



Original article

Long-term (11+ years) outcomes in weight, patient satisfaction, comorbidities, and gastroesophageal reflux treatment after laparoscopic sleeve gastrectomy

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Received November 25, 2015; accepted January 13, 2016

Abstract

Background: More than 10 years of outcomes for sleeve gastrectomy (LSG) have not yet been documented.

Objectives: Analysis of > 11 years of outcomes of isolated LSG in terms of progression of weight, patient satisfaction, and evolution of co-morbidities and gastroesophageal reflux disease (GERD) treatment.

Setting: Two European private hospitals.

Methods: Chart review and personal interview in consecutive patients who underwent primary isolated LSG (2001–2003).

Results: Of the 110 consecutive patients, complete follow-up data was available in 65 (59.1%). Mean follow-up was $11.7 \pm .4$ years. Two patients had died of non-procedure-related causes. Twenty (31.7%) patients required 21 reoperations: 14 conversions (10 duodenal switch (DS), 4 Roux-en-Y gastric bypass (RYGB), and 3 resleeve procedures) for weight issues and 2 conversions (RYGB), and 2 hiatalplasties for gastroesophageal reflux disease (GERD). For the 47 (74.6%) individuals who thus kept the simple sleeve construction, percentage of excess body mass index loss (%EBMIL) at 11+ years was 62.5%, versus 81.7% ($P = .015$) for the 16 patients who underwent conversion to another construction. Mean %EBMIL for the entire cohort was 67.4%. At 11+ years postoperatively, 30 patients versus 28 preoperatively required treatment for co-morbidities. None of the 7 patients preoperatively suffering from GERD were cured by the LSG procedure. Nine additional patients developed de novo GERD. Overall satisfaction rate was 8 (interquartile range 2) on a scale of 0–10.

Conclusion: Isolated LSG provides a long-term %EBMIL of 62.5%. Conversion to another construction, required in 25% of the cases, provides a %EBMIL of 81.7% ($P = .015$). Patient satisfaction score remains good despite unfavorable GERD outcomes. (Surg Obes Relat Dis 2016;■:00–00.) © 2016 American Society for Metabolic and Bariatric Surgery. All rights reserved.

Keywords:

Obesity surgery; Sleeve gastrectomy; Long-term outcomes; Gastroesophageal reflux; Weight loss; Long-term satisfaction

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<http://dx.doi.org/10.1016/j.soard.2016.01.013>

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Obesity and related co-morbidities constitute a significant health problem worldwide [1] because of their impact on quality of life, life expectancy [2], and healthcare finances [3]. Consequently, effective treatment modes, including

surgical procedures, are under constant investigation to address this gigantic issue. Laparoscopic sleeve gastrectomy (LSG) constitutes the restrictive component of duodenal switch (DS) and was initially used as first stage in the 2-stage approach of DS for super-obese patients [4,5]. Recently it has appeared that substantial weight loss and resolution of co-morbidities may be obtained by the LSG alone, making the second stage obsolete [6,7]. LSG is gaining popularity to the point of becoming for some surgeons the preferred surgical treatment in patients with morbid obesity [8,9]. The considerable popularity of the procedure partly may be due to its seemingly technical ease and good results, mostly, however, documented in short and mid-term only [10].

In our department LSG was selected as 1-stage procedure for those candidates for obesity surgery (according to the National Institutes of Health [NIH] guidelines [11]) who, in conformity to our algorithm (Fig. 1), a priori did not suffer from diabetes or gastroesophageal reflux disease (GERD) or who refused a bypass procedure, provided they did not present a significant hiatal hernia. After having published the 6-year results of LSG in our practice in 2010 [12], we now aim at evaluating the results of the procedure after > 11 years in a similar (albeit not identical) group of patients. Endpoints of the study were progression of weight, patient satisfaction, and evolution of co-morbidities and GERD requiring medical treatment or reoperation.

Materials and methods

All consecutive patients referred for surgical obesity treatment from our 2 private institutions who underwent primary LSG intended as 1-stage procedure by the same surgeon (J.H.) between November 2001 and June 2003 were analyzed. Referral was performed after extensive multidisciplinary evaluation, including medical history and physical examination, gastroscopy, abdominal ultrasound, psychiatric evaluation, and specialty consultations as needed. All patients were placed on a strict protein diet for 10 days before surgery to reduce liver volume, which is why some patients' body mass index (BMI) had dropped under the NIH threshold.

The surgical technique of LSG has been published previously [13,14]. In brief, the linear gastrectomy was started some 5–6 cm proximal to the pylorus and was performed using a 34F bougie as a guide inside the stomach lumen. The technique thus did not involve extensive dissection of the hiatus.

All patients had provided a written consent to undergo the LSG procedure and both hospitals' central ethical committees approved the study.

Data that had been prospectively collected by the same data nurse were retrospectively verified. Data sources included patient charts with follow-up notes and all reports

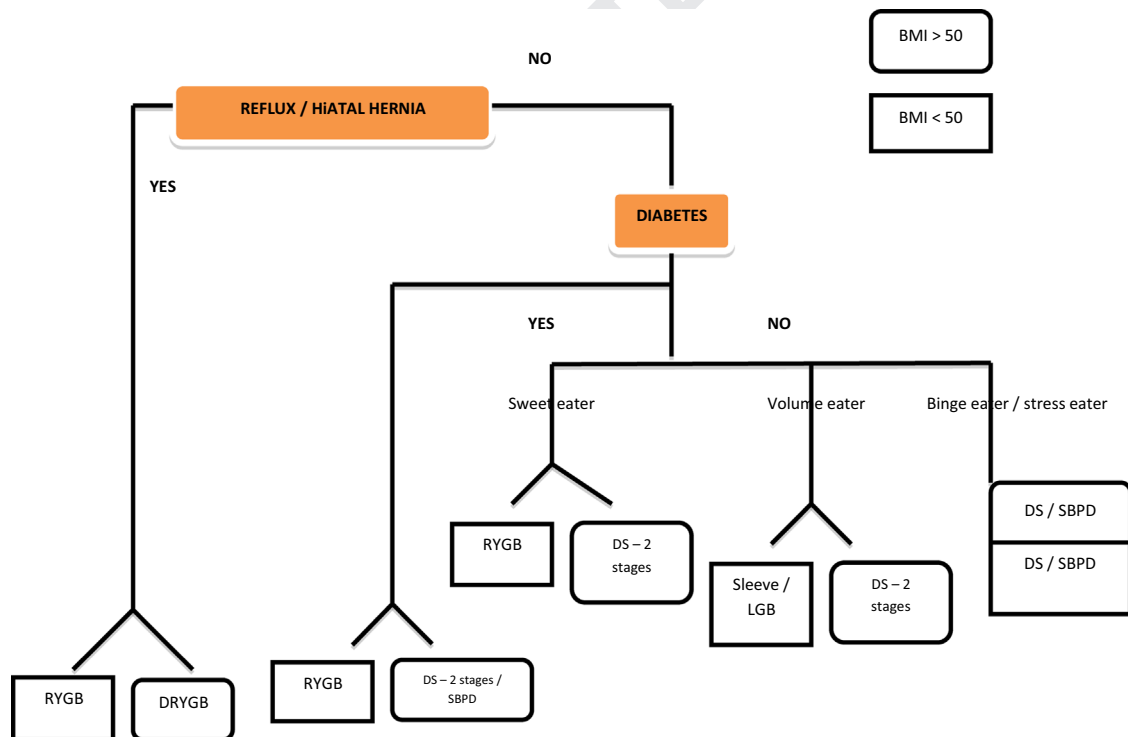


Fig. 1. Empirically established bariatric algorithm as used between 2001 and 2003. Decision tree (2001–2003) in patients who qualified for bariatric surgery according to the National Institutes of Health criteria. Treatment option differed depending on BMI > 50 kg/m² or < 50 kg/m². First indicator was the presence or absence of a hiatal hernia, second the presence or absence of type 2 diabetes. BMI = body mass index; RYGB = Roux-en-Y gastric bypass; DRYGB = distal Roux-en-Y gastric bypass; DS = duodenal switch; Sleeve = sleeve gastrectomy; LGB = laparoscopic gastric banding; SBPD = Scopinaro biliopancreatic diversion.

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