

## Revisional Bariatric Surgery

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**ABSTRACT:** *Obesity can be defined as a chronic disease with a serious impact on an individual's quality of life; moreover, it is a leading risk factor for global death. Bariatric surgery has already proven its efficacy in providing the patient with a healthier life. Nonetheless, failure of initiated treatment can occur in medical practice. We can and should offer our patients correct, patient-tailored revisional therapy conducted by an experienced surgeon in a high-volume hospital facility. In this article, current indications and strategies for secondary bariatric procedures were summarized and include type and number of cases (105 cases) that was converted from restrictive procedure (sleeve gastrectomy and gastric plication) to mal absorptive procedure (gastric bypass Roux en Y or MGB or to SASI or others.*

**KEYWORDS:** Duodenal Switch; revisional bariatric surgery; Roux en Y gastric bypass; single anastomosis gastric bypass MGB; SASI; sleeve gastrectomy.

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### INTRODUCTION

According to the World Health Organization (WHO), more than 500 million adults' worldwide or 11% of the population at the age of 20 and older were obese in 2008. Since then, 3.5 million adults have died each year as a result of being obese or overweight. [1] Moreover, serious morbidities are related to obesity like the burden of diabetes, ischemic heart disease and cancer. At this point, unfortunately, obesity is linked to more global deaths than the underweight. In low- and middle income countries, the problem of obesity is rapidly rising to the levels of high-income countries. Another disturbing evolution in developing countries can be seen in younger populations, with a 30% increase of childhood obesity compared to developed countries. Globally, 42 million children under the age of 5 were overweight or obese in 2013. Therefore, WHO developed a Global Strategy on Diet, Physical Activity and Health with the aim of halting global obesity rates by 2020. This action plan formulates advice for an individual patient, societal measures, and food industry to prevent and cure this chronic disease. The responsibility of having an easily accessible healthcare system, not only for preventing overweight, but also for curing obesity is not discussed. In this setting, bariatric surgery has already proven its efficacy and was found to be more effective than non-surgical treatment methods in achieving weight loss and remission of comorbidities. [2] A patient-tailored approach for choosing the best surgical strategy is initially necessary to cure the

patient in the long term. However, when this therapy fails, a revisional operation can be offered in well-selected patients.

### **Motivation and Indication for Revisional Bariatric Surgery**

The problem of failed bariatric procedures is multifactorial. Before proposing bariatric surgery in the first place as primary treatment for obesity, every patient should be worked-up in a multidisciplinary team. A patient-tailored approach can lead to better outcomes in weight loss and morbidity relief in the long term. For instance, patients with co-morbidities related to metabolic syndrome will have proven to benefit after performing Roux-en-Y gastric bypass (RYGB), and in patients presenting with reflux disease, RYGB might also be the first choice procedure.[3] On the contrary, sleeve gastrectomy will be the preferred primary treatment in case of osteoporosis, dumping symptoms, or vitamin deficiencies. Consequently, weight or morbidity recidivism, or anatomical/technical complications can be related to an inappropriate primary surgical strategy, but also to changes in surgical knowledge and techniques, or patient related factors. An inconsistent definition of failure of a primary bariatric procedure is the reason of heterogeneous numbers in the reported literature. The most frequently used definition of failure of the initial operation is less than 50% of excessive weight loss EWL 35 m/ kg<sup>2</sup> at 18 months post-operatively.[4] None of the reviewed articles described failure of remission of type 2 diabetes or hypertension as an indication for reoperation. Henry Buchwald has stated recently that revisional bariatric surgery is a moral obligation to the patient with a failed bariatric procedure.[5] This expressed indignation arouse in a climate of negative responses to revisional bariatric surgery manifested in the US healthcare system. However, evidence-based literature supports a reoperation strategy for conversion or correction of acute or chronic complications after failed bariatric surgery. An improved weight loss, reduction in comorbidities, and resolution of complications is achieved after re-intervention.[6,7] Revision of LAGB

High rates of failure in weight loss due to maladaptive eating, and band-related complications such as slippage, tubing leakage, esophageal motility disorders (and pseudo achalasia) are reasons why placing a laparoscopic adjustable band (LAGB) has almost currently become obsolete as primary bariatric treatment. A few studies have reported success rates in converting LAGB to sleeve gastrectomy when performed in a one- or a two-step procedure,[8,9] but overall, RYGB is the revisional procedure of choice. In most cases, conversion to RYGB can be performed in a one-step procedure.[10–12] In the postoperative three year, revisional RYGB provides good additional weight loss and similar rates of improvement and remission of coexisting conditions compared to primary RYGB.[13 ,14,15]

### **Revision of SG Sleeve gastrectomy (SG)**

can be considered a primary procedure or the first restrictive step of a 2-step bariatric therapy. Inadequate weight loss is an important reason for re-intervention, but severe stenosis or reflux (20% of patients after SG) can also form the motivation for conversion to RYGB[16] if endoscopic therapy fails.[17] In rare cases, conversion to RYBG can be the solution for chronic gastric fistula after SG.[14] A recent systematic review concerning failed sleeve gastrectomy due to inadequate weight loss has concluded that both RYGB or re-sleeve gastrectomy are appropriate procedures with similar weight loss outcomes after 24 months,[18] depending on whether malabsorption or more restriction has to be added. Each decision has to be tailored depending on a specific case. Other strategies can include conversion to a classic duodenal switch operation (with Roux-en-Y configuration) or to single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) to add malabsorption, with good results in primary cases in terms of additional weight loss and normalization of HbA1c levels in diabetic patients. [19,20]. developed a procedure combining sleeve gastrectomy with enterectomy to the first 100 cm of jejunum or the last 200 to 250 cm of the ileum SASI [21] and also reported good initial weight loss. An important goal with this type of interventions is to change neuroendocrine responses in bariatric patients, which is also targeted in sleeve gastrectomy with ileal transposition. Although it is interesting, these new developments currently lack evidence, and can only be used in well selected cases and in experienced hands.

### **Revision of RYGB**

Severe dumping symptoms or invalidating hypoglycemic episodes, refractory to any conservative therapy, can sometimes be the reasons to convert a RYGB to normal anatomy or SG. More frequently, inadequate weight loss after RYGB or weight recidivism is the cause for considering alternative surgery. Options include either conversion of RYGB to duodenal switch, distal bypass, adjustable banding, pouch revision, or endoscopic procedures. Endoscopic gastric plication results in weight regain after one year, and is not generally accepted as treatment strategy.[22] In selected patients with increased caloric intake or dilated gastrojejunostomy, favorable results have been described adding LAGB.[23] Other cases with anatomical gastric pouch enlargement on barium esophagograms can benefit from performing gastric pouch or gastrojejunal revision, leading to significant weight loss one year after revisional surgery.[24] (In patients known to have low caloric intake (<1500 kcal/day), without vitamin deficiencies or anatomical deformities, a laparoscopic lengthening of the Roux limb[25] or biliopancreatic limb in case of failed RYGB[26] will offer good additional weight loss.

## **Revisions of gastric plication**

In case of increase sign and symptom of reflux and in case of regain the weight can be converted the gastric plication to sleeve gastrectomy or to gastric bypass any type or we can do re plicate the stomach[22] .

The approach to redo gastric plication is more difficult due to more adhesion and fibrosis in stomach and routinely need to upper endoscopy in all case of revision in all type of primary procedure[14,15].

Approach: Open vs Laparoscopic vs Robotic?

Revisional surgery is always technically challenging for the bariatric surgeon. These operations carry the possibility for a staged approach or conversion, and a higher risk of complications. This is due to the presence of scarring, adhesions and inflammation with difficulties of identifying anatomical landmarks, and harming vascular supply, which will increase the risk of bleeding and anastomotic complications.

A safe approach is necessary using the preferred conventional laparoscopic approach. This minimally invasive technique has the advantage of giving a good two-dimensional presentation of the region of the upper gastrointestinal tract. However, if this operative strategy is not safe, open surgery must be considered. Nowadays, robotic surgery is also being used for revisional bariatric surgery, leading to a three-dimensional vision, and amplified dexterity of the surgeon. In highly selected cases and

in experienced hands, these robot-assisted interventions are reported to be safe and effective, without causing higher costs in the long term.[28]

Therefore, we can conclude that laparoscopy for bariatric re-interventions remains the preferred approach.

## **DATA AND RESULT**

our study includes about 105 cases of redo bariatric surgery

55 cases of sleeve gastrectomy redo to additional malabsorptive procedure (gastric bypass). and about 20 case of gastric plication redo to malabsorptive procedure (bypass ).

And about 18 cases of gastric band converted to restrictive procedure sleeve gastrectomy or to gastric bypass depend on comorbidity conditions of the patients.

and about 12 cases of bypass redo to normal anatomy or increase or decrease length of elimintary limb or biliopancreatic limb.

All the procedure was did by laparoscope only one case converted to open.

## CONCLUSION

The worldwide problem of overweight and obesity demands a multifactorial approach. Obesity has to be considered a chronic disease, in which bariatric surgery is an evidence-based therapeutic option with excellent results on excessive weight loss and remission of co-morbidities.[2] Nonetheless, some individuals will be refractory to initiated treatment or will present with complications or adverse effects. We need to offer an alternative therapy to this group of patients. In experienced hands, revisional

bariatric surgery can be performed laparoscopically in a safe way with low complication rates and excellent results on additional weight loss.[29,30]

If metabolic surgeons want to gather and keep support in the provider community, they have the responsibility to report the results of primary and secondary bariatric procedures, hospitalization, complication rates and healthcare costs in a standardized way. There is need to reduce

invasiveness of bariatric therapy and re-interventions in the future to enhance societal support, and more importantly, to enable the treatment of more individuals.

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