globalnewsletter

BHATIA GLOBAL HOSPITAL & ENDOSURGERY INSTITUTE NEWSLETTER

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What goes around comes around !

> In helping others, we shall help ourselves, for whatever good we give out completes the circle and comes back to us.
>
> **Flora Edwards**

One day, a man saw an old lady, stranded on the side of the road, but even in the dim light of day, he could see she needed help. So, he went up to her Mercedes. Even with the smile on his face, she was worried. No one had stopped to help for the last hour or so. Was he going to hurt her? He didn't look safe; he looked poor and hungry. He could see that she was frightened. He said, "I'm here to help you, ma'am. Why don't you wait in the car where it's warm? By the way, my name is Bryan Anderson."

Well, all she had was a flat tyre, but for an old lady, that was bad enough. Bryan crawled under the car looking for a place to put the jack, skinning his knuckles a time or two. Soon he was able to change the tyre. But he had to get dirty and his hands hurt. As he was tightening up the nuts, she rolled down the window and began to talk to him. She told him that she was from St. Louis and was only just passing through. She couldn't thank him enough for coming to her aid. Bryan just smiled. The lady asked how much she owed him. Any amount would have been all right with her. She already imagined all the awful things that could have happened had he not stopped. Bryan never thought twice about being paid. This was not a job to him. He told her that if she really wanted to pay him back, the next time, she saw someone who needed help, she could give that person the assistance needed, & Bryan added, "And just think of me." He waited until she started her car and drove off. It had been a cold and depressing day, but he felt good as he headed for home.

A few miles down the road, the lady saw a small cafe. She went in to grab a bite and take the chill off before she made the last leg of her trip home. It was a dingy looking restaurant. The waitress came over and brought a clean towel to wipe her wet hair. She had a sweet smile, one that even being on her feet for the whole day couldn't erase. The lady noticed the waitress was nearly eight months pregnant, but she never let the strain and aches change her attitude. The old lady wondered how someone who had so little could be so giving to a stranger.

Then she remembered Bryan. After the lady finished her meal, she paid with a hundred dollar bill. The waitress quickly went to get change for her hundred dollar bill, but the old lady was gone by the time the waitress came back. Then she noticed something written on the napkin. There were tears in her eyes when she read what the lady wrote: "You don't owe me anything. Somebody once helped me out, the way I'm helping you. If you really want to pay me back, here is what you do: Do not let this chain of love end with you." Under the napkin were 10 more $100 bills. That night when she got home from work and climbed into bed, she was thinking about the money and what the lady had written. How could the lady have known how much she and her husband needed it? With the baby due next month, it was going to be hard…. She knew how worried her husband was, and as he lay sleeping next to her, she gave him a soft kiss and whispered soft and low, "Everything's going to be all right. I love you, Bryan Anderson."

Dear Fellow Travellers,

Humble appeal,

I seek your support, blessings and vote for the post of Governing Council (2010-12) membership (Delhi State), Association of Surgeons of India.

With warmest regards,

Dr. Parveen Bhatia
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Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.

Margaret Mead

EDITORIAL BOARD

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Laparoscopic Sleeve Gastrectomy — The New Platinum Standard?

CLINICAL EVIDENCE - Powering Decision Making In Bariatric Surgery

Dr. Parveen Bhatia MS FICS FIAGES FMAS FIMSA Dr. Suviraj John MS DNB FNB Global Hospital & Endosurgery Institute

Bariatric surgery is still in a state of evolutionary ferment. Laparoscopic Sleeve Gastrectomy, a relatively new bariatric operation, has captured the collective imagination of the global bariatric community since its inception, into the bariatric surgical armamentarium, earlier in the decade. Laparoscopic Sleeve Gastrectomy was first ingenuously performed in the high-risk patient subset by Gagner and colleagues to increase efficacy of the first operation (for patients with inadequate weight loss after biliopancreatic diversion with duodenal switch (BPD/DS))[1] or improve the safety of a second operation (Roux-en-Y Gastric Bypass for the management of the high-risk super-super obese patient (BMI >60 kg/m2))[2]. Mognol and colleagues in 2005 reported good outcomes with Sleeve Gastrectomy and suggested it be utilised as a stand alone bariatric procedure as well[3]. Since then the global bariatric experience with Sleeve Gastrectomy has matured in both these scenarios and we are now equipped with Level 1 'Intermediate-Term' Evidence of the same. Having come so far now, we can somewhat boldly answer a number of crucial questions. These are very important issues both to the emergent bariatric surgeon as well as to the seasoned expert.

Q. How good is the Clinical Evidence with Laparoscopic Sleeve Gastrectomy?

A. Considering the relatively short period of time that Laparoscopic Sleeve Gastrectomy has had in bariatric practice, a significantly large number (over 3000) of citations exist in publication. Unfortunately, as often is the case most of these reports class low in their value as meaningful evidence. Brethauer et al (2009) while systematically reviewing the outcomes of Laparoscopic Sleeve Gastrectomy in medical literature found only two (2) randomised controlled trials (Level 2 Evidence), one (1) non-randomised controlled trial (Level 3 Evidence)and thirty-three (33) case-series (Level 4 Evidence); a total of 38 studies (2570 patients) that met their criteria for systematic analysis[4]. Approximately a third of eligible patients underwent LSG as a staged-procedure and two-thirds as a primary-procedure. The follow-up was ~3-60 months. Well-powered, higher-quality studies are in order.

Q. How safe is Laparoscopic Sleeve Gastrectomy?

A. Like any surgical procedure, Laparoscopic Sleeve Gastrectomy has its share of complications. These include leakage, dilation of the sleeve allowing increased food intake, and other usual complications associated with bariatric surgery. Despite the high surgical risk of this patient population, the reported rates of postoperative leaks, bleeding, and stricture have been acceptably low. Table1. provides a morbidity and mortality profile of LSG with relation to the Laparoscopic Gastric Bypass (LGBP).

Overall, there is very low surgical risk, relative to LAGB (~10%), LGBP (~20%) and BPD + DS (~25%)[6], and an extremely low risk of needing another operation in the future, especially compared to Laparoscopic Gastric Banding procedures. This operation is the only bariatric procedure that has no malabsorption (as the LGBP and DS do) and no foreign body issues (as the Lap-Band does). This has promoted its use with a curative intent in a staged and non-staged manner for high-risk bariatric patients.

Q. How effective is Laparoscopic Sleeve Gastrectomy?

A. The stomach size is reduced to about 60 to 120 cc in volume. In addition, the Ghrelin-secreting fundus is excised.

Table1: Comparative Bariatric Data of Morbidity and Mortality Profiles

OPERATIVE CATEGORY	LSG - 'Staged' Procedure[4]	LSG – 'Primary' Procedure[4]	LGBP [5, 6]
Overall Morbidity	~ 9%	~ 6%	~ 15-25%
Leakage	~ 1%	~ 3%	~ 2%
Bleeding	~ 2%	~ 1%	~ 2%
Stricture	~ 1%	~ 0.5%	~ 5%
MORTALITY	< 1%	< 1%	< 1%

Table 2: Bariatric Efficacy of LSG vis-à-vis LGBP

OPERATIVE CATEGORY	LSG - 'Staged' Procedure[4]	LSG – 'Primary' Procedure[4]	LGBP[7]
Pre-Operative BMI	60	~45	-
Post-Operative BMI	~45	~30	-
EWL	~45%	60%	60%
Improvement in NIDDM	> 70%		~85%
Improvement in Hypertension	~80%		~80%
Improvement in Hyperlipidaemia	~75%		>70%
Improvement in Sleep Apnoea	~85%		~85%

Another benefit is that this procedure preserves the pylorus, which regulates emptying of the stomach. This allows the food to remain longer in the stomach, promoting a longer sense of satiety. Furthermore, there is no rearrangement of the bowel; the normal satiety mechanism is thus enhanced. Therefore, patients lose weight because of a cumulative 'anorexic' / 'satiety-enhanced'/ 'restrictive' effect. Weight loss with the Laparoscopic Sleeve Gastrectomy is in the range of 33 to 85% percent of the patient's excess body weight[4]. It has been shown to have better weight loss than other restrictive procedures such as Lap Banding procedures (EWL=45-50%). Co-morbidity resolution compares favourably with that of a combined restrictive /malabsorptive procedure (Table2.). Additionally, dumping and marginal ulcers are not a problem, when compared to malabsorptive procedures.

There are some disadvantages to Laparoscopic Sleeve Gastrectomy. It does not always produce the desired weight loss that patients hope for, nor does it prevent weight gain. Such a status often mandates a reoperative/ revisional surgical strategy.

Q. What are the Current Indications for Laparoscopic Sleeve Gastrectomy?

A. Broadly, Laparoscopic Sleeve Gastrectomy is performed currently as a –

1. Stand alone (Primary) procedure for –
   1. Those who do not have much weight to lose or for
   2. Those who are older or at a higher operative risk.
2. It may also be done as part of a Staged operation for –

   High-risk patients with a BMI > 60. In this case, the Laparoscopic Sleeve Gastrectomy may precede a gastric bypass or duodenal switch.

Q. Surgeon Factor!?!

A. The Second International Consensus Summit for Sleeve Gastrectomy (ICSSG) was held in March 2009 to evaluate techniques and results in LSG[8]. Seventy-seven (77%) of attending surgeons felt that LSG was comparable with LAGB and LGBP in terms of clinical evidence. Surgeons are more enthusiastic with LSG as they find it technically easier to perform it in comparison to the LGBP and BPD + DS.

Current Evidence points out that LSG is an effective weight loss procedure that can be performed safely as a first stage or primary procedure. LSG results in excellent weight loss and co-morbidity reduction that exceeds, or is comparable to, that of other accepted bariatric procedures. The postoperative major complication rates and mortality rates have been acceptably low. Long-term data are limited, but intermediate-term data have demonstrated the soundness of the SG procedure. Early data suggesting this, prompted us to move over to LSG from LGBP, with subsequent favourable outcomes thus far.

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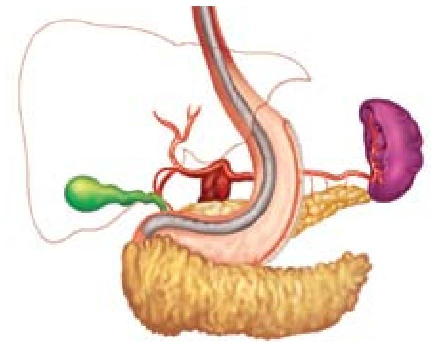
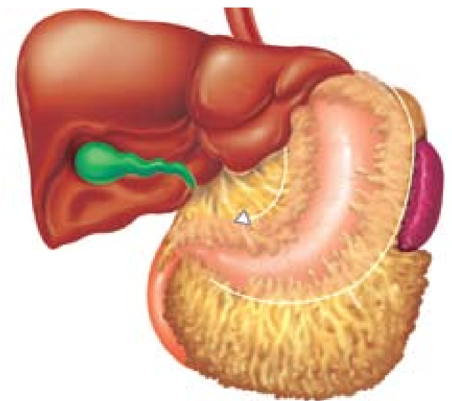
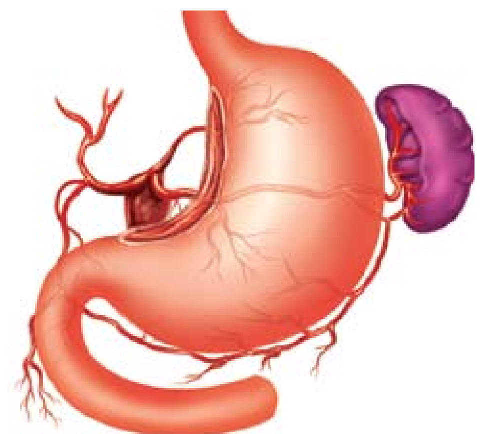


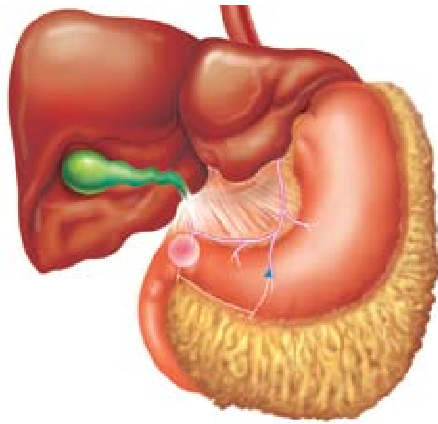
Sleeve gastrectomy

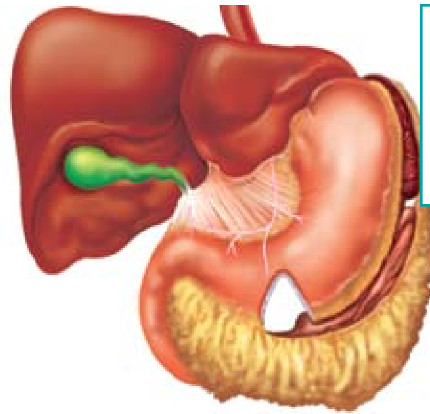


Gastrolysis started from incisura angularis



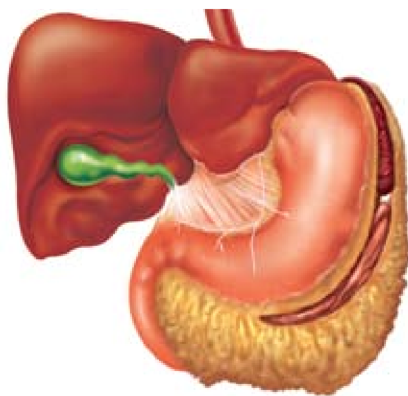
Injury to vessels avoided by remaining close to stomach

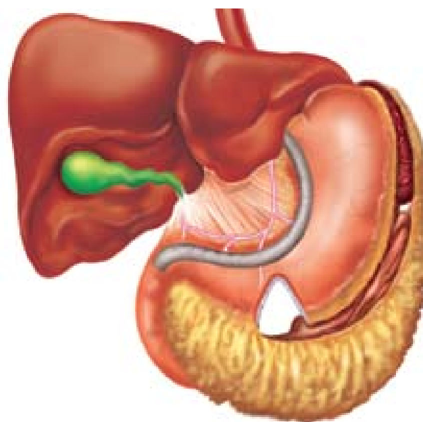

6 cm proximal to pylorus, vertical branch of nerve of latarjet seen


1st stapling done 2cm away from lesser curvature

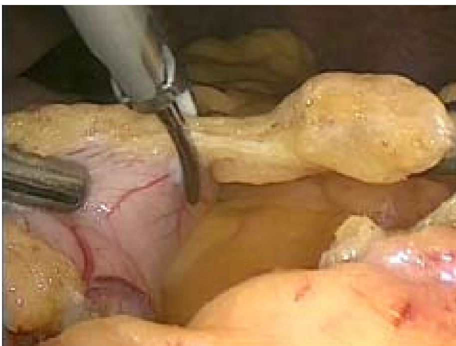
RNI NO.: DELENG/2001/6114
REGD. NO.: DL(W) 10/2076/2009-11
LICENSED TO POST WITHOUT
PRE-PAYMENT: U(W)-38/2009-11
Posted on 21st / 22nd of every month

Echlon 60 blue staples fired upto angle of His


Gastrolysis done upto angle of His


36F Bougie passed and green stapler applied

Suturing done with vicryl


Gastrolysis done with harmonic ACE

Echlon 60 green stapler firing

Delivery of resected specimen

just haemostasis
... safe endoscopy

October 2 – 4, 2009
Live surgery relayed from: Beams
J. W. Marriott Hotel, Juhu, Mumbai.

Dr. Rakesh Sinha

Asian Consensus Meeting on Metabolic Surgery II : ACMOMS 2009

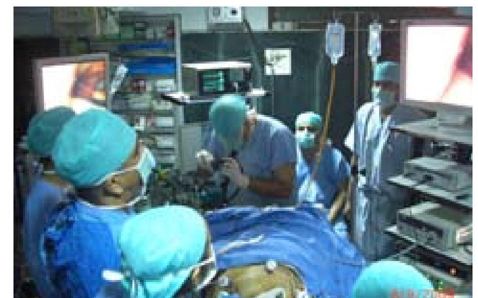
October 2 – 3, 2009,
Jodhpur, India

Dr. Muffy Lakdawala

Clinical Robotic Surgery Association (CRSA)
1st annual meeting

October 9 – 10, 2009
Swissotel Chicago, USA

Dr. Piero Giulianotti, MD,


Intra corporeal leak test done

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