



XXXII CONGRESSO  
NAZIONALE SICOB

23 - 25 MAGGIO 2024  
GIARDINI  
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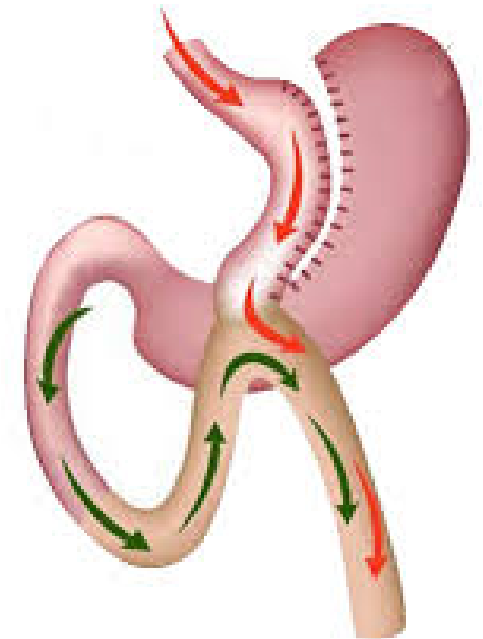
# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB

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# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: CENNI DI STORIA

- ❖ 1997 Routledge Minibypass (combinazione di un Gastroplastica verticale sec Collins ed un anastomosi gastrointestina ante colica sec Billroth II )
- ❖ 2002 Carbajo modificò la tecnica parlando per la prima volta di OAGB;
- ❖ 2014 procedura chirurgica riconosciuta da SICOB;
- ❖ 2018 IFSO Consensus Conference OAGB (Delphy) ;





# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: VANTAGGI

- ❖ Efficace EWL 77% (5 aa), risoluzione 80% e 67% DMII, IA rispettivamente.
- ❖ Basso tasso di complicanze 1% Leak, 4% MU;
- ❖ ↓ learning curve rispetto RYGB;
- ❖ ↓ Tempi chirurgici rispetto RYGB;
- ❖ ↓ incidenza di ernia interna rispetto RYGB;
- ❖ Procedura revisionabile e reversibile;

Obesity Surgery  
<https://doi.org/10.1007/s11695-020-04519-y>



ORIGINAL CONTRIBUTIONS



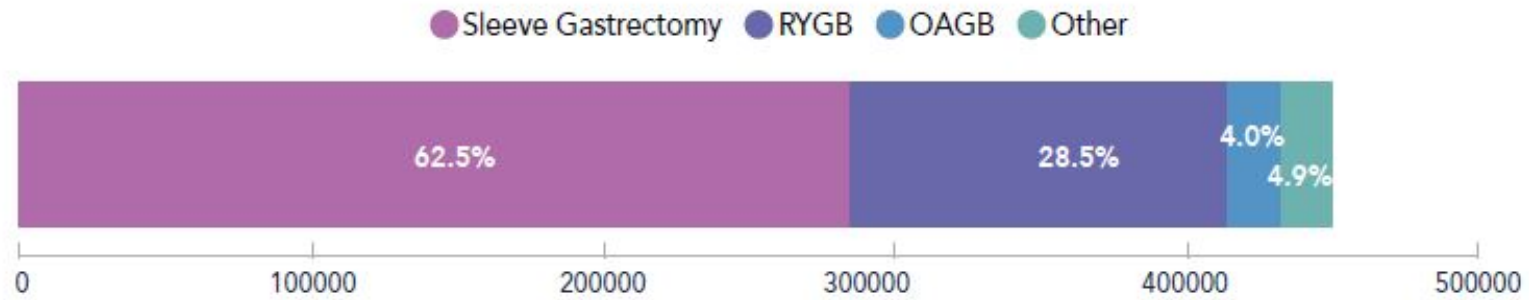
## IFSO (International Federation for Surgery of Obesity and Metabolic Disorders) Consensus Conference Statement on One-Anastomosis Gastric Bypass (OAGB-MGB): Results of a Modified Delphi Study

Almino C. Ramos<sup>1</sup> • Jean-Marc Chevallier<sup>2</sup> • Kamal Mahawar<sup>3</sup> • Wendy Brown<sup>4</sup> • Lilian Kow<sup>5</sup> • Kevin P. White<sup>6</sup> • Scott Shikora<sup>7</sup> - IFSO Consensus Conference Contributors



# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: I NUMERI

- ❖ OAGB è la terza procedura chirurgica bariatrica eseguita nel mondo...



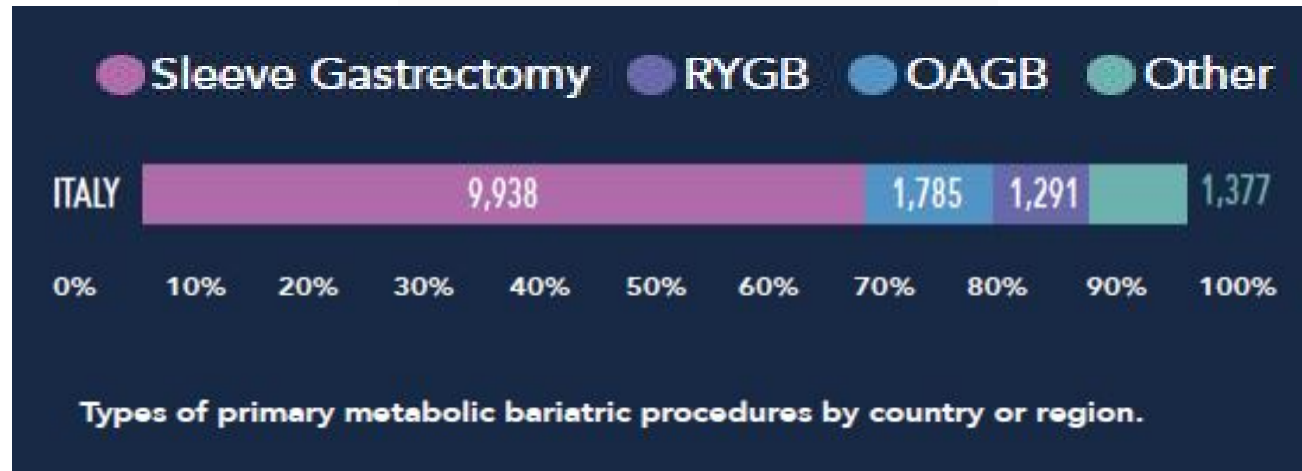
Primary procedure types (n=449,815).

\*potential for procedures to be represented twice due to possible overlaps with the datasets of USA and Michigan.





# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: I NUMERI





# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: INDICAZIONI ALLA CHIRURGIA REVISIONALE

Circa il 4% dei pazienti sottoposti ad OAGB vanno incontro a chirurgia revisionale...

Obesity Surgery (2022) 32:256–265  
<https://doi.org/10.1007/s11695-021-05779-y>



## ORIGINAL CONTRIBUTIONS

### Revisional Surgery After One Anastomosis/Minigastric Bypass: an Italian Multi-institutional Survey

Mario Musella<sup>1</sup> · Antonio Vitiello<sup>1</sup> · Antonio Susa<sup>2</sup> · Francesco Greco<sup>3</sup> · Maurizio De Luca<sup>4</sup> · Emilio Manno<sup>5</sup> · Stefano Olmi<sup>6</sup> · Marco Raffaelli<sup>7</sup> · Marcello Lucchese<sup>8</sup> · Sergio Carandina<sup>9</sup> · Mirto Foletto<sup>10</sup> · Francesco Pizza<sup>11</sup> · Ugo Bardi<sup>12</sup> · Giuseppe Navarra<sup>13</sup> · Angelo Michele Schettino<sup>14</sup> · Paolo Gentileschi<sup>15</sup> · Giuliano Sarro<sup>16</sup> · Sonja Chiappetta<sup>17</sup> · Andrea Tirone<sup>18</sup> · Giovanna Berardi<sup>1</sup> · Nunzio Velotti<sup>1</sup> · Diego Foschi<sup>19</sup> · Marco Zappa<sup>20</sup> · Luigi Piazza<sup>21</sup> · SICOB Collaborative group for the study of OAGB/MGB, Giulia Bagaglini, Domenico Benavoli, Amanda Belluzzi, Cosimo Callari, Mariapaola Giusti, Enrico Facchiano, Leo Licari, Giuseppe Iovino, Giacomo Piatto, Francesco Stanzione, Matteo Uccelli, Gastone Veroux, Costantino Voglino

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**Table 1** Reason for revisional surgery after OAGB-MGB and onset time

Complication	Prevalence in revised population ( <i>n</i> = 181 patients)	Prevalence in the total population ( <i>n</i> = 8676 patients)	Onset time from OAGB-MGB (months) <sup>1</sup>
DGER	82 (45.3%)	82 (0.94%)	43.19 ± 37.52
Weight regain	42 (23.2%)	42 (0.48%)	58.23 ± 35.14
Excessive weight loss	16 (8.8%)	16 (0.18%)	19.50 ± 9.06
Marginal ulcer perforation	12 (6.6%)	12 (0.13%)	26.36 ± 17.43
Gastro-gastric fistula	10 (5.5%)	10 (0.11%)	71.67 ± 33.71
Marginal ulcer bleeding	9 (4.9%)	9 (0.10%)	23.33 ± 20.20
Anastomotic stenosis	5 (2.7%)	5 (0.06%)	8.00 ± 4.69
Diarrhoea	3 (1.6%)	3 (0.03%)	16.00 ± 6.92
Reactive hypoglycemia	2 (1.1%)	2 (0.02%)	5.50 ± 4.94

<sup>1</sup>Mean ± standard deviation

DGER duodeno-gastro-esophageal reflux



# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: DGER

- ❖ DGER ha un incidenza dello 0,6–10 % post OAGB;
- ❖ Tasca gastrica > volume rispetto RYGB;
- ❖ Perenne esposizione al reflusso biliare (omega loop);

Obesity Surgery  
<https://doi.org/10.1007/s11695-021-05542-3>



ORIGINAL CONTRIBUTIONS



## Acid Reflux Is Common in Patients With Gastroesophageal Reflux Disease After One-Anastomosis Gastric Bypass

William A Nehmeh<sup>1,2</sup> · Clement Baratte<sup>1,2,3</sup> · Claire Rives-Lange<sup>1,4</sup> · Chloe Martineau<sup>1,5</sup> · Hortense Boullenois<sup>1,2</sup> · Sylvia Krivan<sup>6</sup> · Vincent Guillet<sup>1,2</sup> · Maude Le Gall<sup>1,3</sup> · Christophe Cellier<sup>1,5</sup> · Claire Carette<sup>1,3</sup> · Sebastien Czernichow<sup>1,4,7</sup> · Jean-Marc Chevallier<sup>1,2</sup> · Tigran Poghosyan<sup>1,2,3</sup>

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**Table 2** Impedance pH monitoring and upper GI endoscopy findings

	All patients	Acid reflux	Biliary reflux	Mixed reflux	No reflux at the impedance pH monitoring
Patients, n	43	13	12	5	13
History of AGB, n (%)	14	4 (30.7)	4 (33.3)	1 (20)	5 (38.4)
History of SG, n (%)	1	0	0	0	1 (7.6)
Initial BMI, mean (±SD)	46.8 (8)	49.4 (9)	47.5 (9)	47 (7)	43.3 (6)
BMI at exploration, mean (±SD)	32.6 (7)	33.4 (6)	30.7 (8)	31.9 (4)	34.2 (5)
Impedance pH monitoring findings					
% of time spent with pH < 4, median (IQR)					
Total	3 (6.4)	9.65 (8)	0.6 (1.75)	7.7 (3.9)	2.2 (1.8)
Upright	4 (10.6)	13.6 (9.65)	0.45 (1)	13.7 (6)	3.5 (2.65)
Supine	0.4 (3.6)	3.65 (11.2)	0	0.5 (8.1)	0.05 (0.4)
DeMeester score, median (IQR)	12 (26.8)	48.95 (27.67)	2.8 (7.4)	28.7 (5.6)	10 (5.45)
Endoscopic finding					
Anastomotic ulcer, n (%)	10 (23.2)	1 (7.6)	7 (58.3)	2 (40)	0
Esophagitis, n (%)	5 (11.6)	1 (7.6)	3 (25)	1 (20)	0
Barrett's esophagus, n (%)	2 (4.6)	2 (15.3)	0	0	0
Hiatal hernia, n (%)	7 (16.2)	1 (7.6)	3 (25)	0	3 (25)
Gastritis, n (%)	9 (20.9)	2 (15.3)	3 (25)	1 (20)	3 (25)
<i>Helicobacter pylori</i> , n (%)	2 (4.6)	0	0	0	2 (15.3)

AGB, adjustable gastric banding; SG, sleeve gastrectomy; BMI, body mass index

# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: DGER

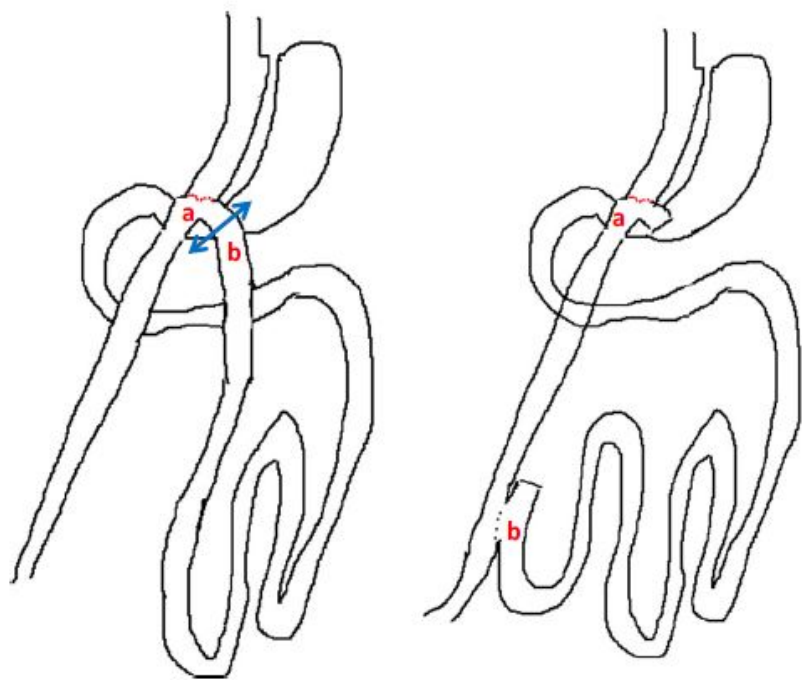


Fig. 1 OAGB conversion to D-OAGB (one-anastomosis reconstruction)

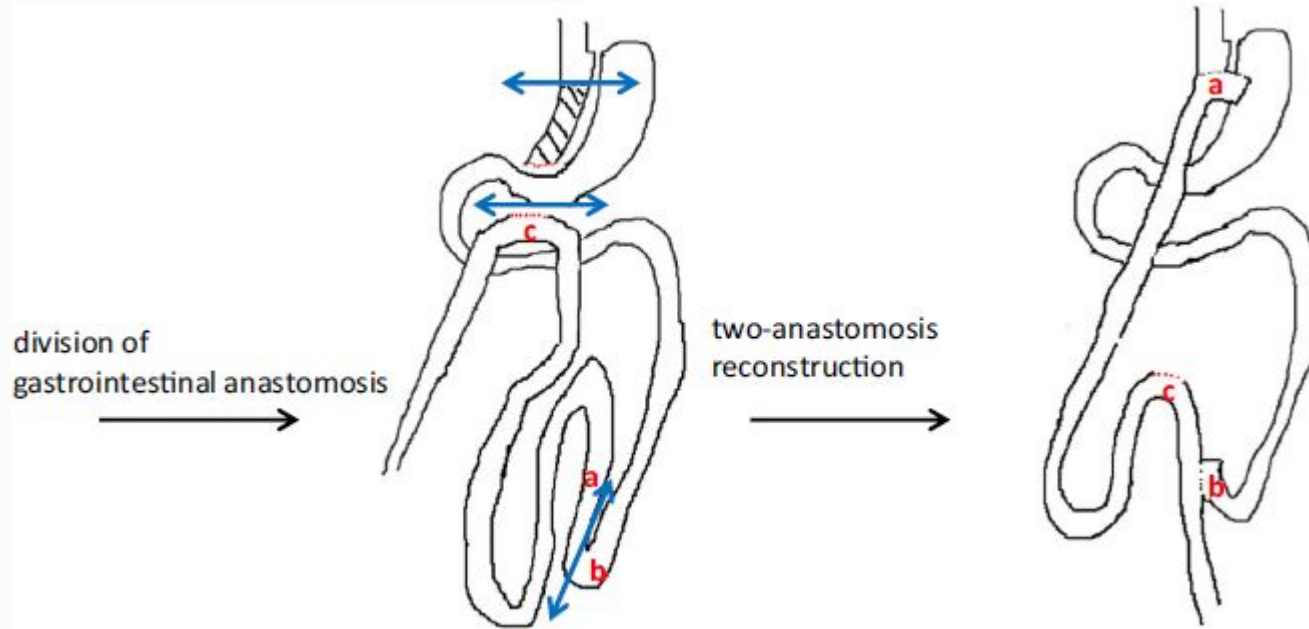


Fig. 2 OAGB conversion to RYGB





# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB:DGER, EFFICACIA DEL RYGB



REVIEW



## Outcomes of One-Anastomosis Gastric Bypass Conversion to Roux-en-Y Gastric Bypass for Severe Obesity: A Systematic Review and Meta-analysis

Narek Sargsyan<sup>1</sup> · Bibek Das<sup>1</sup> · Henry Robb<sup>1</sup> · Christopher Namgoong<sup>1</sup> · Iihan Ali<sup>1</sup> · Hutan Ashrafian<sup>1</sup> · Samer Humadi<sup>2</sup> · Anuja Mitra<sup>1</sup> · Matyas Fehervari<sup>1,3</sup>

Received: 18 September 2023 / Revised: 28 December 2023 / Accepted: 29 December 2023 / Published online: 20 January 2024  
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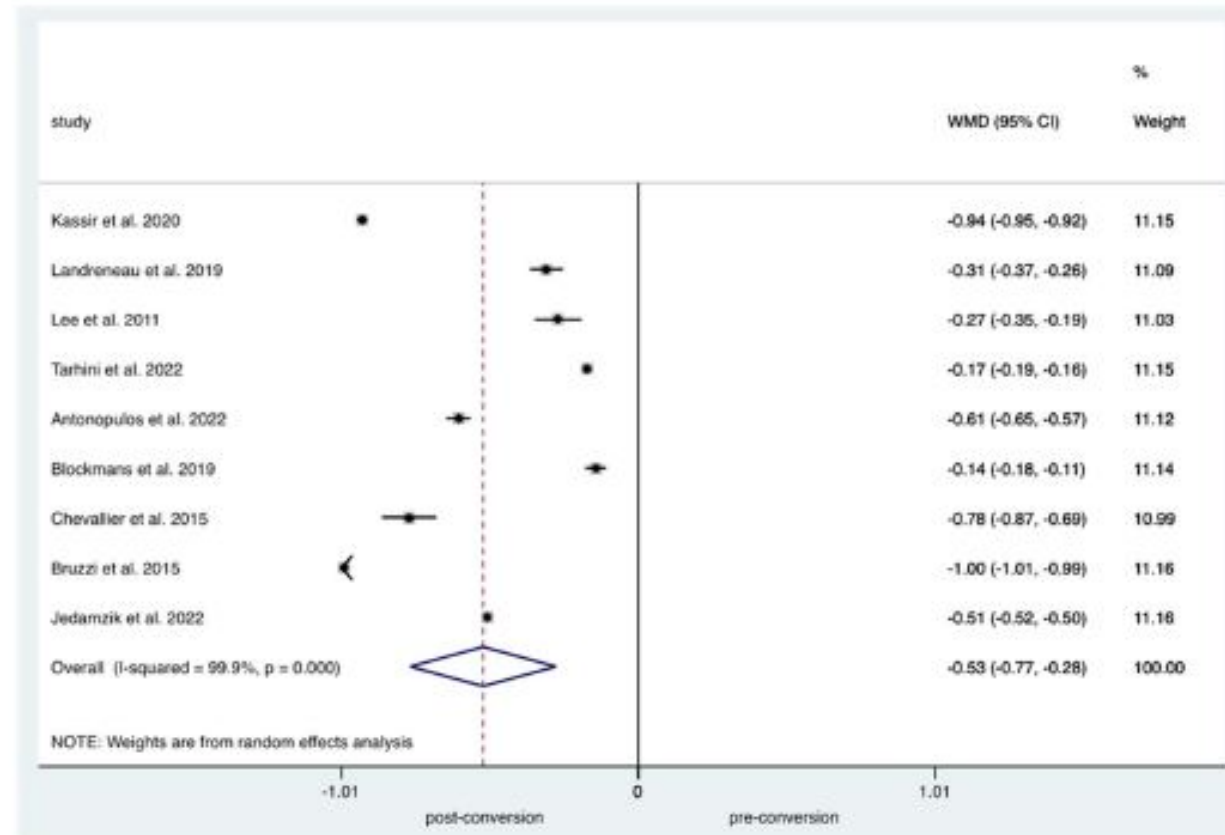


Fig. 4 Forest plot demonstrating bile reflux pre and post OAGB-RYGB conversion



# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: MALNUTRIZIONE

- ❖ La malnutrizione calorico-proteica e l'eccessiva perdita di peso si presentano in circa lo 0,2-2% dei pazienti sottoposti ad OAGB;
- ❖ Solitamente dovuto ad un'eccessiva lunghezza dell'ansa BLP > 2,5 m, ansa comune < 2,5 m;

Obesity Surgery  
https://doi.org/10.1007/s11695-020-04681-3



OBES SURG

ORIGINAL CONTRIBUTIONS



## Comparing the Efficacy and Safety of Roux-en-Y Gastric Bypass with One-Anastomosis Gastric Bypass with a Biliopancreatic Limb of 200 or 160 cm: 1-Year Results of the Tehran Obesity Treatment Study (TOTS)

Alireza Khalaj<sup>1</sup> • Pouria Mousapour<sup>2</sup> • Mohammad Ali Kalantar Motamedi<sup>3</sup> • Maryam Mahdavi<sup>2</sup> • Majid Valizadeh<sup>2</sup> • Farhad Hosseinpanah<sup>2</sup> • Maryam Barzin<sup>2</sup>

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**Table 4** Prevalence of micronutrient deficiencies at baseline and 12 months postoperatively

Variables	N		RYGB	OAGB-160	OAGB-200	P
Anemia	534	Baseline	21/86 (24.4)	51/256 (19.9)	46/192 (24.0)	0.507
		12-month	34/86 (39.5)	98/256 (38.3)	85/192 (44.3)	0.431
Calcium	414	Baseline	0/68 (0.0)	3/198 (1.5)	3/148 (2.0)	0.509
		12-month	6/68 (8.8)	6/198 (3.0)	9/148 (6.1)	0.134
Vitamin D	424	Baseline	39/63 (61.9)	115/214 (53.7)	74/147 (50.3)	0.305
		12-month	51/63 (81.0)	166/214 (77.6)	112/147 (76.2)	0.750
Vitamin B <sub>12</sub>	329	Baseline	5/47 (10.6)	22/165 (13.3)	20/117 (17.1)	0.500
		12-month	5/47 (10.6)	18/165 (10.9)	7/117 (6.0)	0.340
Phosphate	370	Baseline	0/54 (0.0)	2/182 (1.1)	1/134 (0.7)	0.728
		12-month	0/54 (0.0)	1/182 (0.5)	0/134 (0.0)	0.596
Zinc	341	Baseline	3/50 (6.0)	5/177 (2.8)	3/114 (2.6)	0.484
		12-month	1/50 (2.0)	8/177 (4.5)	7/114 (6.1)	0.507
Iron	342	Baseline	6/47 (12.8)	23/180 (12.8)	12/115 (10.4)	0.820
		12-month	4/47 (8.5)	21/180 (11.7)	15/115 (13.0)	0.717
Ferritin	397	Baseline	5/60 (8.3)	34/319 (10.6)	11/118 (9.3)	0.870
		12-month	9/60 (15.0)	70/319 (21.9)	31/118 (26.3)	0.406
Albumin	390	Baseline	0/41 (0.0)	0/243 (0.0)	0/106 (0.0)	N/A
		12-month	0/41 (0.0)	1/243 (0.4)	9/106 (8.5)	<0.001

Variables are presented as n (%)

N, total number of patients with available data regarding each micronutrient



# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: MALNUTRIZIONE

- ❖ In caso di severo deficit proteico è consigliata una restaurazione della normale anatomia;

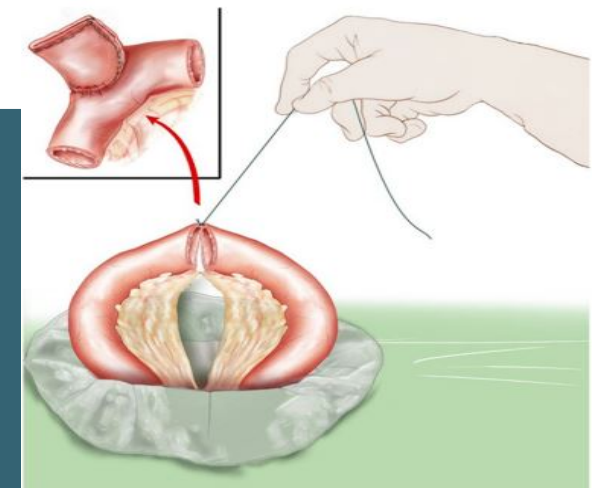
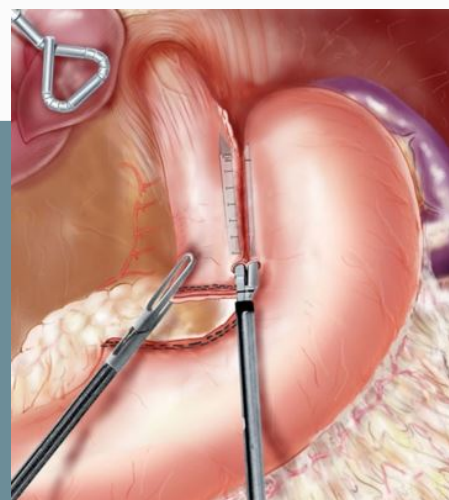
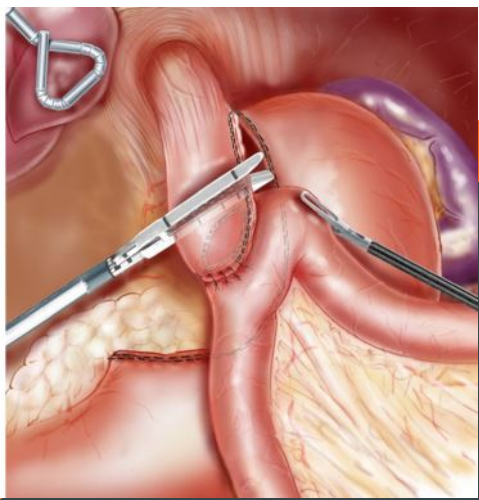
World J Surg  
<https://doi.org/10.1007/s00268-019-05290-7>



ORIGINAL SCIENTIFIC REPORT WITH VIDEO

## Reversing One-Anastomosis Gastric Bypass Surgery due to Severe and Refractory Hypoalbuminemia

Behrouz Keleidari<sup>1</sup> · Mohsen Mahmoudieh<sup>1</sup> · Shahab Shahabi<sup>1</sup> · Erfan Sheikhbahaei<sup>2</sup> ·  
Mohammadtaghi Rezaei<sup>1</sup> · Masoud Sayadi<sup>1</sup> · Hamid Melali<sup>3</sup>





# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: MALNUTRIZIONE

❖ SE la diagnosi è precoce è possibile eseguire un RYGB/ Braun;

JOURNAL OF LAPAROENDOSCOPIC & ADVANCED SURGICAL TECHNIQUES  
 Volume 00, Number 00, 2020  
 © Mary Ann Liebert, Inc.  
 DOI: 10.1089/lap.2020.0226

## Protein Energy Malnutrition After One-Anastomosis Gastric Bypass with a Biliopancreatic Limb $\leq 200$ cm: A Case Series

Ahmed Elgeidie, MD,<sup>1</sup> El-sayed Abou El-Magd, MD,<sup>1</sup> Hosam Elghadban, MD,<sup>2</sup> Mohamed Abdelgawad, MD,<sup>1</sup> and Hosam Hamed, MD<sup>1</sup>

TABLE 4. MANAGEMENT AND OUTCOME OF PROTEIN-ENERGY UNDERNUTRITION

Patient	Readmission number	Medical treatment outcome	Preop. albumin (gm/dL)	Indication of reversal	CL length (cm)	Postoperative course	Surgery and outcome in correcting PEM	1-Year follow-up
1	2	Success	3.5	Intolerable symptoms	370		Reversal to normal/success	DM remission: yes Patient satisfaction: no BMI: 32 kg/m <sup>2</sup> S. albumin: 4.4 gm/dL
2	2	Failure	3.7	Hepatic decompensation	NP		Reversal to normal/mortality (hepatic failure)	
3	7	Mortality (sudden arrest)						
4	2	Failure	3.0	Failed medical treatment	350		Reversal to normal/success	DM remission: no Patient satisfaction: yes BMI: 30 kg/m <sup>2</sup> S. albumin: 4.5 gm/dL
5	2	Mortality (necrotizing fasciitis)						
6 (R)	2	Success	3.5	Patient desire	350	Postoperative bleeding (surgical control)	Reversal to normal/success	DM remission: no Patient satisfaction: yes BMI: 26 kg/m <sup>2</sup> S. albumin: 4 gm/dL
7	3	Failure	4.1	Excess weight loss	300	Leakage (conservative)	Reversal to normal/success	DM remission: no Patient satisfaction: yes BMI: 24 kg/m <sup>2</sup> S. albumin: 3.9 gm/dL
8	4	Failure	2.7	Failed medical treatment	350	Intestinal obstruction After 3 months (lap adhesiolysis)	Reversal to normal/success	Non diabetic Patient satisfaction: no BMI: 30 kg/m <sup>2</sup> S. albumin: 3.8 gm/dL
9	1	Success	3.1	Patient desire	380		Reversal to normal/success	Non diabetic Patient satisfaction: yes BMI: 30 kg/m <sup>2</sup> S. albumin: 4 gm/dL
10	2	Failure	3.3	Failed medical treatment	520	GB stones After 6 months (lap Chole)	RYGB with BPL 75cm and AL 75 cm/success	DM remission: no Patient satisfaction: no BMI: 27 kg/m <sup>2</sup> S. albumin: 4 gm/dL

AL, alimentary limb; BMI, body mass index; BPL, biliopancreatic limb; Chole, cholecystectomy; CL, common limb; DM, diabetes mellitus; Lap, laparoscopic; NP, not performed; PEM, protein energy malnutrition; R, referred case; RYGB, Roux-en-Y gastric bypass; S, serum.



# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: IWL


- ❖ Incidenza 10%;
- ❖ IWL: weight loss < 20% rispetto al peso iniziale del paziente;
- ❖ Non modifica la classe di obesità rispetto la prima valutazione;
- ❖ Non genera un miglior controllo del quadro metabolico generale;

Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity (2023) 28:5  
<https://doi.org/10.1007/s40519-023-01537-4>

ORIGINAL ARTICLE



**SICOB-endorsed national Delphi consensus on obesity treatment optimization: focus on diagnosis, pre-operative management, and weight regain/insufficient weight loss approach**

Marco Antonio Zappa<sup>1</sup> · Angelo Iossa<sup>2</sup>  · Luca Busetto<sup>3</sup> · Sonja Chiappetta<sup>4</sup> · Francesco Greco<sup>5</sup> · Marcello Lucchese<sup>6</sup> · Fausta Micanti<sup>7</sup> · Geltrude Mingrone<sup>8,9,10</sup> · Giuseppe Navarra<sup>11</sup> · Marco Raffaelli<sup>12</sup> · Delphi Expert Panel · Maurizio De Luca<sup>13</sup>

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# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: IWL RESIZING POUCH



**Table 1.** Characteristics of the study population.

Age	47.1 ± 8.3 years
M/F	22/1
LRYGB/OAGB	12/11
BMI before bypass	43.3 ± 5.7 kg/m <sup>2</sup>
Weight before bypass	115.5 ± 19.7
Lower BMI after bypass	27.9 ± 6.2 kg/m <sup>2</sup>
BMI before resizing	36.3 ± 4.7 kg/m <sup>2</sup>
Weight before resizing	96.5 ± 13.9 kg
<b>Comorbidities</b>	
Hypertension	30.4%
Type II Diabetes Mellitus	17.4%
OSAS	17.4%
Dyslipidemia	8.7%
Previous bariatric Surgery	34.8% (n.8)

LRYGB: laparoscopic Roux-en-Y gastric bypass; OAGB: one-anastomosis gastric bypass; BMI: body mass index; OSAS: obstructive sleep apnea syndrome.

**Table 2.** Peri-operative and postoperative outcomes.

Mean operative time	73.8 ± 21.6
Mean time between bypass and LPR (months)	77.9 ± 54.5
Mean follow up after LPR (months)	24.2 ± 16.1
Mean weight after LPR	77.9 ± 17.3 kg
Mean BMI after LPR	29.3 ± 5.8 kg/m <sup>2</sup>
Mean %TWL after LPR	19.6 ± 9%

LPR: laparoscopic pouch resizing; BMI: body mass index; %TWL: % total weight loss.

Article

## Resizing of the Gastric Pouch for Weight Regain after Laparoscopic Roux-en-Y Gastric Bypass and One-Anastomosis Gastric Bypass: Is It a Valid Option?

Silvia Ferro <sup>1,2</sup>, Viola Zulian <sup>3</sup>, Massimiliano De Palma <sup>1</sup>, Andrea Sartori <sup>1</sup>, Anamaria Andreica <sup>3</sup>, Marius Nedelcu <sup>3</sup> and Sergio Carandina <sup>1,3,\*</sup>

# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: IWL, RESIZING POUCH

Obesity Surgery  
https://doi.org/10.1007/s11695-019-03972-8

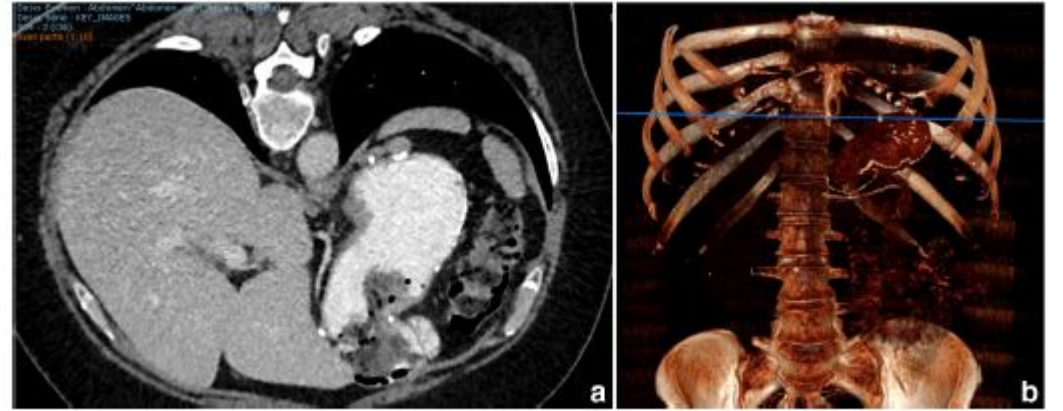
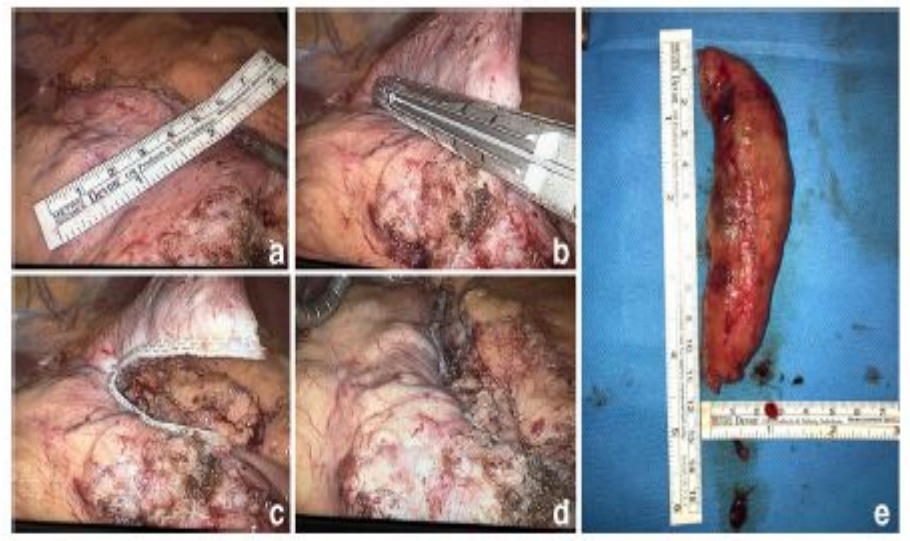


BRIEF COMMUNICATION

## Dilated Gastric Pouch Resizing for Weight Loss Failure After One Anastomosis Gastric Bypass

Adrien Faul<sup>1</sup> · Jean-Marc Chevallier<sup>1</sup> · Tigran Poghosyan<sup>1</sup>

**Fig. 2** a Dilated gastric pouch (laparoscopic view). b, c Beginning of excess gastric tissue resection. d Resized gastric pouch. e Removed gastric tissue



**Fig. 1** a Dilated gastric pouch (7 cm) filled with the contrast medium on CT scan. b 3D reconstruction on CT scan of dilated gastric pouch

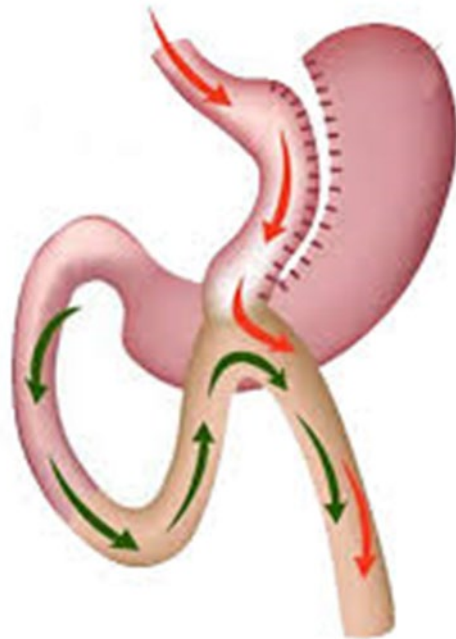
**Table 1** BMI, %TWL, and %EWL changes after gastric pouch resizing over two years of follow-up

	At GPR	6 months	12 months	18 months	24 months
Eligible/available (n)	17/17	17/16	17/15	14/12	10/8
Lost to follow-up (%)	0%	5.8%	11.6%	14.3%	20%
<b>BMI (kg/m<sup>2</sup>), mean ± SD</b>	<b>41.5 ± 11</b>	<b>36.6 ± 5</b>	<b>35 ± 4</b>	<b>34.1 ± 5</b>	<b>33.5 ± 6</b>
%TWL, mean ± SD	15 ± 10	22 ± 7	25 ± 9	28 ± 10	31 ± 13
%EWL, mean ± SD	36 ± 21	51 ± 14	57 ± 16	63 ± 17	69 ± 21

GPR, gastric pouch resizing; TWL, total weight loss; BMI, body mass index; EWL, excess weight loss

# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: ULCERA MARGINALE PERIANASTOMOTICA

- ❖ Incidenza 0,5-5%;
- ❖ Etiologia multifattoriale:
  - (Fumo, Fans, HP, Scarsa compliance PPI);
  - Tensione del loop;
  - Irritazione succhi biliopancreatici;
  - Esposizione acida;



**Table 7** Marginal ulcer-related information in published studies

Authors Number Type of study Year of publication	<i>Helicobacter pylori</i> eradication	Use and duration of PPI prophylaxis	Number of ulcers	Ulcer complications	Surgical revision
Rutledge <i>et al.</i> (15) N = 2410 Retrospective Cohort Study 2005	NA	NA	97	2 Non-healing ulcers	3
Noun <i>et al.</i> (16) N = 1000 Retrospective Cohort Study 2012	NA	Yes 6 months	6	0	0
Lee <i>et al.</i> (10) N = 1163 Retrospective Comparative Study 2012	NA	NA	NA	7	7
Musella <i>et al.</i> (17) N = 974 Retrospective Cohort Study 2014	Yes	NA	14	NA	4
Kular <i>et al.</i> (6) N = 1054 Retrospective Cohort Study 2014	NA	NA	5	0	0
Chevallier <i>et al.</i> (4) N = 1000 Retrospective Cohort Study 2015	NA	Yes NA	20	2 Perforation	2
Pamar <i>et al.</i> (11) N = 125 Retrospective Cohort Study 2016	Yes	Yes 6 months	4	1 Perforation	1
Carbajo <i>et al.</i> (5) N = 1200 Retrospective Cohort Study 2016	NA	Yes 1 month	6	5 bleeding	0

clinical obesity

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## Marginal ulcers after one anastomosis (mini) gastric bypass: a survey of surgeons

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# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: ULCERA MARGINALE PERIANASTOMOTICA

- ❖ Indicazione chirurgica in caso di fallimento di trattamento medico;
- ❖ Trattamento suggerito:
  - Riparazione dell'ulcera con omentoplastica
  - RYGB
  - Ripristino della normale anatomia;

Clinical, laboratory and imaging results at the time of presentation, operative findings, management, and outcomes

Patient	Perf time (mo)	Main symptoms	HR	Temp (°C)	WBC (10 <sup>3</sup> /μL)	CRP (mg/L)	Albumin (g/dL)	CT result	Operative findings	Management	LOS
1	13	abdominal pain, nausea, vomiting	130	36.8	3.7	311	2.1	free air, free fluid	> 50% anastomotic disruption, copious free bilious fluid	"damage control", washout, gastrostomy, jejunostomy	79
2	23	abdominal pain	90	37.1	7.6	10	3.1	free air, free fluid	2 cm perforation covered with fibrin, free gastric content	laparoscopic primary repair, omentopexy, closed suction drainage	10
3	11	abdominal pain, nausea, vomiting	82	36.7	8.6	6.4	2.7	free air, free fluid	1 cm perforation in anterior side of the anastomosis, free bilious fluid	laparoscopic primary repair, omentopexy, closed suction drainage	5
4	4	abdominal pain	65	36.5	2	9	1.9	contrast extravasation, free fluid	2 cm anastomosis perforation, free bilious fluid	laparoscopic primary repair, closed suction drainage	11
5	13	epigastric abdominal pain	80	36.6	11.2	2.4	3.6	free air	was not operated	nonoperative treatment (NPO, TPN, high dose IV PPI)	9
6	15	abdominal pain, nausea, vomiting	87	36.6	8	4	4	3 cm collection adjacent to the anastomosis	spontaneous omental patch over the anastomosis	laparoscopic conversion to Roux en Y gastric bypass	3
7	10	abdominal pain, nausea, vomiting	96	36.5	7.6	110	3.4	free air, free fluid and contrast extravasation	1 cm anastomosis perforation covered with fibrin, free bilious fluid	laparoscopic primary repair, omentopexy, closed suction drainage	7

Perf time = time from OAGB to perforation in months; HR = heart rate; Temp = temperature; WBC = white blood cell; CRP = C-reactive protein; CT = computed tomography scan; LOS = length of hospital stay; NPO = nil per os; TPN = Total parenteral nutrition; IV PPI = Intravenous proton pump inhibitors.



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SURGERY FOR OBESITY AND RELATED DISEASES

Original article

## Marginal ulcer causing delayed anastomotic perforation following one anastomosis gastric bypass (OAGB)

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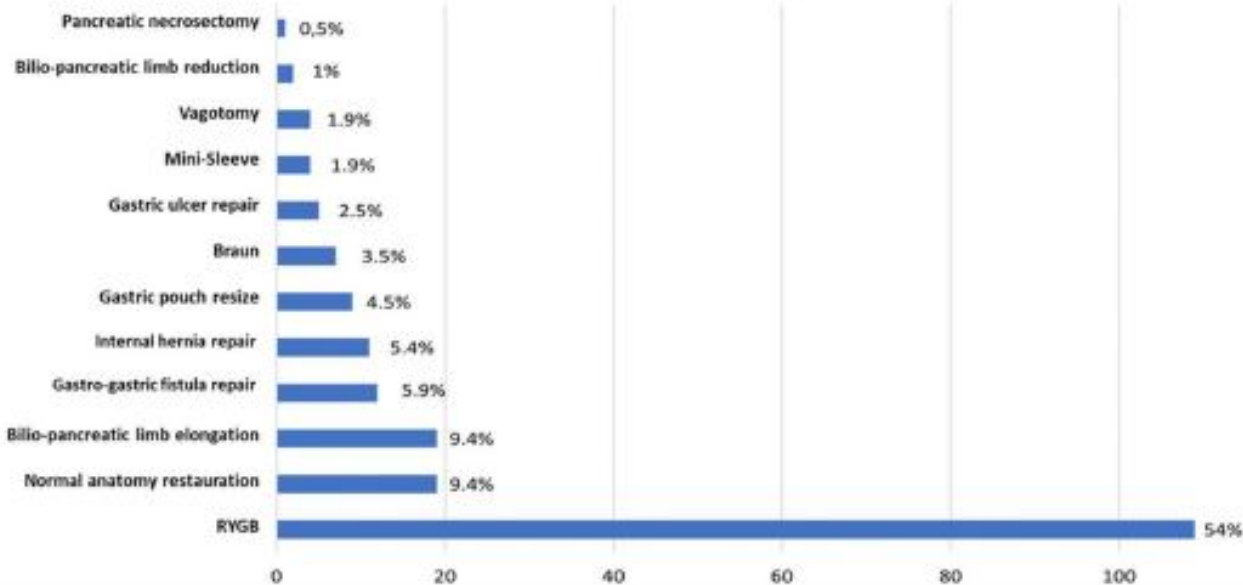
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# QUALE CHIRURGIA DOPO IL FALLIMENTO DI UN OAGB: CONCLUSIONI

- ❖ OAGB necessità di chirurgia revisionale nel 4% dei casi ed ha un eziologia multifattoriale;
- ❖ L'intervento chirurgico revisionale post OAGB più eseguito è il RYGB, ma non possiamo definirlo gold standard;
- ❖ Fondamentale è lo studio multidisciplinare del paziente al fine di comprendere e correggere la causa del fallimento;
- ❖ Tailored surgery;

Most common revisions and reoperations





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