

WEIGHT LOSS E-NEWSLETTER

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Gastric Bypass Linked to Abnormal Glucose Tolerance

The truth about gastric bypass is out!

By Charles Bankhead, Staff Writer, MedPage Today
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DALLAS, June 26 -- Patients who undergo gastric bypass surgery often have undiagnosed glucose abnormalities that can lead to bad eating habits and regained weight, a small clinical study suggests.

Almost 80% of the patients had glucose abnormalities, including hyperglycemia, hypoglycemia, or both, Mitchell Roslin, MD, of Lenox Hill Hospital in New York, reported here at the American Society of Metabolic and Bariatric Surgery meeting. Patients were alarmed by the weight regain, but at the same time, they often had a ravenous appetite soon after a meal, accompanied by an almost uncontrollable urge to eat." Our hypothesis is that . . . patients may have an enhanced insulin response," said Dr. Roslin. "They have

rapid emptying of the pouch that leads to reactive hypoglycemia. The combination of an empty pouch and low blood sugar leads to hunger." The findings have led him to question whether gastric bypass surgery should remain the gold standard procedure for treating obesity, he added. At the very least, surgeons should consider the possible need to include a valve in gastric bypass. The study evolved from clinical observations during patients' periodic postoperative visits. A growing number of patients complained of weight regain and loss of restriction. The complaints often had a common ring." Patients were saying that one or two hours after eating, they were ravenously hungry," said Dr. Roslin. "It sounded a lot like hypoglycemia to me." To investigate the origin of the symptoms, Dr. Roslin and colleagues studied 63 patients who had undergone gastric bypass procedures. All the patients had a 100-g

glucose tolerance test, wherein the maximum/minimum glucose ratio was assessed one to two hours after the glucose challenge. The investigators defined reactive hypoglycemia as a glucose value <60 mg/dL, or a decrease of 100 mg/dL or more within two hours and no glucose value exceeding 200 mg/dL. They defined hyperglycemia as any value >200 mg/dL and no value <80 mg/dL. Follow-up from surgery averaged about four years. The mean age of the group was 48.5, and 81% were women. The patients' average preoperative weight was 138 kg, with an average body mass index of 49. One-third had preoperative diabetes. The percentage of excess BMI lost averaged 55%, and the patients had regained an average of 12 kg. Glucose tolerance tests showed six patients with hyperglycemia, including five who had normal fasting blood glucose levels. In addition, 35 patients had reactive hypoglycemia, while eight had hyper- and hypoglycemia. "The hyperglycemic cohort was characterized by a rapid rise to high

sugar levels," said Dr. Roslin. "The fact that most of these patients had normal fasting glucose means we need to be very careful of what we call cure or control of diabetes." Reactive hypoglycemia manifested as a rapid upsurge of glucose levels that correlated with a rise in insulin and then a rapid decline during the second hour after the glucose challenge. Patients with both hyper- and hypoglycemia had even more pronounced swings in glucose and insulin levels, said Dr. Roslin.

The most dramatic rises and falls in blood glucose have been associated with small pouches and wide anastomoses, he added. The findings suggest a need to consider alterations in the standard gastric bypass procedure, such as use of valves, or possibly abandonment of the procedure in favor of another approach. "I believe that vertical-sleeve gastrectomy and duodenal switches that are not severely malabsorptive will be the best options in the future," said Dr. Roslin.

Commentary: The about article was sent to me by Vicki Blackburn- Thank you Vicki.

This was one of the many presentations that was made at the ASMBS meeting held in Dallas. I will be sharing other presentation in the future newsletters.

This article describes what those if us that have been performing duodenal switch operation have knows for years. This explains why the size of the pouch does not matter, that dumping does not protect against weight gain and why duodenal switch operation is far better option that the alternatives.

As with other procedures the science will eventually shed light on all the facts. Dr. Roslin indicates the time is now to consider what should be the benchmark standard for weight loss.

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