

Surgical Treatment of Obesity: *Procedure Choice and* *Algorithm for Conversion or Revision Surgery*

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Disclosures

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- I'm presenting the findings of consensus meeting, not my opinion.

Definitions (1)

Statement	Most common selection	% consensus
Surgical or endoscopic procedures to convert to a new type of metabolic/bariatric operation (conversion surgery) & those to re-establish normal anatomy (reversal surgery) should be clearly distinguished & considered separately from procedures to modify or enhance the effects of a previous operation (revision or modification surgery).	Agree	97.5%
Modification or revision procedures are typically designed to optimize the effectiveness of previous operations, while conversion procedures most commonly introduce additional mechanisms of therapeutic action.	Agree	95.0%

Definitions (2)

Statement	Most common selection	% consensus
Weight gain recurrence requires a thorough evaluation before even considering a patient a candidate for modifying a prior MBS procedure.	Agree	100%
Suboptimal weight loss has different implications than recurrent weight gain when considering which type of intervention to consider next.	Agree	85.7%
Modification of a prior MBS procedure can be considered for weight issues alone (e.g., when BMI>35), even when preexisting obesity-related complications are cured or are in remission.	Agree	80%

Conversion Surgery after SG

Statement	Most common selection	% consensus
GERD, suboptimal weight loss, and recurrent weight gain are the main reasons for conversions after SG.	Agree	100%

Conversion after SG for GERD

Statement	Most common selection	% consensus
The best option to treat medically uncontrolled GERD after a SG is conversion into a RYGB.	Agree	97.4%
Improved patient selection preoperatively for GERD risk <u>WILL/WILL NOT</u> significantly reduce the rate of sleeve gastrectomy conversions to bypass.	WILL	83.8%

Conversion after SG for Obesity

Statement	Most common selection	% consensus
In the absence of GERD symptoms or Barrett's esophagus, suboptimal weight loss after SG can be treated by: A) Adding an AOM B) Converting to other procedures C) Both D) Neither	Both	87.5%
In the absence of GERD symptoms or Barrett's esophagus, the most appropriate surgical option for suboptimal weight loss after a sleeve gastrectomy would be conversion to: A) RYGB B) OAGB C) DS-SADI	RYGB	60.5%
Considering safety and efficacy, the most appropriate MBS for most patients with a BMI >50 kg/m² and a previous SG is: A) RYGB B) OAGB C) DS-SADI.	DS/SADI	61.1%

Revisional Surgery after RYGB for Obesity

Statement	Most common selection	% consensus
Revision of RYGB to address suboptimal weight loss would include pouch trimming (with or without band placement), GJ anastomosis size reduction, or limb length modification.	Agree	78.4%
For a revisional surgery to address suboptimal weight loss after RYGB, given the risk of nutritional adverse events, revising the size of pouch and GJ anastomosis should NOT be done during the same operation as limb length modification.	Disagree	67.7%

Management of RYGB Complications (1)

Statement	Most common selection	% consensus
Preferred treatment for hypoglycemic syndrome after RYGB, persisting despite adequate nutritional counselling, consists of: A) Medication (e.g., diazoxide, acarbose, octreotide) B) Reducing the pace of gastric pouch emptying endoscopically or laparoscopically C) Reversal to normal anatomy D) None of the above	Medication	75.7%

Management of RYGB Complications (2)

Statement	Most common selection	% consensus
Recurrent anastomotic (marginal) ulcers after a RYGB should be treated surgically by: A) Accurate vagotomy B) Reducing pouch size, resecting anastomosis & creating a new anastomosis C) Resecting the remnant D) None of the above	B	74.1%