

Surveillance for Gastric Cancer After Roux-en-Y Gastric Bypass

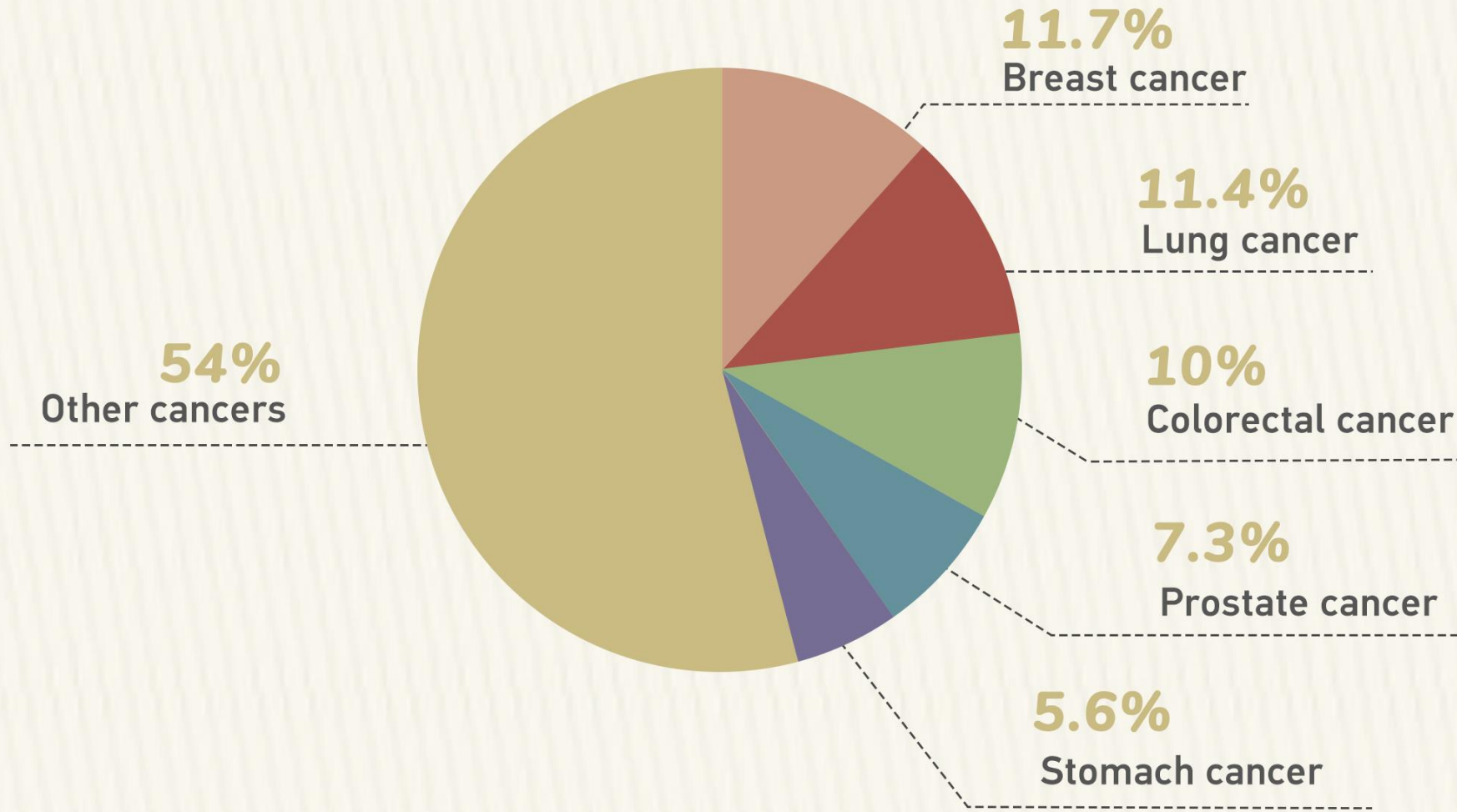
Rami E Lutfi, FACS FASMBS ABOM

President, CEO Chicago Institute of Advanced Surgery
Clinical Professor of Surgery, Rosalind Franklin School of Medicine

Disclosures:

- Consultant:
 - Medtronic
 - Ethicon
 - Gore
 - Storz
 - GT Metabolic
- Educational Grant:
 - Gore
- Medical Advisor:
 - Carrum Health
- Investor
 - GT Metabolic

Most common cancers worldwide in 2020:

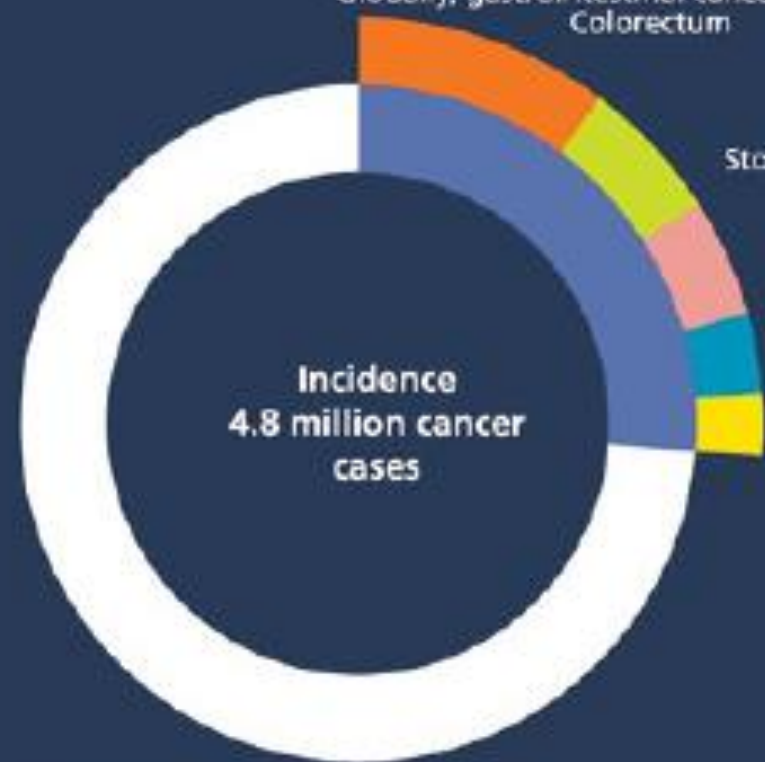


Source: International Agency for Research on Cancer

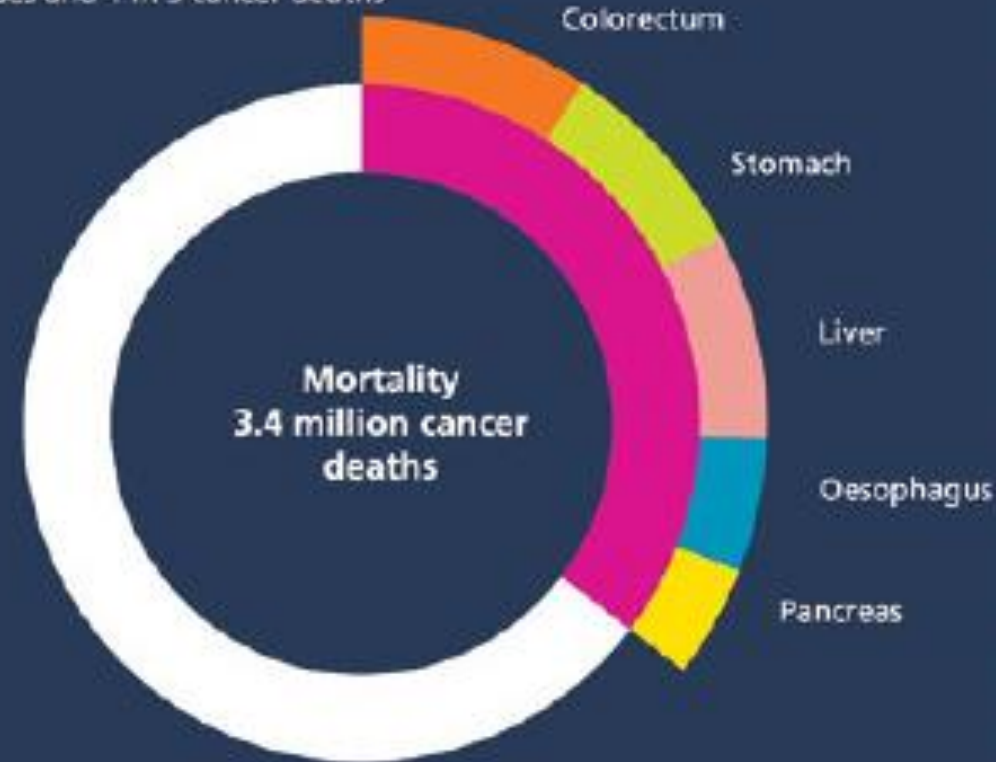
THE STORY OF GASTROINTESTINAL CANCERS

Overall burden

Globally, gastrointestinal cancers (GI) are responsible for 1 in 4 cancer cases and 1 in 3 cancer deaths



Incidence
4.8 million cancer cases



Mortality
3.4 million cancer deaths



And Yet.....

Epidemiology

- True incidence unknown: mostly case reports and small series
- Latency: 5–15 years post-RYGB
- Most cases diagnosed at advanced stage →
- Survival: <20% at 5 years once symptomatic

Challenges

- Remnant still exposed to bile and secretions
- Remnant stomach cannot give much symptoms
- Remnant stomach is collapsed and hidden for Xray
- Remnant stomach is unreachable for endoscopy

Risk Factors

- Helicobacter pylori infection
- Atrophic gastritis, intestinal metaplasia, dysplasia
- Family history of gastric cancer
- High-incidence demographics (East Asia, South America, Eastern Europe)
- Lifestyle: smoking, alcohol, poor nutrition

Diagnostic Tools

- Endoscopic access: double-balloon, spiral enteroscopy, laparoscopic transgastric, PEG-assisted
- Imaging: CT, MRI, PET (limited early detection)

Literature Review



Remnant Gastric Cancer After Roux-en-Y Gastric Bypass: Narrative Review of the Literature

Methods PubMed, EMBASE, and Web of Science databases were consulted. Articles that described the diagnosis and management of remnant gastric cancer after RYGB were considered.

Results Seventeen patients were included. The age of the patient population ranged from 38 to 71 years. The most commonly reported symptoms were abdominal pain, nausea/vomiting, and anemia. Abdominal computed tomography was used for diagnosis in the majority of patients. The most common tumor histology was adenocarcinoma, which was present in almost 70% of patients and in 9 cases (53%). Post-operative mortality rate was 33.3%.

Table 2 Patients' symptoms. Data are reported as numbers and percentages (%)

Symptoms	n (%)
Abdominal pain	13 (76.5)
Epigastric pain	6 (35.3)
Nausea/vomiting	6 (35.3)
Abdominal distention	5 (29.4)
Anemia	3 (17.6)
Weight loss	3 (17.6)
GI bleeding	3 (17.6)
Fever	2 (11.8)
Hyporexia	2 (11.8)

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Conclusion The development of remnant gastric cancer after RYGB is a potential event and its management should be the subject of future studies. Further studies are warranted to evaluate the impact of these findings on clinical practice and patient outcomes.



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Conclusion The development of remnant gastric cancer after RYGB is rare. Surgeons should be aware of this potential event and

new onset of epigastric pain, nausea, and anemia should raise clinical suspicion. Further epidemiologic studies are warranted to help investigate the post-RYGB-related risk of remnant gastric cancer development in high-risk populations.



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REVIEW

Gastric c
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Sotirios G. D

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stomach cancer after bariatric surgery of 35 cases, including 30 cases after RYGB. Based on these studies, there is an increasing trend (41%) in the number of published stomach cancer patients with a previous bariatric procedure in the last decade (22 cases in 2012–2022 versus 13 cases before 2012). In addition, the frequency of females (63%) was found to be higher than males (32%), and the mean age was 57 years [SD (Standard Deviation) ± 9.6 ; range 38–73 years].



Abstract

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advanced stage. In addition to known risk factors such as tobacco smoking (17%), *H. pylori* infection (6%), and family history of gastric cancer (3%), bile reflux, a recently proposed cancer-promoting factor, was also estimated in 18% of the cases. Our data suggest that gastric cancer risk assessment should be considered before gastric bypass surgery, and further investigations are needed to determine the value of post-operative gastric cancer surveillance.

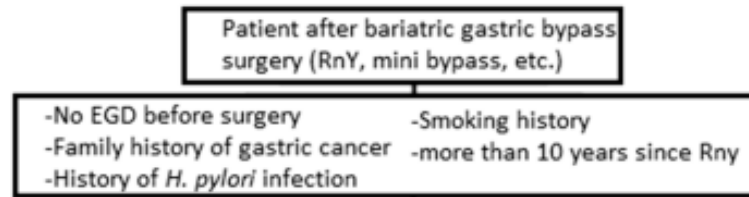


Fig. 3 The scheme shows a proposed diagrammatic approach to gastric cancer diagnosis in patients after gastric bypass surgery

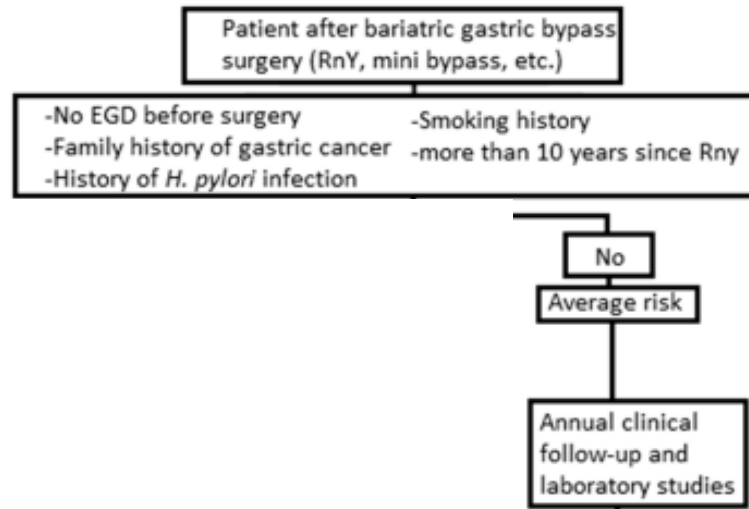


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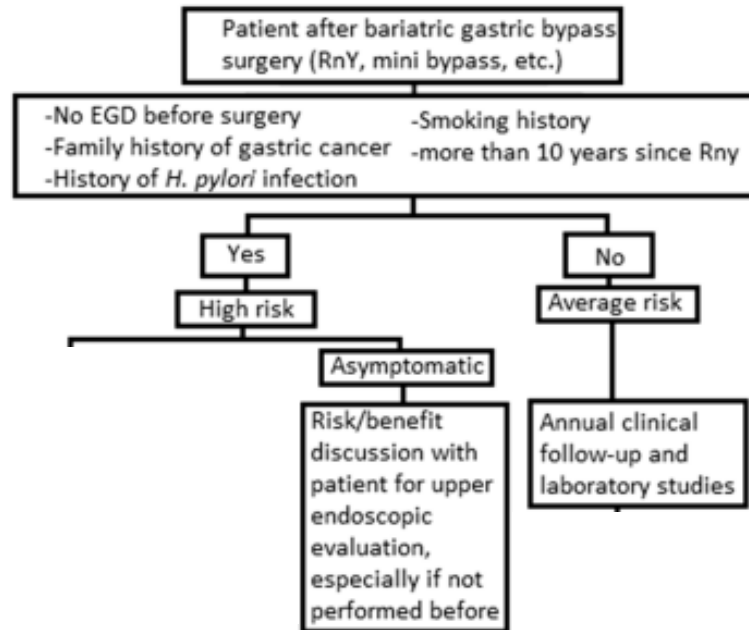


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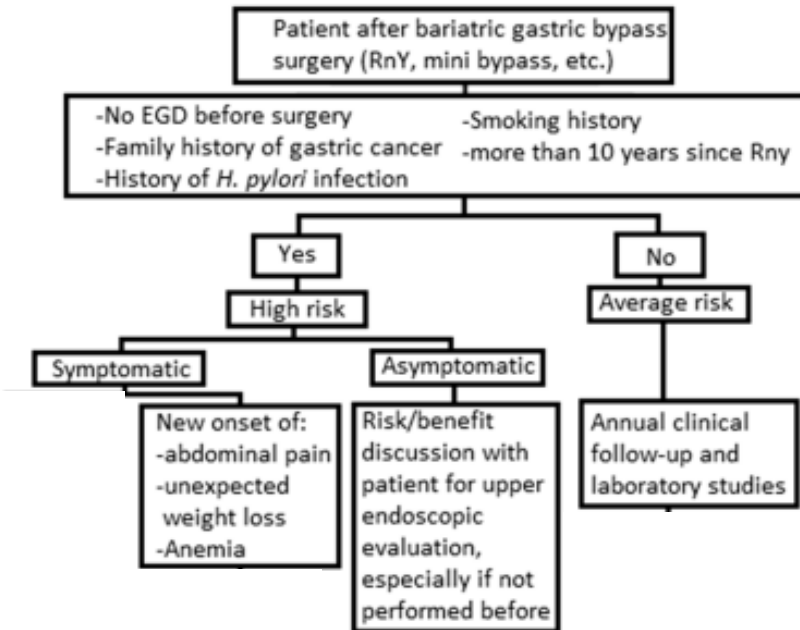


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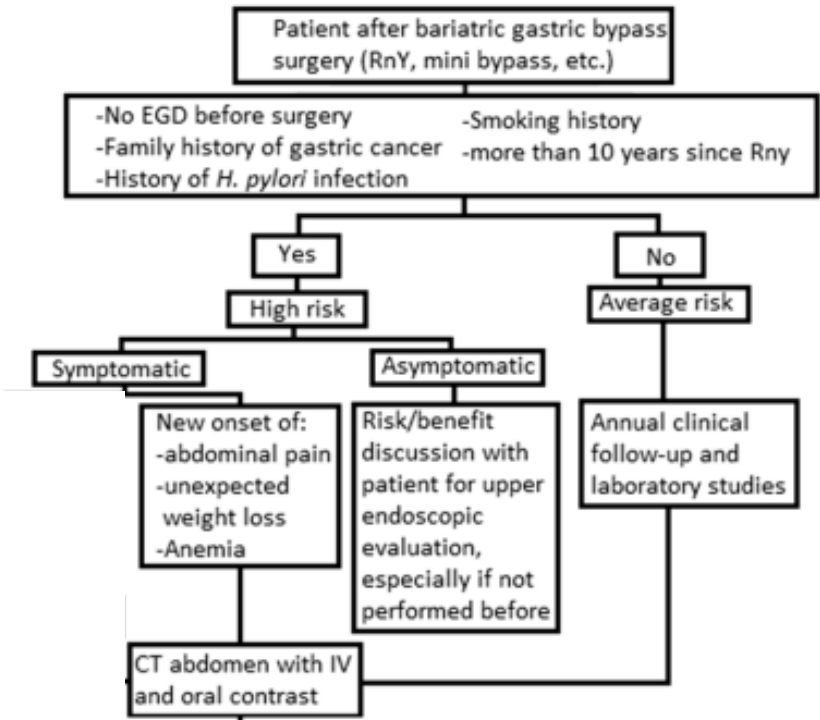


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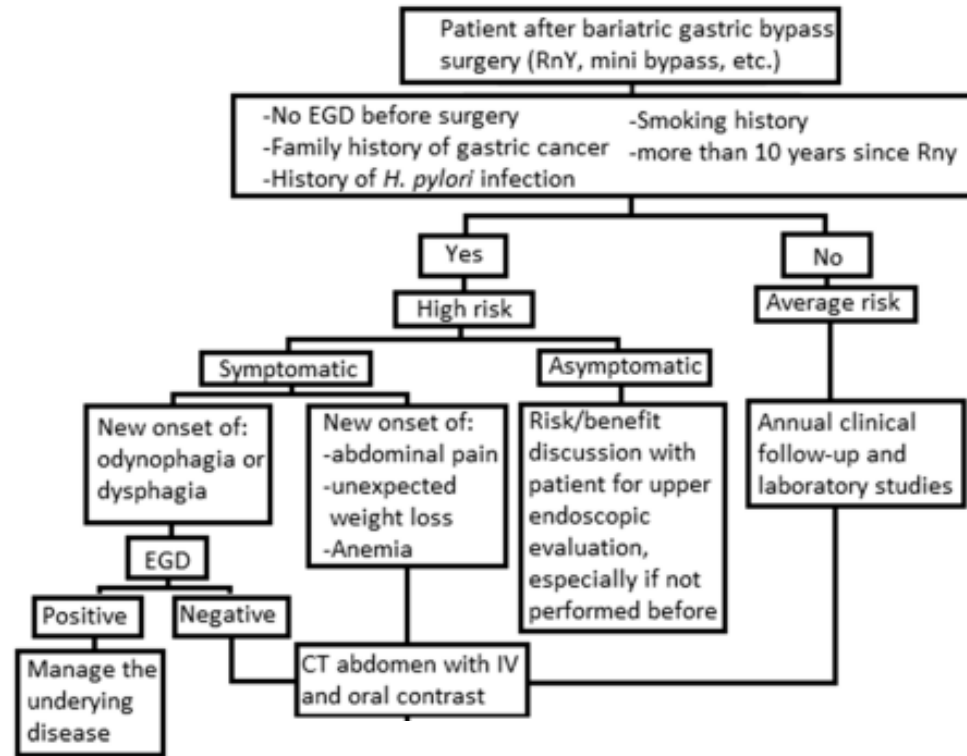


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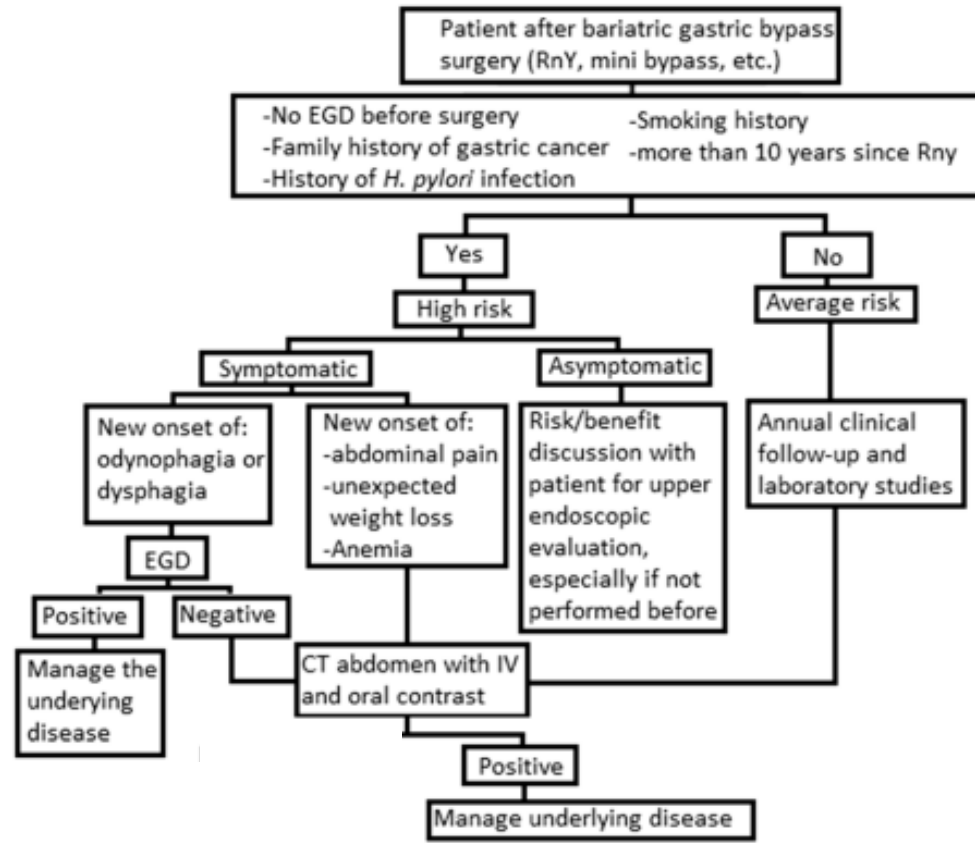


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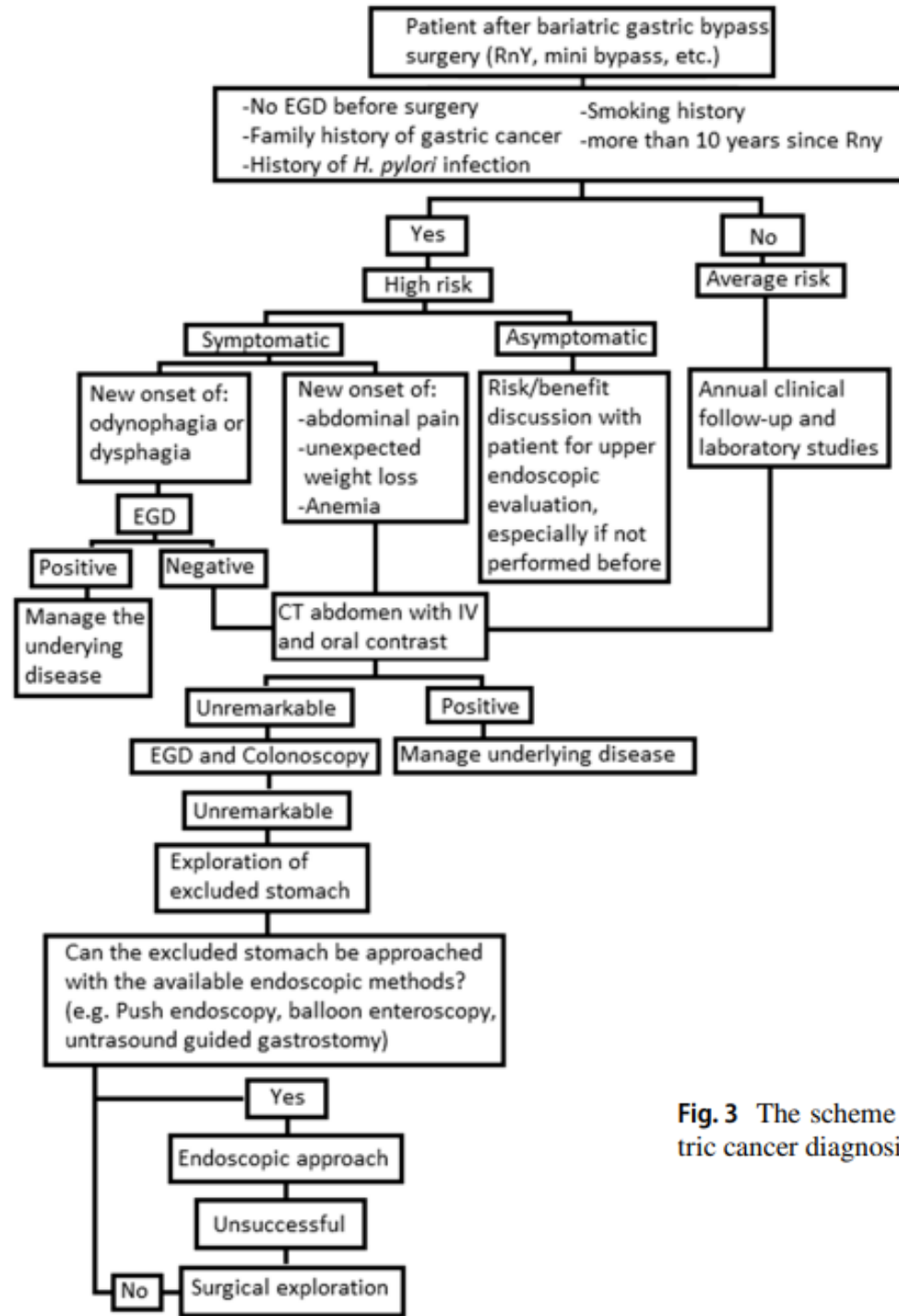


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Laparoscopic resectional gastric bypass: initial experience in morbidly obese Korean patients

Ji Yeon Park · Yong Jin Kim

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Abstract

Purpose Roux-en-Y gastric bypass (RYGB) is thought to be the gold standard treatment for morbid obesity. However, concerns have been raised by investigators in areas where gastric cancer is prevalent regarding the inaccessibility of the excluded stomach to regular surveillance. This study aimed to evaluate the technical feasibility and short-term surgical outcomes of resectional RYGB.

Methods Sixteen consecutive patients who underwent laparoscopic gastric bypass with distal gastric resection for the primary purpose of weight loss between January 2011 and December 2013 were retrospectively reviewed. The perioperative outcomes and weight loss results of these patients were analyzed.

Results All procedures were successfully performed laparoscopically. The mean length of the operation and the mean hospital stay were 170 min (range 110–225) and 4 days (range 2–7), respectively. The prevalence of early postoperative complications reached 18.7 % after resectional RYGB, but a severe complication requiring reoperation occurred in only one patient (6.3 %). The percent of excess weight loss was 78.9 % over a mean follow-up period of 14 months. Obesity-related comorbidities including diabetes, hypertension and dyslipidemia resolved or improved after surgery in most patients.

Conclusion Resectional RYGB is technically feasible and can be a viable option in countries with a high risk of

gastric cancer, where surgeons are already well trained in laparoscopic gastrectomy.

Keywords Morbid obesity · Bariatric surgery · Gastric bypass · Gastrectomy

Introduction

Morbid obesity is a rapidly growing problem worldwide and is accompanied by various kinds of obesity-related comorbidities. Bariatric surgery has proven to be the most effective therapeutic option to achieve sustained weight loss in morbidly obese patients, and consequently, improves obesity-related comorbidities such as type 2 diabetes and cardiovascular diseases. This positive effect is reflected in significant cost savings through a reduction in the utilization of health services soon after bariatric surgery [1].

Roux-en-Y gastric bypass (RYGB) has been the most commonly performed bariatric procedure throughout the world, and is considered the gold standard among the various surgical options available for the management of morbid obesity [2]. Since it was first developed by Mason and Ito in the 1960s [3], this procedure has undergone several modifications with the aims of improving its weight loss efficacy and reducing surgical complications [4, 5]. The outcomes of RYGB have been extensively studied and dis-

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Case Report

Laparoscopic Roux-en-Y Gastric Bypass with Remnant Gastrectomy for Focal Intestinal Metaplasia of the Gastric Antrum

David C. Voellinger, MD; William B. Inabnet, MD

Division of Laparoscopic Surgery, Department of Surgery, Mount Sinai Medical Center, New York, NY, USA

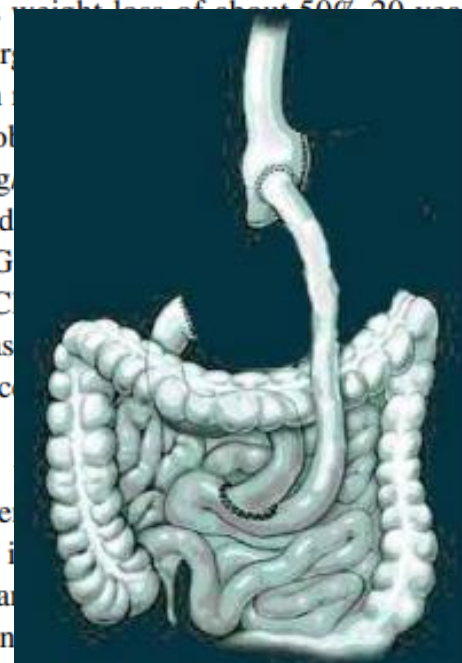
Background: Inaccessibility of the excluded stomach after isolated gastric bypass prevents postoperative evaluation and treatment of disorders of the gastric remnant. Bleeding complications, peptic ulcer disease, and gastric malignancy in the gastric remnant have all been reported. We report a patient with morbid obesity and focal intestinal metaplasia in the antrum of the stomach that was treated with laparoscopic Roux-en-y gastric bypass (LRYGBP) with remnant gastrectomy.

Case Report: A 46-year-old female with a long history of morbid obesity presented with a BMI of 47 kg/m². Preoperative upper endoscopy revealed focal intestinal metaplasia. Since intestinal metaplasia is a risk factor for gastric cancer, a LRYGBP with remnant gastrectomy was performed.

Conclusions: LRYGBP with remnant gastrectomy is a safe and cost-effective treatment for morbidly obese patients with focal intestinal metaplasia of the stomach.

excess weight loss of about 50% 20 years following surgery. Health-related quality of life was significantly better for morbidly obese patients with a BMI of ≥ 40 kg/m² who underwent LRYGBP compared with those who underwent RYGBP. LRYGBP with remnant gastrectomy is a safe and cost-effective treatment for morbidly obese patients with focal intestinal metaplasia of the stomach. This dif-


One of the major advantages of LRYGBP with remnant gastrectomy is the lack of access to the excluded stomach. This difficulty in access to the excluded stomach is the major reason why the diagnosis and treatment of disorders of the excluded stomach are often difficult. This difficulty in access to the excluded stomach is the major reason why the diagnosis and treatment of disorders of the excluded stomach are often difficult. This difficulty in access to the excluded stomach is the major reason why the diagnosis and treatment of disorders of the excluded stomach are often difficult.





REVIEW

Remnant Gastrectomy and Gastric Bypass: A Systematic Review of Indications and Outcomes of Resectional Gastric Bypass

Shahab Shahabi Shahmiri^{1,2} · Erfan Sheikhabahaei^{3,4} · Amirhossein Davarpanah Jazi³  · Hamidreza Zefreh⁴ · Wah Yang^{5,6} · Rohollah Valizadeh⁷ · Rui Ribeiro⁸ · Mohammad Kermansaravi^{1,2}

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Abstract


Background In this systematic review, we aim to evaluate the reasons and outcomes behind remnant gastrectomy with or after gastric bypass procedures.

Results A total of 66 studies examining 1918 patients were included in this study with 70% of female predominance. Twenty studies reported RGB on 1751 patients and 46 studies reported remnant gastrectomy after gastric bypass in 167 patients.

The most common etiology of RGB was related to the in situ remnant stomach neoplasia in 10 studies on 981 patients; mostly for preventive intentions in high prevalence areas. Remnant gastrectomy after gastric bypass was performed to treat a complication such as GGF, retrograde bile reflux gastritis, cancer mostly adenocarcinoma. Studies revealed that RGB has similar weight loss in comparison to standard Roux-en-Y gastric bypass.



IFSO Position Statement on the Role of Esophago-Gastro-Duodenal Endoscopy Prior to and after Bariatric and Metabolic Surgery Procedures

Wendy A. Brown¹  · Yazmin Johari Halim Shah¹ · George Balalis¹ · Ahmad Bashir¹ · Almino Ramos¹ · Lilian Kow¹ · Miguel Herrera¹ · Scott Shikora¹ · Guilherme M. Campos¹ · Jacques Himpens¹ · Kelvin Higa¹

Published online: 29 May 2020

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Abstract

One of the roles of the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) is to provide guidance on the management of patients seeking surgery for adiposity-based chronic diseases. The role of endoscopy around the time of endoscopy is an area of clinical controversy. In 2018, IFSO commissioned a task force to determine the role of endoscopy before and after surgery for the management of adiposity and adiposity-based chronic diseases. The following position statement is issued by the IFSO Endoscopy in Bariatric/Metabolic Surgery Taskforce. It has been approved by the IFSO Scientific Committee and Executive Board. This statement is based on current clinical knowledge, expert opinion, and published peer-reviewed scientific evidence. It will be reviewed regularly.



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Recommendations of the IFSO Endoscopy in Bariatric Surgery Taskforce

Based on the existing data we recommend the following:

1. Esophago-gastro-duodenoscopy (EGD) should be considered for all patients with upper GI symptoms planning to undergo a bariatric procedure due to the frequency of pathology that may alter management.
2. EGD should be considered for patients without upper GI symptoms who are planning to undergo a bariatric procedure due to the 25.3% chance of an unexpected finding that may alter management or contra-indicate surgery.



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3. EGD should be routinely considered in populations where the community incidence of significant gastric and esophageal pathology is high, particularly when the procedure will lead to part of the stomach being inaccessible (for example RYGB and OAGB).
4. EGD should be undertaken routinely for all patients after bariatric surgery at 1 year and then every 2–3 years for patients who have undergone LSG or OAGB to enable early detection of Barrett’s esophagus or upper GI malignancy until more data is available to confirm the incidence of these cancers in practice.



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Abstract

One of the roles of the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) is to provide guidance on the management of patients seeking surgery for adiposity-based chronic diseases. The role of endoscopy around the time of endoscopy is an area of clinical controversy. In 2018, IFSO commissioned a task force to determine the role of endoscopy before and after surgery for the management of adiposity and adiposity-based chronic diseases. The following position statement is issued by the IFSO Endoscopy in Bariatric/Metabolic Surgery Taskforce. It has been approved by the IFSO Scientific Committee and Executive Board. This statement is based on current clinical knowledge, expert opinion, and published peer-reviewed scientific evidence. It will be reviewed regularly.

Recommendations of the IFSO Endoscopy in Bariatric Surgery Taskforce

Based on the existing data we recommend the following:

1. Esophago-gastro-duodenoscopy (EGD) should be considered for all patients with upper GI symptoms planning to undergo a bariatric procedure due to the frequency of pathology that may alter management.
2. EGD should be considered for patients without upper GI symptoms who are planning to undergo a bariatric procedure due to the 25.3% chance of an unexpected finding that may alter management or contra-indicate surgery.
3. EGD should be routinely considered in populations where the community incidence of significant gastric and esophageal pathology is high, particularly when the procedure will lead to part of the stomach being inaccessible (for example RYGB and OAGB).
4. EGD should be undertaken routinely for all patients after bariatric surgery at 1 year and then every 2–3 years for patients who have undergone LSG or OAGB to enable early detection of Barrett's esophagus or upper GI malignancy until more data is available to confirm the incidence of these cancers in practice.
5. EGD should be performed following AGB and RYGB on the basis of upper GI symptoms.

Surveillance for Gastric Cancer After Roux-en-Y Gastric Bypass

Rami E Lutfi, FACS FASMBS ABOM

President, CEO Chicago Institute of Advanced Surgery
Clinical Professor of Surgery, Rosalind Franklin School of Medicine

IFSO position statement about screening for gastric cancer after gastric bypass

Thought for 1m 22s

Bottom line: IFSO does **not** recommend routine screening of the excluded stomach for gastric cancer after RYGB. Do pre-op EGD with H. pylori testing/eradication for all candidates or at least symptomatic ones; post-RYGB, investigate **only if symptomatic or high-risk**. [PubMed](#) [OAE Publish](#) [ResearchGate](#)

Key IFSO points to operationalize:

- **Pre-op:** EGD for risk stratification; treat H. pylori; do not bypass indeterminate lesions. Consider altering procedure if premalignant pathology requires future surveillance. [PubMed](#)
- **Post-RYGB:** No scheduled endoscopic surveillance of the remnant; use symptom-triggered evaluation (anemia, pain, bleeding, weight change). If strong indication, coordinate advanced access (balloon enteroscopy, lap transgastric, or PEG-assisted). [PubMed](#) [OAE Publish](#)
- **Contrast:** IFSO endorses **routine** endoscopic surveillance after SG/OAGB (e.g., ~1 year, then q2–3 years), but **not** after RYGB. [ResearchGate](#) [OAE Publish](#)

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ASMBS position statement about screening for gastric cancer after gastric bypass

ASMBS has no **specific** position statement addressing surveillance or screening for **gastric cancer** after Roux-en-Y gastric bypass. The existing *ASMBS position statement on the rationale for performance of upper gastrointestinal endoscopy before and after metabolic and bariatric surgery* does cover general endoscopy practices, but does **not** address surveillance for gastric cancer in the excluded stomach specifically

[pubmed.ncbi.nlm.nih.gov +14](#)

Key Points from the 2021 ASMBS Position Statement:

- Recommends **preoperative upper GI endoscopy** for all metabolic and bariatric surgery candidates.
- Supports **postoperative surveillance** for mucosal changes such as GERD, esophagitis, and Barrett's esophagus.
- Does **not** propose any strategy for monitoring the gastric remnant for malignancy following Roux-en-Y gastric bypass [pubmed.ncbi.nlm.nih.gov](#)

Conclusion

No ASMBS-endorsed protocol exists for **gastric cancer surveillance** post-RYGB. You may need to rely on expert consensus, regional guidelines, or develop institution-level protocols until such guidance becomes available.

IFSO position statement about screening for esophageal and gastric cancer after sleeve gastrectomy

Thought for 1m 9s

IFSO's position on post-SG cancer surveillance:

- **Pre-op:** Perform EGD for all bariatric candidates, regardless of symptoms, due to a high rate of actionable findings; consensus support ~92%. Treat **H. pylori**. [PubMed](#) [oaepublish.com](#)
- **Post-SG screening cadence:** EGD at 1 year, then every 2–3 years regardless of symptoms to screen for BE and upper GI malignancy. Same cadence for OAGB. Earlier EGD if alarm symptoms. Consensus support ~78%. [dmr.amegroups.org](#) [oaepublish.com](#)
- **RYGB (for context):** Symptom-triggered EGD rather than routine surveillance. [dmr.amegroups.org](#)
- **Rationale:** Meta-analyses show **BE prevalence ~8–11%** after SG within 3–10 years; esophageal adenocarcinoma after SG is rare but documented, justifying scheduled endoscopic surveillance.

[dmr.amegroups.org](#)

ASMBS position statement about screening for esophageal and gastric cancer after sleeve gastrectomy

ASMBS does not currently offer a standalone **position statement** specific to screening for esophageal or gastric cancer after sleeve gastrectomy.

The most directly relevant document is the **ASMBS position statement on the rationale for performance of upper gastrointestinal (UGI) endoscopy before and after metabolic and bariatric surgery**. That statement covers the need for preoperative and postoperative endoscopic evaluation in general. For sleeve gastrectomy (SG) specifically, it does not include dedicated guidance for esophageal or gastric cancer screening [pmc.ncbi.nlm.nih.gov +15](#).

Key points from that statement:

- Recommends **UGI endoscopy before bariatric surgery** to identify pathology (e.g., Barrett's esophagus, gastritis, ulcers) [pmc.ncbi.nlm.nih.gov](#).
- Suggests **selective use of postoperative endoscopy**, guided by symptoms or identified risk factors

[pmc.ncbi.nlm.nih.gov +13](#)

There is **no separate ASMBS guideline** recommending routine surveillance endoscopy for cancer detection in patients after SG—those decisions are left to clinician judgment and symptom-driven evaluation.

Conclusion

- Gastric cancer post-RYGB is rare but often late-stage
- Excluded stomach = diagnostic blind spot
- Prevention, risk stratification, early detection are key
- Surgeons are central in baseline evaluation and education

Future Directions

- Non-invasive biomarkers validation
- Minimally invasive access devices
- AI-assisted risk stratification
- International databases and registries