Sleeve Gasterectomy is doomed to fail as a stand alone procedure

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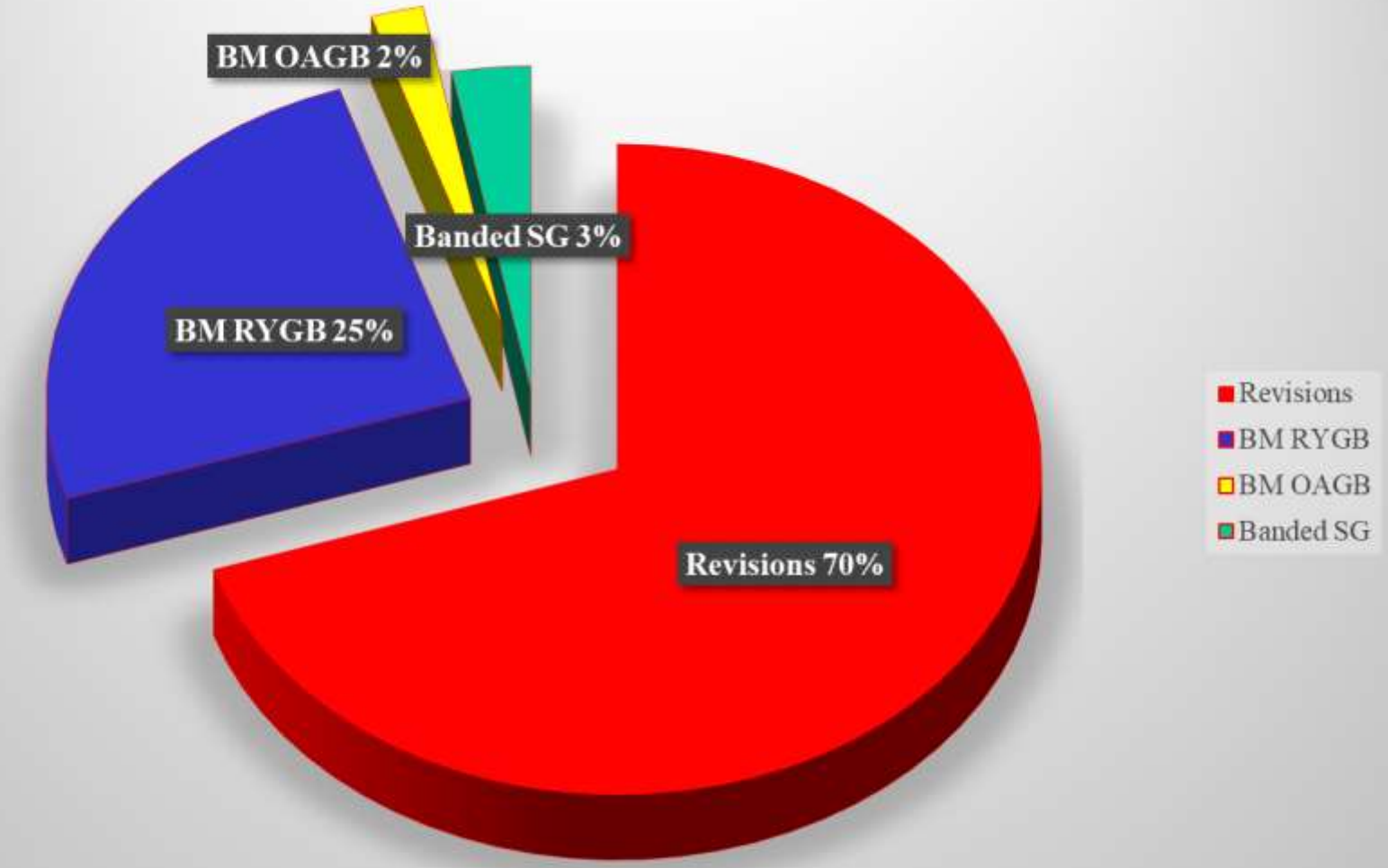
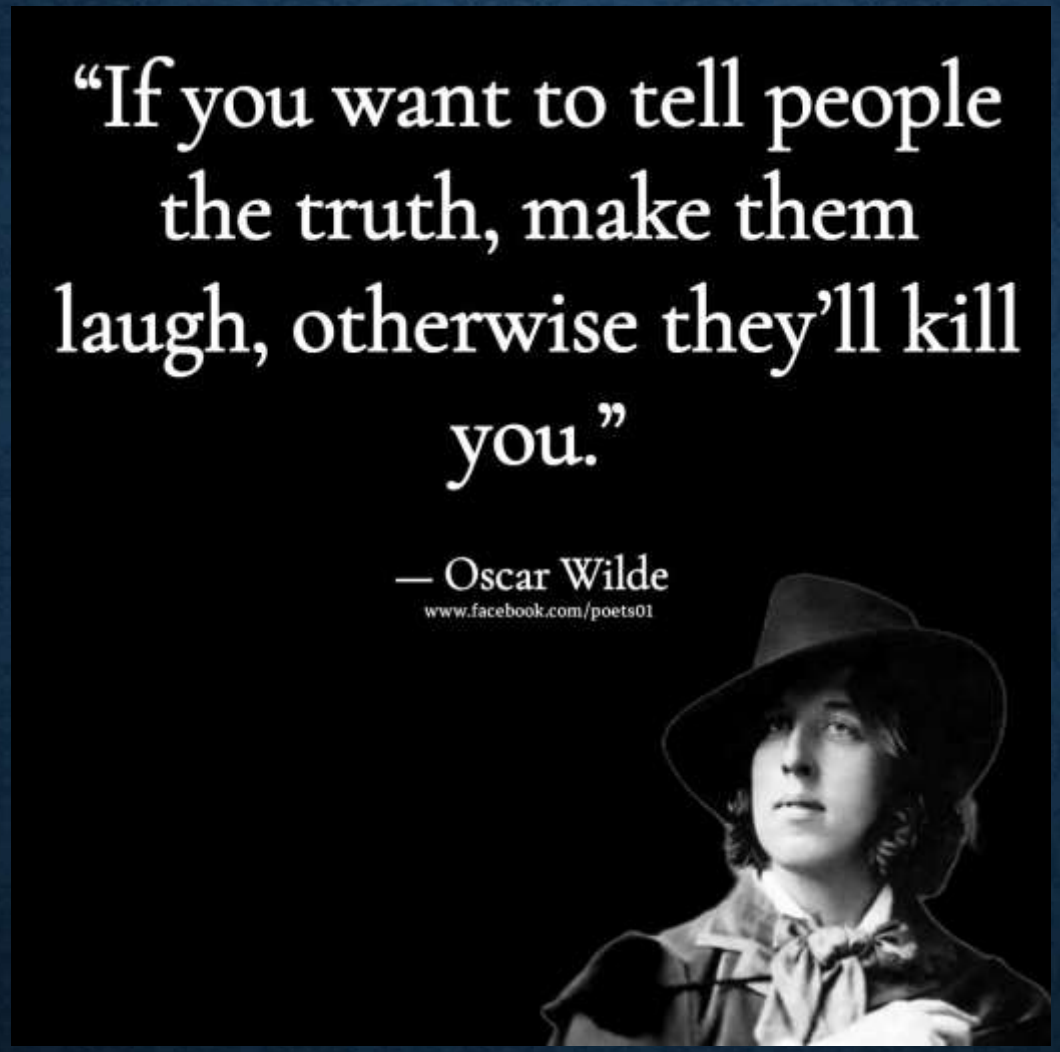
DISCLOSURES

Unfortunately non

Case Mix Disclosure




“If you want to tell people the truth, make them laugh, otherwise they’ll kill you.”
— Oscar Wilde
www.facebook.com/poets01

post sleeve same picture
in 5 years Johnny lost 5 years


A lie often told becomes the truth

The trouble with many of us is that we would rather be ruined by praise, than saved by criticism

Bariatric History: ISLOS Meeting Napoli 1999 The Laparoscopic Explosion

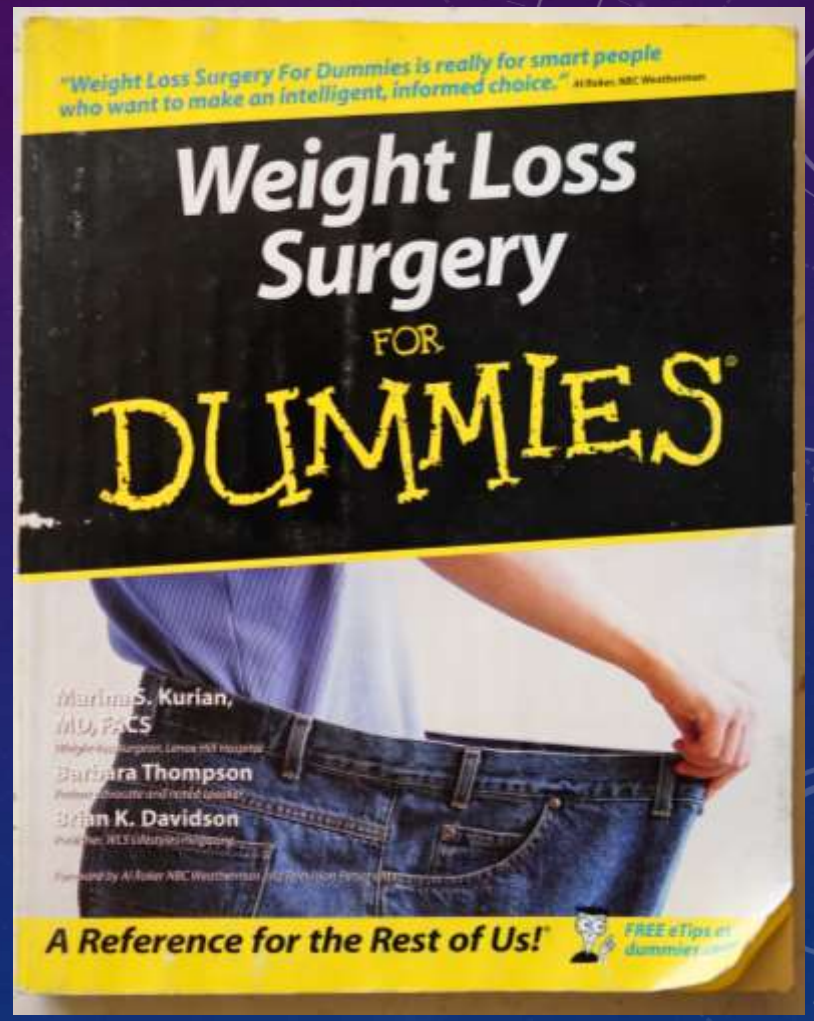
- LAGB, SAGB Belachew, Forssil 1993
- Lap RYGB Wittgroove and Clark 1993
- Lap OAGB (MGB) Ruthlege 1998
- Lap duodenal switch, Lap BPD 1999,2000 Gagnier

LAGB

- Easy, reversible no cutting no stapling adjustable laparoscopic No supplementation, Good weight loss
- The gold standard of any scientific study is weather it can be replicated. (Lap band Blues)
- 1999 44 LAGB

THE PERFECT DECEPTION
THE BIRTH OF COMMERCIAL BARIATRIC SURGERY

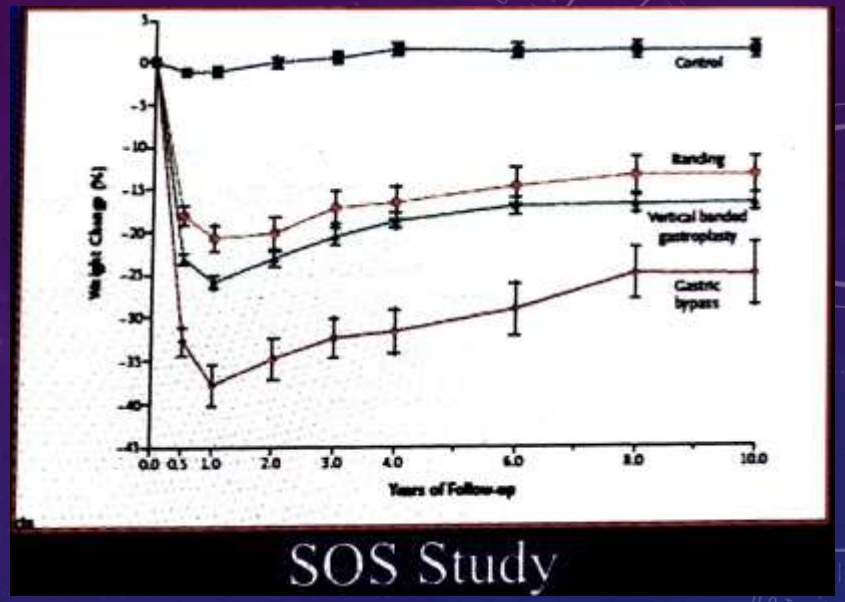
- **Easy Procedure**
- **Short term success**
- **Long term who Cares.**
- **Failure rate: blame the patient**



THE LAP BAND DEMISE

- **Bariatric science did not prove that the lap band should not be used**
- **Patients knew from peers that the lap band does not work with too many failures and stopped asking for them**
- **This is starting to happen with sleeve gastrectomy**

THE HONEY MOON PHENOMENON



- **All Bariatric procedures give some weight loss in the first 18 months.**
- **All bariatric procedures show weight gain after that and results at 5 and 10 years will be completely different than your initial results.**

Honeymooners Dilutional Effect

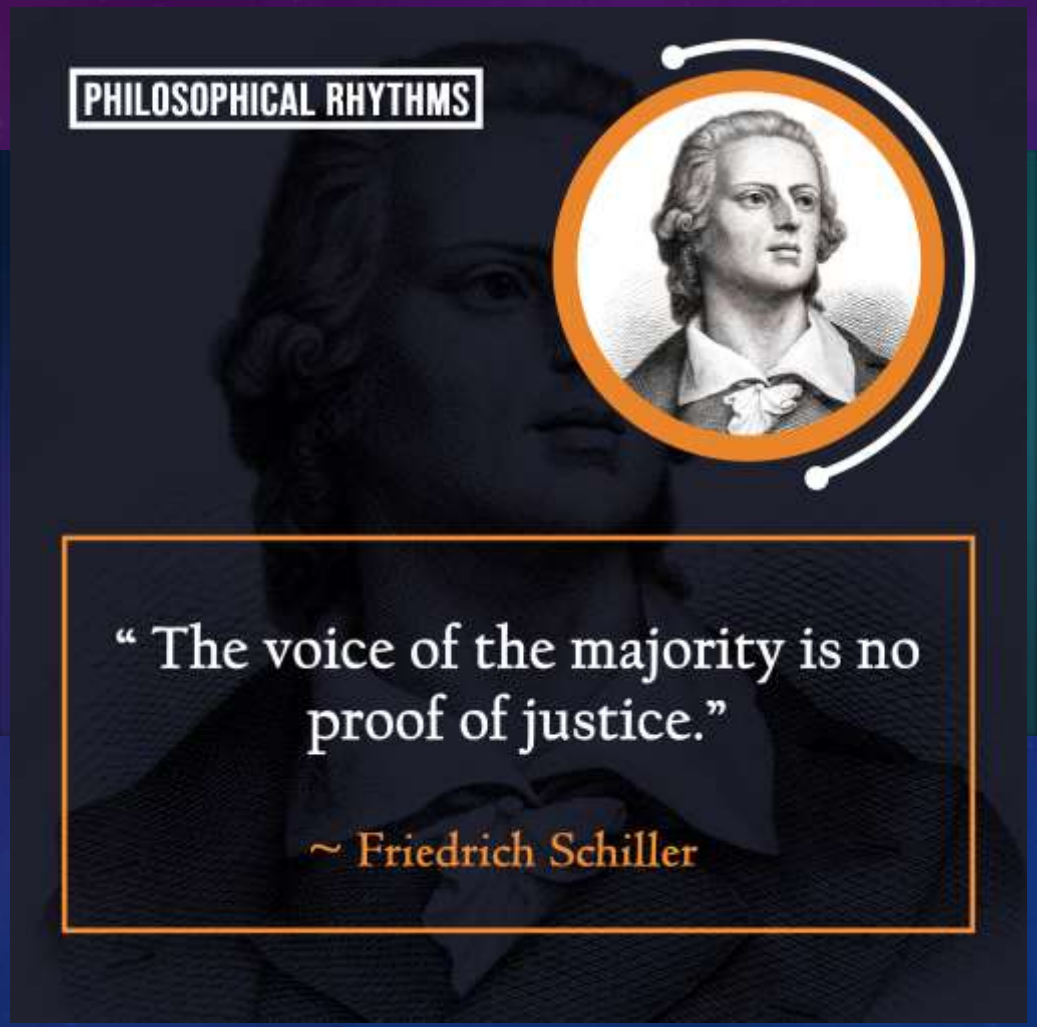
Obesity Surgery, 16, 829-835

A 10-year Experience with Laparoscopic Gastric Banding for Morbid Obesity: High Long-Term Complication and Failure Rates

M. Suter, MD, PD, FACS[1,2]; J. M. Calmes, MD[2]; A. Paroz, MD[2]; V. Giusti, MD, PD[3]

In conclusion, laparoscopic adjustable gastric banding is the least invasive surgical procedure for obesity. It appeared promising after encouraging early results. However, despite improvements in the operative technique and in the material, results worsen over time. The proportion of patients with good weight loss (EWL >50%), even in those without major complication, remains at best between 55 and 65%. Furthermore, each year adds 3-4% to the major complication rate, which contributes significantly to the total failure rate, and seriously questions the durability of the concept. With a success rate <50% and a failure rate that approaches 40% after 7 years, adjustable gastric banding should no longer be considered as the procedure of choice for morbid obesi-

SG:THE NO 1 OPERATION WORLDWIDE



SLEEVE GASTERECTOMY IS DOOMED

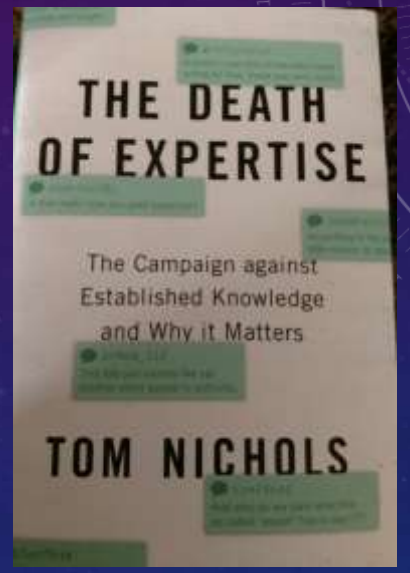
- **Weight loss failure**
- **GE Reflux**

HISTORY OF SLEEVE GASTRECTOMY AS A STAND ALONE PROCEDURE

- Invention of Laparoscopic duodenal switch by Micheal Gagnier 1999
- High morbidity and mortality of the laparoscopic duodenal switch in very high BMI patients prompted the performance of a 2 stage procedure to reduce the risk.
- Planned 2nd stage (6-12 months later) patients did not come back (honeymooners)
- Ok lets keep it at that: serendipity.
- Easy does it and the demise of the lap band pushed the rise of the sleeve gastrectomy

CONFIRMATION BIAS: BECAUSE YOU KNOW THIS ALREADY

- **The natural tendency to accept evidence that confirms what we already believe.**
- **To accept facts that only strengthens our preferred explanation and to dismiss data that challenge what we already accept as truth.**
- **We all have inherent and natural tendency to search for evidence that already meshes with our believes.**
- **It is the nature of confirmation bias itself to dismiss all contradictory evidence as irrelevant, and so my evidence is always the rule, your evidence is always a mistake or an exception.**

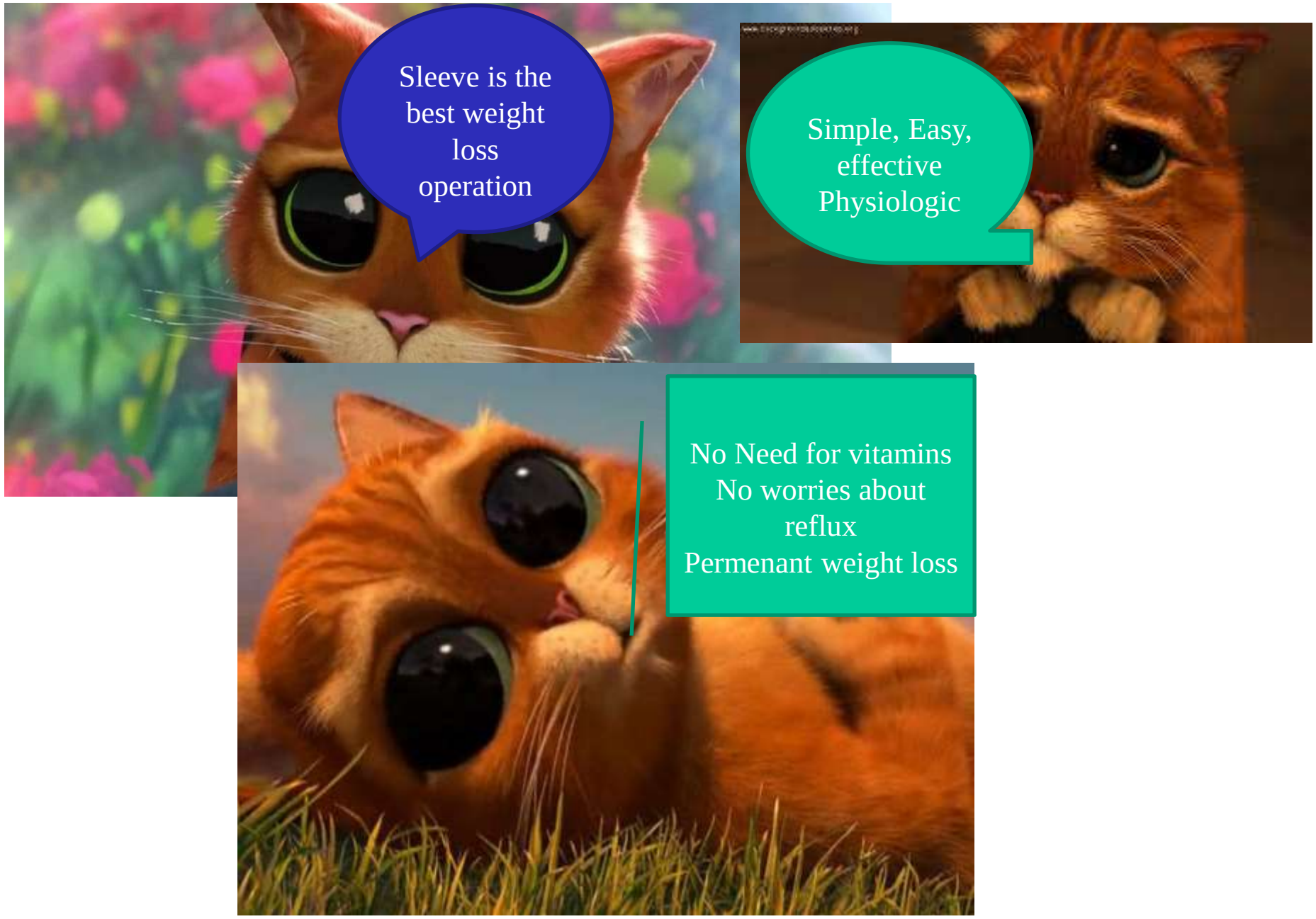


- **Everyone believes they're the good guys and those who differ are the bad ones**

NO ONE ON THE BAD GUYS SIDE FEEL THEY ARE DOING ANYTHING WRONG

It is not hard to do the right thing. It's just hard to know what the right thing is

Commercial (sleeve only) Surgeons trying to convince patients with sleeve gasterectomy


Sleeve is the best weight loss operation
Simple, Easy, effective Physiologic
No Need for vitamins
No worries about reflux
Permenant weight loss

Sleeve is as good as RYGB (which RYGB?)

Every stomach will stretch with time: Wide sleeve is more comfortable and will soon dilate. Narrow sleeves are more uncomfortable and take longer to dilate

Sleeve Gastrectomy is the only self reversing bariatric procedure (give it enough time and it will dilate)

Rationalize failure (weight loss is not important in a weight loss procedure) Co-morbidity improvement is enough. It works through hormones and other mechanisms,

I did my part but You did not change

Logic defying science is wrong

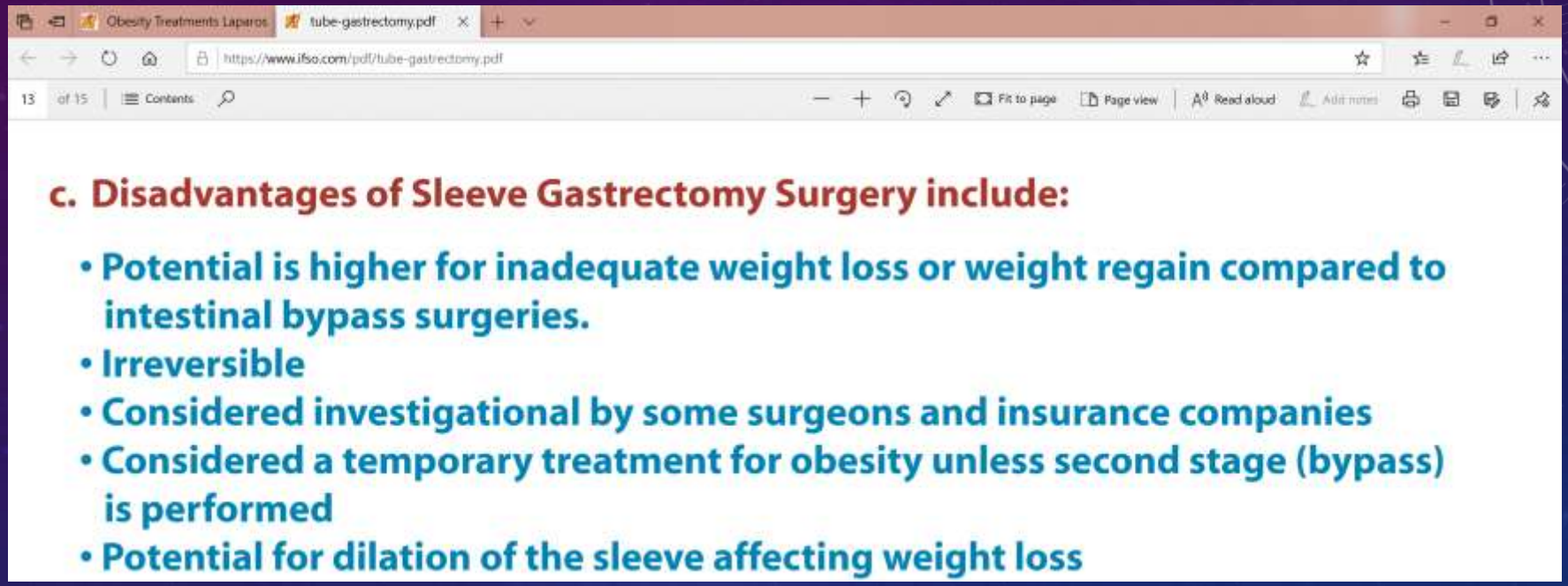
By the time the inevitable long term failures appear we will have Millions of failures

SLEEVE GASTRECTOMY: TRUTH IRREVERSIBLE REFLUX INDUCING RADICAL GASTRIC RESECTION THAT GIVES TEMPORARY GASTRIC RESTRICTION

EVERY STOMACH STRETCHES

- ***Competitive eaters "can train their stomach to enlarge and expand to an extraordinary degree has researched stomach stretching. "Literally the entire abdomen … [becomes] this giant flaccid sack that can take phenomenal volumes of food."***

IFSO WEBSITE



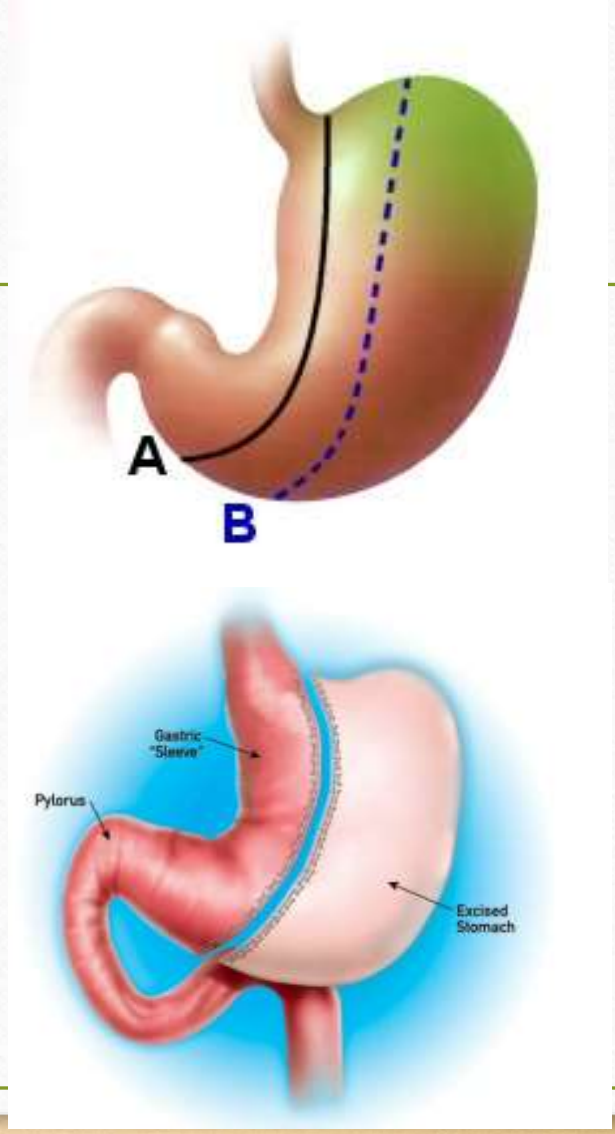
Reflux after Sleeve The Logic

Progressive decrease in bougie size and antral resection

High Pressure system with Intact pylorus

Progressive sleeve dilatation will dilate the upper part of the stomach and start Hiatal hernias

Sleeve intra thoracic migrations due to sleeve mobility (sleeve fixation techniques)



Ref.	Nature of the study	Patients, *n*	Pre-operative BMI (kg/m^2)	GERD evaluation	Follow-up (mo)	GERD (%) Preop	GERD (%) Postop
Himpens et al[21], 2006	Prospective randomized: GB *vs*LSG	40	39	Clinical evaluation	36	-	*De Novo* At 1 yr: 21.8% At 3 yr: 3.1%
Arias et al[23], 2009	Retrospective review	130	43.2	NA	36	0	*De novo*: 2.1%
Braghetto et al[25], 2010	Retrospective review, and literature review	167	37 ± 4.4	Clinical score: EGD, EM	-	-	Increase
Braghetto et al[26], 2010	Retrospective review	20	38.3	Clinical score: EM	-	-	Increase
Lakdawala et al[27], 2010	Retrospective review	50	-	-	12	-	Increase
Himpens et al[22], 2010	Retrospective review	30	39.9	NA	72	3.30%	23%
Carter et al[28], 2011	Retrospective review	176	46.6	Clinical evaluation	24	34.60%	47.2% 33.8% (of total) under medication
Howard et al[29], 2011	Retrospective review	28	55.5	Clinical evaluation UGICS	8	7 (25%)	11 (39%) *De novo*: 18%
Soricelli et al[24], 2013	Retrospective review: SG + HHR	378	44 ± 3.5	Clinical score: EGD, UGICS, EM. 24-h pH	18	60/378 (15.8%) SG: 19/281 (6.7%) SG+HHR: 41/97 (4.[illegible]%)	71/ 378 (18.7%) SG: 68 (24%) SG+HHR: 3/97 (3.1%)
Sieber et al[30], 2014	Retrospective review	68	43 ± 8	Clinical evaluation: EGD, UGICS, EM	60	50%	Persistance : 44.1% *De novo*: 16%
Gorodner et al[31], 2014	Retrospective review. Influence of LSG on GERD	14	40 ± 6	Demeester score: BM, EGD, EM. 24-h pH	14	4 (29%)	9 (64%)
Burgerhart et al[32], 2014	Prospective study	20	47.6 ± 6.1	RDQ; EM. 24-h pH	3	14 (70%) Acid exposure: 4.1 %	Persistance: 8 (57%) No change: 2 (14%) Worsening: 6 (43%) *De novo*: 10% Acid exposure: 12%
Dupree et al[33], 2014	Retrospective review	4832	47 ± 9	Clinical evaluation	36	44.50%	Persistence: 84.1% *De novo*: 8.6%
Total: 13 studies							

Surg Obes Relat Dis. 2017 Apr;13(4):568-574. 2016.11.029. Epub 2016 Dec 9.

Gastroesophageal reflux disease and Barrett's esophagus after laparoscopic sleeve gastrectomy: a possible, underestimated long-term complication.

Genco A1, Soricelli E2, Casella G1, Maselli R1, Castagneto-Gissey L1, Di Lorenzo N3, Basso N1.

- **METHODS:**
- From July 2007 to January 2010, 162 patients underwent primary SG. Preoperatively all patients underwent visual analogue scale (VAS) evaluation of GERD symptoms, proton pump inhibitors (PPIs) consumption recording, and esophagogastroduodenoscopy (EGD). Stomach resection started 6 cm from pylorus on a 48Fr bougie. Staple line was reinforced by an oversewing suture. A postoperative clinical control with VAS evaluation, PPI consumption, and EGD was proposed to all patients. Three patients were excluded because of the occurrence of major postoperative complications.
- **RESULTS:**
- A total of 110 patients accepted to take part in the study (follow-up rate: 69.1%). At a mean 58 months of follow-up, incidence of GERD symptoms, VAS mean score, and PPI intake significantly increased compared with preoperative values (68.1% versus 33.6%: P<.0001; 3 versus 1.8: P = .018; 57.2% versus 19.1%: P<.0001) At EGD, an upward migration of the "Z" line and a biliary-like esophageal reflux was found in 73.6% and 74.5% of cases, respectively. A significant increase in the incidence and in the severity of erosive esophagitis (EE) was evidenced, whereas nondysplastic Barrett's esophagus (BE) was newly diagnosed in 19 patients (17.2%). No significant correlations were found between GERD symptoms and endoscopic findings.
- **CONCLUSION:**
- In the present series the incidence of EE and of BE in SG patients was considerably higher than that reported in the current literature, and it was not related to GERD symptoms. Endoscopic surveillance after SG should be advocated irrespective of the presence of GERD symptoms.

Obes Surg. 2017 Jun 8. doi: 10.1007/s11695-017-2748-9. [Epub ahead of print]

Reflux, Sleeve Dilation, and Barrett's Esophagus after Laparoscopic Sleeve Gastrectomy: Long-Term Follow-Up.

Felsenreich DM Kefurt R Schermann M Beckerhinn P Kristo I Krebs M Prager G Langer FB

- METHODS:
- We performed 24-h pH metries, manometries, gastroscopies, and questionnaires focusing on reflux (GIQLI, RSI) in SG patients with a follow-up of more than 10 years who did not suffer from symptomatic reflux or hiatal hernia preoperatively.
- RESULTS:
- From a total of 53 patients, [illegible] patients after adjustable gastric banding were excluded. From the remaining 43, six patients (14.0%) were converted to RYGB due to intractable reflux over a period of 130 months. Ten out of the remaining non-converted patients (n = 26) also suffered from symptomatic reflux. Gastroscopies revealed de novo hiatal hernias in 45% of the patients and Barrett's metaplasia in 15%. SG patients suffering from symptomatic reflux scored significantly higher in the RSI (p = 0.04) and significantly lower in the GIQLI (p = 0.02) questionnaire.
- CONCLUSIONS:
- This study shows a high incidence of Barrett's esophagus and hiatal hernias at more than 10 years after SG. Its results therefore suggest maintaining pre-existing large hiatal hernia, GERD, and Barrett's esophagus as relative contraindications to SG. The limitations of this study-its small sample size as well as the fact that it was based on early experience with SG-make drawing any general conclusions about this procedure difficult.

Gastroesophageal reflux disease after laparoscopic Sleeve gasterectomy with concomitant hiatal hernia repair
Bassem Safadi et al
Obesity surgery April 2017

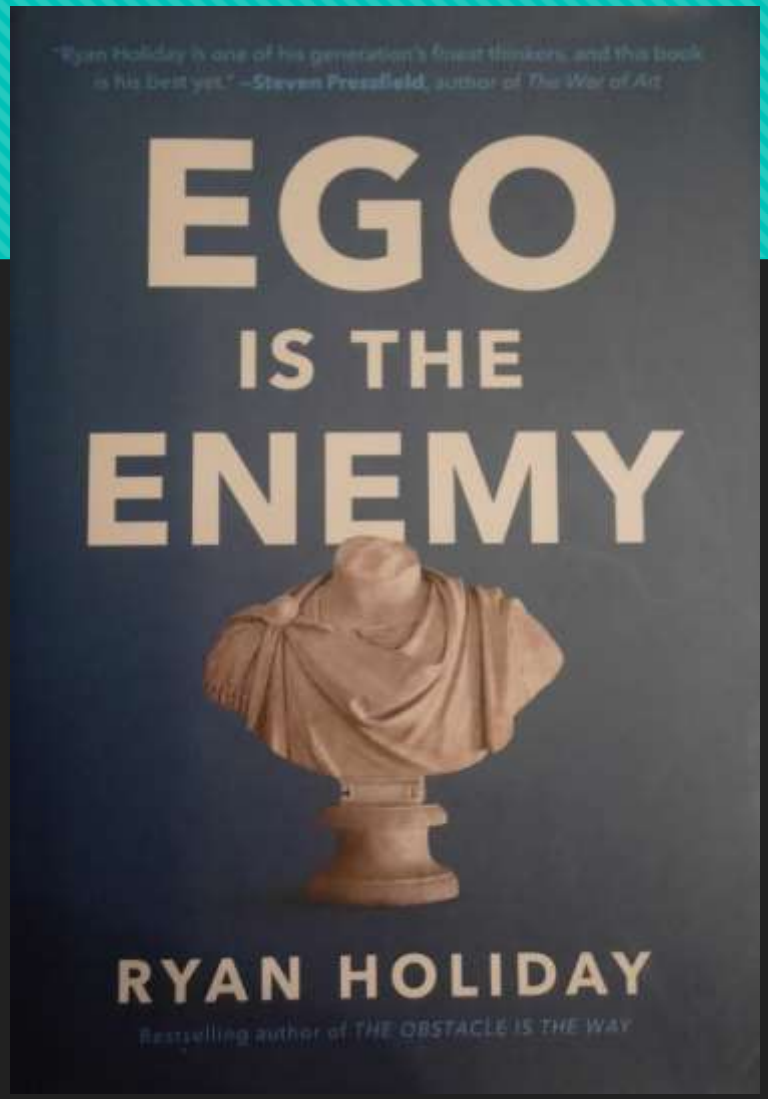
- Routine HHR at the time of LSG does not show an improvement in GERD symptoms.

THE GREATEST OF MANKIND'S CRIMINALS ARE THOSE WHO DELUDE THEMSELVES INTO THINKING THEY HAVE DONE THE RIGHT THING

The Duodenal Switch Group

- Annual Meeting ASMBS (ASBS)
- Hess, Maurcoux, Scopinaro, Baltasar.
- 100 cm cc, the role of thirds,
- Baltasar Publications Smaller Bougie, Shorter CC
- My experience 65 open DS, Guess What? They fail

Ego is the anesthesia that deadens the pain of stupidity Dr Rick Rigsby



Current Problems with Designing a Bariatric procedure

01

Every procedure has a Honeymoon period and that goes away

02

It takes 5-10 years to really know the result of what you are doing now

03

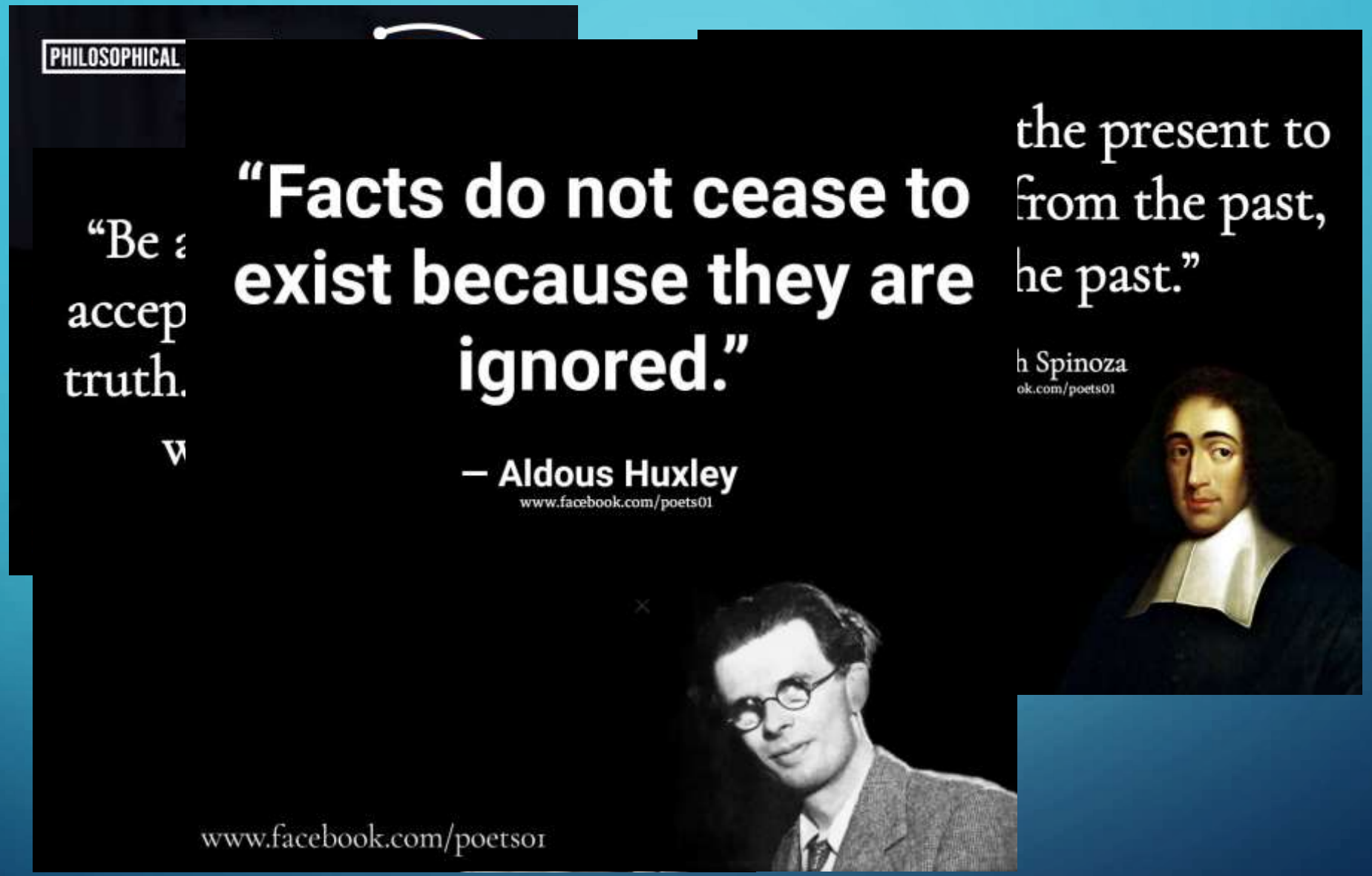
Dilutional effect of Honeymooners.

04

Non standard reporting and statsiticulation.

Why Procedures Fail?

- Obesity is not a GIT problem.
- All Pouches Stretch and dilate
- Small bowel always Adapts Hyperplasia, Hypertrophy (short bowel syndrome lessons)
- Dumping resolves.
- Food intolerance improves.
- Appetite returns.
- Hormonal changes (if any) come back.
- Social and cultural pressures remain, Behavioral issues.

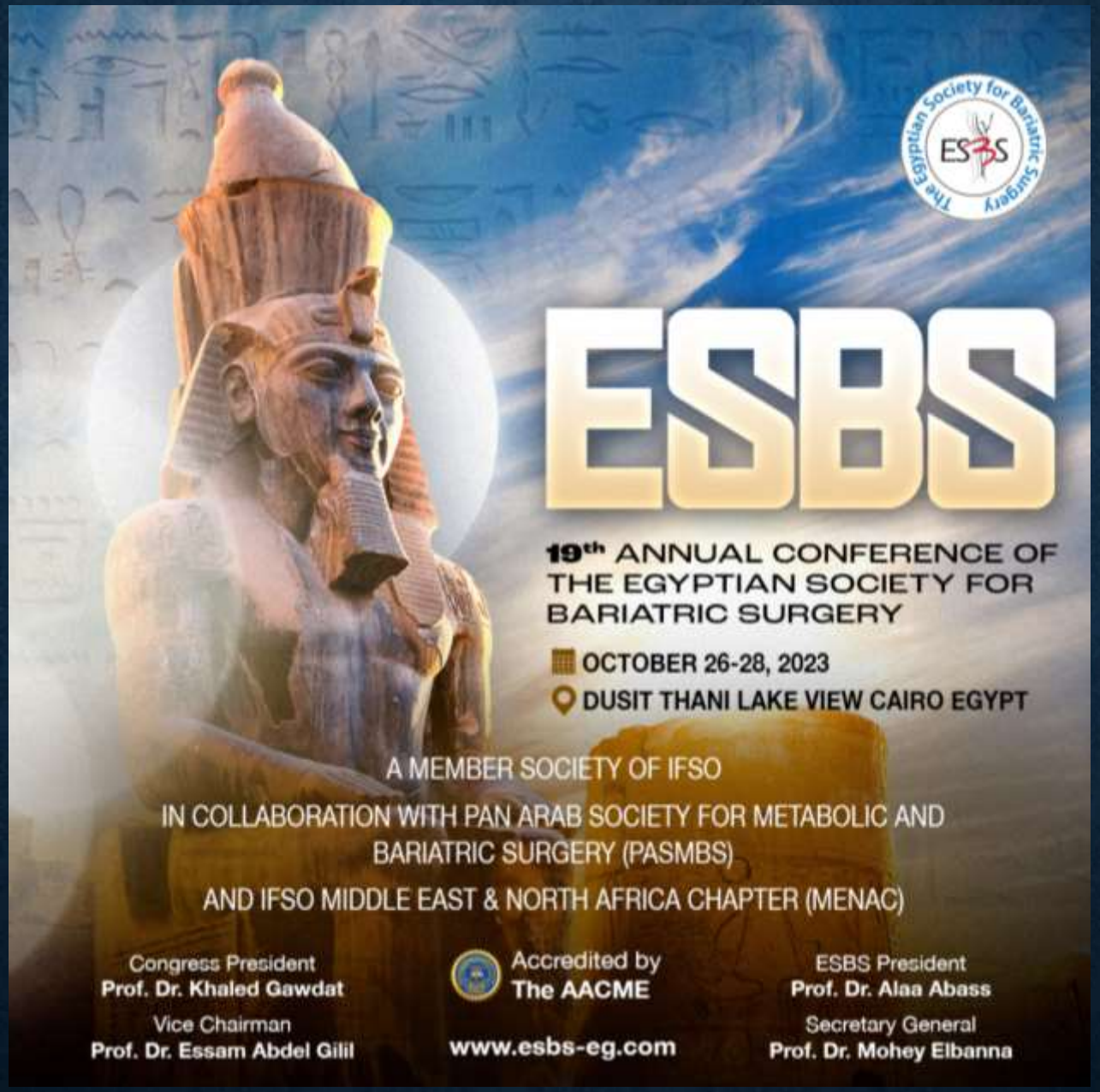

PHILOSOPHICAL
"Be a
accep
truth.
w
"Facts do not cease to exist because they are ignored."
— Aldous Huxley
www.facebook.com/poets01
the present to
from the past,
he past."
h Spinoza
ok.com/poets01
www.facebook.com/poets01

- The Truth will set you free, but first it will piss you off

There are patients whom we cannot help but there are none whom we cannot harm (Alfred Cuschieri)

Conclusion

- Sleeve gastrectomy is doomed
- Sleeve patients should come back for the second stage after the honeymoon
- Weight loss failure and reflux will cause the demise of the procedure
- Logic defying Science is Wrong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THANK YOU