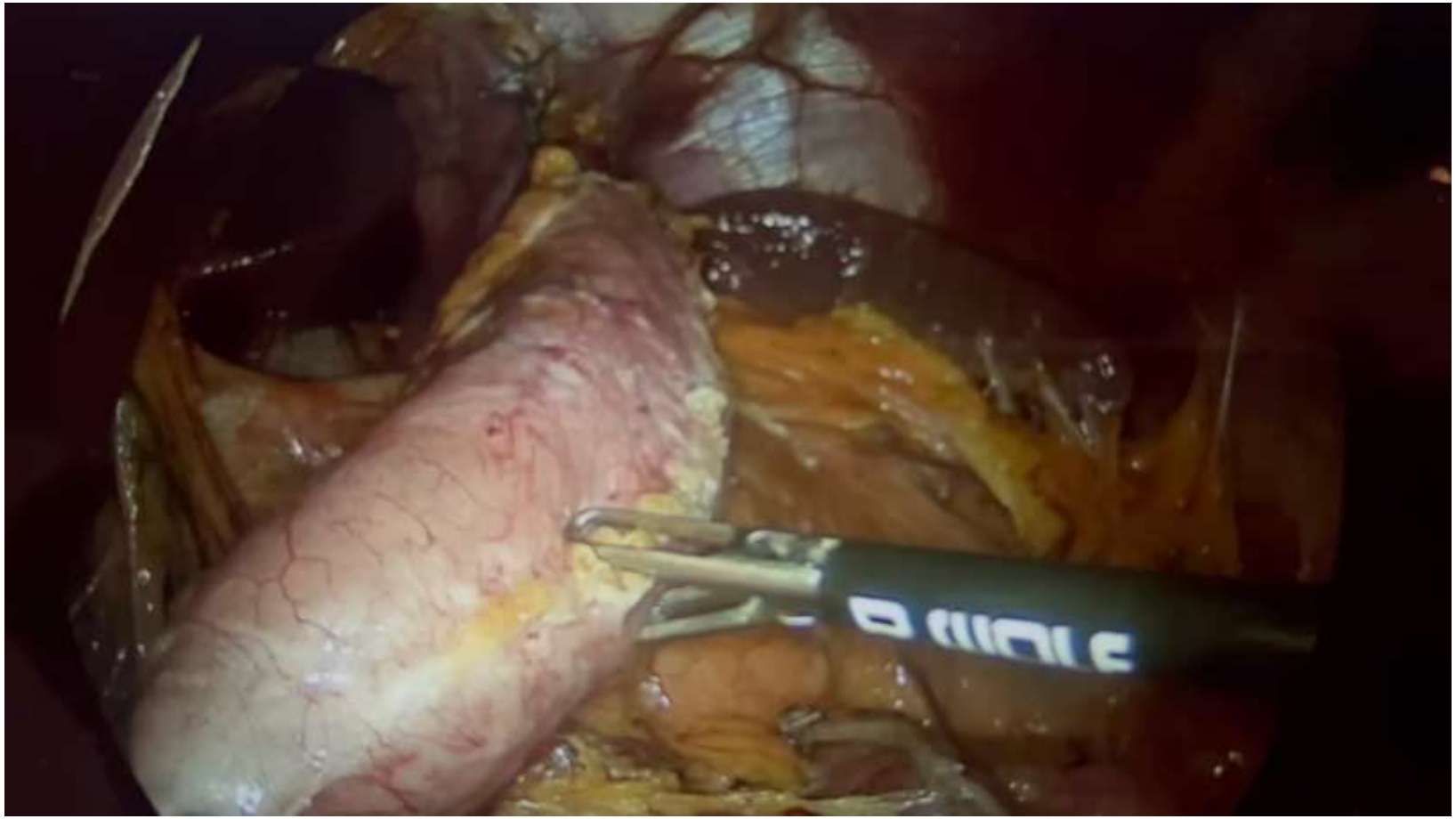

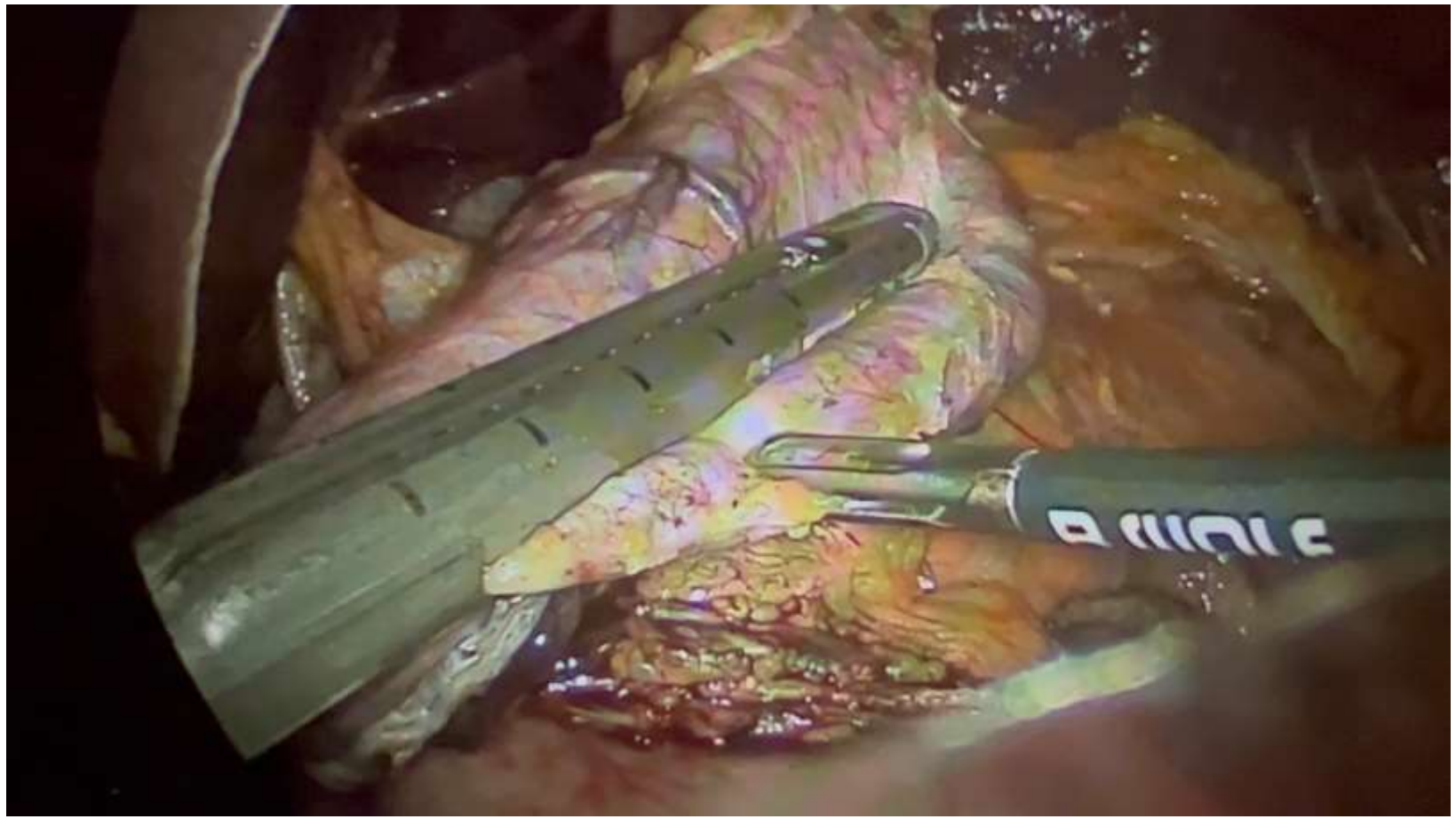

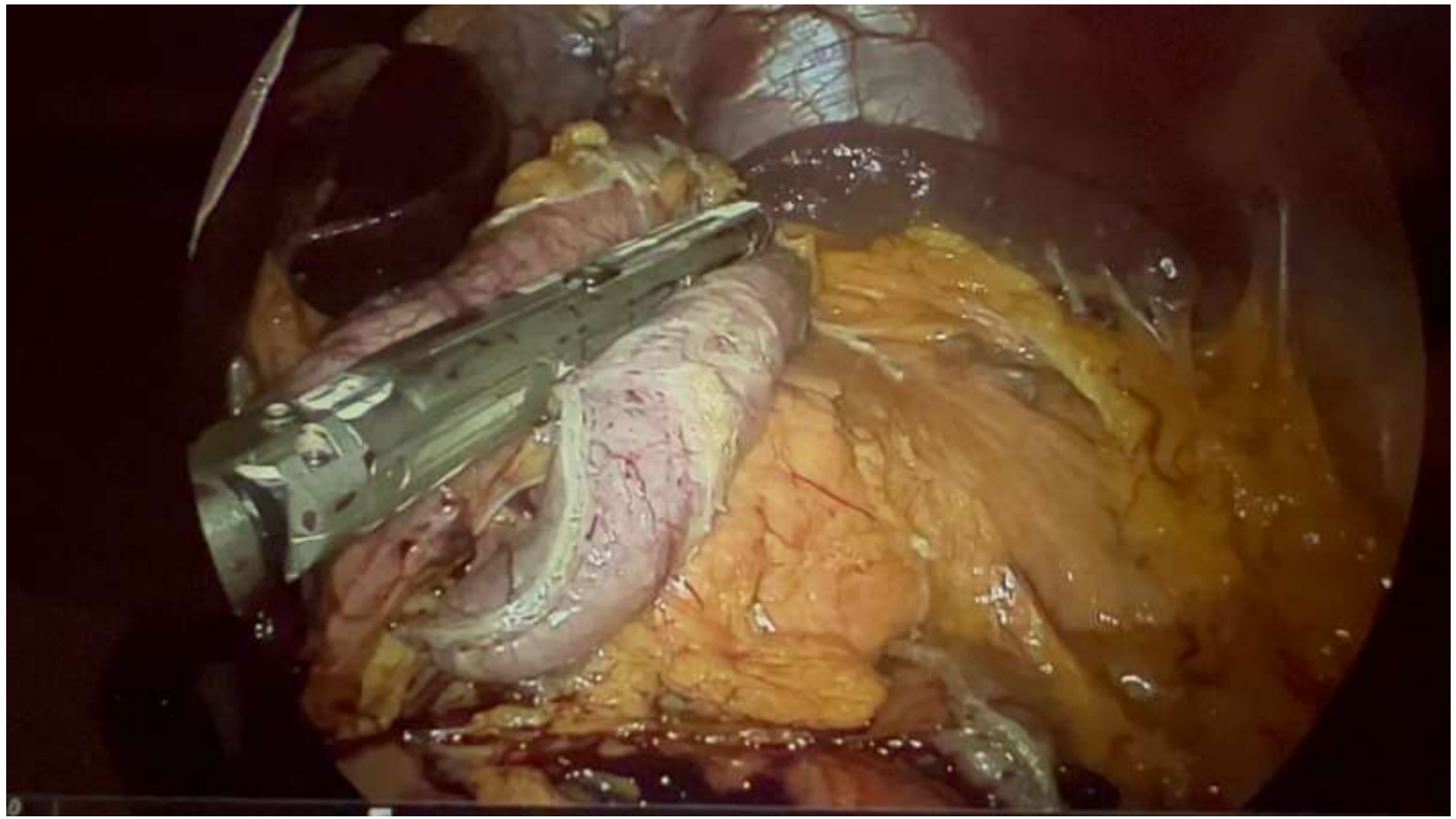

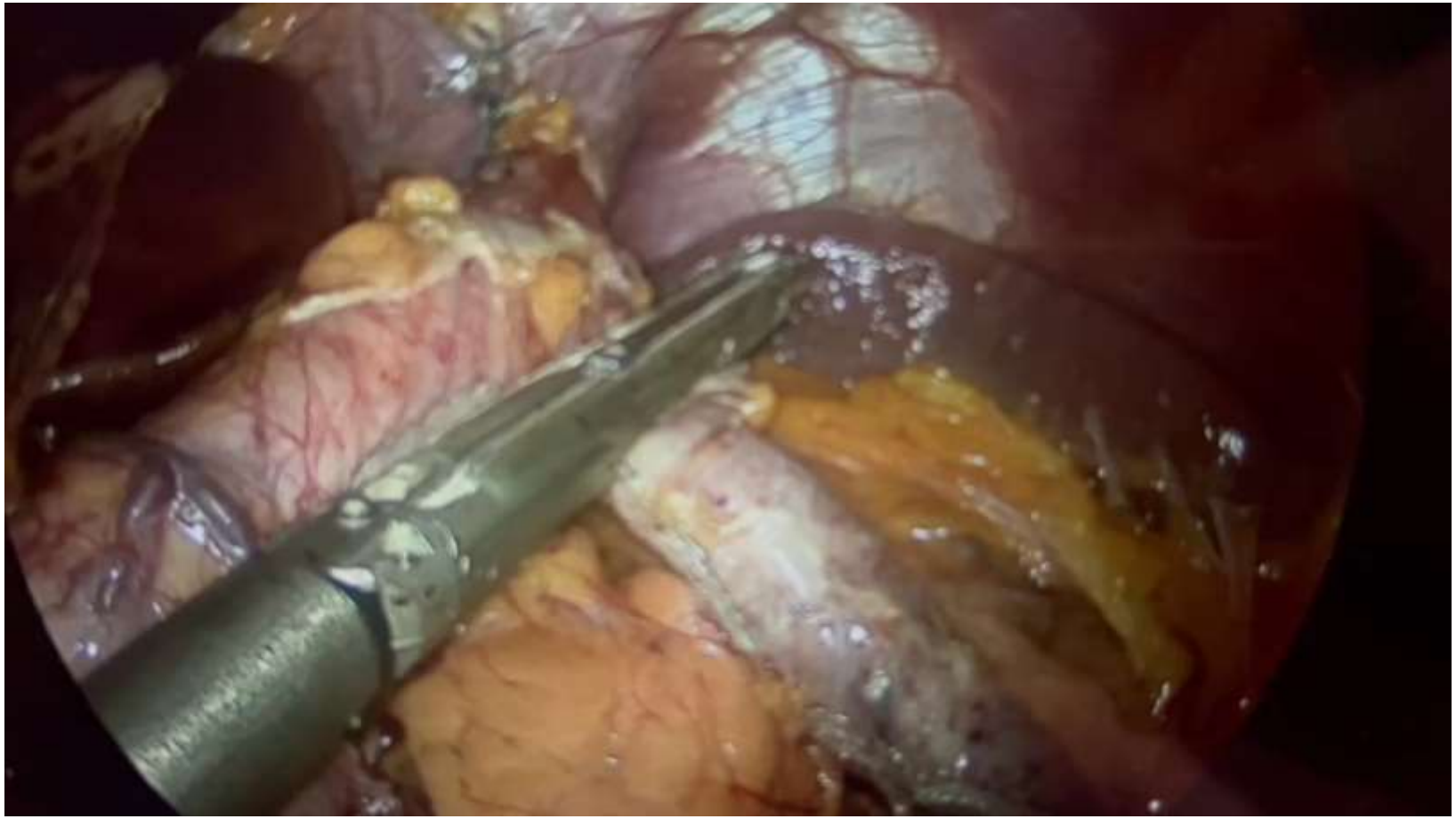

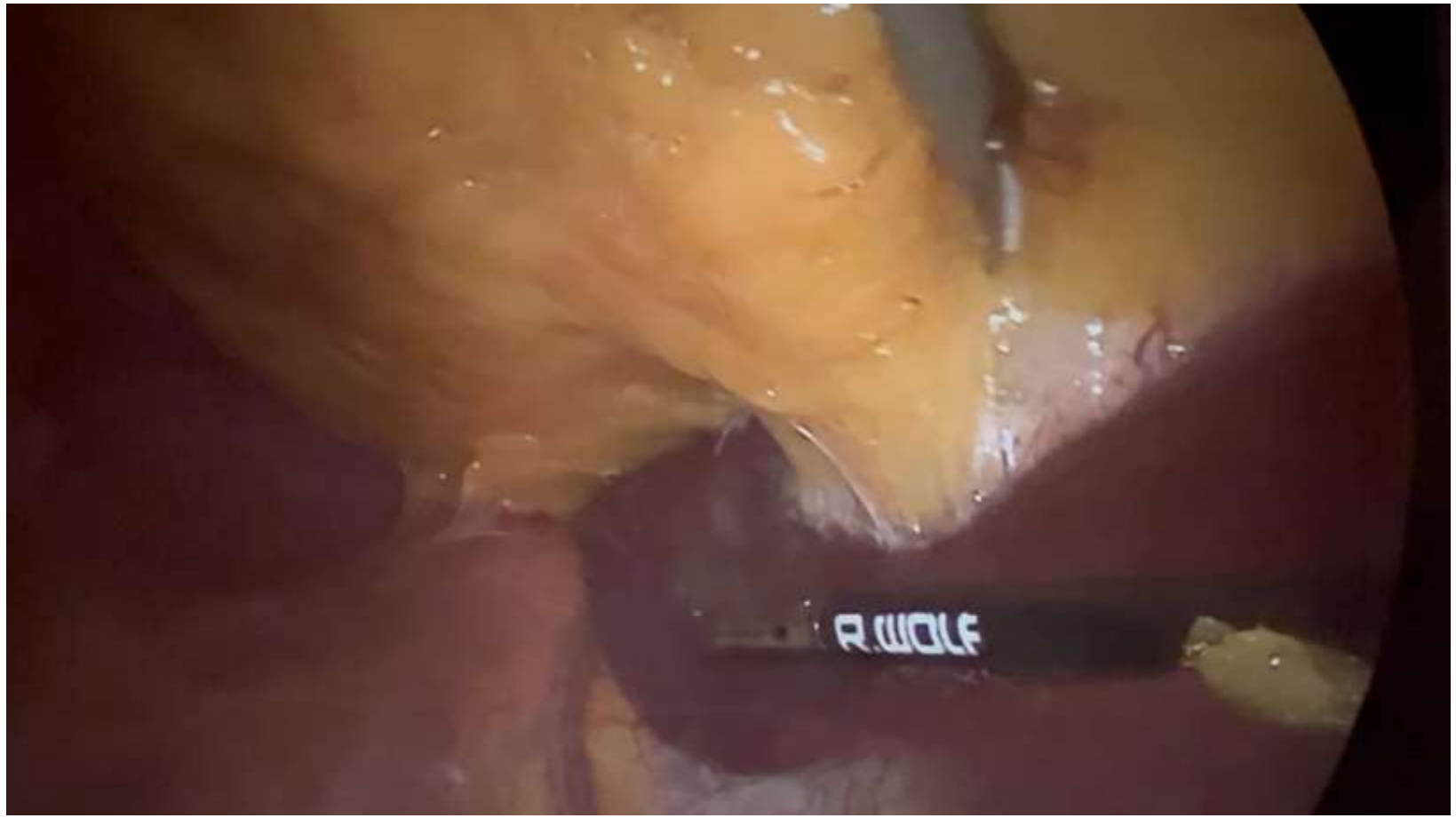
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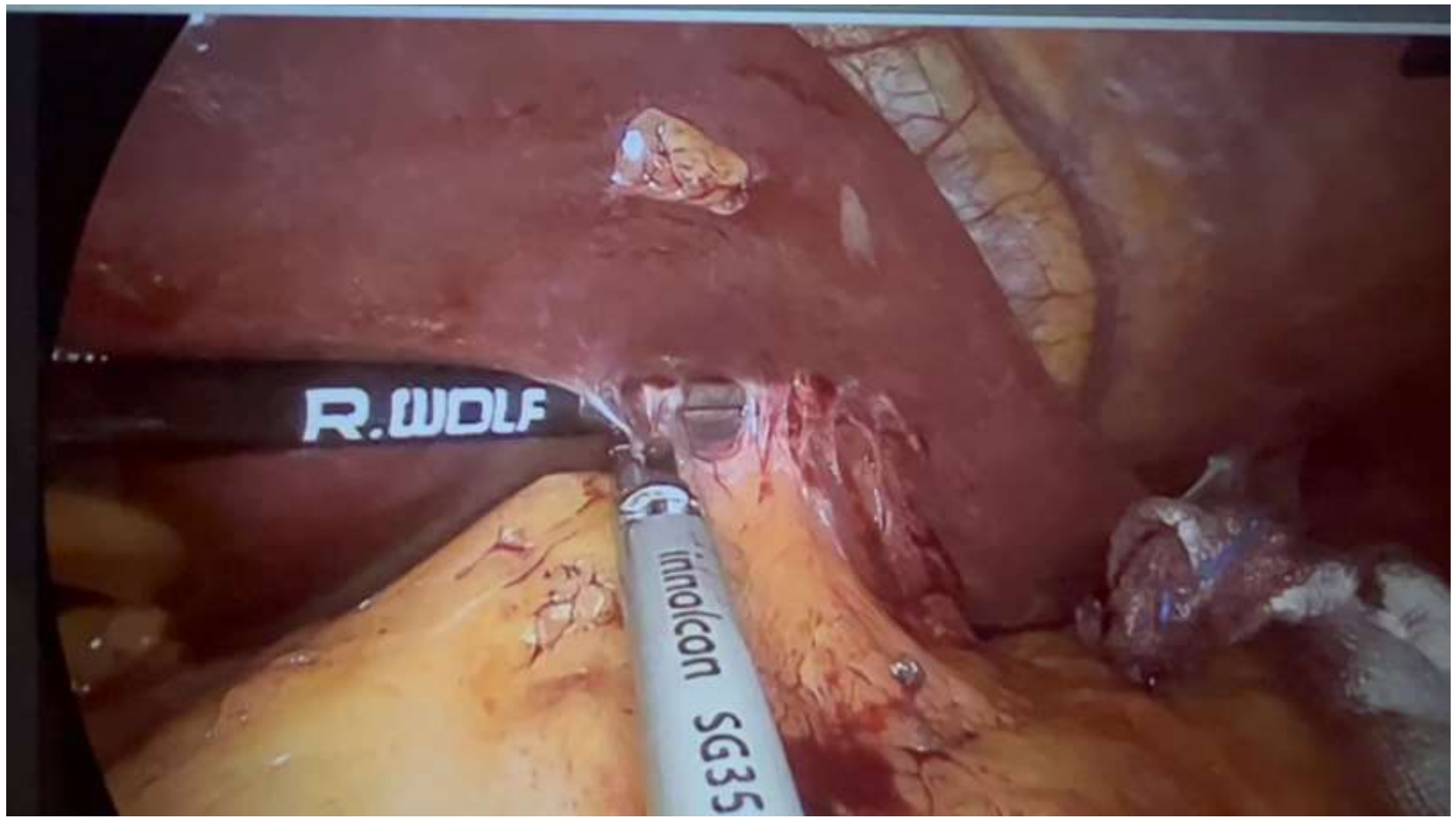
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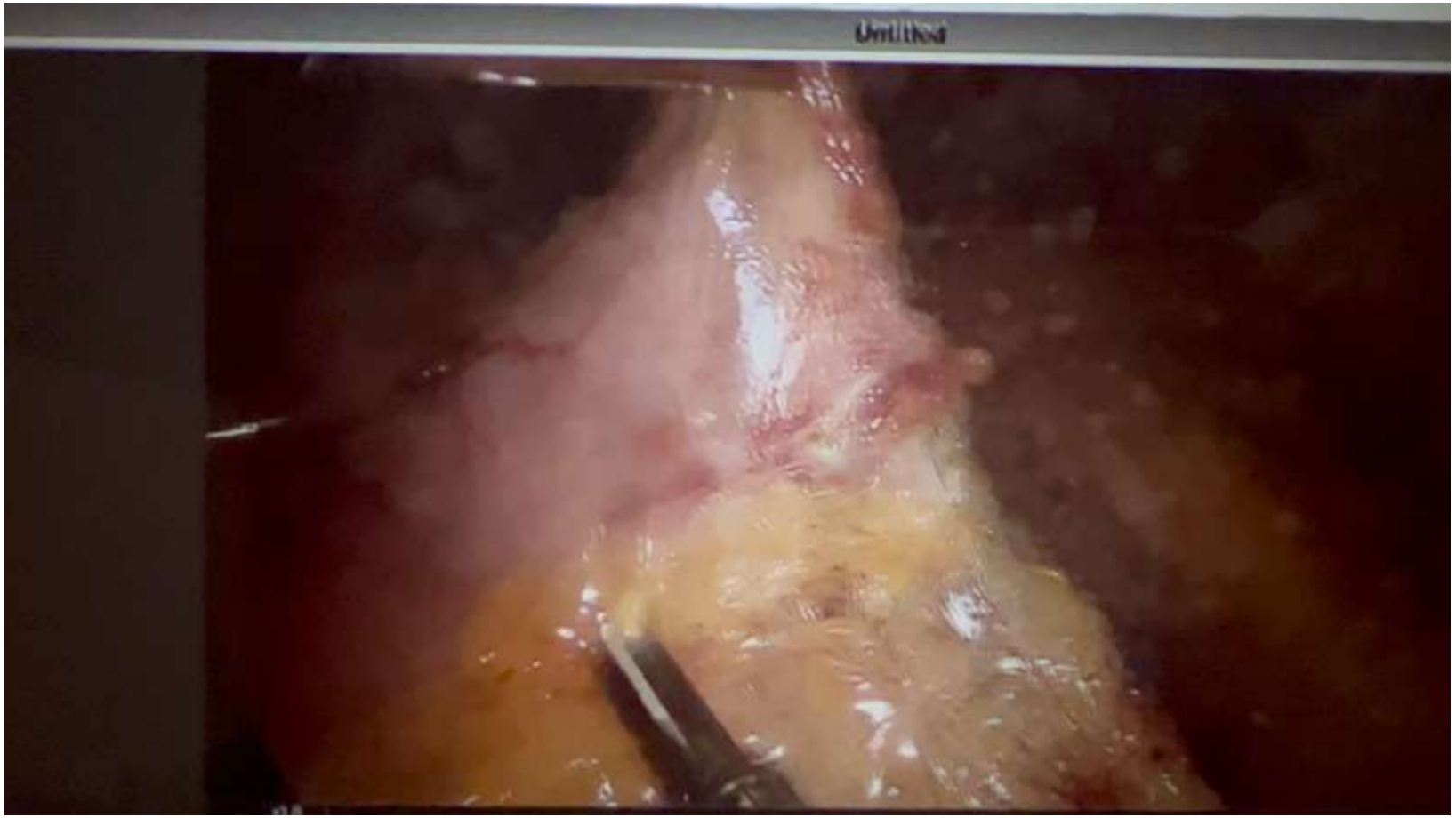

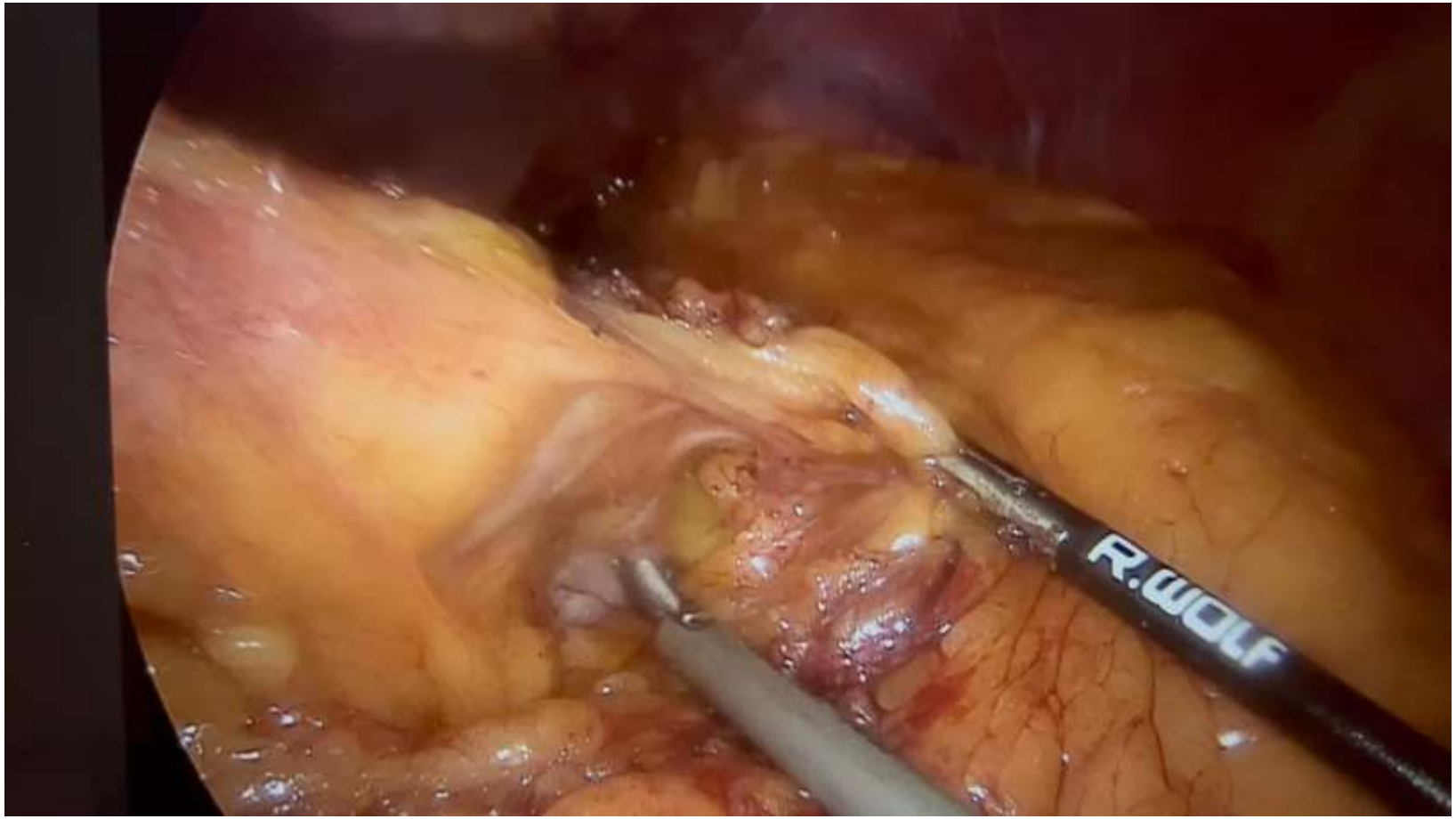
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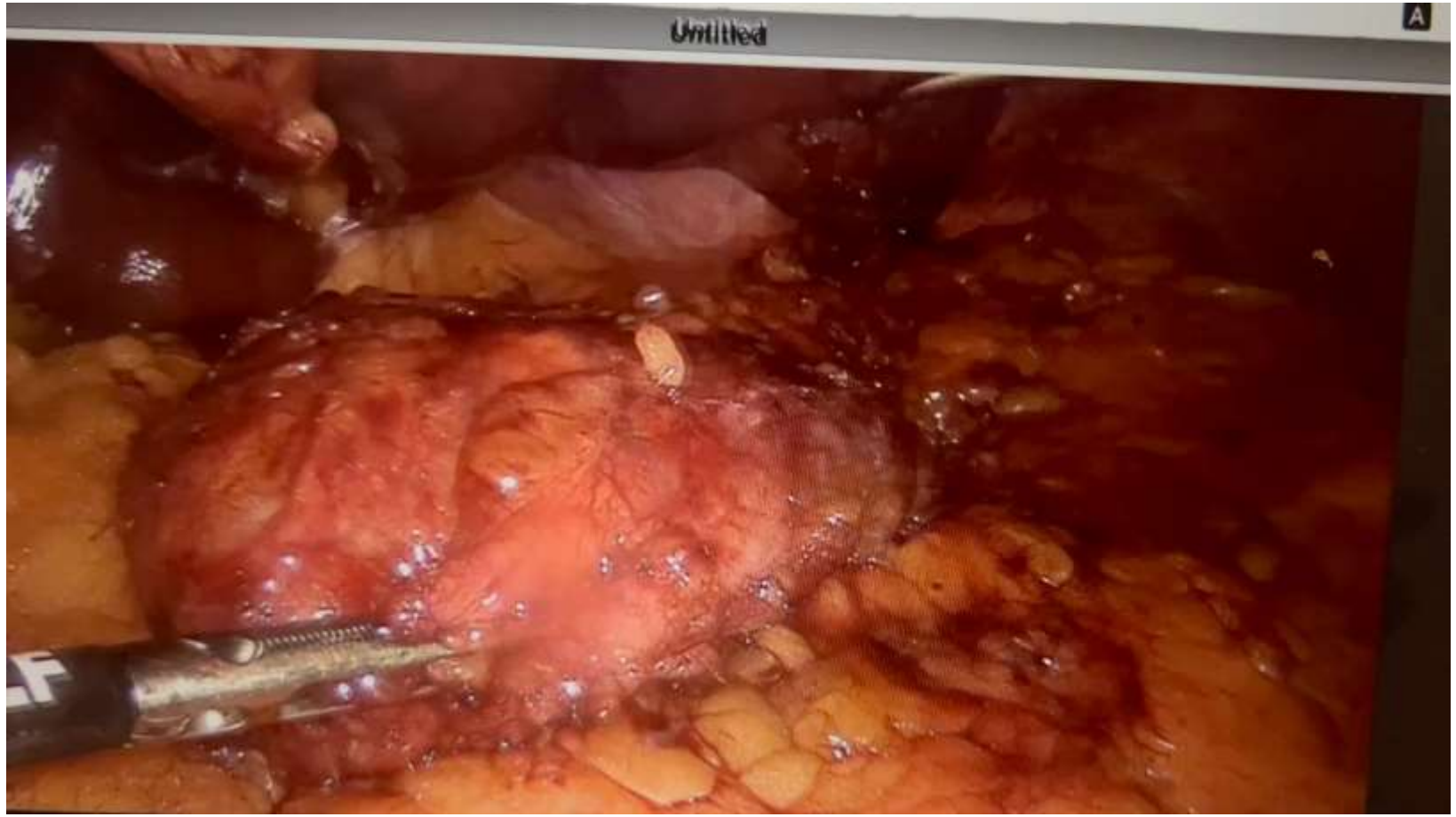
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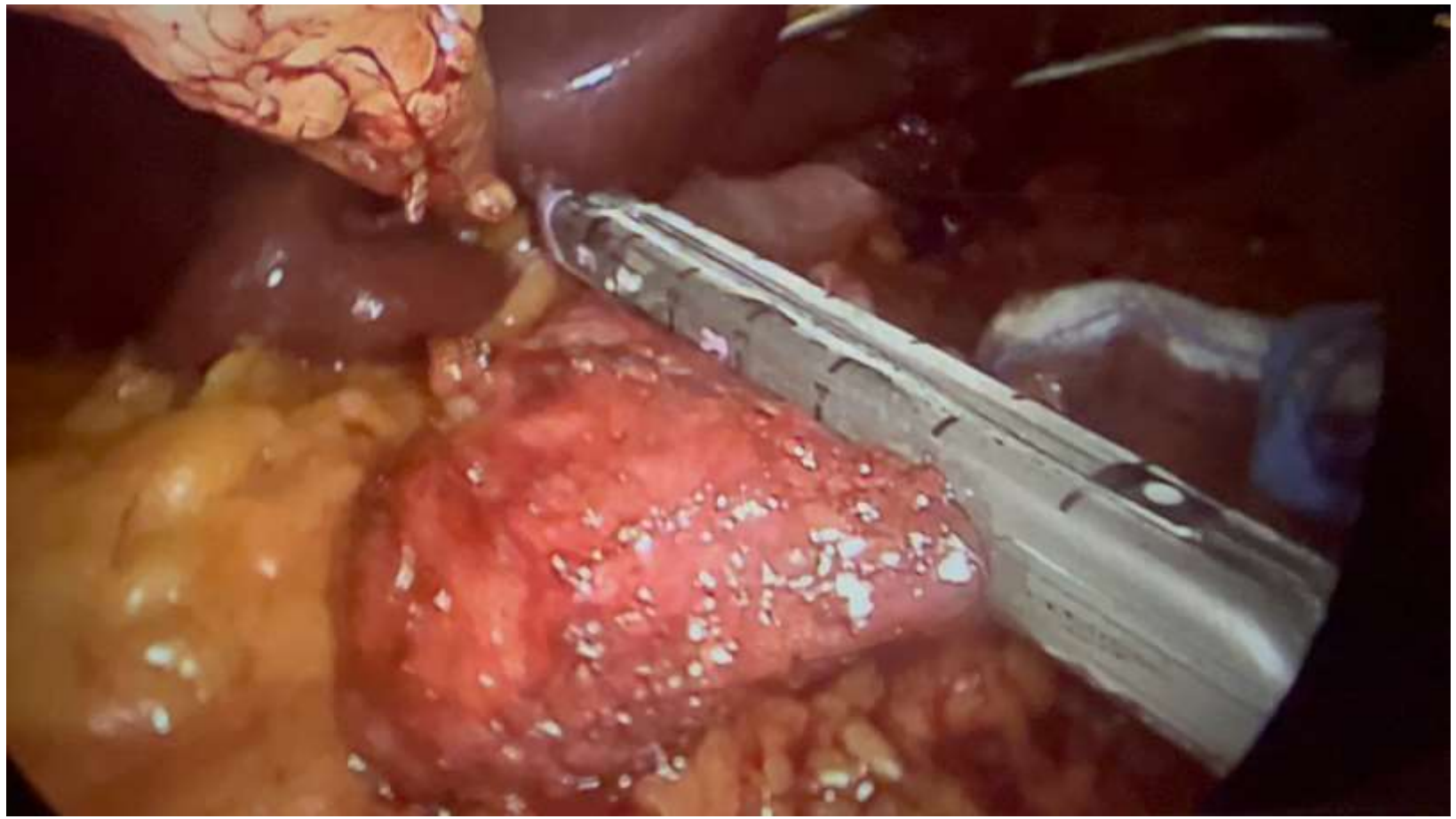

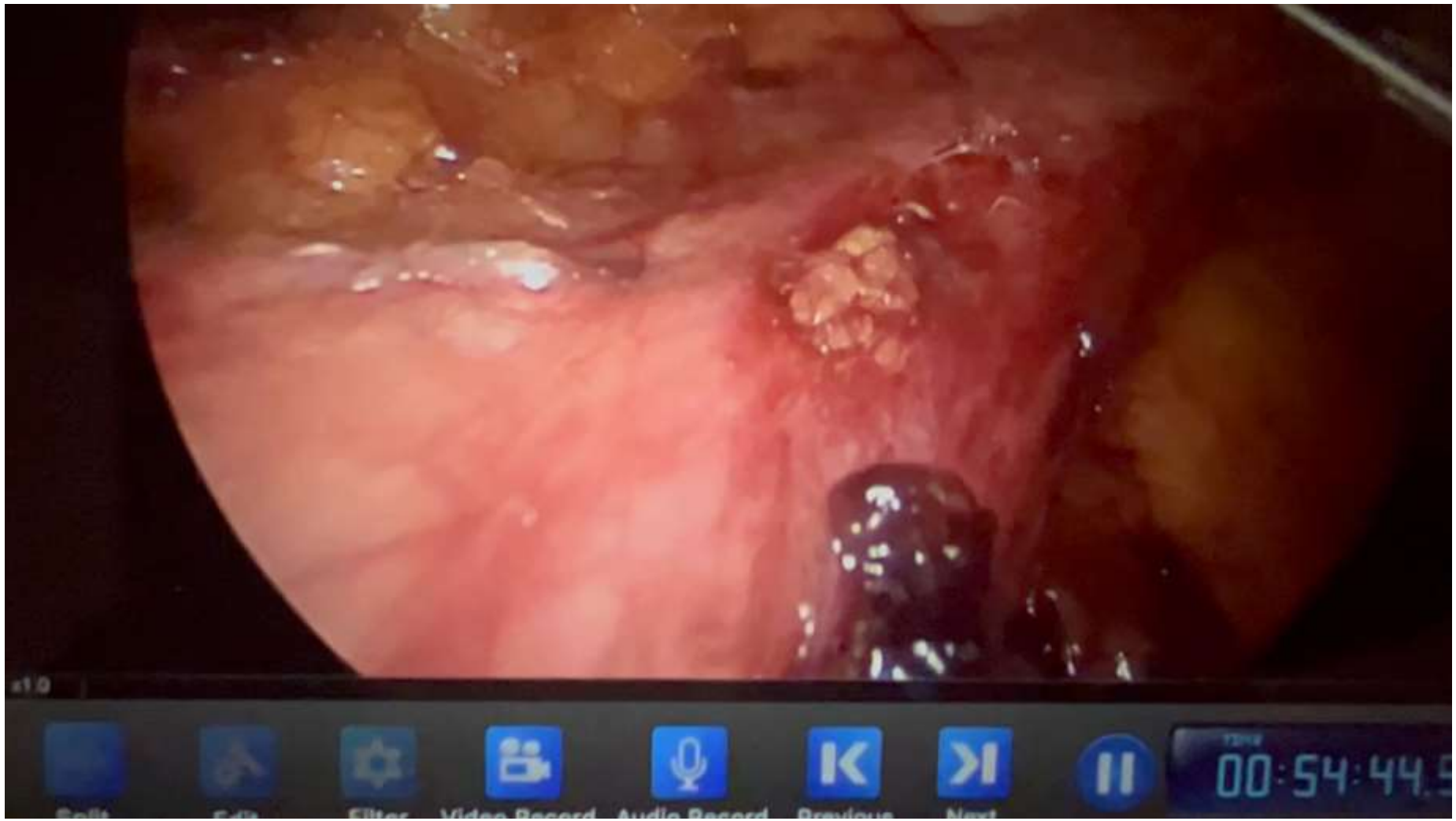
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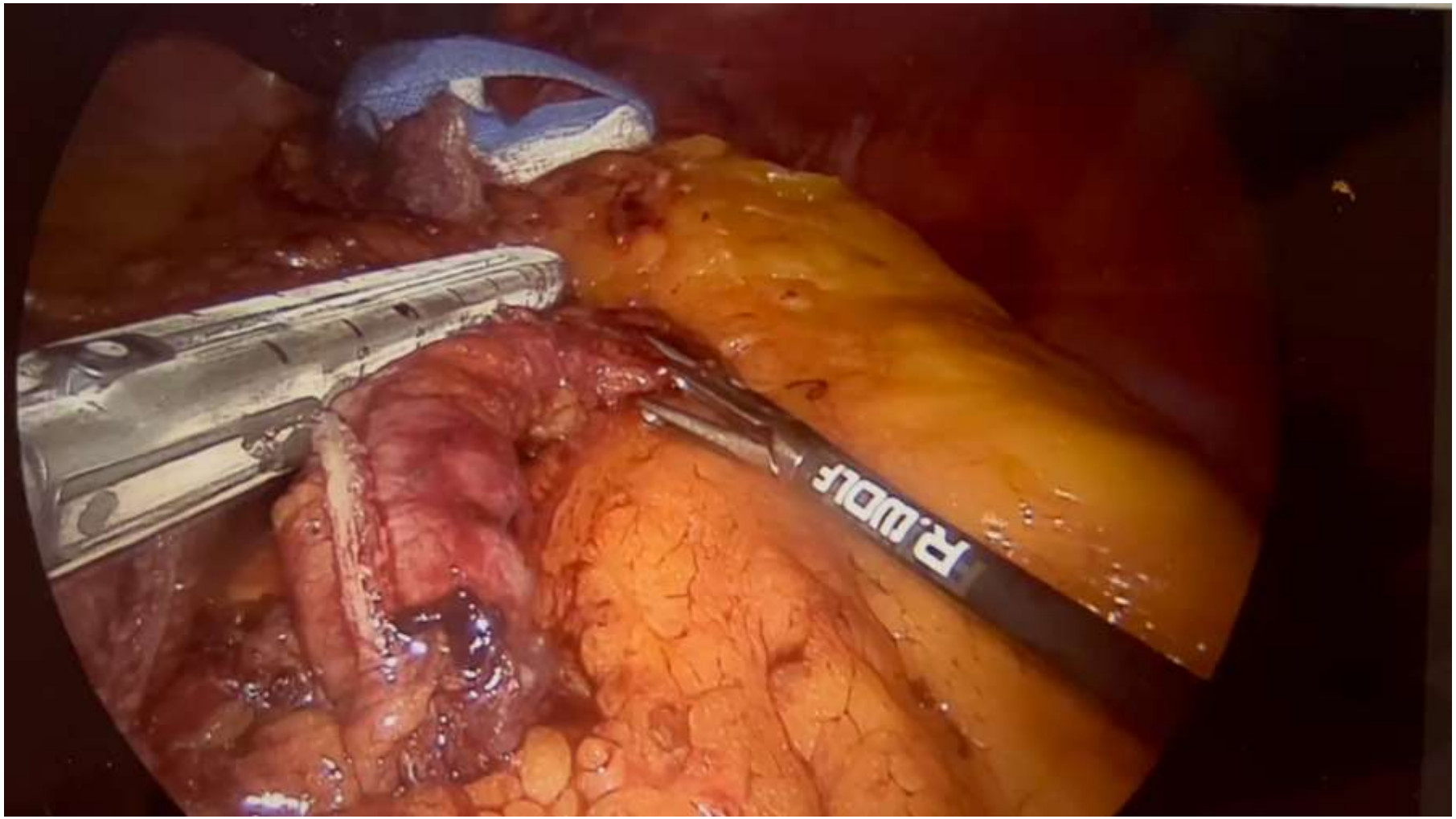
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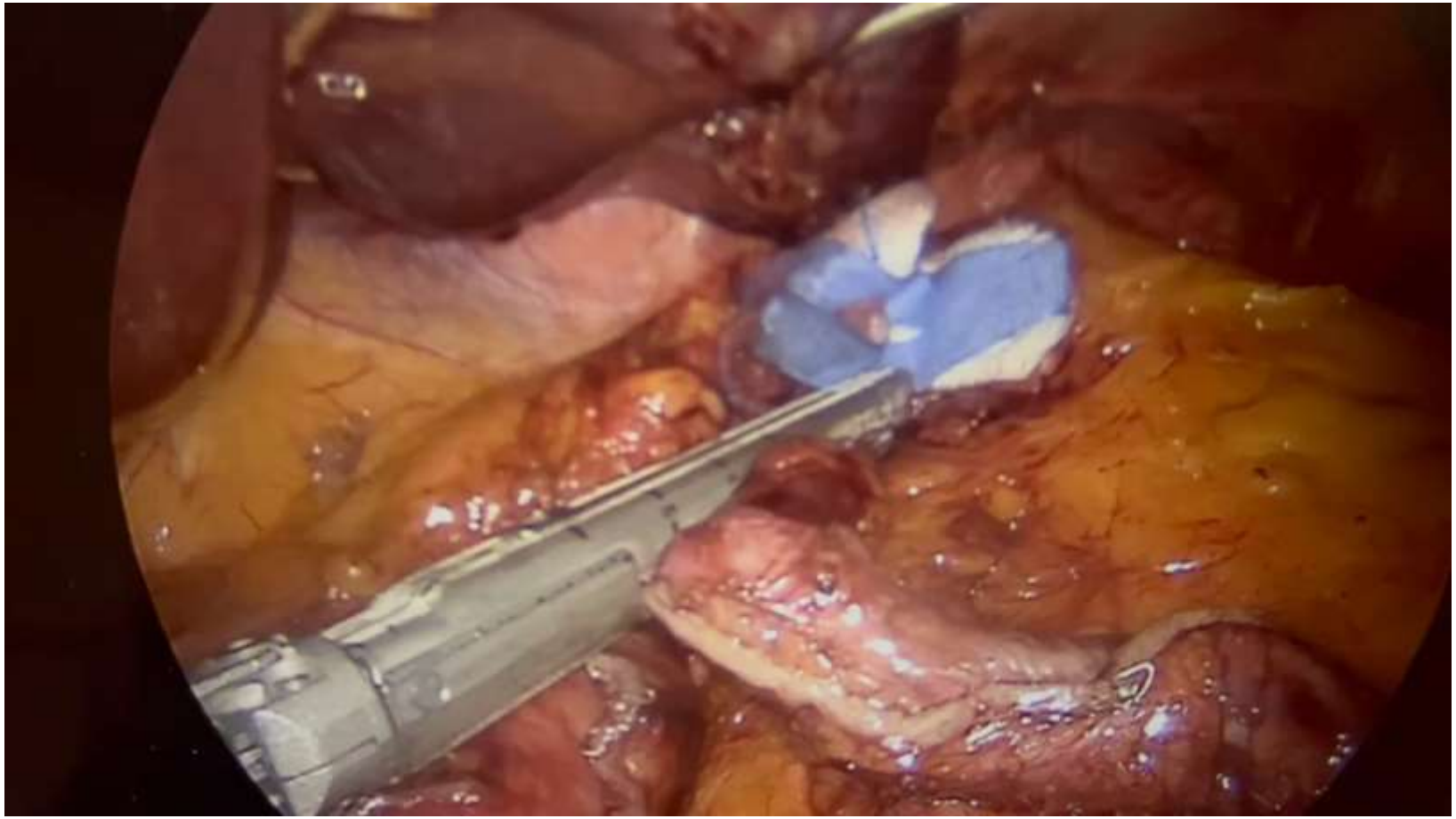

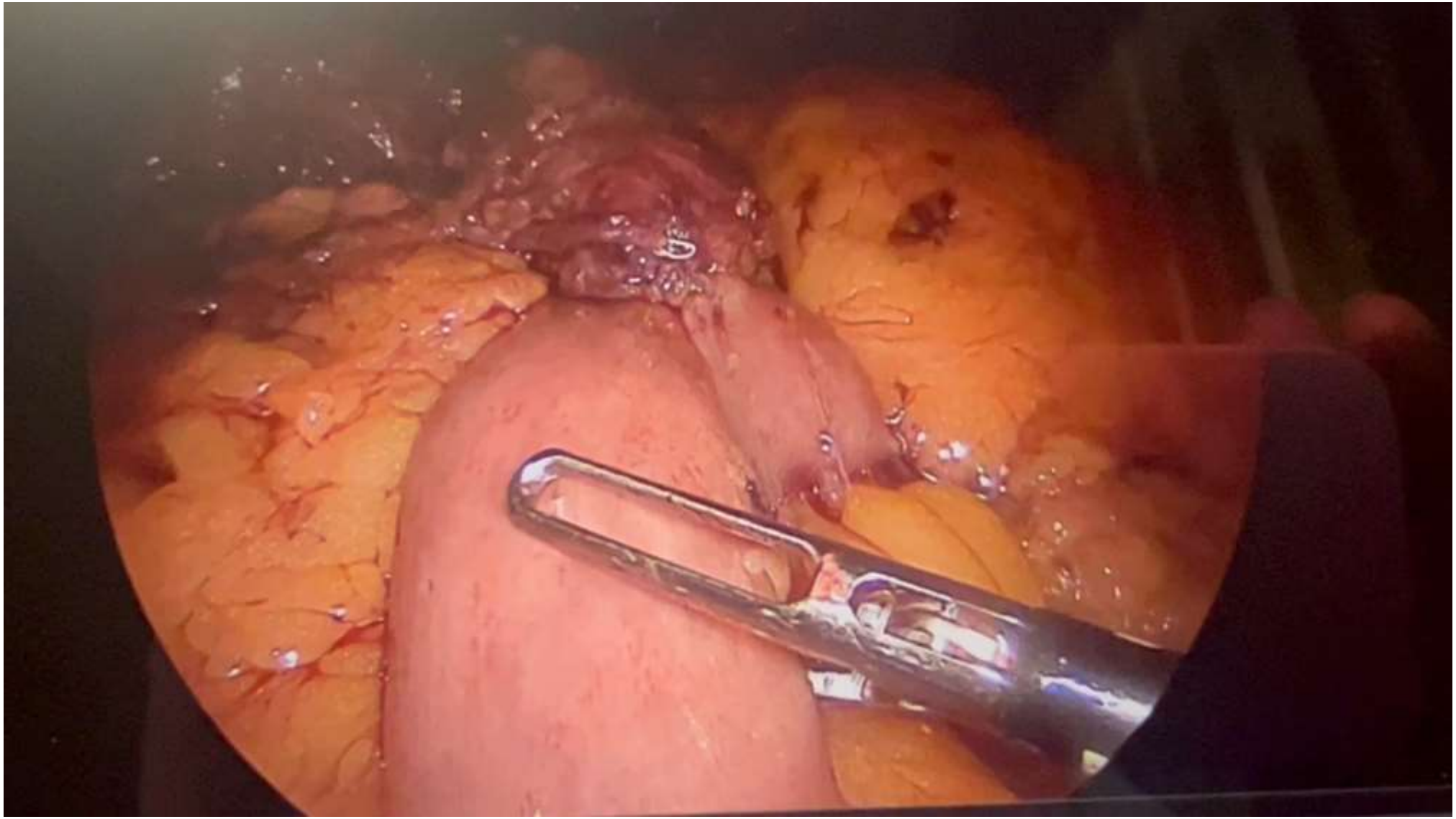

Considerations

- Extended pouch RYGB became the standard for patients with Failed Sleeves with UGI/GERD symptoms
- More than Grade B Reflux esophagitis and patients with HH are advised for revision to RYGB rather than OAGB
- OAGB has superior results in patients where there are no UGI/GERD symptoms, hiatal hernias or more than grade B esophagitis

Conclusion

- Weight loss is significantly higher in the Sleeves revised to OAGB rather than RYGB
- Both revisions were safe with no morbidity and mortality
- The reoperation rate for OAGB as a revisional procedure is much higher (24%) than primary procedures (5%)