Challenging Bariatric Cases

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What was one of your most challenging bariatric surgery cases? How did you handle it, and what advice do you offer fellow surgeons facing a similar case?

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One of the most challenging cases I had to deal with was a female with a previous history of gastro esophageal reflux that underwent a laparoscopic Nissen fundoplication five years prior. As she gained weight, she had developed an incisional hernia that was repaired with a mesh over the mid line.

When she came to our center her BMI was 49 and had a recurrence of her reflux symptomatology. At this point she had developed diabetes, hypercholesterolemia, hypertension and was diagnosed with severe sleep apnea. Her PCP recommended her to have a bariatric operation and she was turned down twice by other local programs due to her past surgical history.

She was enrolled in our program and underwent a rigorous and multi disciplinary evaluation.
I had a long discussion with her and explained her that she needed to lose some weight in order to increase the chance of having a successful laparoscopic approach; this is a routine requirement in our program. I have also discussed with

her the possibility of not being able to complete the gastric bypass if I encountered too many adhesions from the previous surgeries that would prevent me from performing her surgery in a safe manner. Her insurance approved her to have a sleeve gastrectomy if the bypass was not an option.

With the assistance and supervision of our dietitians, she successfully lost 5 % of her weight prior to the surgery and we took her to the OR.

I decided to stay away from her incision and the mesh that was placed circumferentially and gained access into her abdomen on her right upper quadrant. Once I had obtained pneumoperitoneum I was able to visualize the area that was covered with the mesh and found out that there were many dense adhesions involving not only the omentum but also loops of small bowel. Upon identifying the ligament of Treitz we run the bowel to determine if we would have enough length for the Roux limb and found that the jejunum was severely adherent to the mesh. Taking these loops down was labor intensive but eventually was done. I had my concerns about converting her to a sleeve with the prior history of reflux and due to the fact that the sleeve creates a high pressure system that often makes the GERD worse.

We evaluated the stomach for the gastric bypass and exposed the area of the fundoplication. The undersurface of the liver was severely adherent to it and we needed to take it down carefully with blunt dissection and with the energy device. I cut the sutures of the wrap and the fundus was freed. Due to the intense inflammatory and scarring reaction the planes were not that clear and the wrap take down was very challenging as well. Once this was completed, we ended up with two gastrotomies at the level of the fundus. These injuries were in the periphery of the greater curvature and were repaired easily with free hand suturing. We then noticed that she had a hiatal hernia.

As the mobilization was already done, I decided to repair the hernia with a posterior imbrication of the crura. The whole area was scarred and thickened so when we were building the gastric pouch we used the stapler with green cartridges. The rest of the operation was perfomed in a usual fashion. The gastrojejunostomy was created with a 25 mm circular stapler.

An insufflation test and endoscopy were performed at the end of the operation. No evidence of a leak or bleeding was found at the level of the anastomosis.

The patient underwent a contrast study the next morning and this was again negative for a leak. The diet was advanced to liquids with good tolerance and she was discharged home on POD 3 without complications.

At her six month follow up, she had lost 90 lbs, no longer was a diabetic, her sleep apnea has resolved, and has no longer symptoms of reflux disease either.

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