OAGB versus RYGB

XXIX IFSO World Congress
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Mohamad Hayssam ElFawal

Case mix disclosure slide

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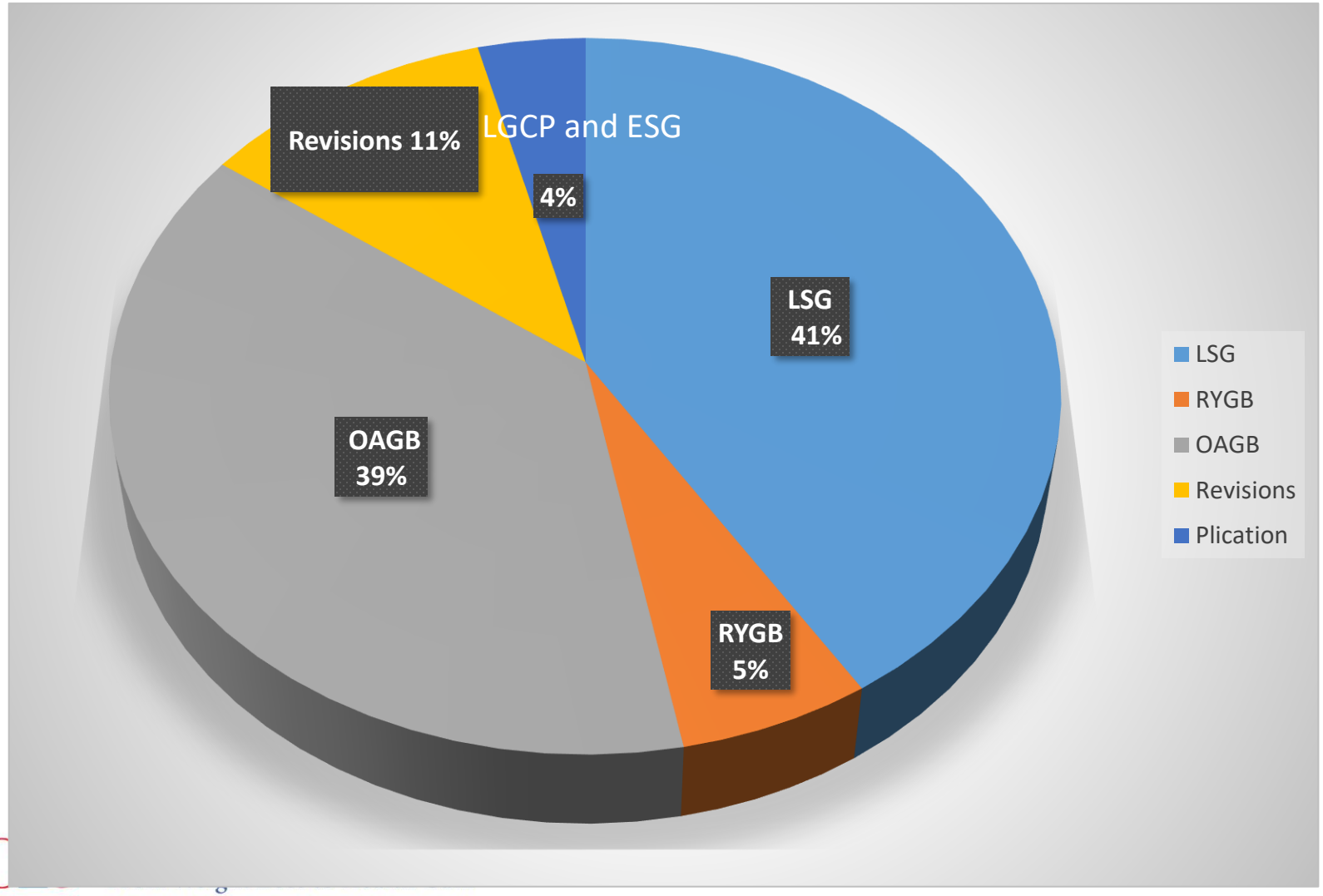

OAGB

RYGB

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What makes A Succesfull Bariatric and Metabolic Surgery Procedure

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- Reproducibility
- Safety
- Long term Weight loss and metabolic outcome
- Low Long term complications
- Ease of Reversibility and convertibility

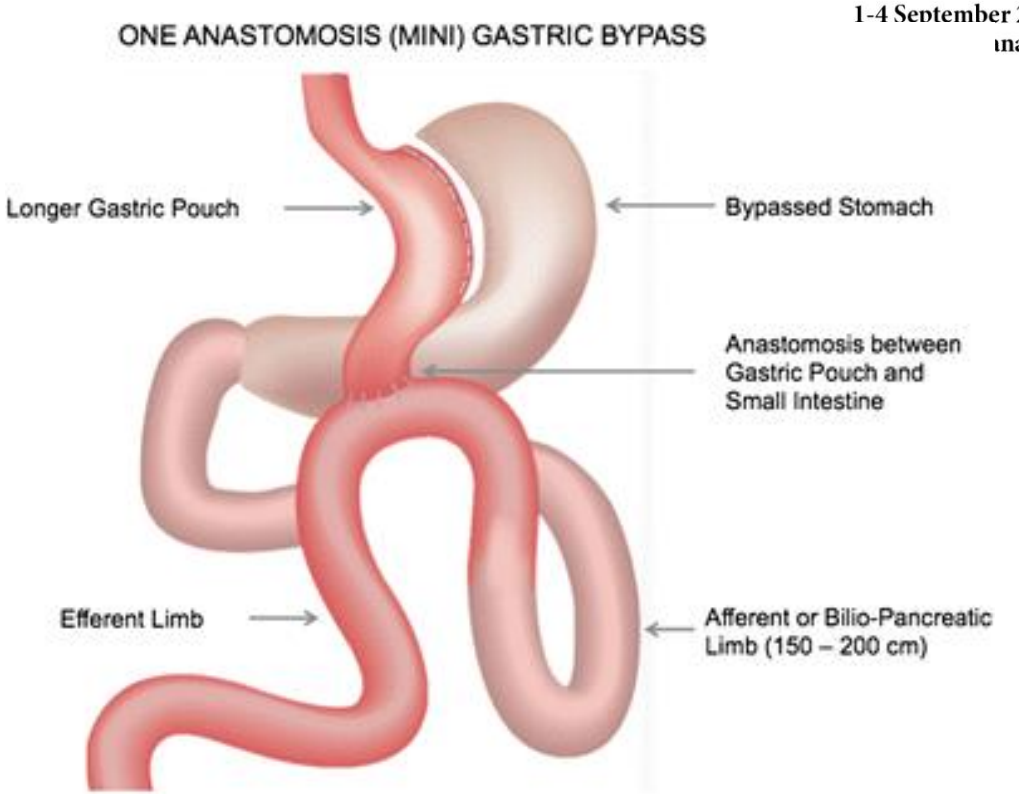
"OAGB is easier than RYGB" is the wrong message.

- OAGB has a simpler construct: one gastrojejunostomy and no jejunojejunostomy.
- Simplicity of the operation does not mean simplicity of the complication profile.
- The appropriate message is: reproducible when performed with a disciplined technique and adequate learning curve.

A reproducible operation still requires judgment, experience and structured complication management.

What makes OAGB reproducible?

- One anastomosis
- Standardized pouch construction
- Gastrojejunostomy performed below the crow's foot
- A relatively short, standardized anastomosis (2–4 cms)
- No jejunojejunostomy → lower opportunity for internal hernia compared with RYGB



> The key advantage is procedural standardization—not "ease."

Evidence of reproducibility

Large published series

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2,410
consecutive OAGB/MGB cases
Rutledge • Obes Surg 2005

1,000
consecutive OAGB/MGB cases
Noun • Obes Surg 2012

1,163
consecutive OAGB/MGB cases
Lee • Obes Surg 2012

974
consecutive OAGB/MGB cases
Musella • Surg Endosc 2014

1,300
consecutive OAGB/MGB cases
Chevallier • Obes Surg 2014

1,054
consecutive OAGB/MGB cases
Kular • Obes Surg 2014

1,200
consecutive OAGB/MGB cases
Carbajo • Obes Surg 2017

2,678
consecutive OAGB/MGB cases
Musella • Obes Surg 2017

12,807
consecutive OAGB/MGB cases
Parmar & Mahawar • Obes Surg 2018

Key source: Parmar CD, Mahawar KK. Obes Surg. 2018;28:2956–2967. The systematic review included 12,807 procedures. cite turn0search0

GERD and bile reflux: what do we know?

40
studies

17,299
patients

2%
pooled GERD rate

×6
higher after revisional OAGB

- Reported GERD rates varied widely (0–55%) depending on how reflux was defined.
- The pooled rate was approximately 2%, close to the rate reported in RYGB in the cited review.
- Revisional OAGB was associated with substantially more reflux than primary OAGB.
- The evidence supports vigilance—not dismissal of reflux concerns.

Davarpanah Jazi AH et al. Expert Rev Gastroenterol Hepatol. 2023;17:1321–1332. cite turn0search1

GORD and Barrett's oesophagus after bariatric procedures: multicentre prospective study.

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- A total of 241 patients were enrolled. A minimum follow-up of 10 years was completed by 193 patients following AGB (57 patients), SG (95 patients), and RYGB (41 patients), and of >3 years by 48 subjects following OAGB.

- The overall **prevalence of erosive oesophagitis** was greater in the SG group (74.7 per cent) than in the AGB (42.1 per cent), RYGB (22 per cent), and OAGB (22.9 per cent) groups

- ***Alfredo Genco, Giovani Casella. BJS Dec 2021.***

Conversion after sleeve: OAGB versus RYGB

Recurrent weight gain

78	22%	4.4%	p<0.001
patients	TWL after OAGB	TWL after RYGB	difference in TWL

- OAGB: n=31; RYGB: n=47.
- PPI use and pathological endoscopic findings were similar between groups.
- Major complications: 0% vs 8.5% (p=0.09).
- GERD resolution: 77.4% after OAGB vs 91.9% after RYGB (p=0.03).

Dayan D et al. Obes Surg. July 2023. Data as presented in the original deck.

Long-term effect of Roux-en-Y gastric bypass versus sleeve gastrectomy on reflux and Barrett's oesophagus: *a randomized controlled trial*

Anz J Surg Jan 2025. Lee, Robertson, Booth

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- **Results:** Forty-eight of 109 patients were enrolled into the study (LSG 26 vs. LRYGB 22). Mean follow-up was 7.5 years for the LSG group, and 7.4 years for the RYGB group (P = 0.22). 8 LSG patients had BO while 3 LRYGB patients had **BO (30.8%vs13.6%, P = 0.19).** There was no significant difference in the mean reflux (8.1 ± 9.4(0-36) vs. 9.3 ± 8.8(0-34), P = 0.47) and regurgitation scores (7.7 ± 6.9(0-22) vs. 11.5 ± 10.5(0-44), P = 0.23) for LSG versus LRYGB patients or between those with and without BO. PPI usage before and after surgery was 6/26 (23.1%) versus 13/26 (50.0%) and 8/22 (36.4%) versus 12/22 (54.5%) for LSG and LRYGB patients respectively.

Esophageal cancer after bariatric surgery

Why long-term surveillance and access matter

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> The issue is uncommon, but altered anatomy can make diagnosis and treatment challenging.

0.05%

estimated post-bariatric esophageal cancer burden in the cited analysis

15

patients with esophageal cancer or Barrett's after prior bariatric surgery in a multicentre cohort

46.7%

had prior RYGB in that cohort

> Do not frame this as evidence that RYGB causes esophageal cancer. The paper addresses epidemiology, altered anatomy and treatment challenges.

Plat VD et al. Obes Surg. 2021;31:4954–4962. DOI: 10.1007/s11695-021-05679-1. cite turn0search36

MGBOAGB and Gastric cancer

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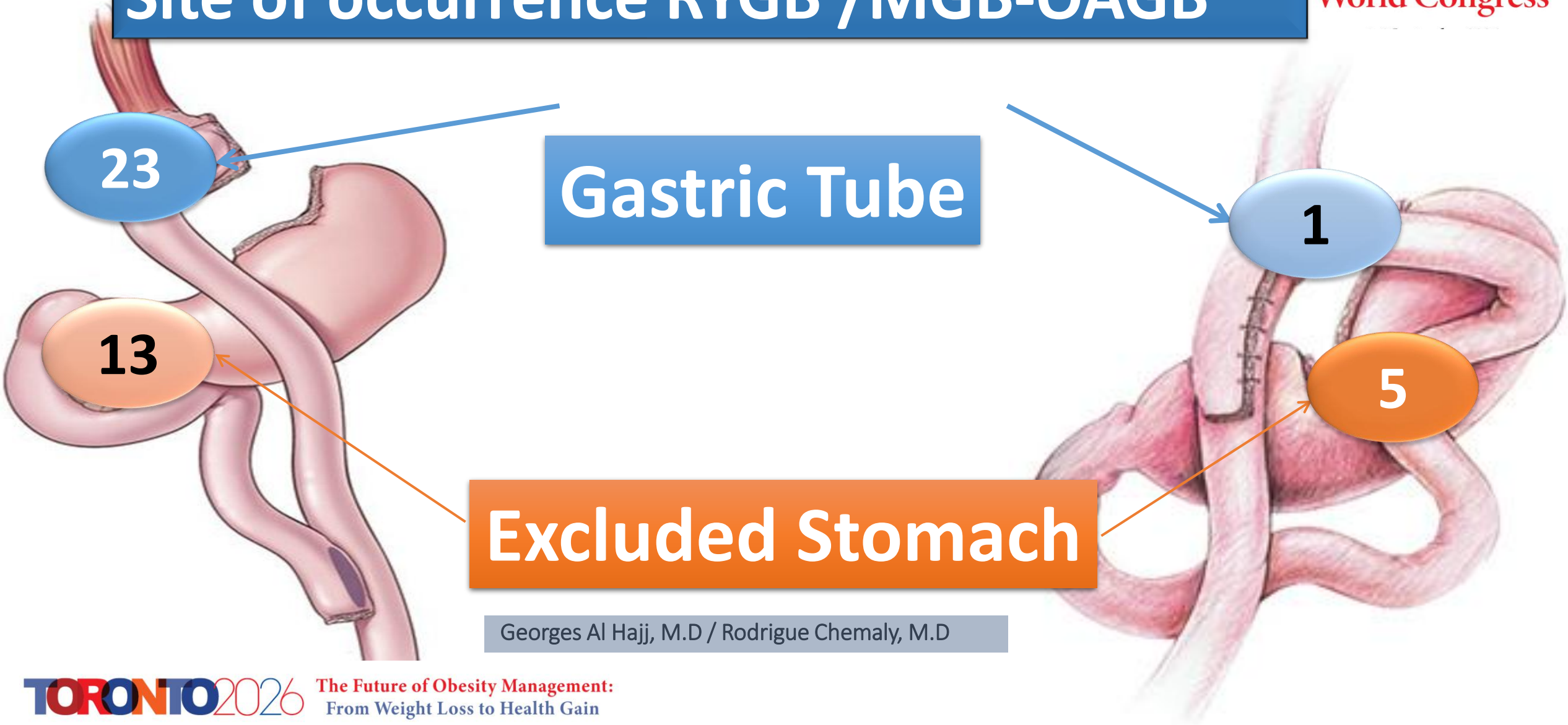
Site of occurrence RYGB /MGB-OAGB



Georges Al Hajj, M.D / Rodrigue Chemaly, M.D

Complications, conversion and reversal

A practical framework

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GJ leak

Drainage • endoscopy • surgery

JJ-related issues

Stenosis, intussusception, leak

Internal hernia

Lower risk without a JJ, but not zero

Refractory reflux, Barret's Cancer

Close to RYGB
Medical therapy → conversion to RYGB when indicated

Protein-caloric malnutrition

negligible% if BP l 150 cms

Reversal / conversion

OAGB can be rev
when clinically necessary

1. OAGB is reproducible
2. Weight-loss and metabolic efficacy are stronger than RYGBP(primary and revisions)
3. Reflux and protein caloric malnutrition warrant technique standardization and follow up
4. Relatively easier convertibility and reversibility in case of complications.
5. For all of the above my vote goes for OAGB


INTERCONTINENTAL
JORDAN
Conversion of LSG to OAGB; Why and How!
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FACS
United Arab Emirate
Chapter
ACS Chapters

Thank you

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