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## Sleeve Gastrectomy plus Jejunal By Pass

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# No conflict of interest



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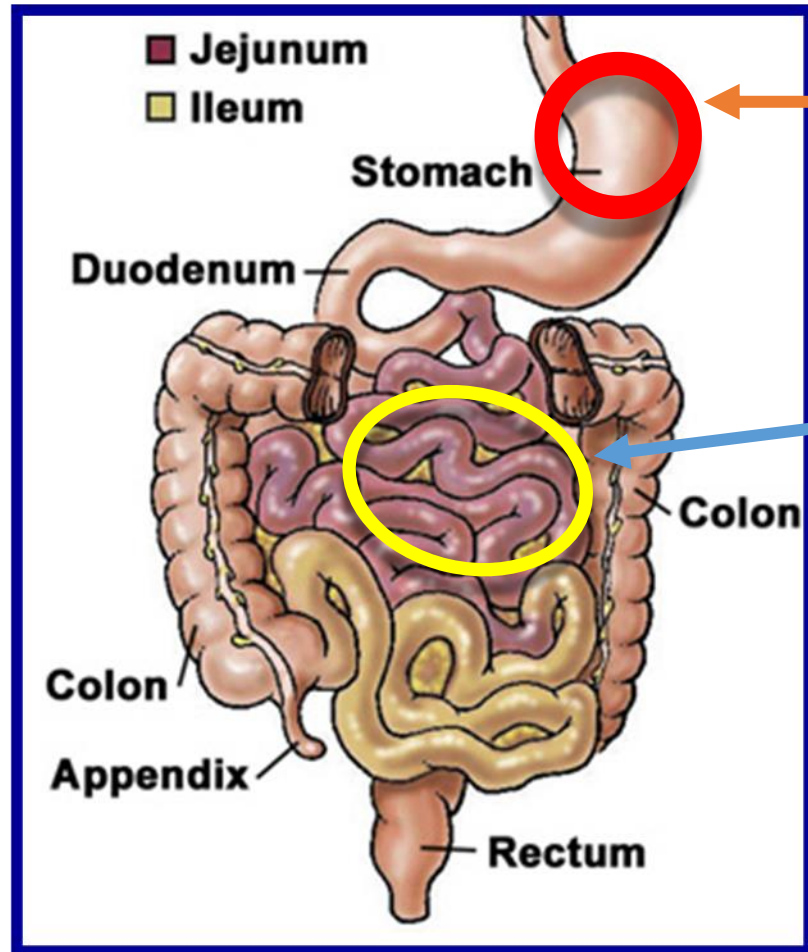
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# Prehistoric Food/Digestive Reality



Less food

More storage capacity

Unprocessed  
carbohydrates:

Longer smallbowel



# Alimentary reality of the 21<sup>st</sup> century:



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- Abundance of food
- Refined or predigested carbohydrates
- Diminished function of hindgut ( Less GLP-1)
- Absorption of processed carbohydrates in the Foregut ( antiincretin hormones )
  
- &



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Due to modern diet:

The stomach is inadequately large

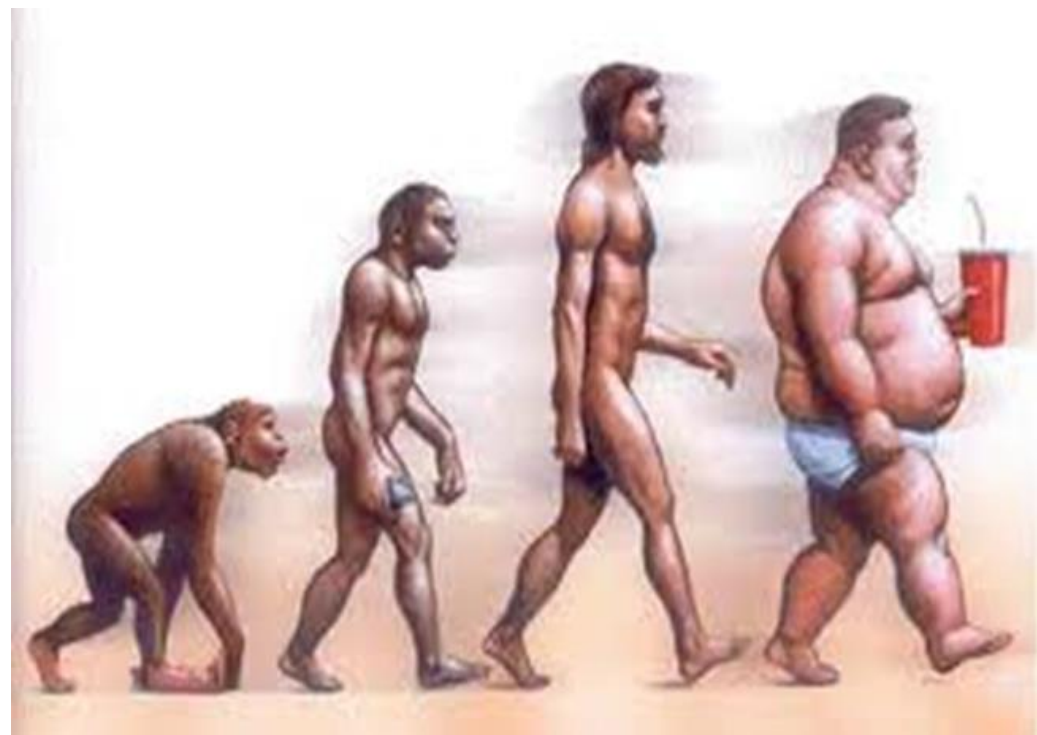
And the small bowel inadequately long

SANTORO



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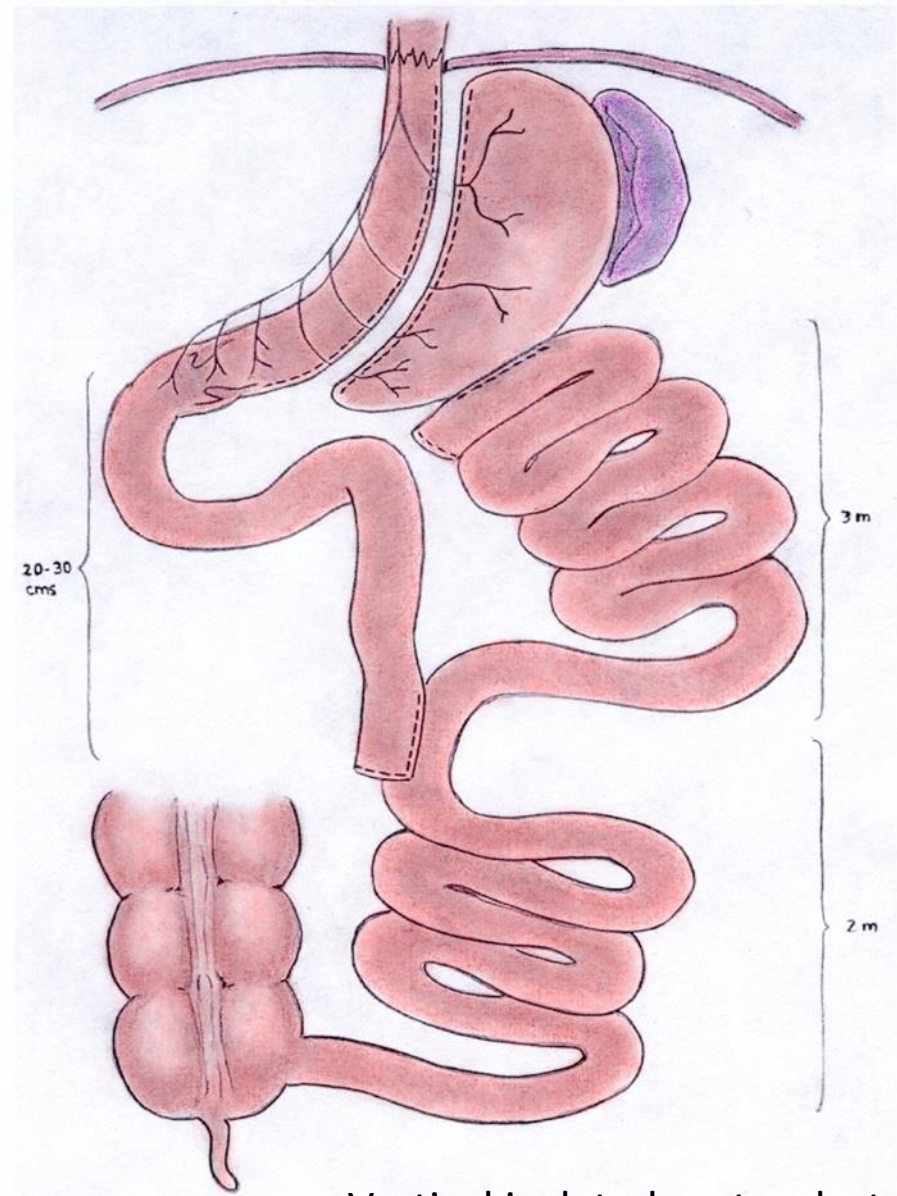
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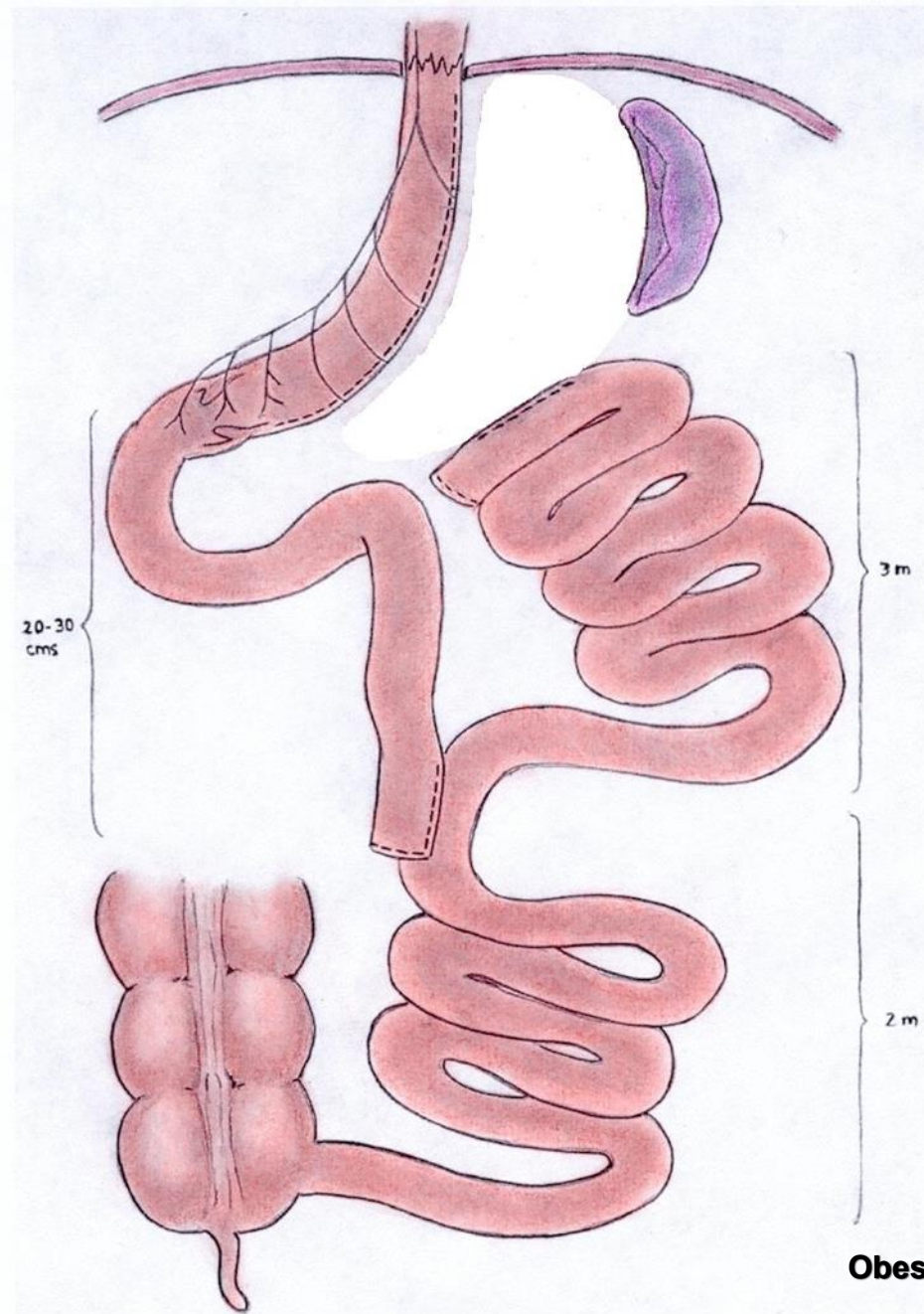
Vertical isolated gastroplasty with gastro enteral by pass  
Alamo et al. Obesity Surgery, 2006 Vol 16;3:353-8 M. Dietel





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Obesity Surgery 2006 Vol 16; 9:1263-6

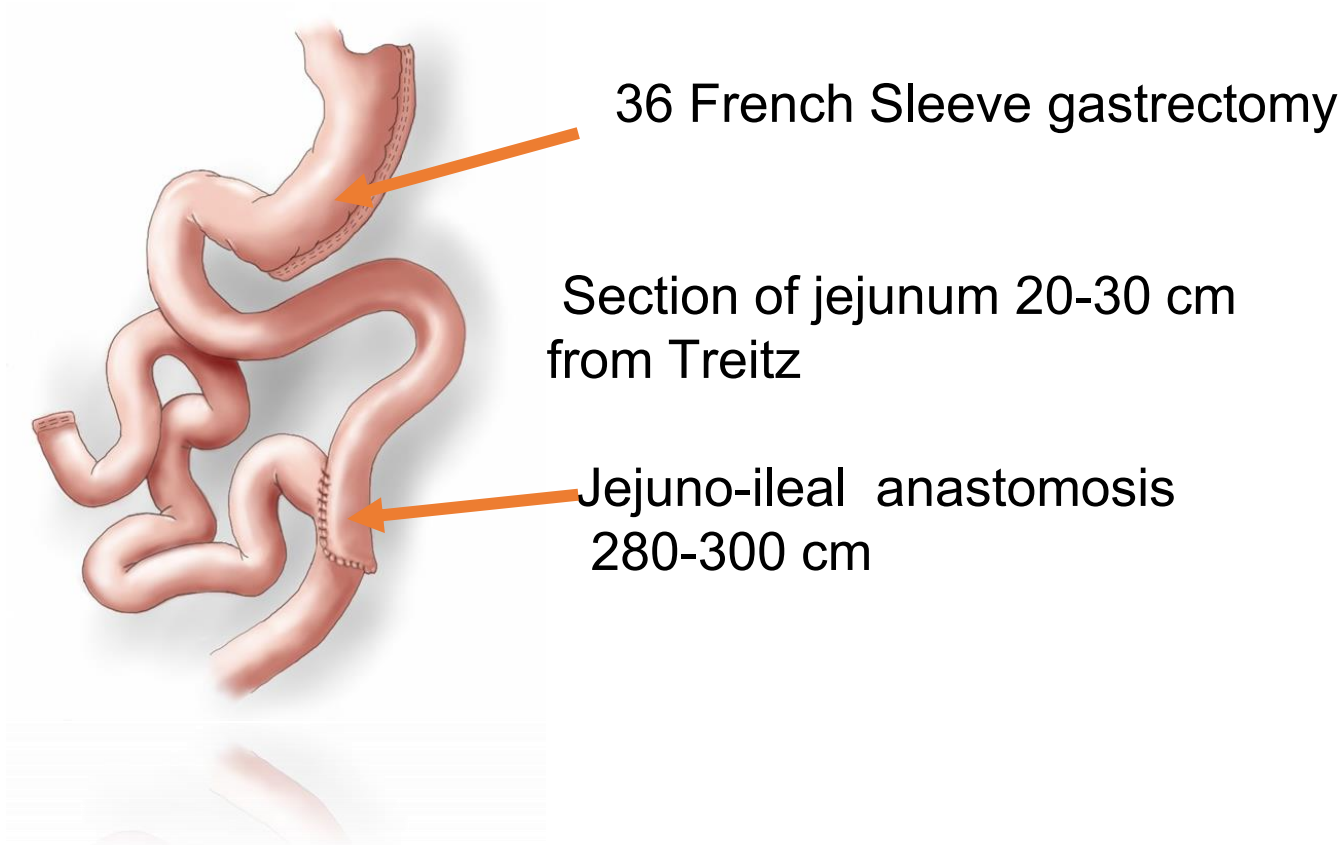


# Sleeve Gastrectomy with Jejunal Bypass



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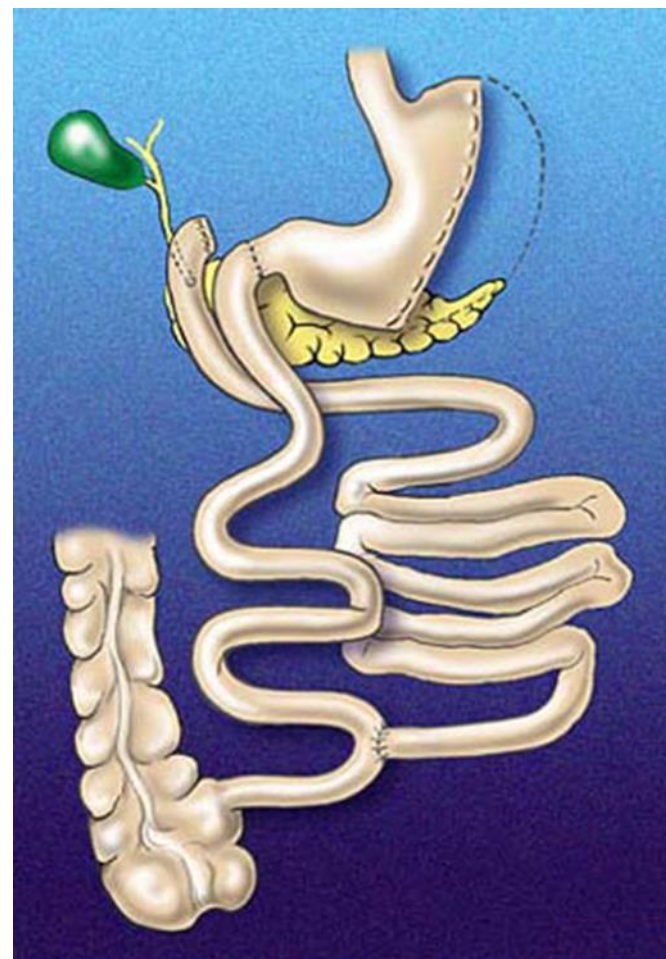
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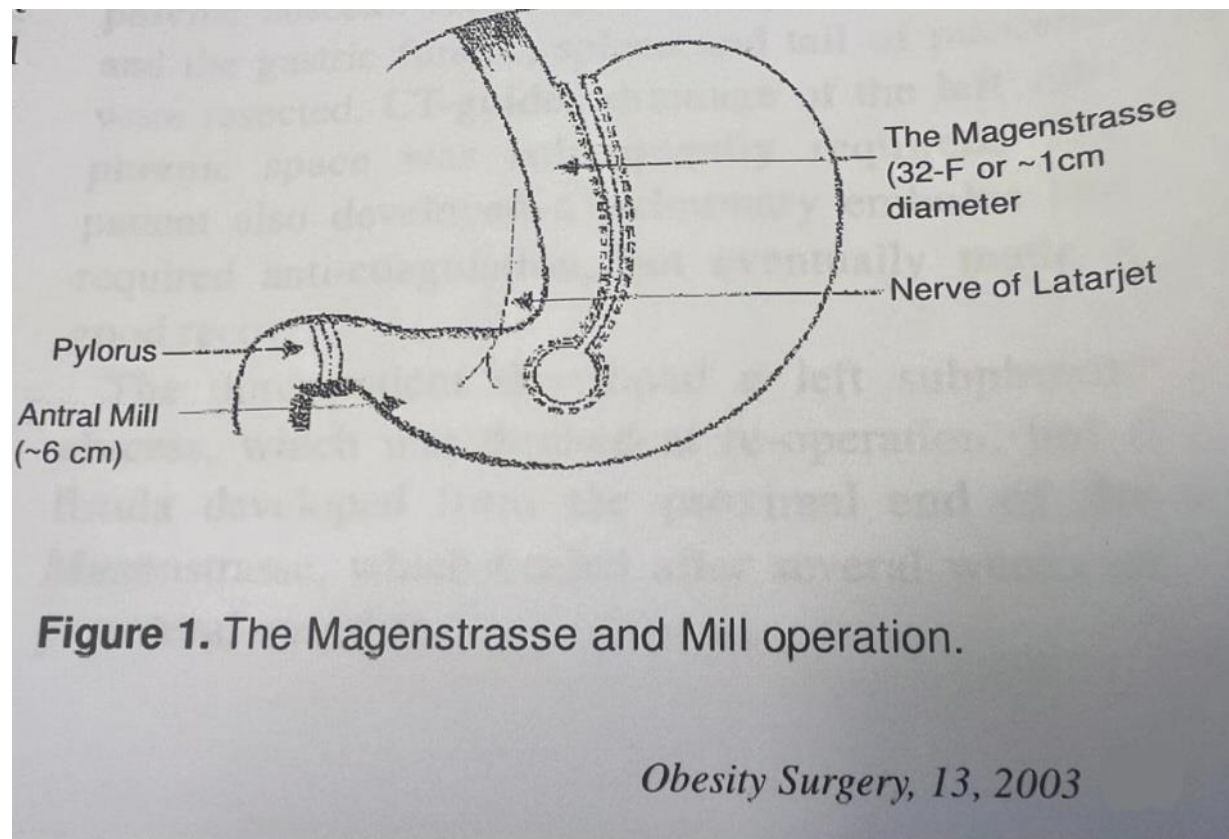
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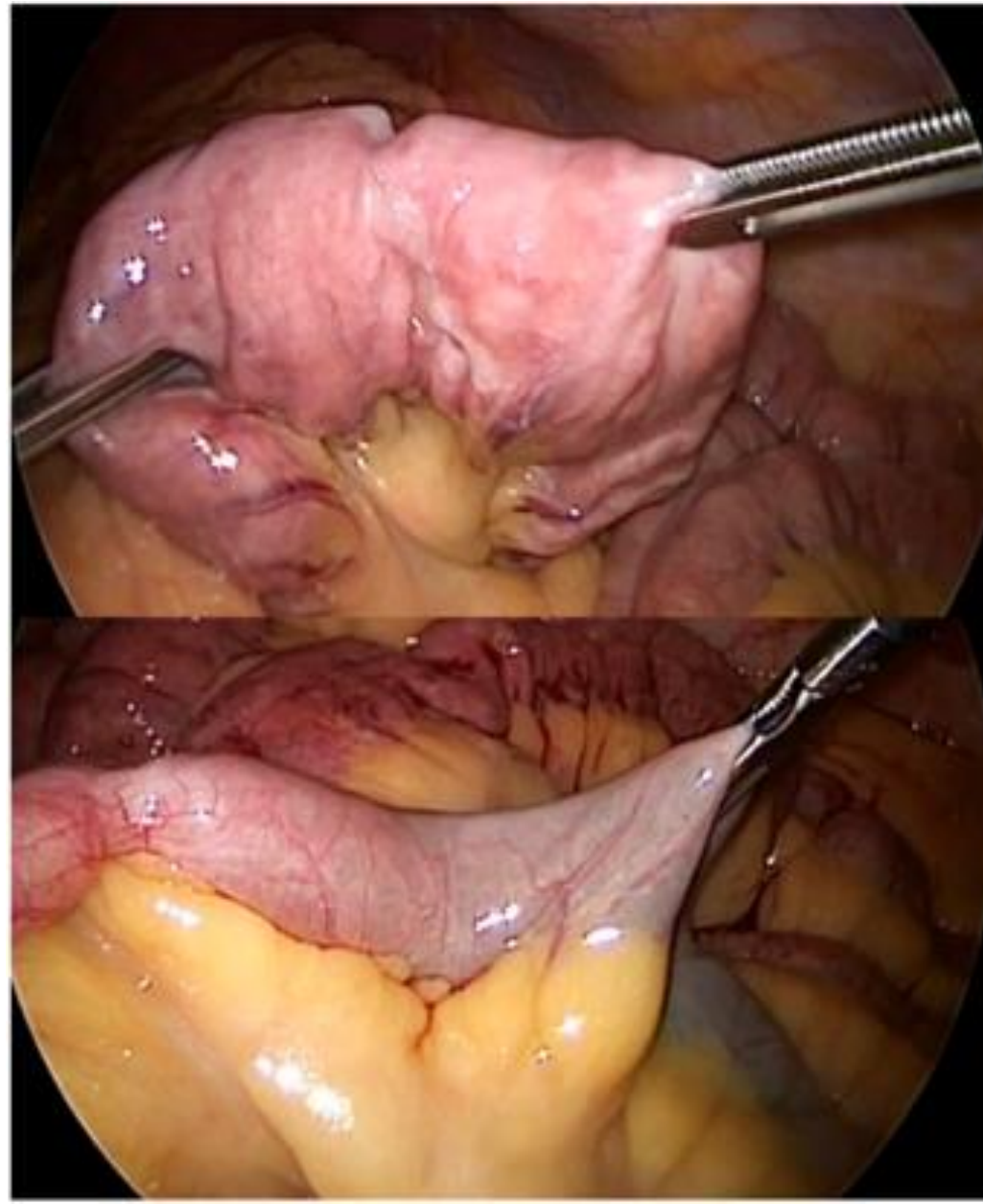
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# Results

## Excess Weight Loss %

<b>Time (year)</b>	<b>EWL</b>	<b>P<sub>25-75</sub></b>
1	73.6 %	19.9
2	68.6 %	22.3
3	64.5 %	26.7
4	65.3 %	18.9
5	66.7 %	14.7
6	74.3 %	31.6



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# Comorbidities Evolution

<b>Comorbidities</b>	<b>Resolved</b>	<b>Improved</b>	<b>Total</b>
Insulin Resistance	90 %	8 %	98 %
Diabetes	79 %	11 %	90 %
Dislipidemia	89 %	7 %	96 %
Arterial Hypertension	61 %	29 %	90 %
Sleep Apnea	66 %	25 %	91 %
Gastroesophagus Reflux	58 %	33 %	91 %





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OBES SURG  
DOI 10.1007/s11695-012-0652-x

TECHNICAL INNOVATION

## **Sleeve Gastrectomy with Jejunal Bypass for the Treatment of Type 2 Diabetes Mellitus in Patients with Body Mass Index $<35 \text{ kg/m}^2$ . A cohort study**

**Munir Alamo • Matías Sepúlveda • José Gellona •  
Mauricio Herrera • Cristián Astorga • Carlos Manterola**



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# Objectives

**To evaluate the Sleeve Gastrectomy with Enteral Bypass for the treatment of Type 2 Diabetes Mellitus in patients with BMI <35 kg/m<sup>2</sup>**

# Methods



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- Prospective Cohort
- Multicentric
  - DIPRECA Hospital Surgery Department at Santiago, Chile
  - Hospital Base Osorno Surgery Department at Osorno, Chile
- From January 2009 to March 2011



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# Surgical Procedure Data

- Approach
  - Laparoscopy 95.5 %
  - Laparotomy 4.5 %
  - Conversion 0 %
- Additional Surgery
  - Cholecistectomy 14.2 %
- Surgery time (min) 121 ± 16 (90 - 155)
- Postoperative hospital stay 2 ± 0.2 (2 - 3)



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# Results

## Patients Characteristics

- Total Patients 45
- Follow up Patients 100%
- Female 64.9%



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# Results

## Patients Characteristics

<b>Insulin Therapy:</b>	8 patients (17.8%)
<b>OHGA:</b>	37 patients (82.2%)
	(100%)





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# Surgical or Medical Morbidity

<b><i>Morbidity</i></b>	<b><i>N</i></b>	<b><i>%</i></b>
Gastrointestinal Bleeding	1	2.1 %
Hemoperitoneum	0	0 %
Gastric Tube Leak	0	0 %
Gastric Tube Stenosis	0	0 %
Anastomotic Leak	0	0 %
Internal Hernia/Intestinal Obstruction	0	0%
<b>Total</b>	<b>1</b>	<b>2.1 %</b>

***Mortality***      **0%**





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# Diabetes Resolution

	Partial Resolution	Complete Resolution
Total	4 (8.9%)	41 (91.1%)
Diabetes NID	0%	37 (100%)
Diabetes ID	4 (50%)	4 (50%)

n = 45 patients,  
NID = Non Insulin Dependant  
NI = Insulin Dependant





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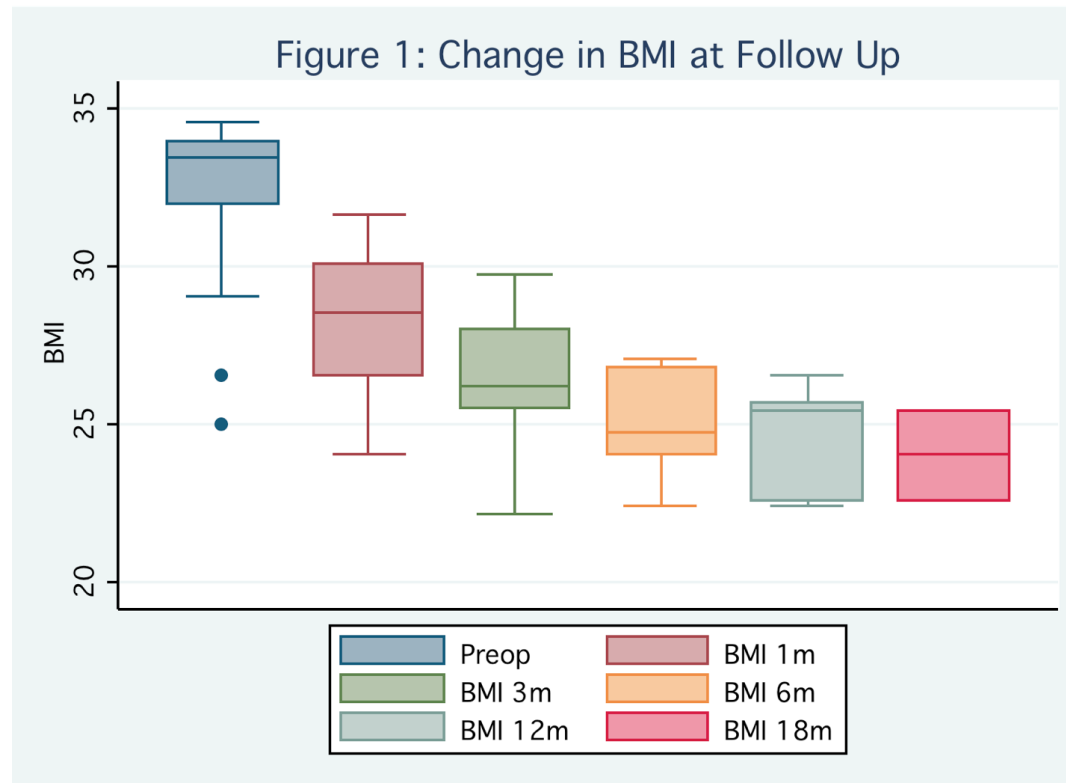


Figure 1: Change in Body Mass Index at follow up of 18 months

BMI at 18 months:  $24.5 \pm 1.9 \text{ kg/m}^2$  (22-26)





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# Roux-en-Y gastric bypass versus sleeve gastrectomy with jejunal bypass for the treatment of type 2 diabetes. Results at 12 months of follow-up

Matías Sepúlveda MD<sup>1,2</sup>; Munir Alamo<sup>3</sup> MD; Jorge Saba<sup>1,2</sup> MD;  
Cristián Astorga<sup>1,2</sup> MD; Leopoldo Peñaloza<sup>2</sup>; Hernán Guzmán<sup>1</sup> MD; **Yudith Preiss** <sup>1</sup> MD



Obesity Surgery Center  
DIPRECA HOSPITAL





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# Objective

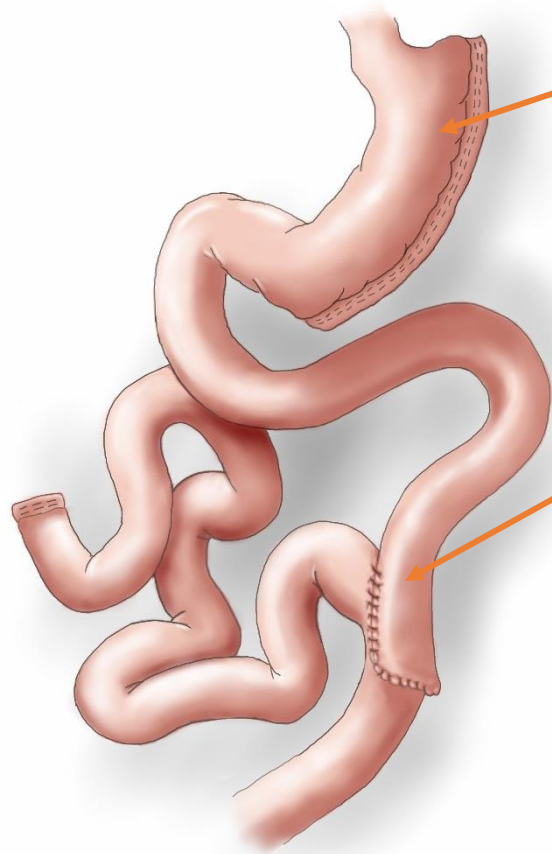
The objective of this study is to compare SGJB and RYGB in Type 2 Diabetes remission at 12 months.



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# Sleeve Gastrectomy with Jejunal Bypass



- 36 French Sleeve gastrectomy
- Section of jejunum 20-30 cm from Treitz
- Jejununo-ileal anastomosis 250-300 cm



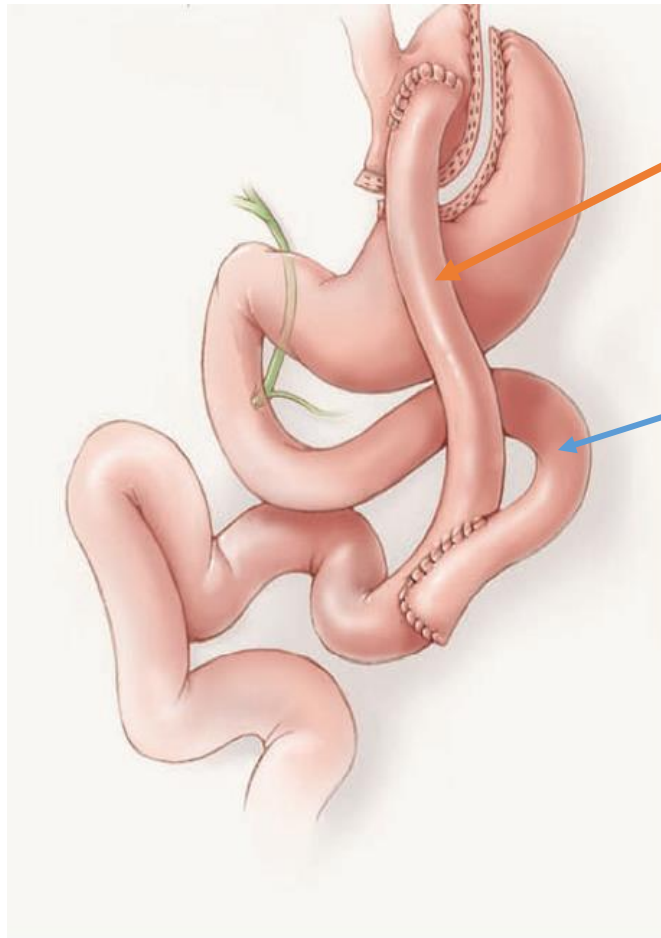
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# Surgical Technique: RYGB



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- Alimentary limb 120 cm

- BP limb 80 cm



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# Methods

- Prospective selection of patients between 2011 and 2013

28 SGJB and 28 RYGB

- Inclusion criteria:
  - BMI  $\geq 30$  kg/m<sup>2</sup>
  - T2D according ADA
- Exclusion criteria:
  - Previous bariatric surgery
  - Autoimmune Diabetes
  - GERD

# T2D Remission Criteria (American Diabetes Association 2009)



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## – Complete remission

- Fasting Plasma Glucose <100 mg/dl
- HbA1c <6.0%
- ≥ 1 year
- No medication

## – Partial Remission

- Fasting Plasma Glucose 100-126 mg/dl
- HbA1c ≤ 6.5%
- ≥ 1 year
- No medication



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# Methods

## Statistical analysis

- Mann-Whitney or t-test for continuous variables
- Differences between T2D remission:  
Pearson  $\chi^2$

# Results



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**Table 1: Preoperative data**

Caracteristics	SGJB	RYGB	p value		
Patients	28	28			
Age (years)	50 ± 13	52 ± 10.5	0.36	ns	
Female	68%	78.6%	0.20	ns	
BMI (kg/m <sup>2</sup> )	35.7 ± 5.5	37 ± 5.2	0.86	ns	
FPG	131 ± 77	124 ± 77.5	0.71	ns	
HbA1c (%)	7.2 ± 2.6	7.1 ± 2.4	0.95	ns	
Time of T2D (years)	3 ± 5	4 ± 5.5	0.14	ns	
Number of medication	1 ± 1	1 ± 1	0.25	ns	
1 OHA (n)	67.9%(19)	57.1%(16)	0.22	ns	
2 OHA (n)	25%(7)	42.9%(12)	0.20	ns	
3 OHA (n)	10.7%(3)	0%(1)	0.75	ns	
Insulin (n)	21.4%(6)	7.1%(2)	0.22	ns	
High Blood Pressure	53.9%(14)	75%(21)	0.25	ns	
Dyslipidemia	58.3%(14)	56%(14)	0.87	ns	



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# Results



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## Table 2: Type 2 Diabetes remission

	12 meses		P value	
	SGJB n=28	RYGB n=28		
Complete remission %(n)	67.9% (19)	57.1% (16)	0.4	ns
Partial remission %(n)	21.4% (6)	25% (7)	0.74	ns
No remission %(n)	10.7% (3)	17.9% (5)	0.45	ns
Patients with NO T2DM	89.3% (25)	82.1% (23)	0.45	ns

### Complete remission (ADA)

- Fasting Plasma Glucose <100 mg/dl
- HbA1c ≤ 6.0%
- ≥ 1 year
- No medication





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**Table 3:** Weight loss and laboratory data results, one year after surgery

Variables	SGJB (n=28)	RYGB (n=28)	P value	
BMI (kg/m <sup>2</sup> )	24.4 ± 3.7	26.9 ± 4.7	.294	NS
%EWL	95.8 ± 30.5	85.3 ± 31.9	.372	NS
<b>Laboratory</b>				
FPG (mg/dL)	89.5 ± 19.5	91.5 ± 23.7	.818	NS
HbA1c (%)	5.55 ± 0.75	5.75 ± 0.65	.126	NS
Total Cholesterol *	172.4 ± 31.3	165.2 ± 38.7	.455	NS
LDL Cholesterol *	104.7 ± 28.4	89.5 ± 34	.076	NS
HDL Cholesterol	55.5 ± 17	54 ± 17	.775	NS
Triglycerides	106 ± 45	100.5 ± 59	.793	NS
Hematocrit *	41.8 ± 3.4	39.4 ± 4.2	.022 ¶	
Hemoglobin	14.1 ± 1.5	13.7 ± 1.7	.025 ¶	
GOT	24 ± 7	29 ± 18	.308	NS
GPT	32.5 ± 20	28 ± 18	.498	NS
GTT	18.5 ± 20	24 ± 20	.309	NS
Albumin	4.1 ± 0.3	4.1 ± 0.5	.834	NS

SGJB: Sleeve gastrectomy w/ jejunal bypass; RYGB: Roux-en-Y gastric bypass; BMI: Body Mass Index; FPG: Fasting Plasma Glucose; HbA1c: Glycated Hemoglobin; T2D: Type 2 Diabetes Mellitus; LDL: Low Density Lipoproteins; HDL: High Density Lipoproteins; OHA: Oral Hypoglycemic Agents

Nonparametrical quantitative variables presented as median ± IQR;

\* Parametrical quantitative variables presented as the mean ± standard deviation

¶ P value <0.05 - significance at 95% of confidence



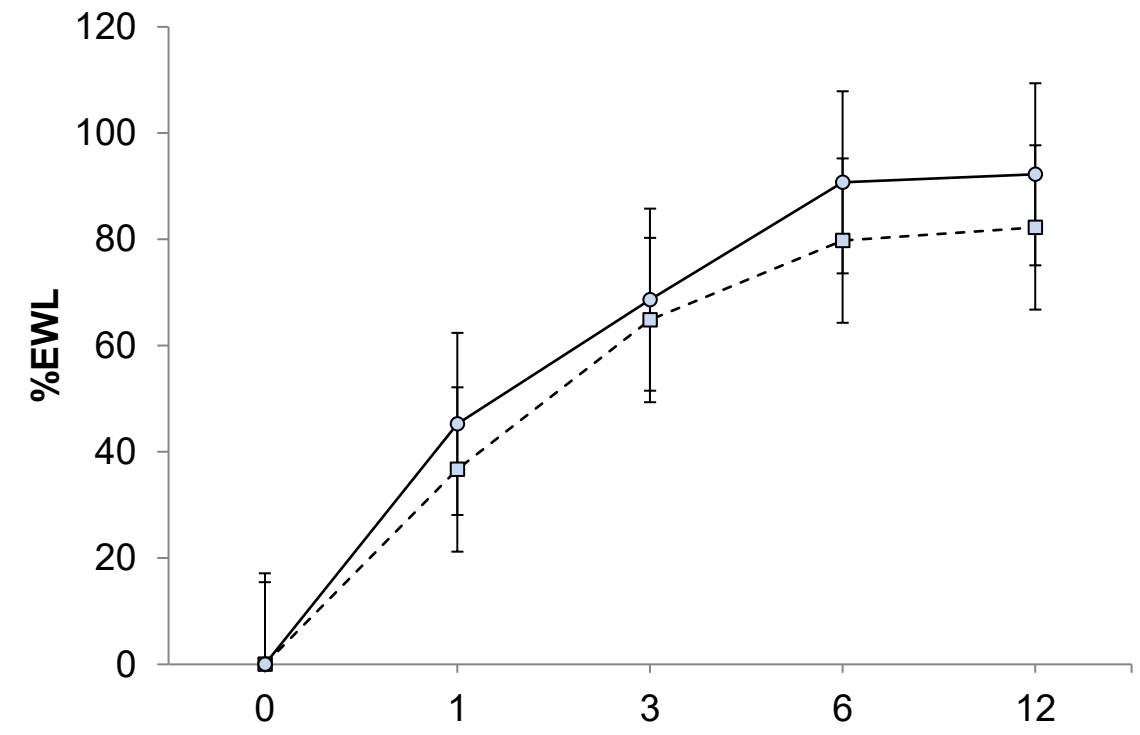
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## Percentage of Excess Weight Loss



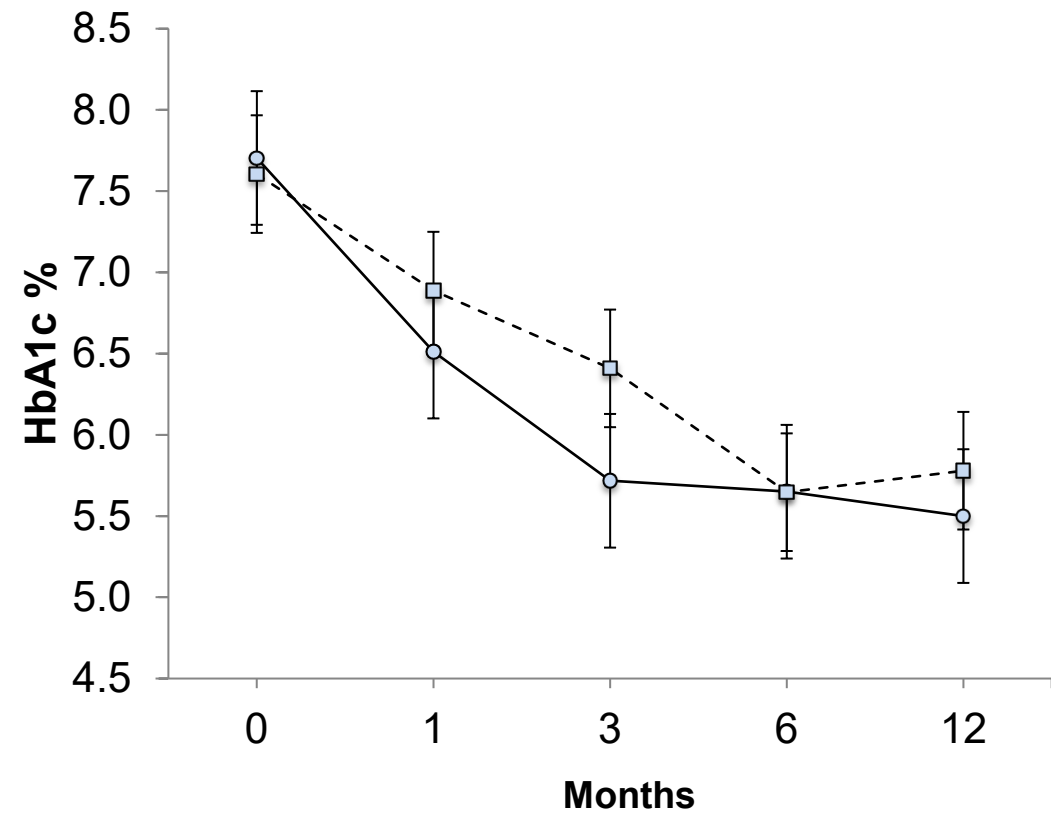
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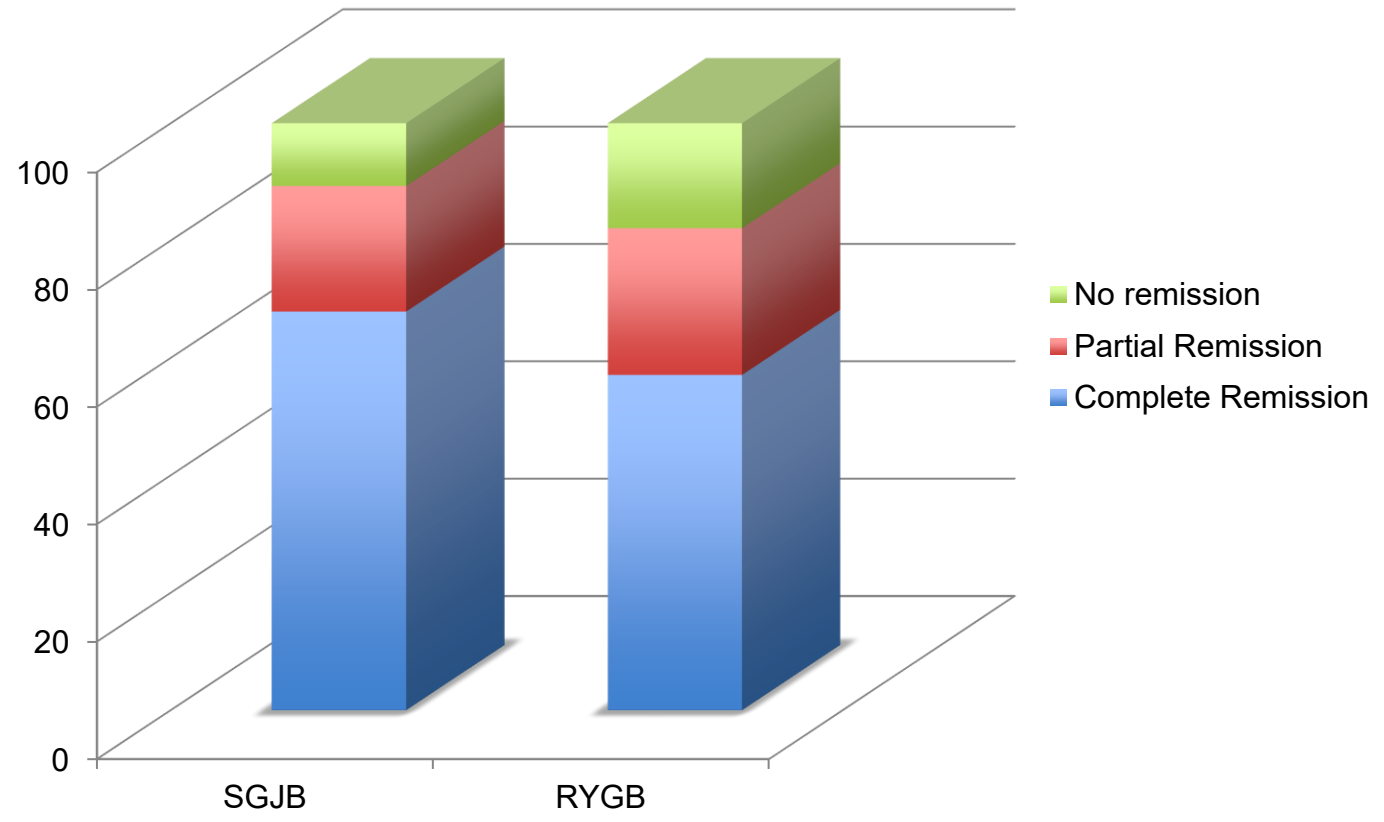
## HbA1c reduction





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# Limitations

- **Number of patients**
- **Follow-up of only 12 months**

# Conclusions

- **There is no significant differences in:**
  - Type 2 Diabetes remission
  - %EWL
  - FPG
  - HbA1c
- **Sleeve Gastrectomy with Jejunal Bypass is a safe technique and is as comparable to RYGB**
- **This study also suggests that duodenal exclusion doesn't play a main role in T2D control**



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# Comparison of long-term weight loss between sleeve gastrectomy and sleeve gastrectomy with jejunal bypass. A case-control study



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Matías Sepúlveda MD, Munir Alamo MD, Raúl Lynch MD, Gonzalo Castillo MD, Yudith Preiss MD, Ximena Prat MD, Hernán Guzmán MD

Universidad Diego Portales

Centro de Cirugía Bariátrica y Metabólica - Hospital Dipreca,  
Santiago, CHILE

MSChCBM – MSCCh – FASMBS - IFSO

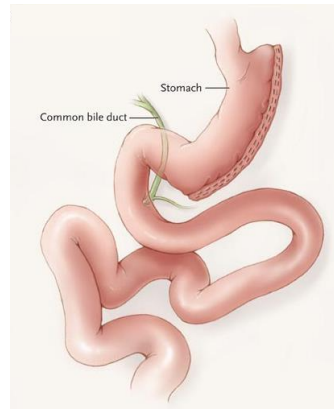


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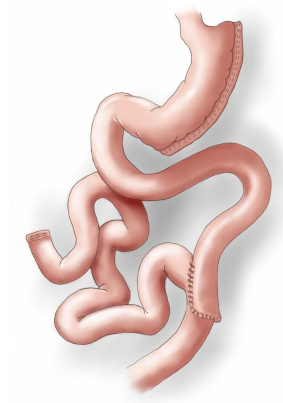
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## Objective

# To compare long-term weight loss between sleeve gastrectomy and sleeve gastrectomy with jejunal bypass



versus





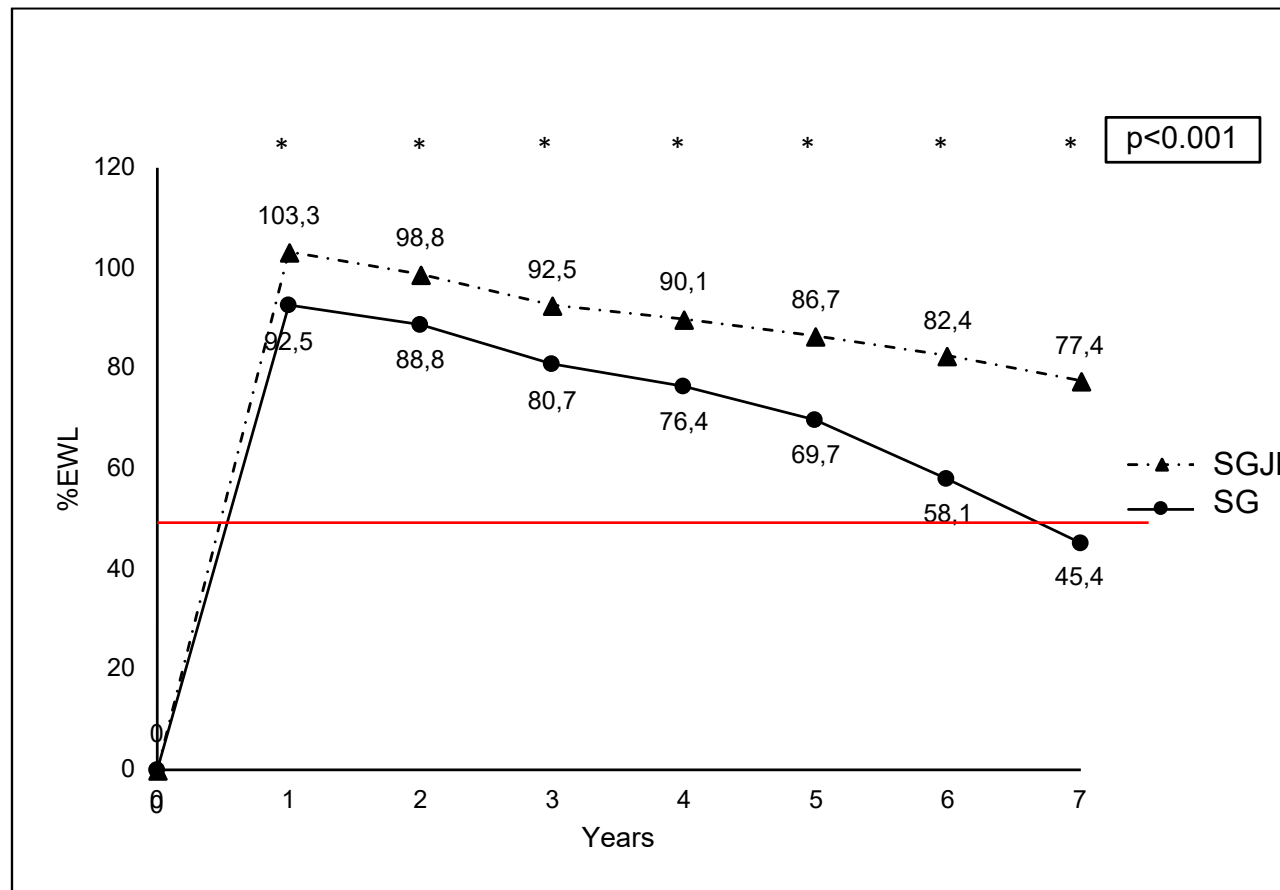
## RESULTS

**Tabla 1: Baseline characteristics of the groups**

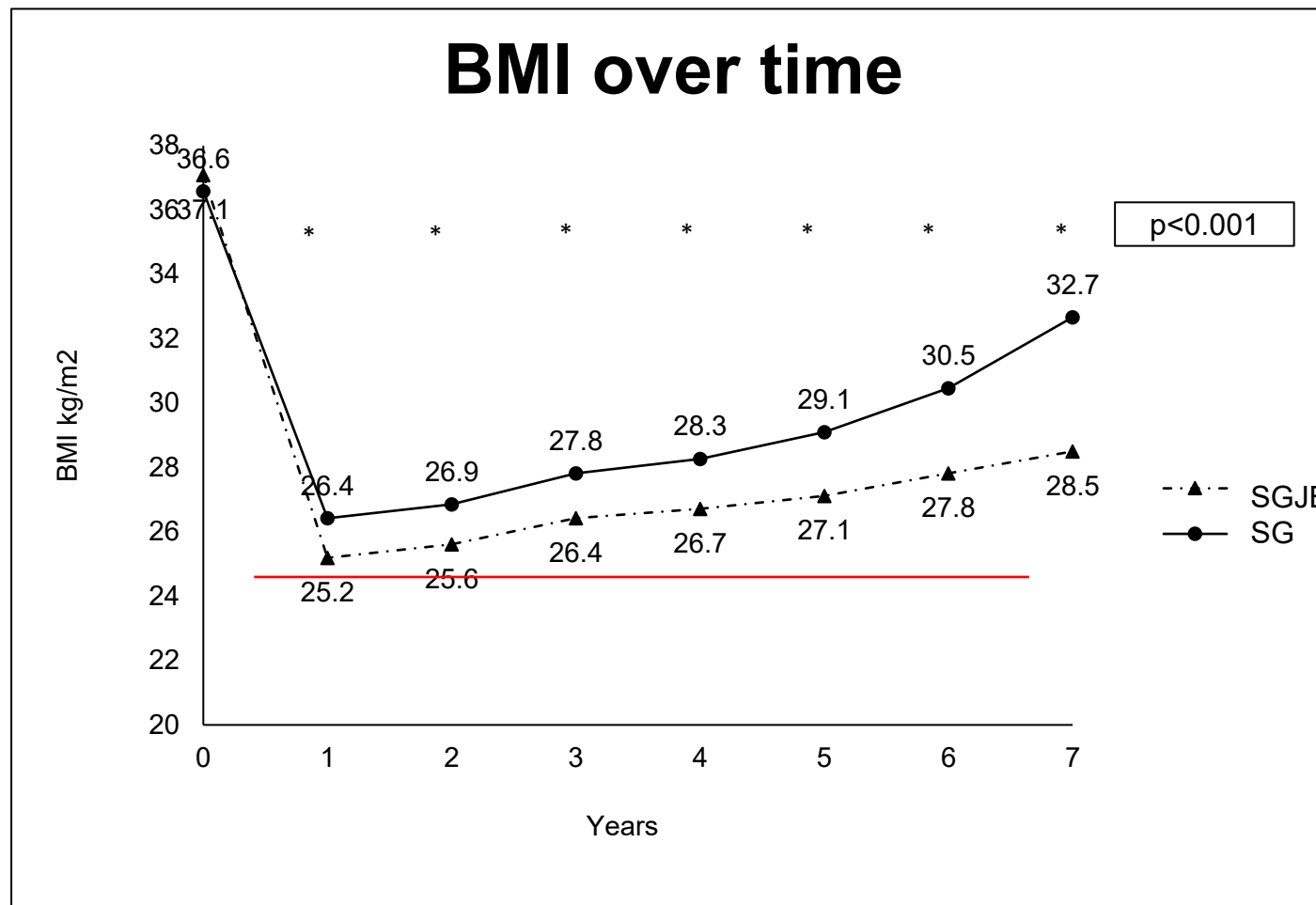
	SGJB	SG	p value
Total N	149	145	
Female gender (%)	100 (70.42%)	100 (76.92%)	0.225
Mean age (years)	40.5 ± 1.06	37.8 ± 0.97	0.06
Preoperative weight (kg)	100.9	98.5	0.192
Preoperative BMI (kg/m <sup>2</sup> )	36.9 ± 0.34	36.5 ± 0.34	0.336
Operative time (minutes)	127 ± 2.2	89.3 ± 3.2	< 0.01



# % Excess weight loss in SG and SGJB at 7 years



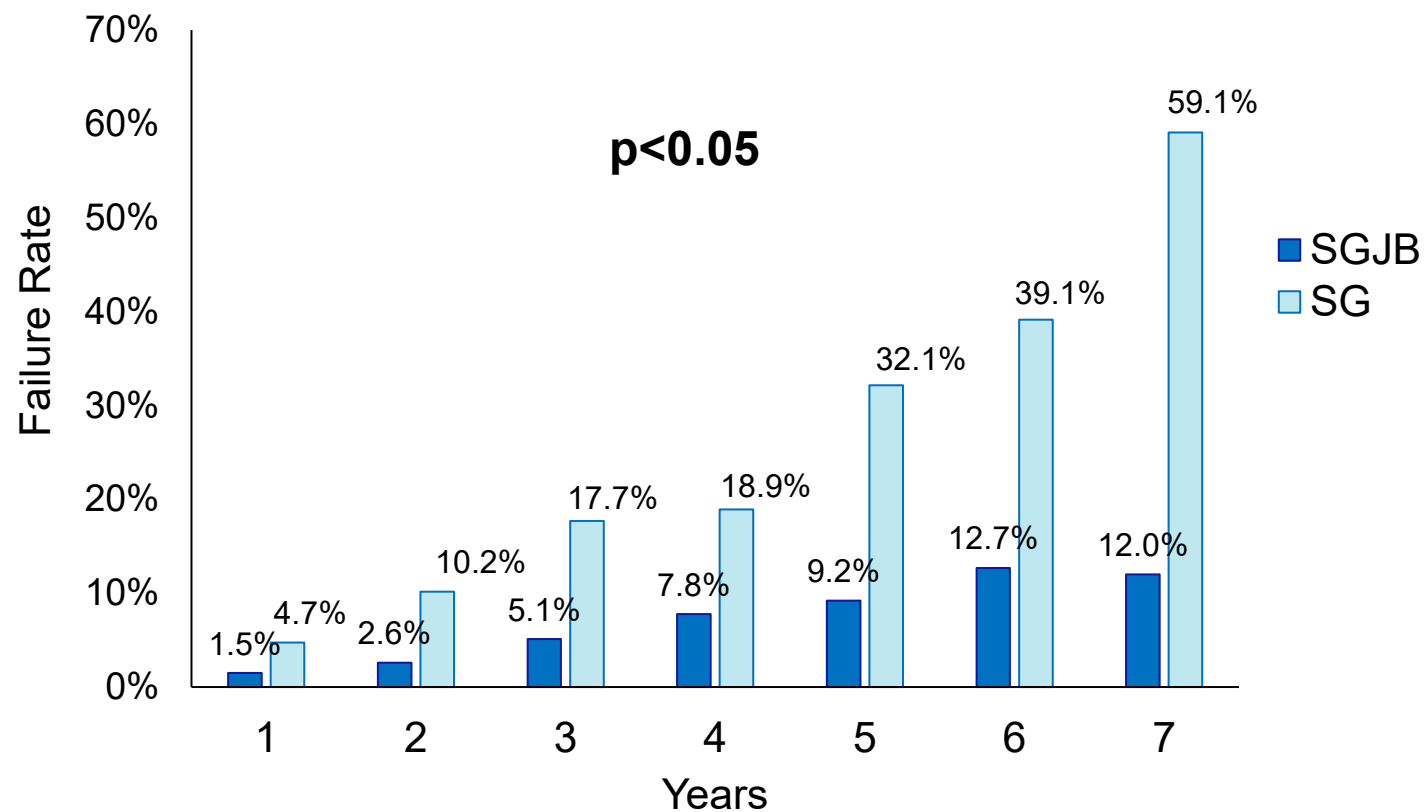
	0	1	2	3	4	5	6	7
SG	149	149 / 130	149 / 121	149 / 115	149 / 113	149 / 47	105 / 39	39 / 22
SGJB	145	145 / 134	145 / 116	145 / 98	145 / 90	145 / 87	124 / 63	88 / 50
	% FOLLOW UP AT YEARS							
SG %	100%	87%	81%	77%	76%	77%	45%	56%
SGJB %	100%	92%	80%	68%	62%	60%	51%	57%



	0	1	2	3	4	5	6	7
SG	149	149 / 130	149 / 121	149 / 115	149 / 113	149 / 47	105 / 39	39 / 22
SGJB	145	145 / 134	145 / 116	145 / 98	145 / 90	145 / 87	124 / 63	88 / 50
% FOLLOW UP AT YEARS								
SG %	100%	87%	81%	77%	76%	77%	45%	56%
SGJB %	100%	92%	80%	68%	62%	60%	51%	57%

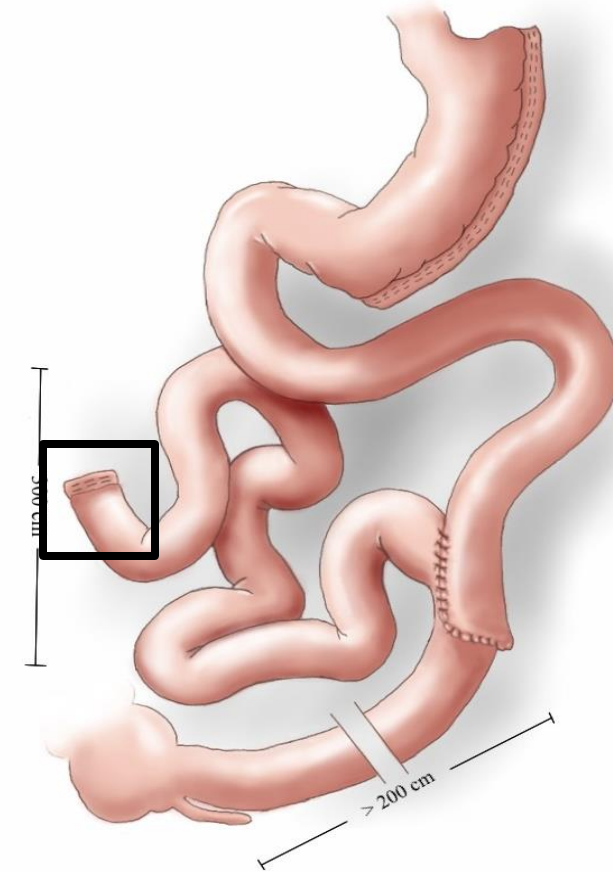


## Failure rate (EWL<50%) in SG and SGJB over the years



# Methods

- 10 patients submitted to laparoscopic cholecystectomy for gallbladder disease post SGJB
- Mean post SGJB time: 18 mo (11-25)
- Informed consent
- **Tissue Cultures**
- **Gramm**
- **Histological study of samples**



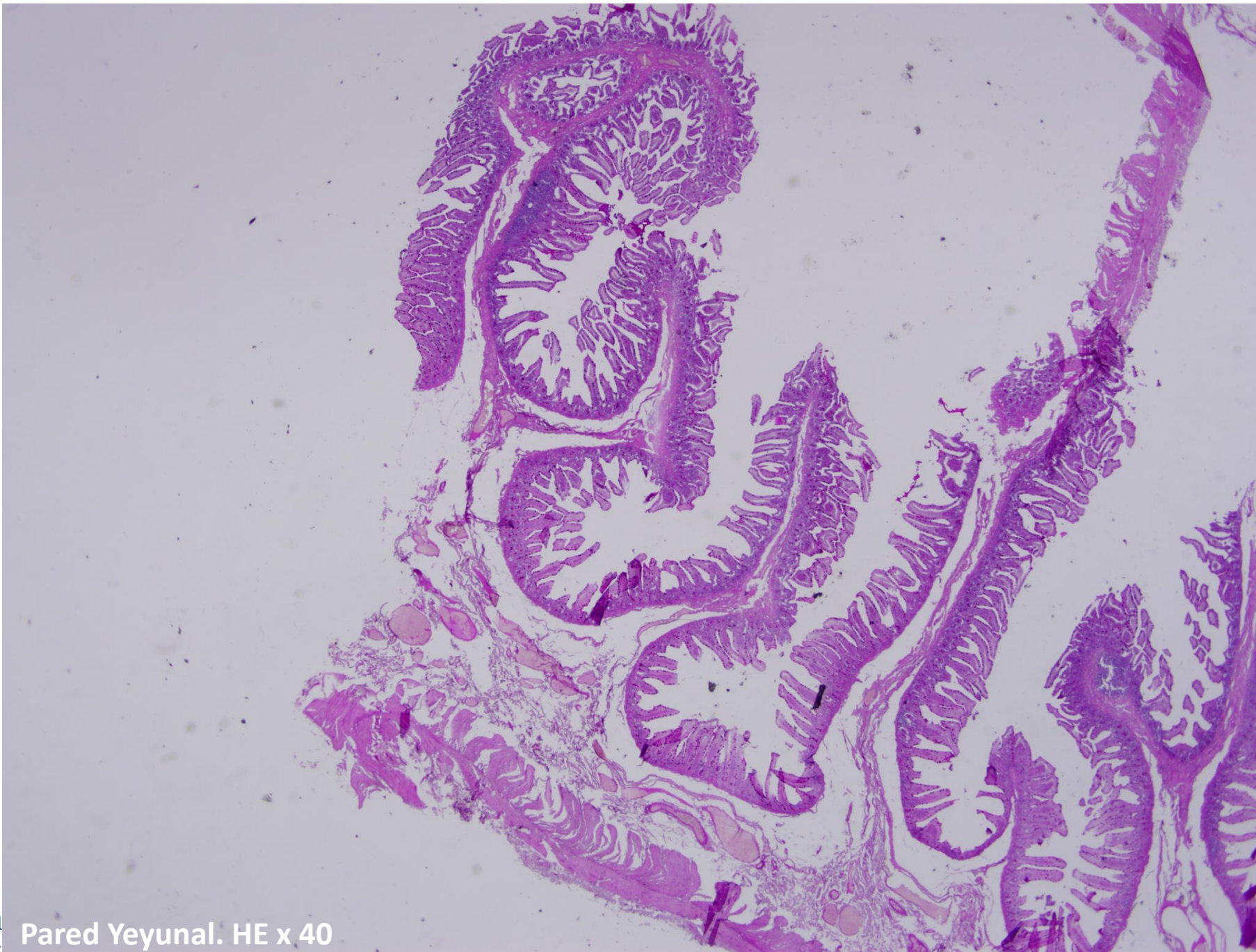
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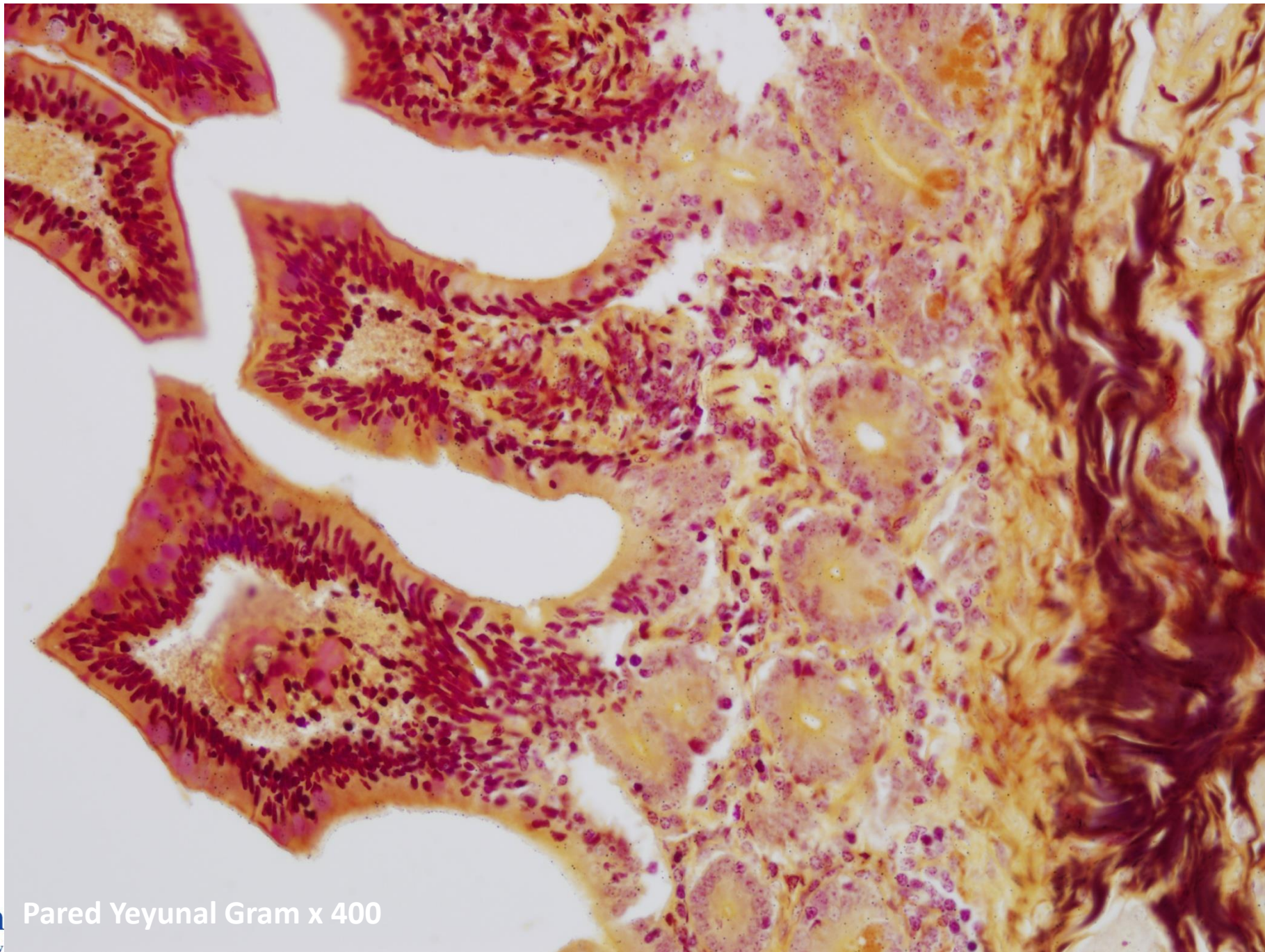


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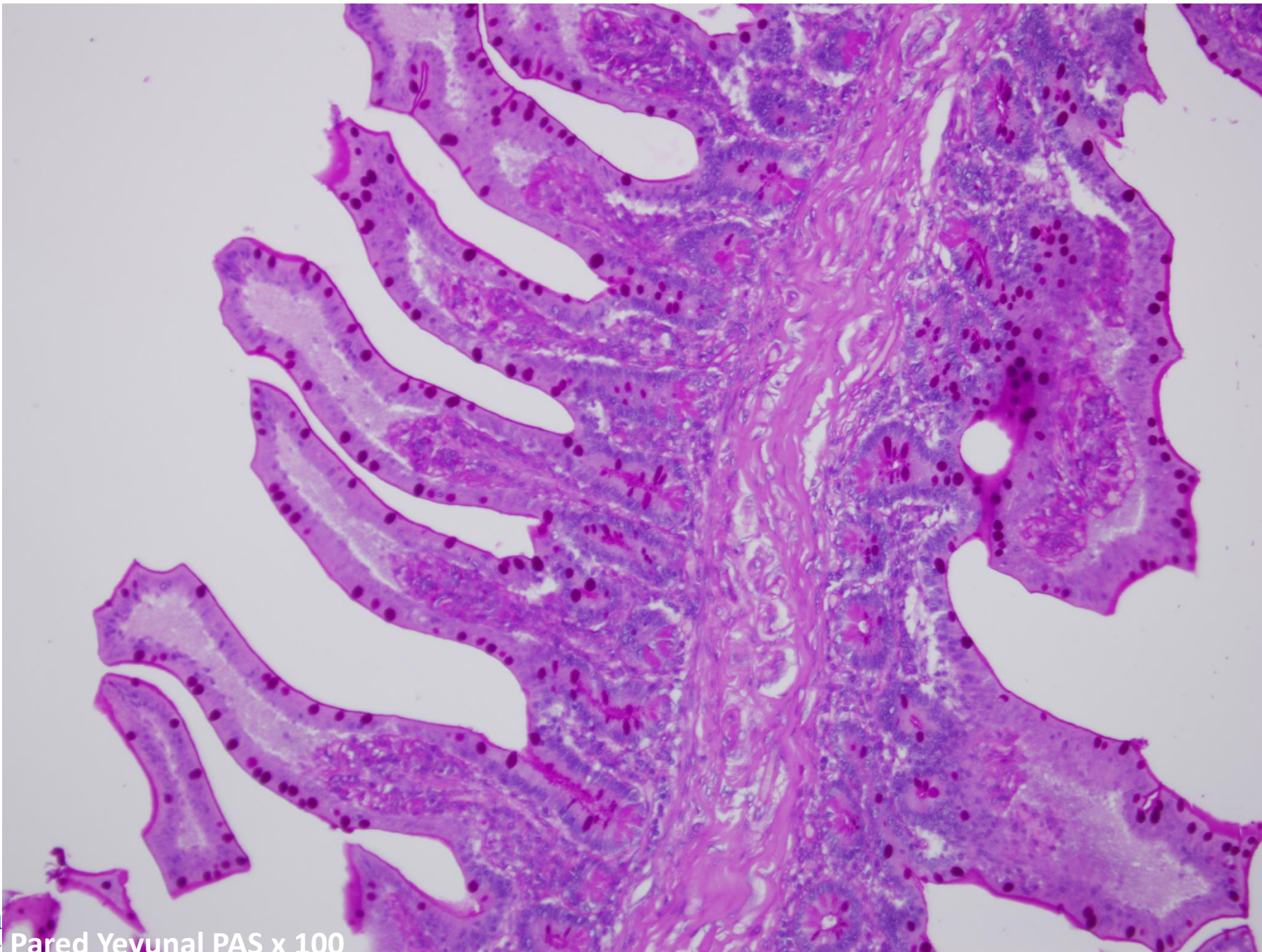


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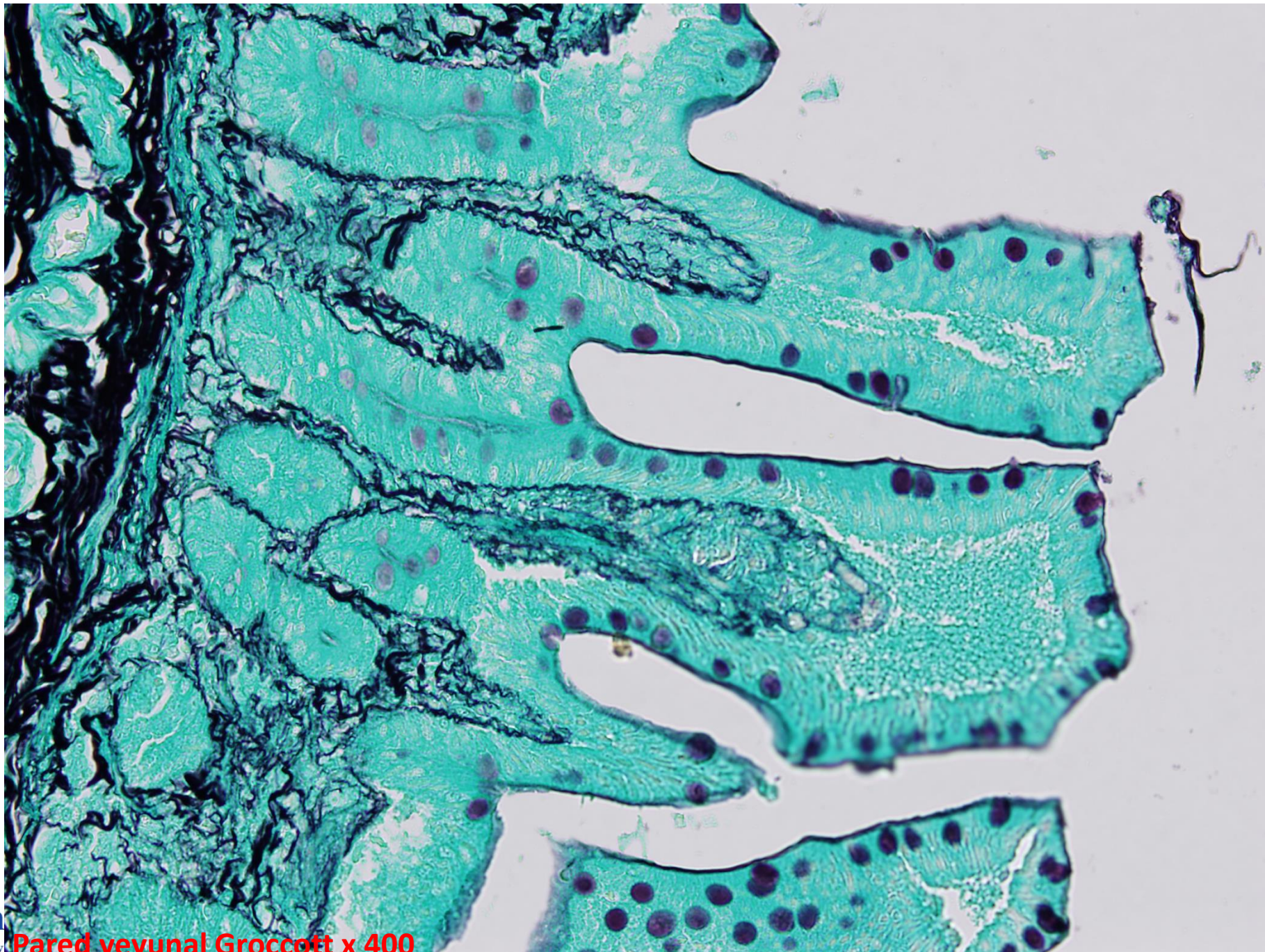


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# Sleeve gastrectomy with jejunal bypass

## 10-year follow-up

Autores: Dr. Matías Sepúlveda, Dr. Andrés San Martín, Dr. Munir Alamo, Dra. Gabriela Rodríguez, Dr. José Álvarez, Dra. Luana Wosiack

Award for the best research paper at the Chilean Congress of Bariatric Surgery 2024, La Serena



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## Sleeve Gastrectomy plus Jejunum Bypass

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# Resultados

1)

2)

3)



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# Resultados

4)

5)

6)



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# Conclusión



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Original Article

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# Novel metabolic surgery: first Asia series and short-term results of laparoscopic proximal jejunal bypass with sleeve gastrectomy

Chih-Kun Huang<sup>1</sup>, Rajan Mahendra<sup>2</sup>, Ming-Che Hsin<sup>1</sup>, Po-Chih Chang<sup>3</sup>

<sup>1</sup>Body Science & Metabolic Disorders International (B.M.I) Medical Center, China Medical University Hospital, Taichung, Taiwan, China;

<sup>2</sup>Department of Surgery, Medcare Hospital, Dubai, United Arab Emirates; <sup>3</sup>Department of Surgery, Kaohsiung Medical University Hospital, Kaohsiung, Taiwan, China

*Contributions:* (I) Conception and design: CK Huang; (II) Administrative support: PC Chang; (III) Provision of study materials or patients: MC Hsin; (IV) Collection and assembly of data: R Mahendra; (V) Data analysis and interpretation: R Mahendra; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

*Correspondence to:* Chih-Kun Huang, MD. Body Science & Metabolic Disorders International (B.M.I) Medical Center, China Medical University Hospital, Taichung, Taiwan, China. Email: dr.ckhuang@hotmail.com.

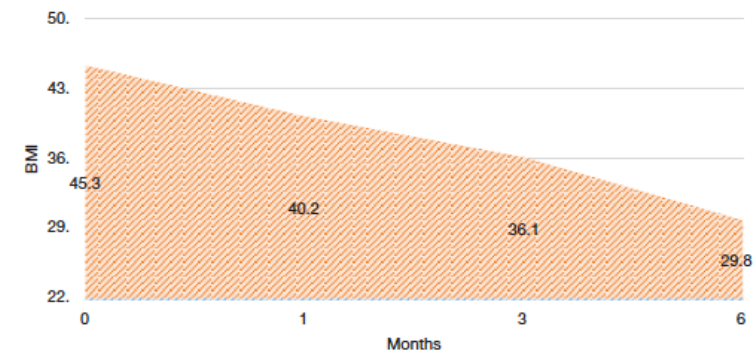


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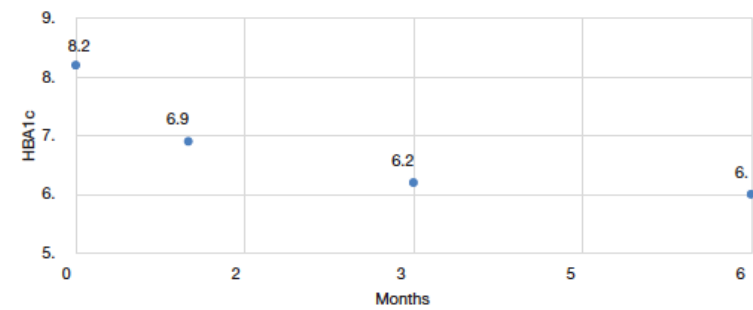
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**Table 1** Patient characteristics and pre-surgical data

Characteristics	Number (N=65)/values	Range/% (SD)
Age (years)	38.72	19–71
Females	33	50.7%
BMI preoperative	45.3	27–92.8/11.74%
T2DM	37	56.9%
Duration T2DM (months)	4.96	1–15
HBA1c	8.26	5.9–11.9
Fasting sugar (mg/dL)	166.4	94–343/55.9%
C-peptide (ng/mL)	3.7	1.5–11.4 (SD: 2.01)
Hypertension	44	67.69%
Dyslipidaemia	56	86.15%
Fatty liver	63	96.92%



**Figure 2** BMI (mean) over 6 months post-operatively.



**Figure 3** HBA1c levels (mean) over 6 months post-operatively.

# Huan et al. 2017



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easy reproducibility, reversibility of bowel anatomy and comparable results would translate it to wider adoption worldwide soon. It's a logical combination of excellent results from sleeve gastrectomy with minimal malabsorption to add in weight loss, would play an important role in remission of diabetes. Long term results and comparative studies with other surgeries in vogue are definitely required to validate this concept.



### 3.2. Sleeve gastrectomy with proximal jejunal bypass (Figure 28)

#### 3.2.1. Indication and contraindication

The indications and contraindications of PJB-SG are the same as that of the conventional stand-alone sleeve gastrectomy. Furthermore, this can also be offered as a metabolic surgery for patients with BMI between 27.5 and 35 with type 2 Diabetes.



Figure 28. Schematic diagram of LPJB-SG.

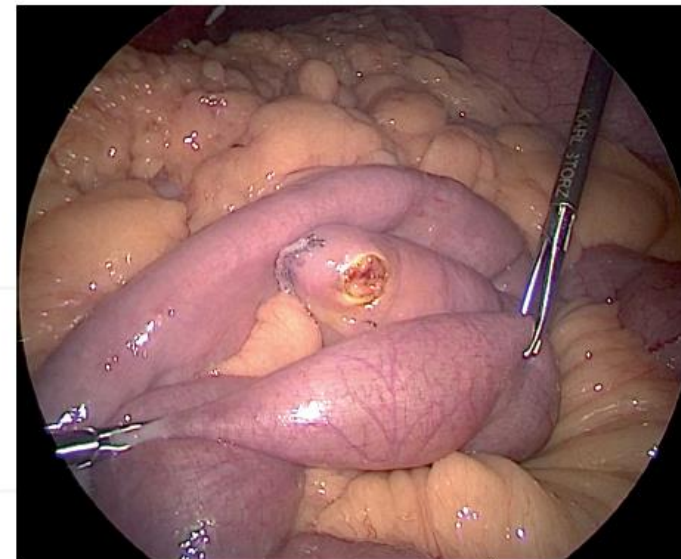
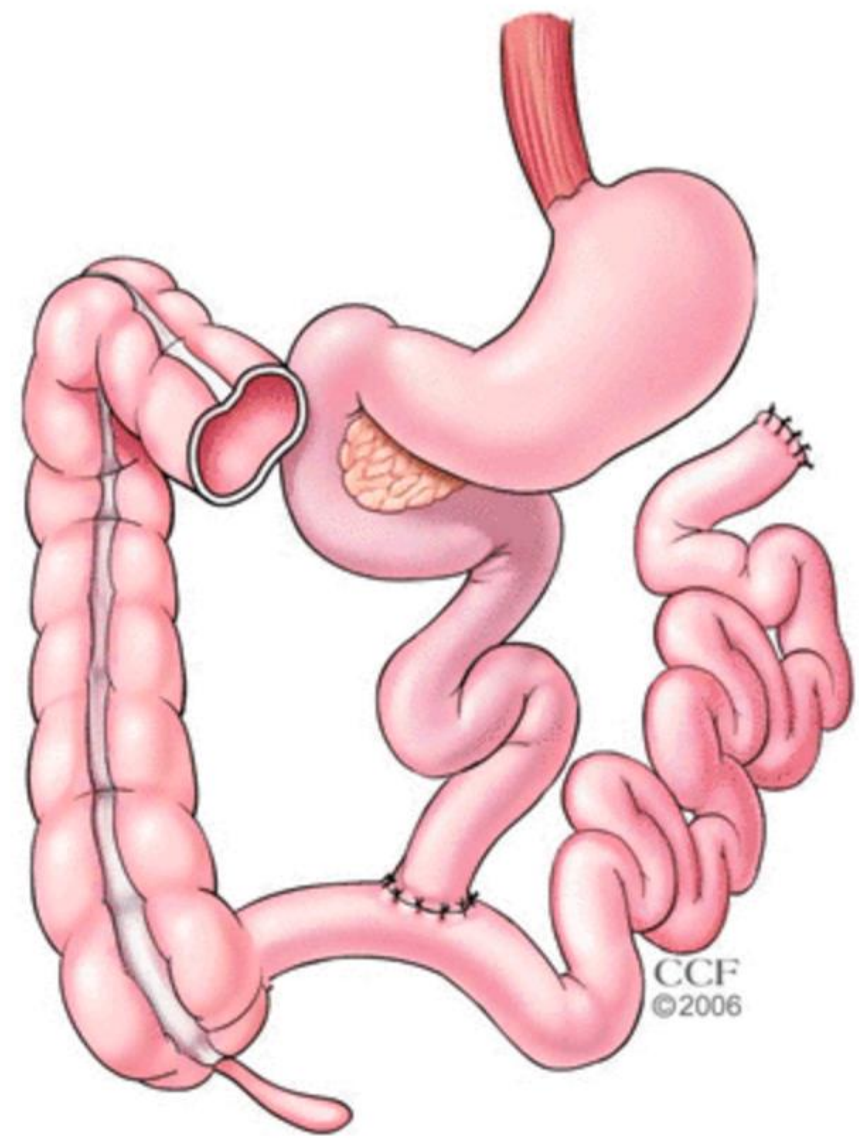


Figure 31. 300 cm bypassed proximal jejunum.



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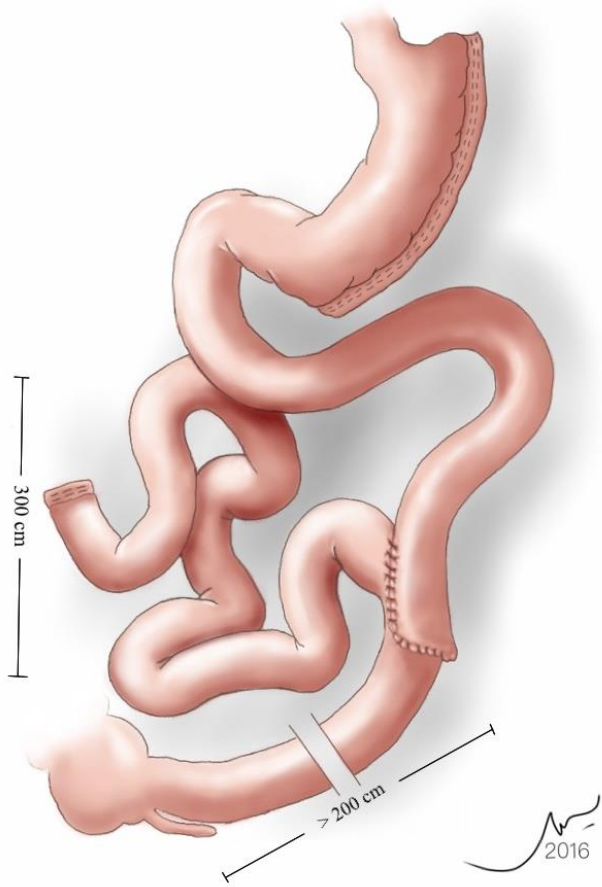
Bypass yeyunoileal



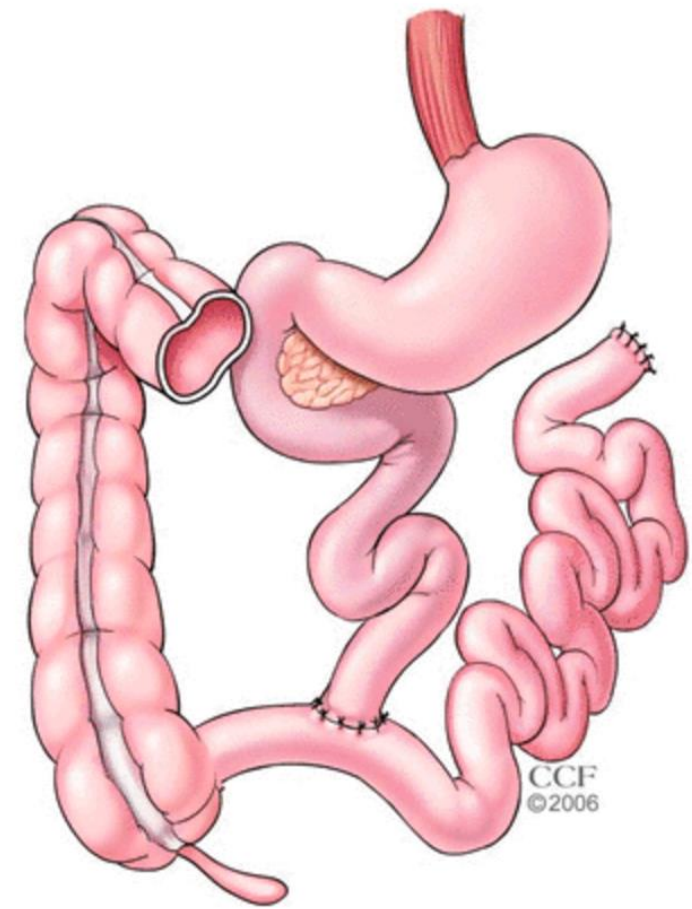


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≠



SGJB

Jejunioileal bypass (JIB)





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# ¿Why not?

- 25.000 JIB were done
- Good results but lot of complications in the mid-term:
  - Intractable diarrhea
  - Electrolytic imbalance
  - Kidney stones
  - Hypoalbuminemia
  - Hepatic failure



Abandoned at the  
end of 1980 and  
reversion or  
conversion to  
RYGB

- Holzbach RT. Am J Clin Nutr. 1977;30(1):43-52.
- Iber FL. Am J Clin Nutr. 1977;30(1)





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# ¿Why not?

- Reversion or conversion occurred in the
- Among the causes are:
  - Anaerobic bacterial overgrowth → “liver toxicity by endotoxins”
  - Caloric-protein malnutrition
  - Excessively rapid weight loss
  - Impaired biliary acid metabolism

- O’leary JP. Pathogenesis of hepatic failure following jejunioileal bypass. Gastroenterology 1974;66:859
- Hollenbeck JI An etiological basis for fatty liver after jejunioileal bypass. J Surg Res 1975;18: 83
- Moxley RT. Protein nutrition and liver disease after jejunioileal bypass for morbid obesity. New Engl J Med 1974;290: 921

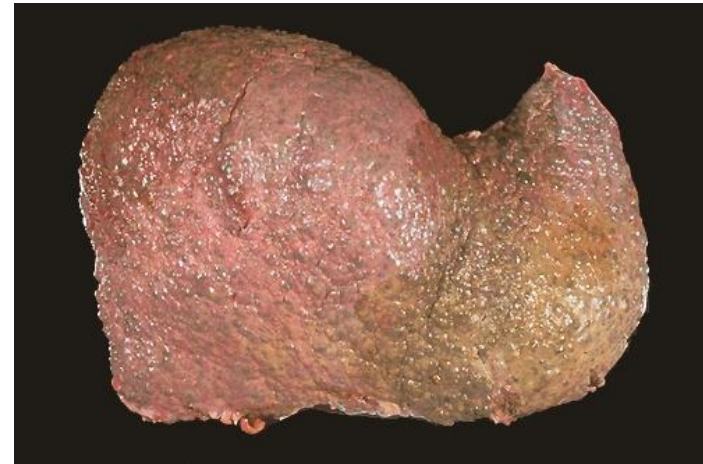


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# ¿Why not?

- Mild liver damage 25%
  - Hepatic Cirrhosis 5%
  - Hepatic Failure 1-2%
- 
- Mortality from hepatic failure 2-3%



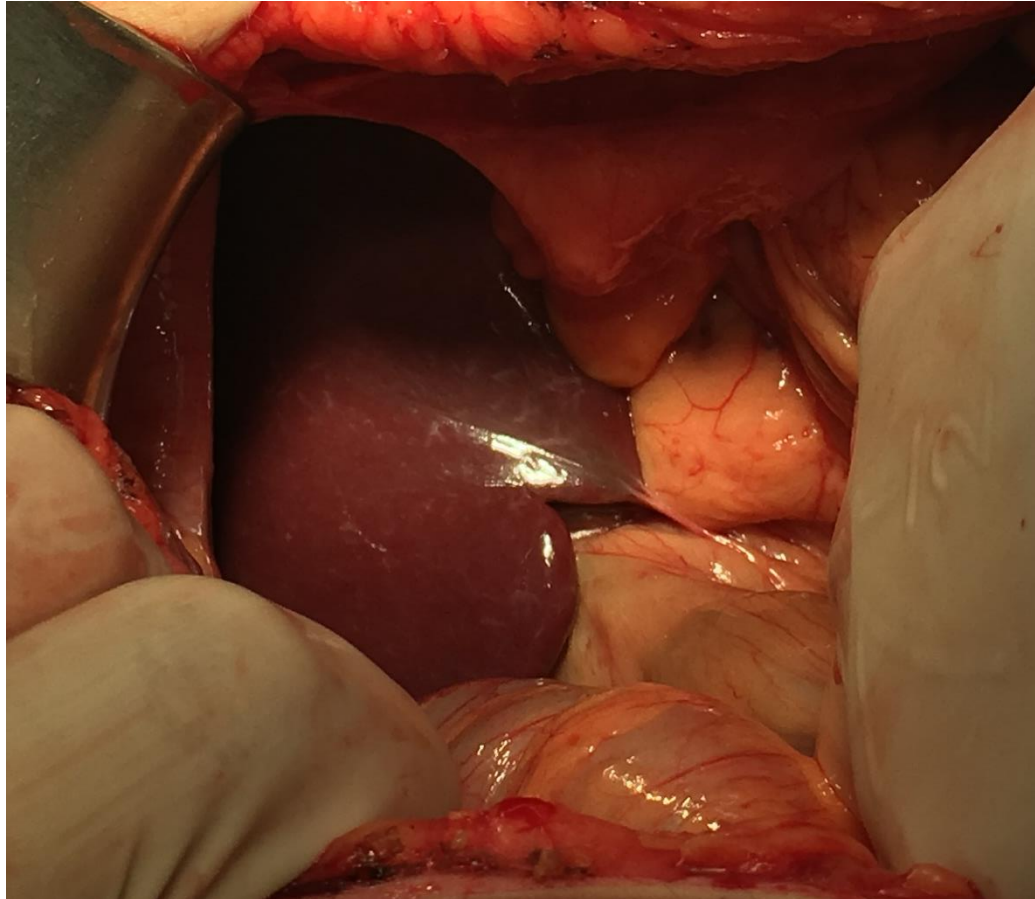
- Brown R. Am J Surg 1974;127:53-8
- Deitel M. Obes Surg 1993;3:247-52

# Sleeve gastrectomy and jejunal bypass on 2004



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Female: T.G.  
45 years  
Initial BMI: 36  
Actual BMI: 23

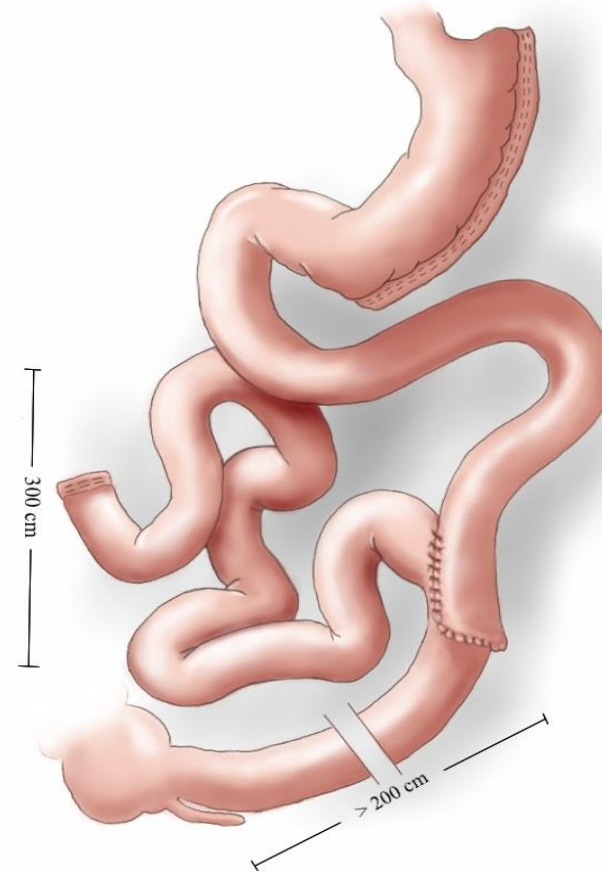
1 week with vomit,  
obstipation.  
TAC: compatible  
Dg: Bowel obstruction

Laparotomy for adhesions.  
Internal hernia resolved.

Liver of healthy look  
Defunctionalized loop of 80  
cm, 3 cm of diameter, no  
inflammatory signs

# Methods

- 3 patients submitted to laparoscopic cholecystectomy for gallbladder disease post SGJB
- Resection of the distal tip of the functionless loop with stapler 45 mm White load (ETS 45<sup>®</sup>, Johnson & Johnson)
- Informed consent
- Obesity center Dipreca Hospital, Santiago Chile

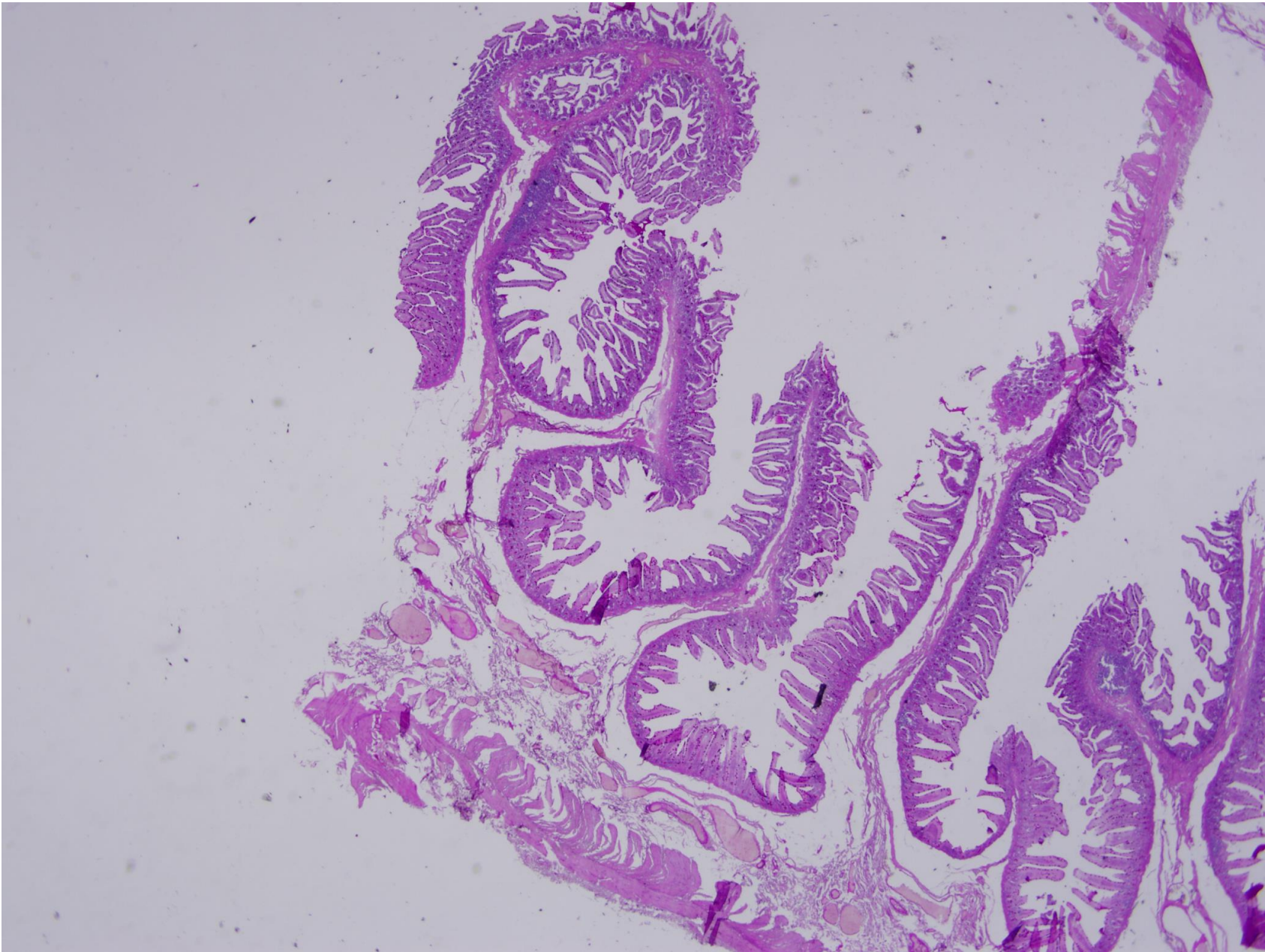


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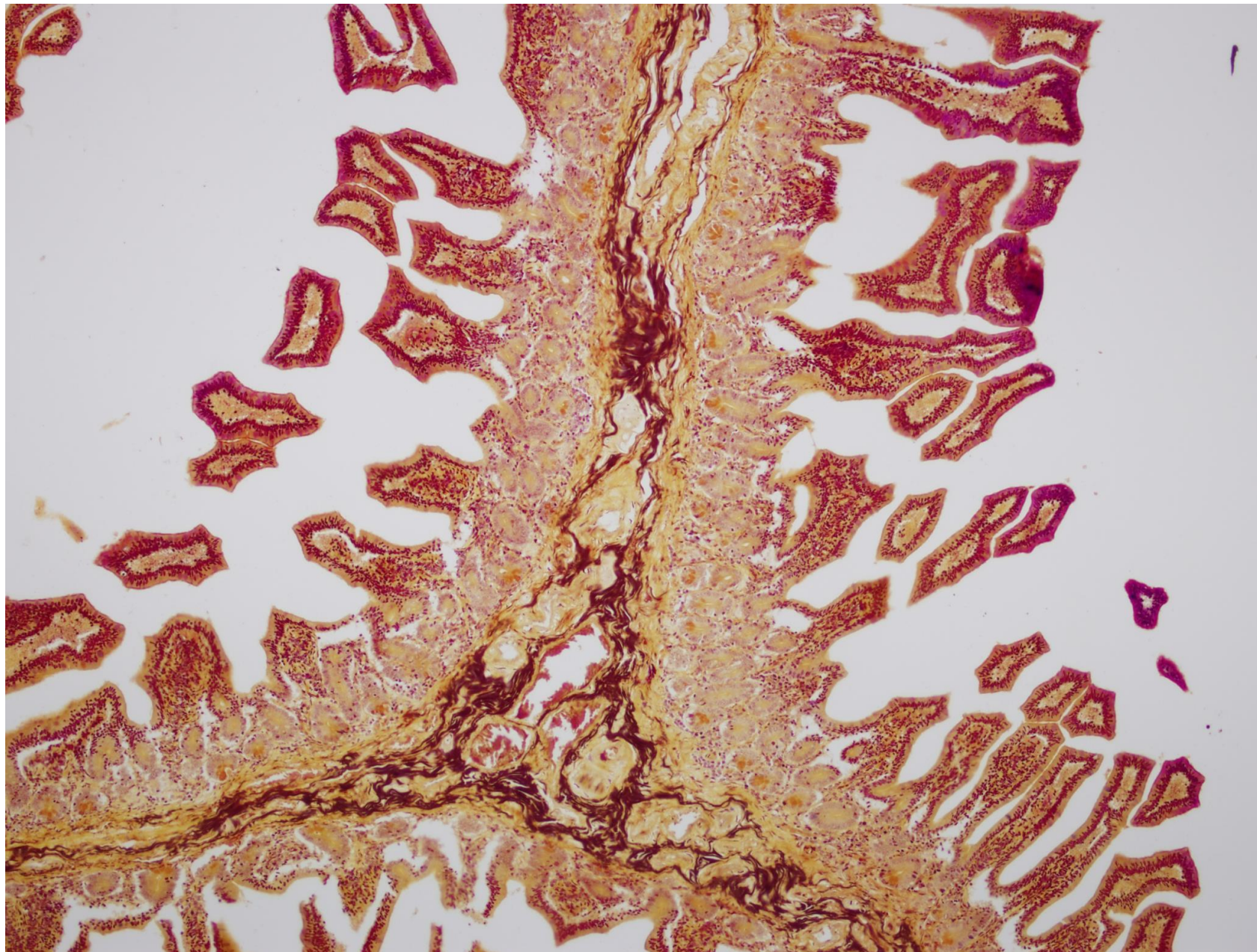
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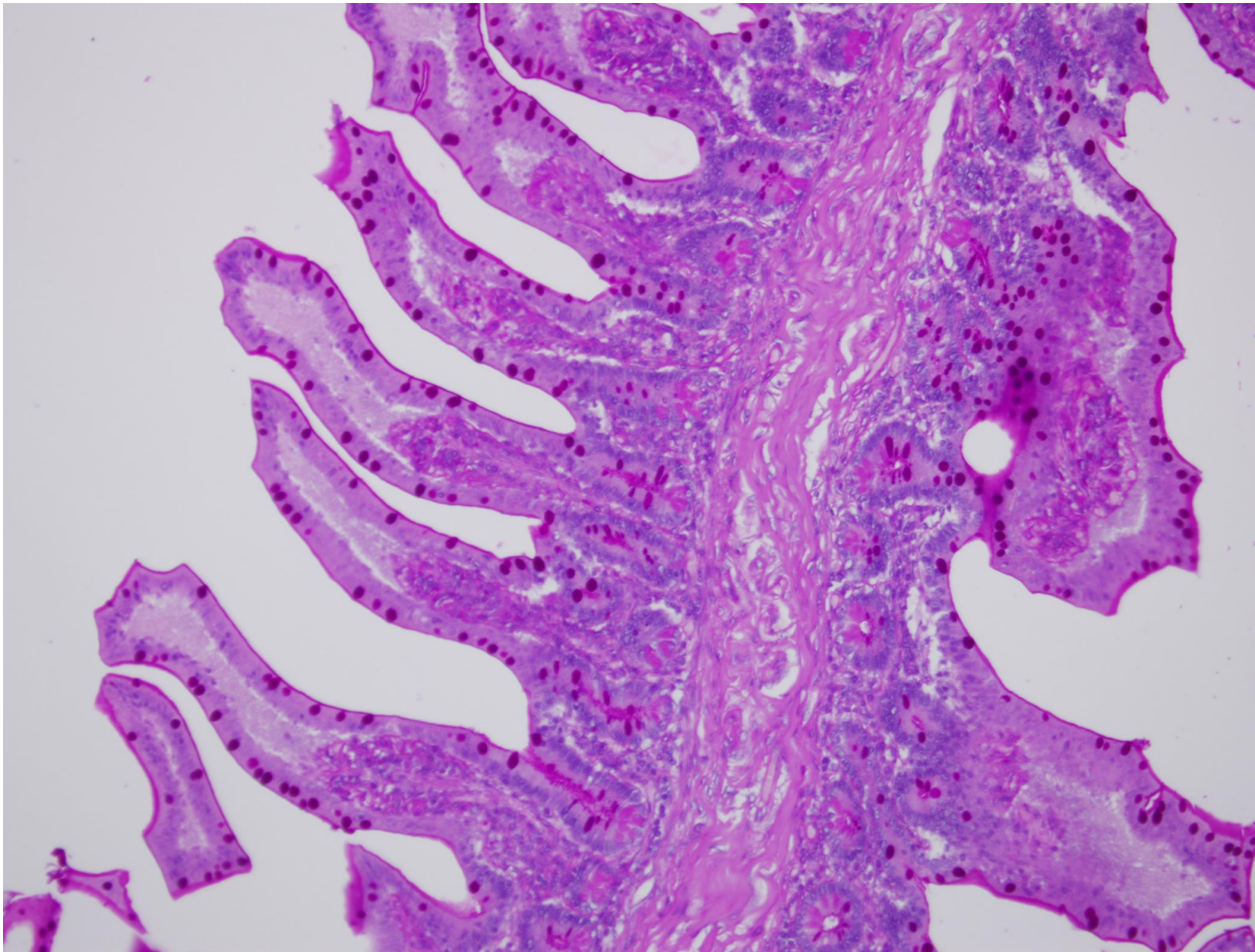


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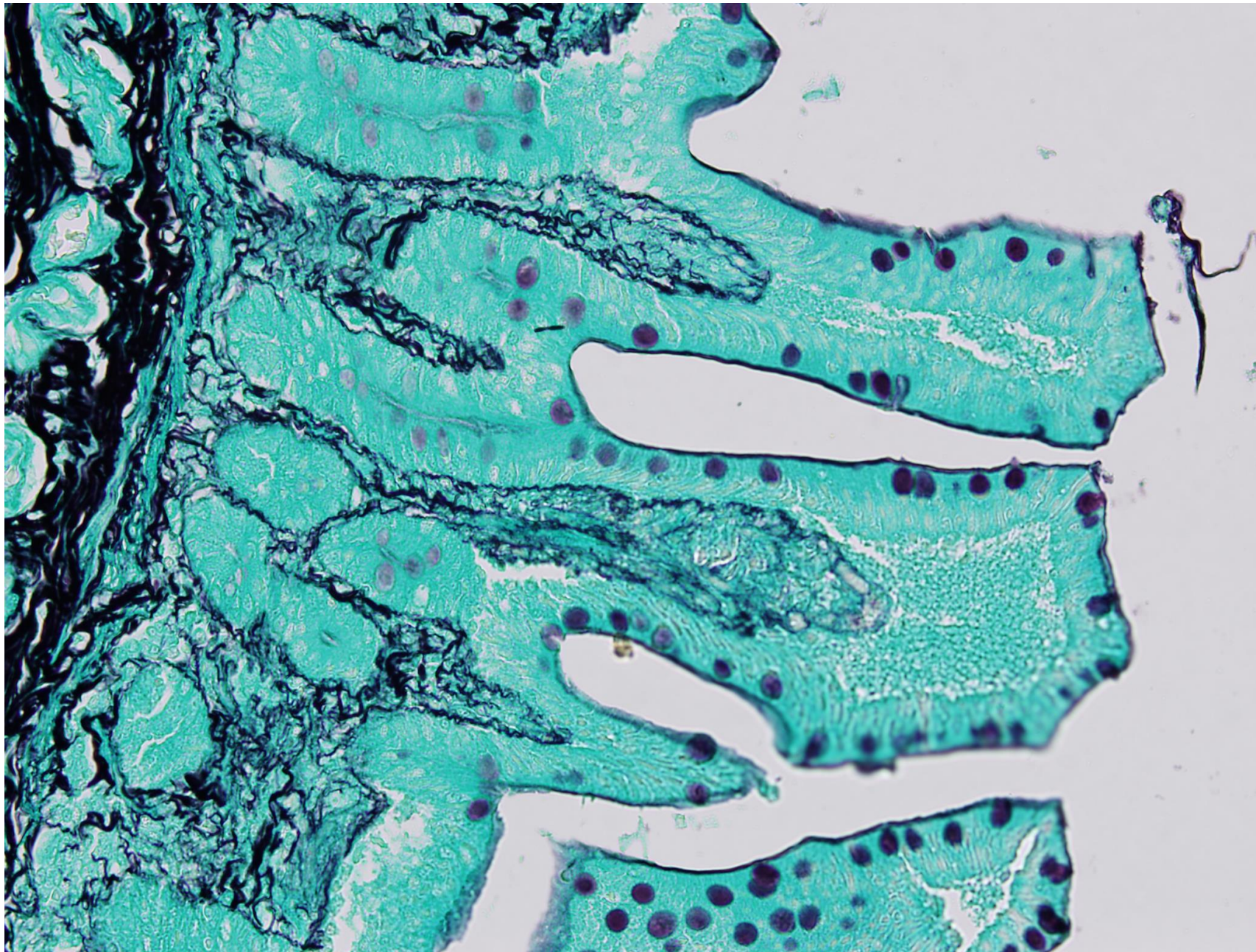
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- 2005: Preliminary Results in the LXXVII Congreso de la Sociedad Chilena de Cirugía, Pucón, Chile

### **PUBLICATION 2006 Alamo et al. Vertical Isolated Gastroplasty with Gastro-enteral Bypass: Preliminary Results. Obesity Surgery 2006: 16;1265-66**

2008 25th ASMBS Meeting, Washington, USA (Plenary Session)

- 2008 III IFSO Latinoamericano, Viña del Mar, Chile (Sesión Plenaria)
- 2009 XIV IFSO Meeting, Paris, France (Poster)
- 2010 27th ASMBS Meeting, Las Vegas, USA (Poster)
- 2010 XV IFSO Meeting, Long Beach, USA (Plenary Session)
- 2011 28th ASMBS Meeting, Orlando, USA (Poster)
- 2011 XV IFSO Meeting, Hamburg, Germany Plenary session
- 2012 29th ASMBS Meeting San Diego Award Poster



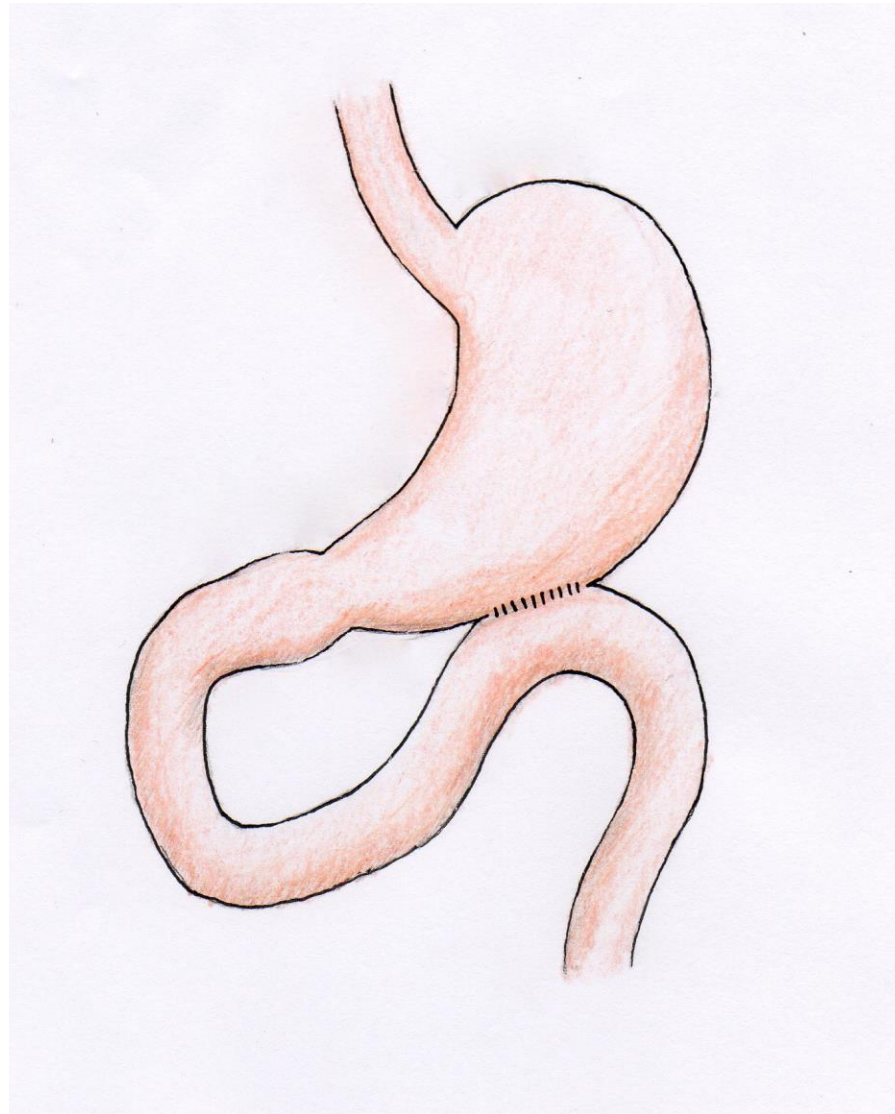
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Francesco Rubino



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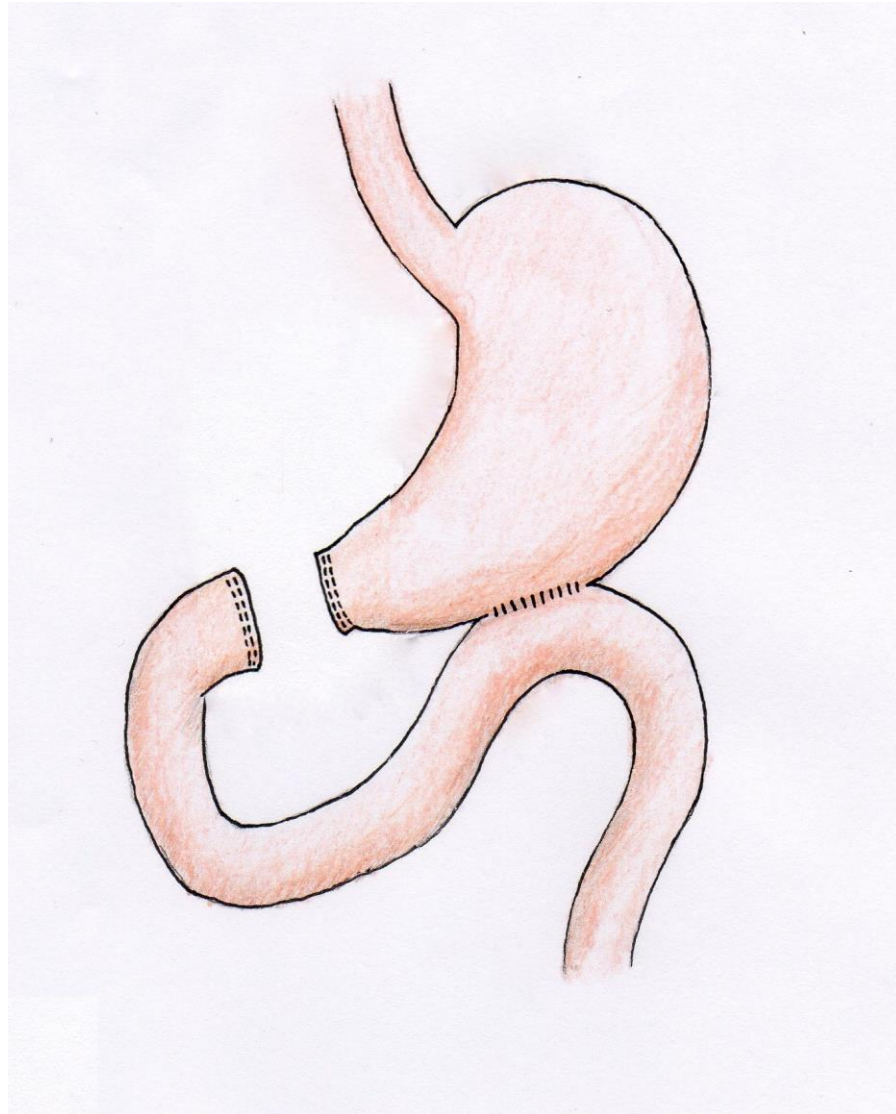




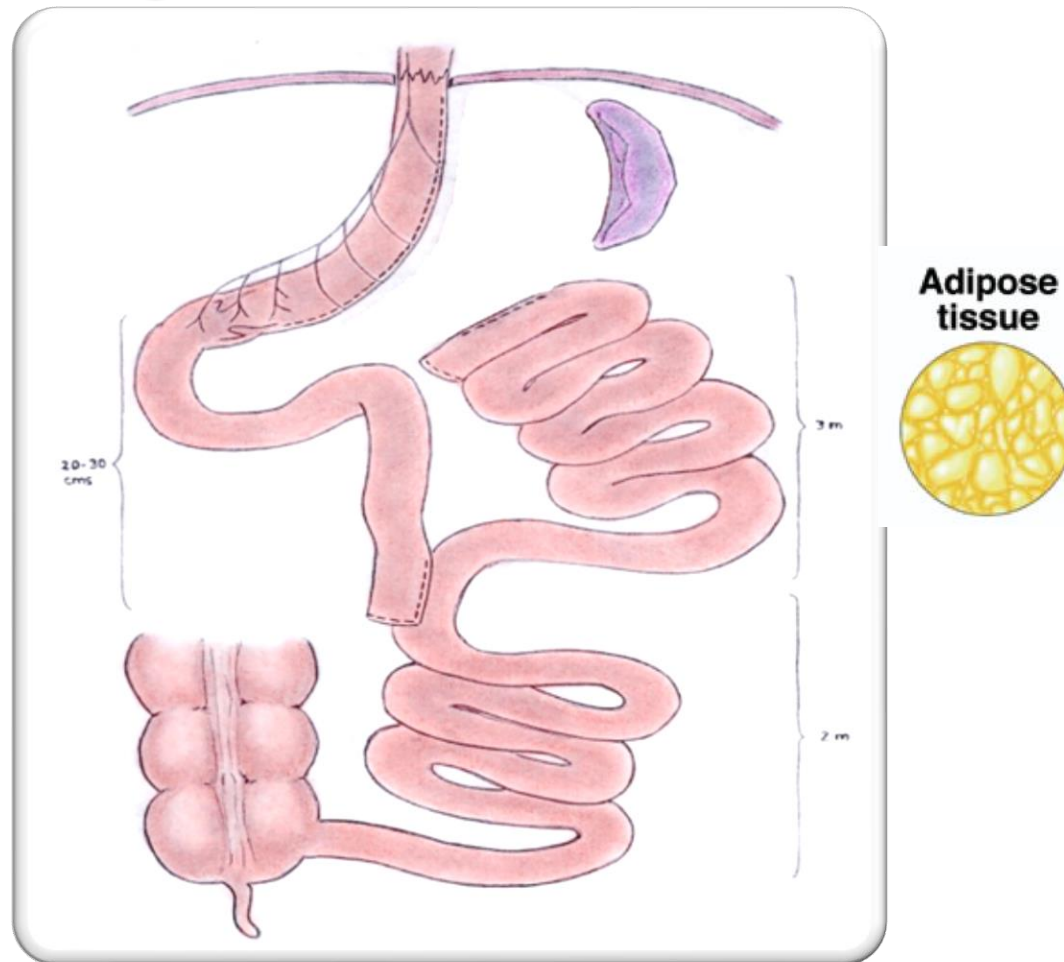
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Francesco Rubino



# Surgical Technique



Alamo et al. Obesity Surgery 2006: 16;1265-66

Baggio LL, Drucker DJ. Gastroenterology. 2007 May;132(6):2131-57



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ORIGINAL ARTICLE

# Gastric Bypass vs Sleeve Gastrectomy for Type 2 Diabetes Mellitus

*A Randomized Controlled Trial*

Wei-Jei Lee, MD, PhD; Keong Chong, MD; Kong-Han Ser, MD; Yi-Chih Lee, PhD;  
Shu-Chun Chen, RN; Jung-Chien Chen, MD; Ming-Han Tsai, MD; Lee-Ming Chuang, MD

**Conclusions:** Participants randomized to gastric bypass were more likely to achieve remission of T2DM. Duodenum exclusion plays a role in T2DM treatment and should be assessed.

*Arch Surg.* 2011;146(2):143-148



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J Gastrointest Surg. 2012 May;16(5):967-76. Epub 2012 Feb 18.

### **Surgical treatment of type 2 diabetes in patients with BMI below 35: mid-term outcomes of the laparoscopic ileal interposition associated with a sleeve gastrectomy in 202 consecutive cases.**

DePaula AL, Stival AR, DePaula CC, Halpern A, Vencio S.

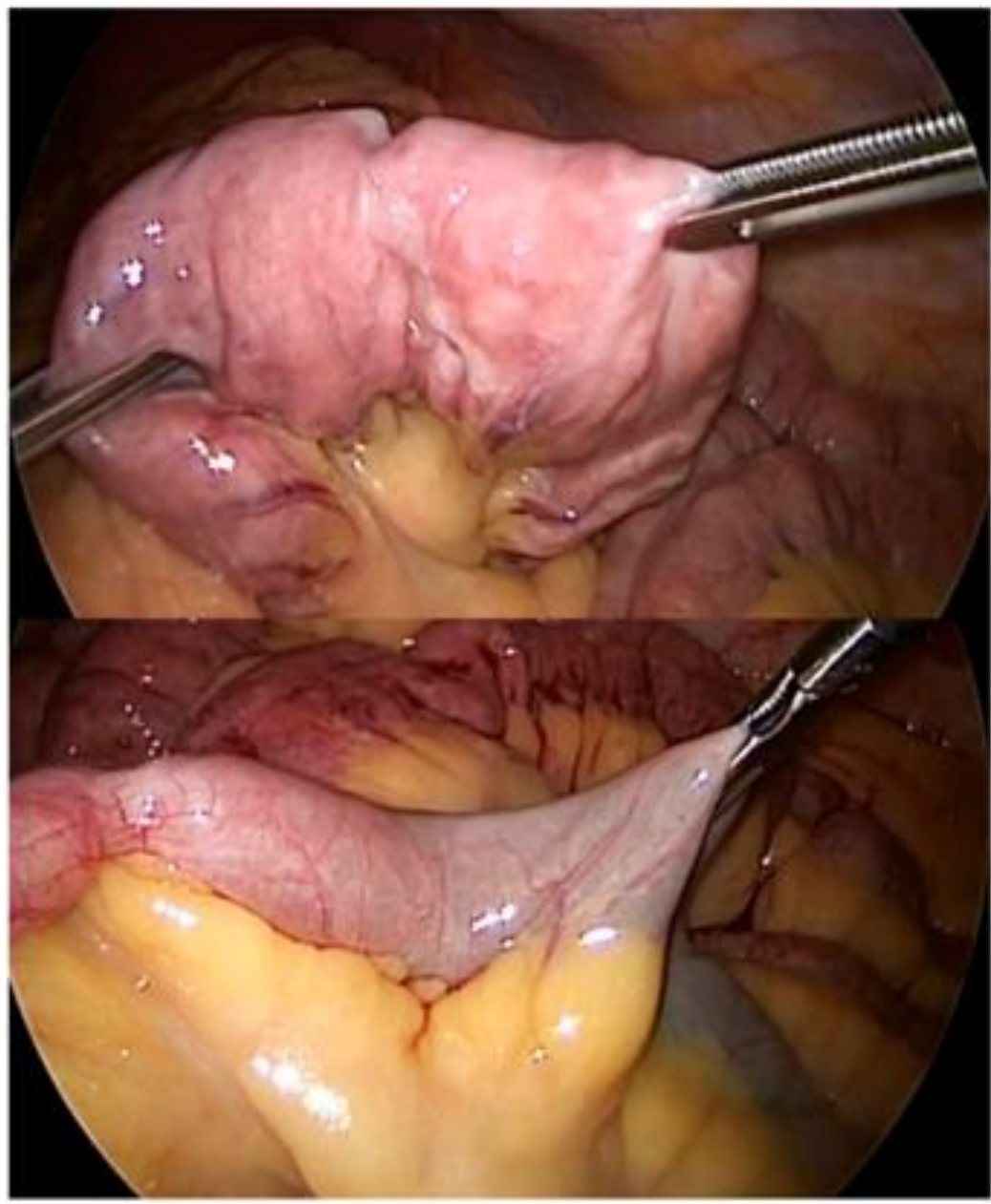
Department of Surgery, Hospital de Especialidades, Av. 136, no. 961, 14° andar, Setor Marista, 74.093-250, Goiânia, Goiás, Brazil. [adepaula@uol.com.br](mailto:adepaula@uol.com.br)

**CONCLUSION:** Both JII-SG and DII-SG demonstrated to be safe, effective, and long-lasting alternatives for the treatment of T2DM patients with BMI <35. Beyond glycemic control, other benefits were achieved.



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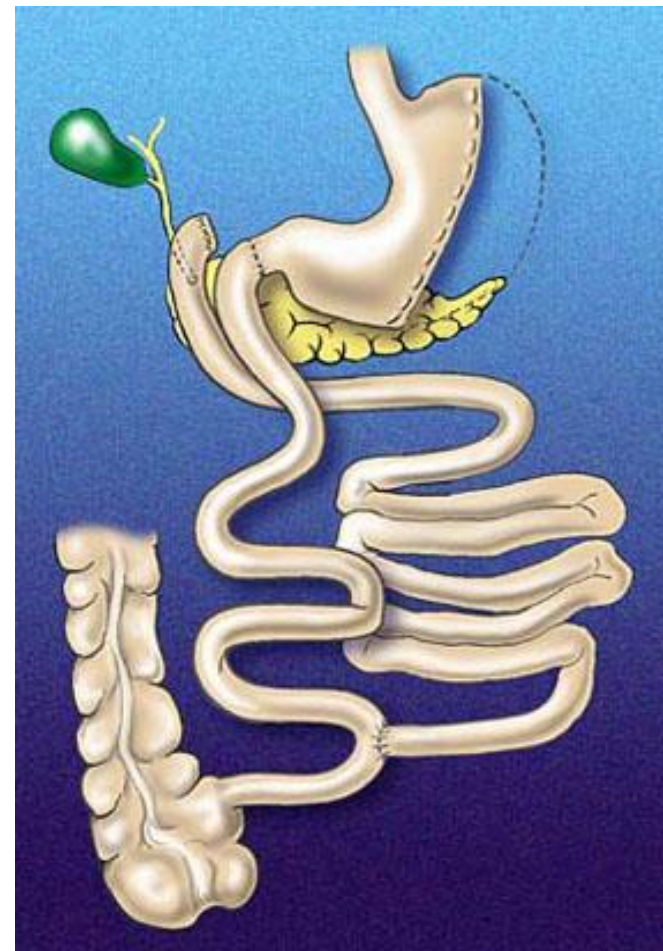
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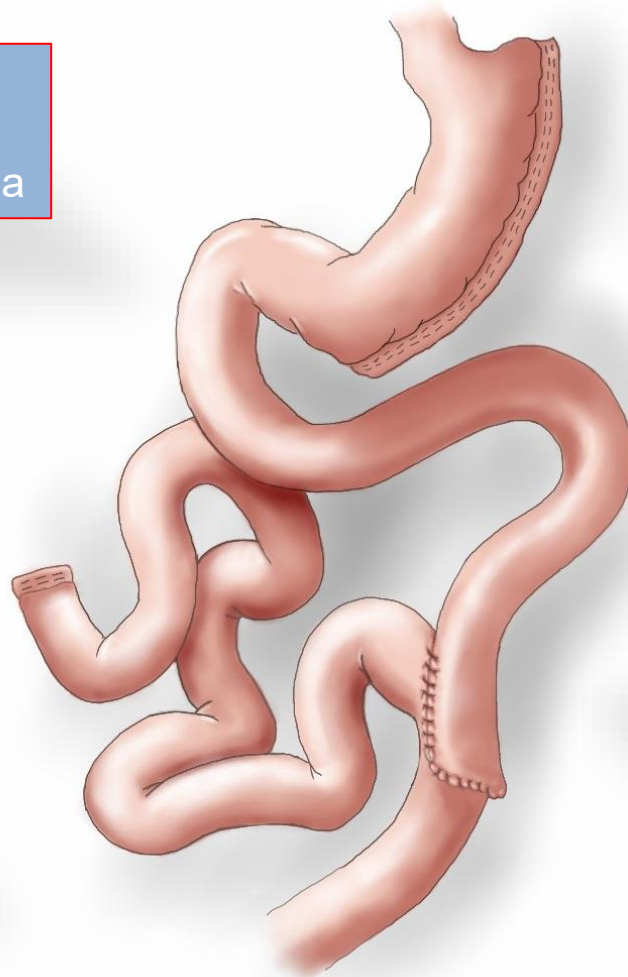


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# Sleeve Gastrectomy with Jejunal Bypass

Duodenal transit  
Less nutritional problems  
Endoscopic access to the ampula

Restriction  
Ghrelin suppression



- Defunctionalized loop  
(jejunum excluded)  
- No bacterial overgrowth

- Jejunum-ileal anastomosis  
280-300 cm  
- 1 intestinal anastomosis