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V-095 - REVISIONAL SURGERY FOR WEIGHT REGAIN AFTER *SLEEVE* GASTRECTOMY AND ROUX-EN-Y GASTRIC BYPASS: WHAT'S NEXT?

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Resumen

Introduction: Sleeve gastrectomy (SG) and Roux-en-Y Gastric Bypass (RYGB) are commonly performed bariatric procedures with generally positive outcomes. However, a notable minority of patients may experience significant weight regain, in some cases up to 50% of the total weight lost. Factors contributing to this phenomenon can include anatomical changes such as pouch dilatation, increased width of the gastrojejunostomy, variations in the lengths of the gastro alimentary and biliopancreatic limbs, or an extended common channel length. Given these complexities, various strategies for enhancing weight loss have been proposed, tackling both surgical and anatomical challenges. Resizing the gastric pouch or distalizing the RYGB, by elongating the gastroalimentary or biliopancreatic limb, is recommended for an effective RYGB revision to control the percentage of excess body weight regained. A video demonstrating the laparoscopic distalization of RYGB is presented.

Methods: We detail the case of a 42-year-old male who underwent *sleeve* gastrectomy in 2012 with an initial BMI of 60 kg/m². Despite an initial total weight loss of 50%, he experienced a weight regain of 50% of this loss, leading to a BMI of 45 kg/m² three years later, requiring a second surgery with a RYGB. Following five years of unsuccessful conservative treatment, the patient's weight increased to a BMI of 55 kg/m². Endoscopy revealed a dilated gastric pouch and anastomosis. Upper gastrointestinal tract dynamic fluoroscopy revealed a "candy cane" configuration. A laparoscopic revision involving the resizing of the gastric pouch and distalization of RYGB was proposed.

Results: The laparoscopic revision identified the common limb length as 5 meters, measured from the enteroenterostomy to the ileocecal valve. The alimentary limb was extended to 2 meters, and the biliopancreatic limb to 60 cm. The alimentary limb was divided before the existing anastomosis and relocated 3 meters proximal to the ileocecal valve. The new anastomosis was created using a 45 mm linear stapler. The procedure included resizing the gastric pouch and resecting the 'candy cane' portion using a 36 Fr oro-gastric tube. There were no complications and the patient was discharged on the second postoperative day.

Conclusions: We recommend the routine measurement of the total intestinal length to prevent bariatric surgery failure. Revisional surgery, involving RYGB distalization at the expense of the biliopancreatic limb, might be a viable option for patients experiencing a secondary non-response after SG and RYGB.