

Question

for Dr. Peter Benotti

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sion, severe osteoarthritis and obstructive sleep apnea, for which she is currently on C-PAP therapy.

- 1) Would you consider this patient for a revision?
- 2) If yes, would you consider a band removal and a redo of the gastrojejunostomy to achieve appropriate restriction?
- 3) Would you suggest another option?
- 4) Do you have any algorithm for evaluation and revision of failed bariatric procedures?

Dr. Benotti's Reply

The expected long-term weight loss from vertical banded gastroplasty is 40% to 50% of excess body weight. The average long-term weight loss after gastric bypass is two-thirds excess body weight. After gastric banding, expected long-term weight loss is 40% to 50% of excess body weight.

This patient has apparently failed all three procedures.

An important aspect of the informed consent process for gastric surgery for morbid obesity is that patients understand that these procedures do require behavior modification and lifestyle changes to obtain successful, enduring results. For any weight loss treatment to work, patients must sustain a period of time when their energy consumption as food must be less than their energy expenditure. For durable weight maintenance, energy consumption as food must approximate energy expenditure.

For some reason, despite three operations, this patient only lost 20 lb. One must ask the patient, "Did the surgery fail, or did you fail the surgery?" If the surgery was performed well and there is no documented structural failure of the operation when fluoroscopy and upper endoscopy are performed,



Peter Benotti, MD

A 62-year-old morbidly obese female patient underwent a vertical band gastroplasty in 1986. She regained a significant amount of weight and was converted to gastric bypass in 1990, with eventual loss of restriction that we attempted to treat by placing a laparoscopic adjustable gastric band in 2004. She has managed only a net weight loss of 20 lb, despite multiple adjustments. Her height is 4'9" and current weight is 219 lb, resulting in a body mass index of 47.4 kg/m². Her comorbid conditions include hyperten-

sion, severe osteoarthritis and obstructive sleep apnea, for which she is currently on C-PAP therapy. we must assume that the patient has been unable to alter her eating behavior and lifestyle. *We must remember that surgery is not a cure for obesity, but simply a palliative treatment that requires patient participation and commitment for success.* The success rate for the gastric obesity operations is not 100%, and never will be.

As part of the evaluation for obesity treatment for this patient, I would recommend she keep food records and then,

based on these, conduct a detailed evaluation of her caloric intake. I suspect that the patient has altered her food preferences to soft, high-calorie foods to allow comfortable food consumption for satiety and to avoid restrictive symptoms. This issue should be thoroughly explored in the psychological and behavioral assessment. In addition, energy expenditure should be measured to determine how many calories this patient is consuming daily to maintain her 219-lb weight.

Once this is deduced, she should be placed on a 300- to 400-kcal/day negative energy balance diet and closely observed. Her ability to follow this new regimen for the short term will indicate whether she can comply with a possible revision operation in the future.

If the behavioral evaluation is favorable and the patient is compliant with a medical weight reduction program—that is, she achieves weight loss,

keeps appointments—she can be considered for possible surgical revision. Revision options are limited, and revisional surgery for this patient is considered controversial at best. Age is a proven risk factor for any bariatric procedure, and surgical risks increase with each revision. There are no published results of outcomes in patients undergoing three revision operations for morbid obesity; clearly, careful patient selection is an important component. The surgical team must be convinced that the benefits of revision surgery will outweigh the risks. In this patient, who has already failed three operations, this risk-benefit decision will be difficult. Thorough medical evaluation, control of all comorbidity and detailed cardiopulmonary workup are an important part of the risk analysis for this patient.

I would intentionally have a long evaluation process for this patient—possibly four to six months—to get to know more about her and assess her capacity for dietary compliance. Although I am not enthusiastic about offering this patient surgical treatment, for obvious reasons, there is really no other treatment available with any potential for achieving lasting weight loss. If the preoperative evaluation process is productive and the patient is compliant and genuinely motivated, surgical options are a consideration.

My preference would be to redo the gastric bypass as a transected banded gastric bypass and to increase the malabsorptive component by extending the Roux-en-Y limb length. The extent of the malabsorptive component will be dictated by measurement of energy expenditure (the lower the resting energy expenditure, the greater the malabsorption component).

References

- Behrns K, Smith D, Kelly K, et al. Reoperative bariatric surgery: lessons learned to improve patient selection and results. *Ann Surg.* 1993;218:646-653.
- Capella J, Capella R. An assessment of vertical banded gastroplasty-Roux-en-Y gastric bypass for the treatment of morbid obesity. *Am J Surg.* 2002;183:117-123.
- Fobi M, Lee H, Felahy B, et al. Choosing an operation for weight control, and the transected banded gastric bypass. *Obes Surg.* 2005; 15:114-121.
- Kral J. Selection of patients for anti-obesity surgery. *Int J Obes.* 2001;25(suppl 1): S107-S112.