

WEIGHT LOSS E-NEWSLETTER

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Revision of Gastric Bypass

Terry had the gastric bypass operation 3 years ago in an a major referral center by an established surgeon. The surgery went well, and lasted about one hour. The post-operative course was uneventful, and the patient was discharged home on post op day 2. The 3-6 month post-op period was complicated by a stricture at the gastro-jejunosomy anastomosis. An upper endoscopy and dilation. He continued to loose weight as expected. He attended the support meetings early on and then ended up missing some of them after the third year. The follow up appointments with the surgeon were all kept. The episodes of dumping syndrome, the feeling of passing out, diarrhea, high heart rate, nausea amongst others were scary early on. They became less frequent but not any less concerning. He was told by the surgeon that it s a part of the gastric bypass operation. In fact someone at the surgeons office told

him that "..you hope you have it, since it will help you with your diet and prevent weight regain.."

He started feeling weak and tired at times after the second year. He also gained about 50 pounds back after the third year. The weight gain did not stop till I was within reach of my pre gastric bypass operation. What is worse is that he had to use CPAP machine for sleep apnea that had gone away with weight loss. He also was started back on some of his medications including those for diabetes.

He went back to his surgeon, whose first reaction was that "....You must be doing something wrong..."He was then referred to see the nutritionist, had an upper endoscopy, and an upper GI series. When he went back, he was told that there is nothing wrong and that he should eat correctly and exercise more.

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This is not a story but a real example of many more patient that I see in our office all the time. As the facts are pretty accurate, clearly the name, and the specific details have been altered in this article.

What this patient has experienced is what I hear in the office all the time from patients who had the gastric bypass and they "...did not know..." about any other weight loss surgical procedure. After the surgical "honey moon" period of about 2-3 years (much longer than my real honey moon) the reality sets in. Weight regain, inadequate weight loss, nutritional deficiencies, dumping syndrome, and solid intolerance are examples of problems which will direct a patient to seek a solution.

The published data show that the small size of the pouch, in gastric bypass, does not predict excess weight loss (*O'Connor et.al. SOARD 4, 2008, 399-403*), (*Nishie et.al. Obesity Surgery 17, 2007, 1183-1188*). The size of the gastro-jejunosotomy anastomosis also does

not assure adequate weight loss (*Cottam et.al. Obesity Surgery 19, 2009, 13-17*). Dumping syndrome does not improve gastric bypass surgery outcome. And the incidence of resolution of the obesity related illnesses is significantly better with duodenal switch operation than the gastric bypass or the adjustable gastric banding procedure. Patients with diabetes or cholesterol and triglyceride problem, in my opinion, should not have gastric bypass or adjustable gastric banding done.

A review of the published scientific articles in JAMA, shows that the outcome of Duodenal switch operation is far better than the alternatives with all measured parameters of excess weight loss, diabetes resolution, and improvement of hyperlipidemia.

Let me pose a question. If a patient is told that there are two antibiotics and one of them will treat the urinary track infection in 83.7% of the time and the alternative will treat it in 98.9% of the time, which one would you like to be treated with, if the overall risks all the same?

	Significant Hyperlipidemia improvement	Diabetes Resolution	Excess weight loss
Duodenal Switch	99.50%	98.90%	70.10%
Gastric Bypass	93.60%	83.70%	61.60%
Gastroplasty	80.90%	71.60%	68.20%
Gastric Banding	71.10%	47.90%	47.50%

Source: JAMA, review of published data based on more than 22000 patients outcome.

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As a Duodenal switch surgeon the answer is clear. I am only trying assure that no patient ever goes to the operating room without having all their options entertained. An informed consent is only valid if all the information was presented. Too often the alternative are either never discussed or barely discussed. A review of the websites demonstrates this point. Very few surgical practices that do not offer the duodenal switch operation discuss this alternative.

And to those that ask, "Why are there more surgeons doing the duodenal switch operation?" I think this a question that needs to be posed to those that do not do it. Here are some of the reasons:

- I. The perceived malnutrition is usually given as a reason. There is a large body of published data in the literature that documents the incidence of malnutrition to be significant in gastric bypass operation. In fact, because of the dietary restriction after gastric bypass there are as many if not more nutritional deficiencies that develop after this operation than the duodenal switch operation.
- II. The need for follow up. I am not clear as to why would this be a reason not to offer a surgery. The scientific evidence again shows that the more structured the follow up the better the outcome. Obesity is a chronic disease, that has a surgical, medical and maintenance phase. The broad picture of treatment plan for obesity in my opinion is no

different than that of a cancer patient, who may need surgery, followed by chemo-radiation, and routine follow up.

- III. Last, and most vividly discussed is the issue of increased flatus, and loose bowel movements. There is no dispute that the duodenal switch operation does cause increase in flatulence and loose bowel movement. But here are the facts- in my more than 10 years in private practice, in an office that at times the waiting room is full of pre and post op patients, we have never had to evacuate the building because someone let one go! It has been my experience that that in overwhelming number of cases that have problem with significant gas and diarrhea the problem is easily corrected with minor changes in diet. Polish sausage, bagel and cream cheese for breakfast, deep dish pizza for lunch, and deep fried turkey may give some patients increased gas and diarrhea! With this said however, I have had patients in whom after exhausting all non surgical options (dietary modifications, medications etc) revision of the duodenal switch operation has been done.

In my opinion, the best patient is the most knowledgeable patient. Please make sure that you have taken the time to investigate not only the the surgeon, but also the available procedures.

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