

7th INTERNATIONAL B.E.S.T. CONGRESS 2011:



Bariatric Endoscopic Surgical Trends

**Report on the
7th International B.E.S.T. Congress 2011
Bariatric Endoscopic Surgical Trends, Nov 3-4, 2011
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The BEST congresses started in Brazil in 2005 and were held there in different cities every year until 2009. Last year it was moved to Lisbon, Portugal for its first European venue. This year it was the turn of the US to host it.

The meeting, which lasted 2 days, covered the latest trends in bariatric surgery, as well as a review of various topics in the field. There were also sessions with live surgeries. A world-class interdisciplinary faculty was invited for this intensive 2-day course.

The program in detail can be viewed here:

<http://goo.gl/iZYxt>

Day 1

Metabolic surgery-Diabetes resolution-Live surgeries-Complications

A review of the 2nd Diabetes Surgery World Congress was given. Metabolic surgery is defined by the effects the procedures have in glycemic control, HTN, survival/death rate. While the surgery reduces mortality and morbidity, and is life-saving and cost-effective, less than 2 % of the US eligible patients undergo bariatric surgery every year. This is the case despite the fact that within 2 years the investment of insurance companies is returned. One may assume that this applies to the population of other countries as well.

An interesting paradox was mentioned here: while the rate of coronary heart disease is decreasing, the rates of obesity and diabetes are increasing. The need for more RCT was stressed in order to convince skeptics of the effects of bariatric/metabolic surgery. In the last year studies on patients with a BMI less than 35 show positive results with regard to diabetes (DM) resolution. Since last April the International Diabetes Federation recommends that bariatric surgery on some diabetics with a BMI as low as 30 should be considered.

A lecture about the pathophysiology of various procedures was held. Without going into much detail in this report, it is obvious that hormonal changes that occur after surgery, result in a diminished appetite, in contrast to what happens after dieting. These changes are more potent after a gastric bypass than after a gastric sleeve or a gastric band procedure.

Four lectures were given on the effects of various bariatric procedures on diabetes. It is clear that the best effect on DM is that of duodenal switch (DS), but the procedure is not a common one (actually less than 1 % of all bariatric procedures in the US are DS).

Next on the program were live surgeries from hospitals in NY, Florida and Brazil (sic!). We had the opportunity to watch a SILS sleeve gastrectomy, a robotic LGBP, and a reoperation after a GBP because of a fistula to the remnant stomach (the fistula was stapled and an endoscopic control was done). In the gastric bypass an innovative leak test was shown: a nasogastric tube was put in place and connected to a nasal cannula, inflating the pouch with a liter of oxygen. In one of the LGBP a plication of the alimentary tract was shown, 20 cm in length with a boogie inside as a guide.

An excellent review-lecture on nutrition followed. Once again it was stressed out that sleeve patients should be on vitamins/minerals as LGBP patients do. In addition, as 80 % of the obese population has a preop vit D deficiency, patients should have their Vit D-levels checked before surgery. For those who want to learn more about vitamin requirements after bariatric surgery, they should read the ASMBS-guidelines in its web site.

A session on complications followed. Some highlights:

Complications such as leaks, are more frequent on re-do's. For example in one study the leak rate of LSG as a primary procedure was 2.8 % but 16 % after previous LAGB.

Morbidity jumped from 7% to 32.2 %. A lecture on stent demonstrated the use of stents in the management of leaks in various bariatric procedures. The success rate has been reported between 75-100 % (duration of stent placement 22-96 days).

Day 2

Revisional Surgery-Live surgeries-Surgical Innovations and Robotics

On this second day the focus was on revisional surgery and new endoscopic techniques as well as emerging technology in the field. Various endoscopic systems were presented (StomaphyX, ROSE, BARD, APOLLO Overstich [currently the only one approved and marketed in the US], Valen TX, Endo-barrier implant) which target the following areas: reduction of pouch size, closure of fistulas, malabsorption in the small intestine.

A group from Brazil presented a transvaginal (!) SG with no mortality, comparable op-time and somewhat better weight loss than LSG.

A lot was discussed also on gastric plication, which is an emerging procedure, still though an investigational one according to the ASMBS. It was initially performed in Iran as a way to make up for the lack of staplers. It is not risk-free as sometimes the public has been made to believe. In a sample of 1466 patients (from various studies) the leak was 0.2 %, stenosis 1.87 % and bleeding 0.62 %. About 1.4 % of patients required a reoperation. In small studies, gastric plication has been tried after a failed LAGB (slippage or pouch enlargement). All patients lost over 50 % EWL. In a non-homogenous group (i.e. boogie size varying from 40-60 Fr) of 8 patients with failed SG, gastric plication was done. Preliminary results at 6 months (in 4 of them), showed a weight loss of at least 50 % EWL. Finally gastric plication has also been performed in GBP-patients with a dilated pouch and GE anastomosis. In that report, 21 patients had

no intra-operative complications and a weight loss of at least 50 % EWL at 6 months (apart from one patient).

During the 2nd day live surgeries were again on the agenda: A gastric plication, and a LSG with a Nissen fundoplication at the same time (on a patient who insisted on having a LSG).

We also had the opportunity to watch an ileal interposition procedure (another emerging procedure which seems to have some promising results on diabetes remission). During this procedure a portion of the ileum (170cm in length) 30 cm proximal of the caecum is moved and anastomosed 30 cm from the Treitz ligament.

Overall an excellent meeting which I warmly recommend to any bariatric surgeon who wishes to get the latest on emerging technology and procedures in the field. Next year the meeting will be held at Guadalajara, Mexico. See you there!

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