



Report on the Mini-Gastric Bypass Conclave

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A prime mini-gastric bypass (MGB) Conference was held at the Apollo Hospital, New Delhi, India, July 17 and 18, preceded by a day of instructive surgery. The “Conclave” was organised by Arun Prasad and Kuldeepak S Kular, with course leaders Robert Rutledge and Mervyn Deitel, plus an energetic Indian advisory and local committee with an illustrious national faculty.

The 240 attendees intensively discussed the rapidly emerging MGB/ One-Anastomosis Gastric Bypass (OAGB), including the controversial aspects. This operation has had a large increase in many countries in recent years, and now makes up about 50% of the bypass operations in India.

On July 16, there was a pre-conference operating-room workshop with 20 surgeons. Four MGB operations were performed, two by robotics by Dr Arun Prasad, one laparoscopic by Drs Rutledge/Kular, and one laparoscopically by Dr Mohit Bhandari. The four operations were accomplished with an operating time of 35-40 minutes each, with discussion of key technical aspects of the robotic and laparoscopic procedures. Robotics were demonstrated to be simple and accurate, with a particular advantage for super-obese patients.

The techniques for the MGB were emphasised, including the perpendicular division of stomach below crow’s foot, the vertical long pouch stapler-divided without crimping the stomach, extending to the left of the angle of His (the cardia not dissected), and a wide gastrojejunostomy. Dr Rutledge pointed out when dissecting upwards parallel to the lesser curvature, that a twist should not be made, so that vomiting is avoided postoperatively, and this was by a counter-clockwise adjustment of the stomach before firing the stapler vertically.

On July 17, there was live transmission of lap MGB by Drs Rutledge/Kular from the operating theatre to the delegates in the auditorium. This was followed by a plenary session where Dr Pradeep Chowbey discussed the need for newer bariatric procedures. Dr Deitel discussed the global bariatric perspective, noting that the world’s greatest obesity is in Polynesia/Micronesia, followed by USA, India and China together, and Russia due to the large populations of these countries. He noted that the MGB was now the 4th most common bariatric operation, and appears to be moving to number three.

Dr Kamal Mahawar discussed the comparative studies on the MGB, which has shown it to be superior in treating aspects of the metabolic syndrome. Finally, Dr Rutledge presented the history and physiology of the MGB, which he started in 1997, noting that steatorrhea was the main cause of its weight loss.



Professors Prasad, Kular, Deitel and Rutledge with the robotic set-up behind them

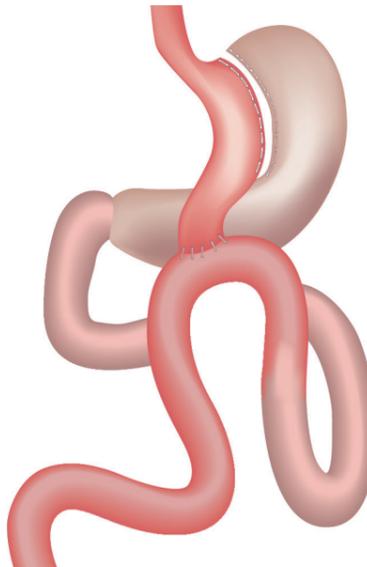


MGB by Robotics

The remainder of the day consisted of panel discussions with indications and contra-indications under examination. Concerns were expressed with young (menstruating) females who require iron surveillance. Approximately, 50% of Indians are vegetarian, their diet was discussed to avoid postoperative protein malnutrition (low albumin); this consists of consuming yogurt, dairy milk, legumes (lentils, beans, chick peas, etc.), tofu, brown rice, peanuts, and possibly whey protein supplementation. When used as a re-do operation, MGB is not suitable following a gastric plication because of danger of leaks.

Modifications and individual preferences in technique were discussed, along with videos. It was pointed out by Dr Rutledge that shorter bypass lengths should be used in certain situations, eg 150cm for type 2 diabetics who are not greatly obese. The general length has been 200cm (190 in many), but for super-obese, 250cm has been used. Lesser lengths may be used in vegetarians. It is important that there is at least 300cm of ileum distal to the bypass.

A panel on nutrition after MGB included dietitians. The importance of supplements of calcium, vitamin D3, folic acid (especially in those intending to



Mini-gastric bypass

from the Apollo operating theatre to the auditorium. Dr Prasad demonstrated advantages of robotic MGB. This was followed by panel discussions by MGB ‘doers’ and ‘non-doers’. Those without experience in the MGB, especially those doing RYGB, tended to be opposed to the MGB. There were surgeons who expressed their concerns and worries regarding some of the negative statements about MGB that have been made at various conferences. All these concerns were discussed in detail.

It was noted that those performing the MGB had previously performed the other bariatric operations, and that there were less complications with the MGB. They also found the long-term weight loss to be more durable. There is also ease of revision for excess or inadequate weight loss, moving the GJ anastomosis which is a rather small procedure. With the uncommon occurrence of too great weight loss, the MGB is readily reversible by taking off the gastrojejunal loop and constructing a gastrogastrostomy. There were questions about long-term weight loss with the MGB, but long-term studies were noted showing durable weight loss by Drs Lee, Noun, Rutledge, Kular, Chevallier and Musella.

Regarding the threat of carcinoma, Dr Deitel presented data which showed that this was without evidence. He pointed out 45 cases of carcinoma of stomach after RYGB, and a number after gastric banding and after sleeve gastrectomy. The fear from studies of bile applied to the rat’s stomach has no merit; the proximal 2/3 of the rat’s stomach is squamous cell where hyperplasia occurs, but the distal 1/3 is glandular like the human stomach, which shows no change. As has been shown by Dr Rutledge, preoperative reflux greatly disappears after MGB, and this is proven by the recent study, ‘Effects of omega-loop bypass on esophago-gastric junction function’ by S Tolone S et al in SOARD, where the MGB as a low-pressure tube with low gastro-esophageal pressure gradient was without GE reflux, whereas the sleeve gastrectomy as a high-pressure tube showed GE reflux. The general feeling was that performance of MGB will increase.

Gurvinder Jammu discussed his audit of 1,107 bariatric operations consisting of LSG, RYGB and MGB, in which the MGB had shown the least complications, no deaths, the best weight loss and the best resolution of diabetes (94%), hypertension and dyslipidemia.

All patients operated during the MGB Conclave went home within 24 hours, have seen Dr Prasad on routine one-week follow-up, and are doing well without any complaints. Four were diabetics, and all have normal blood sugar now, and are not using their anti-diabetic medications as per advice by their endocrinologists.

(A list of published papers on MGB/OAGB is available from Dr Deitel at: book@obesitysurgery.com)



Mohit Bhandari, team and observers



Left to right: Rutledge, Shah and Layani

become pregnant), and adequate protein intake were emphasized. Of importance was Proferrin (heme-iron polypeptide) which is readily absorbed down the intestine; this preparation does not require ionic action in a duodenal sweep. The incidence of marginal ulcer appears to be less than after RYGB; when present, PPI and yogurt and used, with cessation of smoking and NSAIDs.

An interactive panel on insurance for bariatric surgery was provided by the CEOs of insurance companies. Hospitals in India are mainly private.

On July 18, there was live transmission of a robotic MGB by Dr Arun Prasad