BYPASS GASTRICO CON FUNDECTOMIA E STOMACO ESPLORABILE

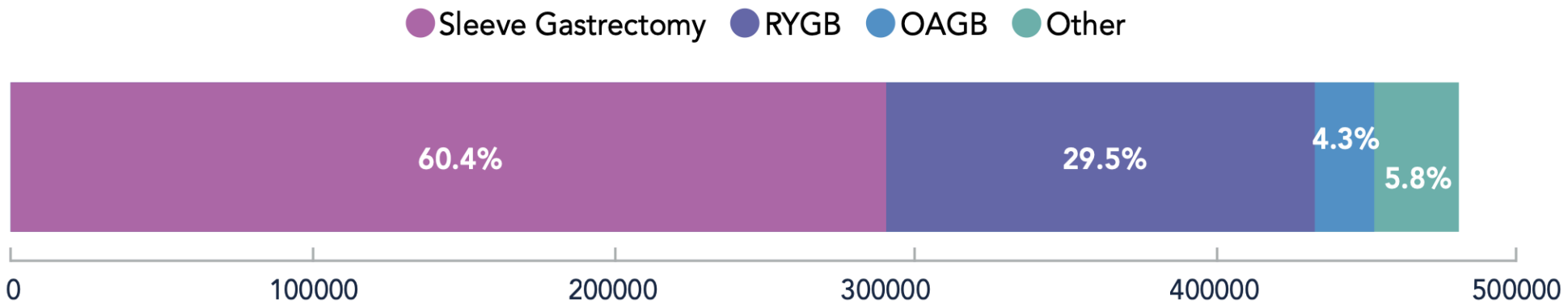
DOTT. LUIGI ROMEO

U.O. CHIRURGIA GENERALE RICCIONE

DIRETTORE DOTT. ANDREA LUCCHI

IFSO

8TH GLOBAL REGISTRY REPORT



All procedure types (n=480,970).

NUMERO DEI PAZIENTI INSERITI AD OGGI 153.689 SUL TERRITORIO NAZIONALE

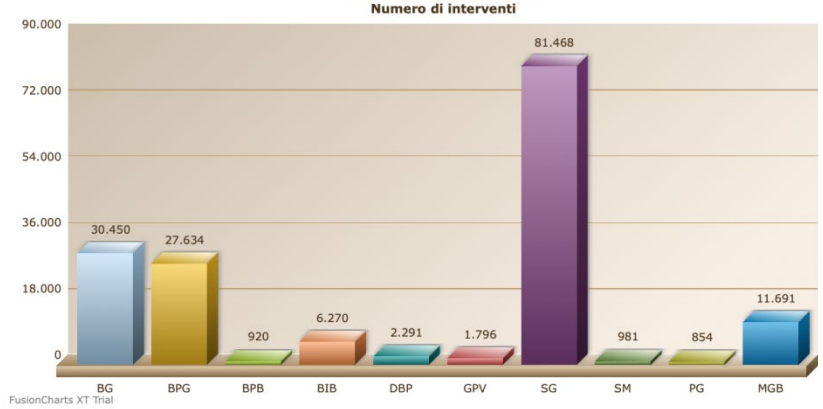
numero di accessi del centro 185.574

Selezionare l'anno Tutti

TIPO DI INTERVENTO	CASISTICA	MASCHI	FEMMINE	ETA'		
				Media	Min	Max
Bendaggio gastrico	30.450	5.762	24.687	40,13	8	78
By pass gastrico	27.634	6.549	21.085	44,48	12	79
By pass biliointestinale	920	288	632	39,13	16	68
Pallone intragastrico	6.270	2.029	4.241	39,63	8	78
Diversione biliopancr.	2.291	824	1.467	42,59	15	79
Gastroplastica verticale	1.796	286	1.510	40,42	13	70
Sleeve gastrectomy	81.468	21.155	60.311	42,51	8	79
Super Magenstrasse	981	193	788	45,09	8	78
Plicatura gastrica	854	178	676	45,19	19	75
Mini gastric bypass	11.691	3.172	8.519	45,09	8	78
TOTALI	**164.355**	**40.436**	**123.916**			

STATISTICHE NAZIONALI

Numero di interventi



NUMERO DEI PAZIENTI INSERITI AD OGGI 153.689 SUL TERRITORIO NAZIONALE

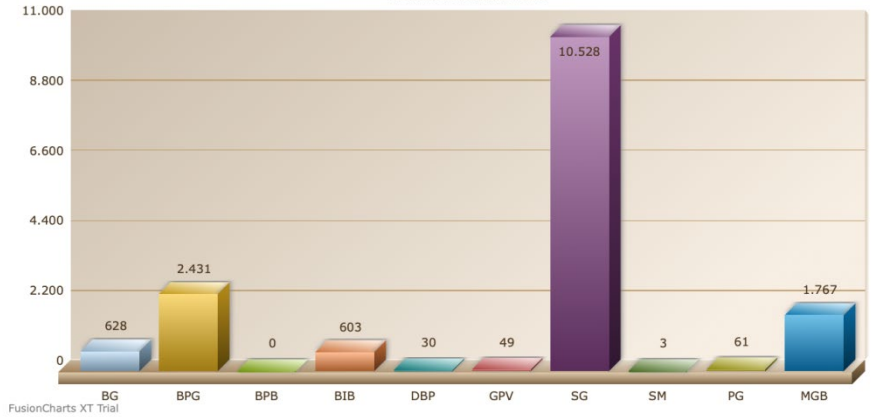
numero di accessi del centro 185.574

Selezionare l'anno 2022

TIPO DI INTERVENTO	CASISTICA	MASCHI	FEMMINE	ETA'		
				Media	Min	Max
Bendaggio gastrico	628	100	528	40,90	16	78
By pass gastrico	2.431	560	1.871	46,97	19	72
By pass biliointestinale	0	0	0	0,00	0	0
Pallone intragastrico	603	176	427	38,72	12	73
Diversione biliopancr.	30	6	24	51,07	31	67
Gastroplastica verticale	49	11	38	47,37	18	69
Sleeve gastrectomy	10.528	2.683	7.845	42,57	11	79
Super Magenstrasse	3	0	3	46,07	11	73
Plicatura gastrica	61	11	50	48,46	22	62
Mini gastric bypass	1.767	456	1.311	46,07	11	73
TOTALI	**16.100**	**4.003**	**12.097**			

STATISTICHE NAZIONALI ANNO 2022

Numero di interventi



NUMERO DEI PAZIENTI INSERITI AD OGGI 153.689 SUL TERRITORIO NAZIONALE

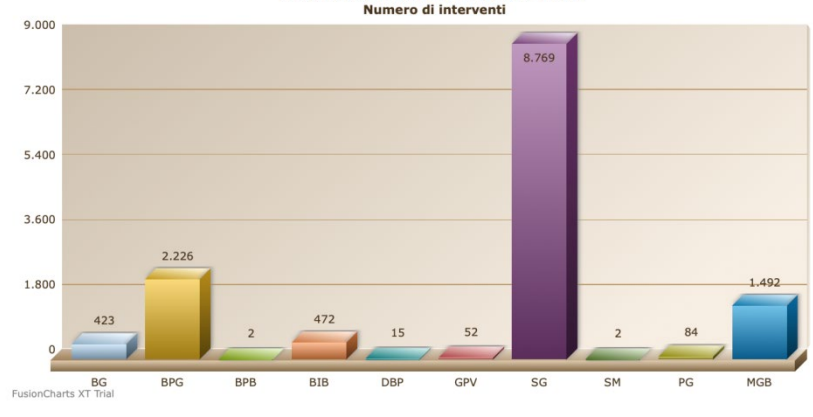
numero di accessi del centro 185.574

Selezionare l'anno 2023

TIPO DI INTERVENTO	CASISTICA	MASCHI	FEMMINE	ETA'		
				Media	Min	Max
Bendaggio gastrico	423	51	372	42,17	15	71
By pass gastrico	2.226	520	1.706	47,70	18	79
By pass biliointestinale	2	1	1	51,50	51	52
Pallone intragastrico	472	153	319	40,45	11	78
Diversione biliopancr.	15	5	10	55,00	36	68
Gastroplastica verticale	52	11	41	47,38	21	64
Sleeve gastrectomy	8.769	2.498	6.271	43,07	13	71
Super Magenstrasse	2	0	2	46,27	17	72
Plicatura gastrica	84	15	69	45,69	19	72
Mini gastric bypass	1.492	442	1.050	46,27	17	72
TOTALI	**13.537**	**3.696**	**9.841**			

STATISTICHE NAZIONALI ANNO 2023

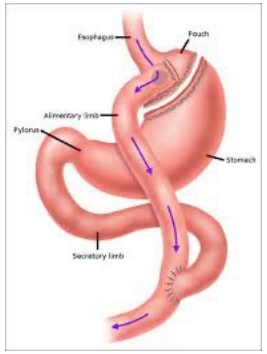
Numero di interventi



Registro Nazionale SICOB

Chirurgia dell'Obesità e delle Malattie Metaboliche

Gastric remant, duodenum, CBD after RYGB



-Tumor
-Common bile duct lithiasis exploration
-Acute complications: bleeding, perforation, necrosis

Review paper

Epidemiology of gastric cancer: global trends, risk factors and prevention

Prashanth Rawla[1], Adam Barsouk[2]

[1]Department of Internal Medicine, SOVAH Health, Hospitalist, Martinsville, USA
[2]Hillman Cancer Center, University of Pittsburgh, PA, USA

Gastroenterology Rev 2019; 14 (1): 26–38
DOI: https://doi.org/10.5114/pg.2018.80001

American Cancer Society. https://www.cancer.org/cancer/stomach-cancer/detection-diagnosis-staging/survival-rates.html. Last Revised: March 1, 2022

Gastric cancer is the **third leading cause of cancer-related death worldwide**, with about **33.3% of patients having a 5-year survival** rate. One of the main reasons for the significantly low survival rates is associated with **late diagnosis.**

AIOM ASSOCIAZIONE ITALIANA ONCOLOGIA MEDICA

Roma, 2 ottobre 2022 – I principali tumori del tratto gastro-intestinale colpiscono ogni anno 78mila uomini e donne nel nostro Paese. Nello specifico si registrano **43.700 casi di tumore** del colon-retto; **14.500 allo stomaco**; 14.300 al pancreas e 5.400 colangiocarcinomi

La neoplasia gastrica rappresenta la **quarta causa di morte in Italia**, con particolare incidenza **nell' appennino tosco-romagnolo**

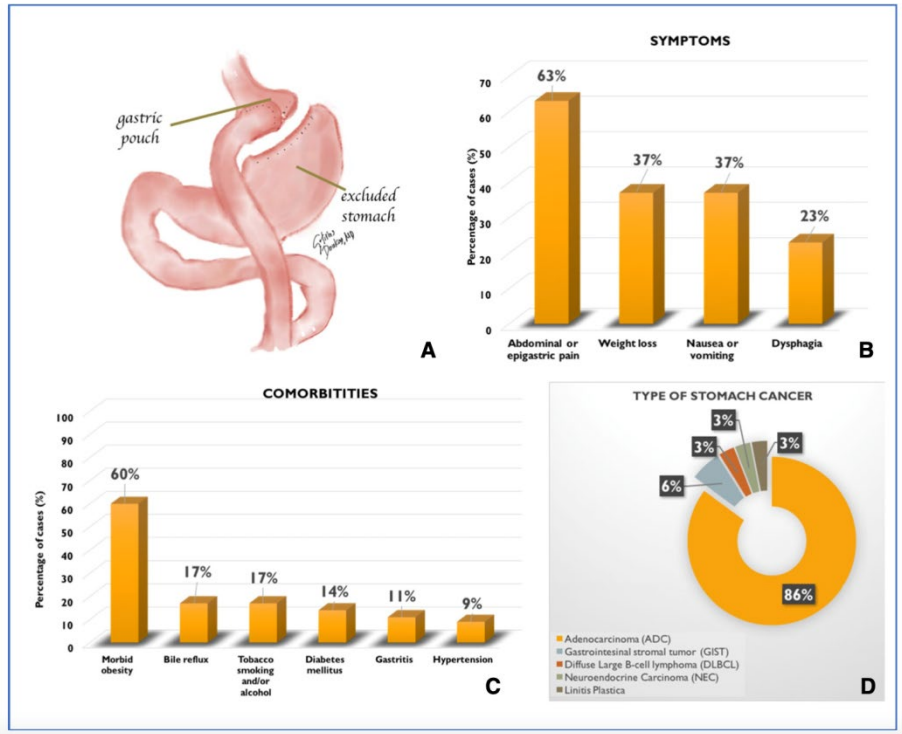
Obesity Surgery (2023) 33:1876–1888
https://doi.org/10.1007/s11695-023-06567-6

REVIEW

Gastric cancer after Bariatric Bypass Surgery. Do they relate? (A Systematic Review)

Sotirios G. Doukas[1] · Panagiotis G. Doukas[2] · Dimitra P. Vageli[2] · Arkady Broder[1]

Received: 13 November 2022 / Revised: 18 March 2023 / Accepted: 28 March 2023 / Published online: 11 April 2023



-30 articles

-**35 cases, including 30 cases after RYGB.**

-increasing trend (41%) in the number of published stomach cancer patients with a previous bariatric procedure in the last decade (22 cases in 2012–2022 versus 13 cases before 2012)

-**Post-bypass gastric cancer was described in 27 (77%) cases** in the bypassed or excluded stomach

--Most of the excluded stomach tumors (55%) were identified by exploratory laparotomy or laparoscopy

-In 33.3% of cases examined, the excluded stomach could be approached endoscopically. Double-balloon enteroscopy was used in only one of the cases

-Most of the tumors were adeno- carcinomas (ADC) (86%), followed by gastrointestinal stro- mal tumors (GIST) (6%), diffuse large B-cell lymphoma (DBCL) (3%), neuroendocrine carcinomas (NEC) (3%) and a rare gastric linitis plastica tumor (3%) were also identi- fied

-considerable proportion of tumors with **evidence of local or distant metastasis (47%).** The mean time of tumor presentation was 10.5 years

Table 2 Patients and tumor characteristics of post-bariatric surgery gastric pouch cancer

Characteristics	Bariatric surgery
No. of subjects	35
RYGB, N (%)	30 (86%)
Gastric bypass, N (%)	3 (9%)
OAGB, N (%)	2 (6%)
Year of incidence	
2000–2012	13
2012–2022	22
Sex	
Female, N (%)	22 (63%)
Male, N (%)	11 (31%)
N/A, N (%)	2 (6%)
Age	
years (mean ± SD)	57 (±9.6)
Symptoms	
Abdominal or epigastric pain, N (%)	22 (63%)
Weight loss, N (%)	13 (37%)
Nausea or vomiting, N (%)	13 (37%)
Dysphagia, N (%)	8 (23%)
Comorbidities	
Morbid obesity, N (%)	21 (60%)
Bile reflux, N (%)	6 (17%)
Diabetes, N (%)	5 (14%)
Tobacco smoking and/or alcohol, N (%)	6 (17%)
Gastritis, N (%)	4 (11%)
Hypertension, N (%)	3 (9%)
H. pylori, N (%)	2 (6%)
Family history of gastric cancer, N (%)	1 (3%)
Type of stomach cancer	
Adenocarcinoma (ADC), N (%)	30 (86%)
Gastrointestinal Stromal Tumor (GIST), N (%)	2 (6%)
Diffuse Large B-cell lymphoma (DLBCL), N (%)	1 (3%)
Neuroendocrine Carcinoma (NEC), N (%)	1 (3%)
Linitis Plastica, N (%)	1 (3%)
Location of bypassed stomach tumor	
Excluded stomach	27 (77%)
Gastric pouch	8 (23%)
Stage of ADC stomach tumor	
$T_{1\text{-}3}N_{0\text{-}1}M_0/M_x$, N (%)	10 (33%)
$T_{1\text{-}4}N_{1\text{-}3}M_1$, N (%)	14 (47%)
N/A, N (%)	6 (20%)
Time of presentation, years (mean ± SD.)	10.5 (±9.4)

Risk factors for gastric cancer

-H. pilory
-history fo gastric cancer
-tobacco
-bile reflux
-n-nitrosamine
-changes in gastric and intestinal microbiota following gastric bypass
-obesity (pre-malignant molecular alteration previous to weight loss)

Conclusion

Our study suggests that cancer in the excluded stomach or gastric pouch after bariatric bypass surgery might be a rare but devastating complication, particularly in patients at considerable risk for gastric cancer. Given that most of the patients were diagnosed in an advanced stage, an assessment of gastric cancer risk should be considered as part of the pre-operative assessment. Also, further studies should be made to evaluate the clinical significance of surveillance after gastric bypass surgery. Finally, the new onset of upper gastrointestinal symptoms, even years after bariatric bypass surgery, should raise the suspicion of gastric cancer and suggest further evaluation.

Gastric remnant diagnosis

Percutaneous endoscopic gastrostomy (PEG), percutaneous endoscopic transgastric jejunostomy (PEG-J), and direct percutaneous endoscopic jejunostomy (DPEJ)

Double balloon enteroscopy

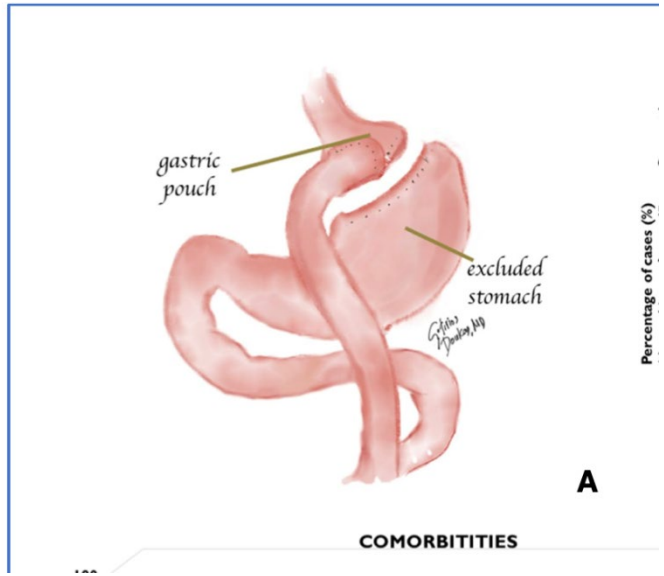
Intragastric single-port surgery (IGS) accesses the gastric remnant

Cureus. 2018 Jun; 10(6): e2825.
Published online 2018 Jun 18. doi: 10.7759/cureus.2825
PMCID: PMC6101468
PMID: 30131918

Exploring the Excluded Stomach: A Case Series of Novel Endoscopic Techniques to Diagnose Gastric Cancer in the Excluded Stomach After Roux-en-Y Gastric Bypass Surgery

Monitoring Editor: Alexander Muacevic and John R Adler

Saeed Ali,[1] Abdelkader Chaar,[2] Wesam Frandah,[3] Rola Altoos,[4] Zeeshan Sattar,[5] and Muhammad Hasan[6]



Choledocholithiasis management after RYGB

Meta-Analysis > Surg Endosc. 2022 Sep;36(9):6868-6877.
doi: 10.1007/s00464-022-09018-y. Epub 2022 Jan 18.

Management of choledocholithiasis after Roux-en-Y gastric bypass: a systematic review and pooled proportion meta-analysis

Matthew Connell [1], Warren Y L Sun [2], Valentin Mocanu [1], Jerry T Dang [1], Janice Y Kung [3], Noah J Switzer [1], Daniel W Birch [1], Shahzeer Karmali [1]

Affiliations + expand

PMID: 35041054 DOI: 10.1007/s00464-022-09018-y

> Endosc Int Open. 2023 May 26;11(5):E529-E537. doi: 10.1055/a-2057-5984.
eCollection 2023 May.

Endoscopic ultrasound-directed transgastric ERCP (EDGE): A multicenter US study on long-term follow-up and fistula closure

Prashant Kedia [1], Sardar Shah-Khan [2], Amy Tyberg [3], Monica Gaidhane [1], Avik Sarkar [1], Haroon Shahid [1], Eric Zhao [1], Shyam Thakkar [4], Mason Winkie [4], Matthew Krafft [5], Shailendra Singh [5], Eugene Zolotarevsky [6], Jeremy Barber [6], Mitchelle Zolotarevsky [6], Ian Greenberg [1], Dhiemeziem Eke [1], David Lee [1], Frank Gress [7], Iman Andalib [8], Gregory Bills [9], Patrick Carey [9], Moamen Gabr [10], Michael Lajin [11], Enrique Vazquez-Sequeiros [12], Douglas Pleskow [13], Neal Mehta [13], Allison Schulman [14], Richard Kwon [15], Kevin Platt [16], John Nasr [4], Michel Kahaleh [2]

Affiliations + expand

PMID: 37251793 PMCID: PMC10219784 DOI: 10.1055/a-2057-5984

laparoscopy-assisted ERCP (LAERCP)
balloon-assisted enteroscopy (BAE)
ultrasound-directed transgastric ERCP (EDGE)
laparoscopic common bile duct exploration (LCBDE)
EUS-guided intra-hepatic puncture with antegrade clearance (EGHAC)
percutaneous trans-hepatic biliary drainage (PTHBD),
rendezvous guidewire-associated (RGA) ERCP.

Acute remnant complications after RYGB: management

Obesity Surgery (2020) 30:2637–2641
https://doi.org/10.1007/s11695-020-04537-w

ORIGINAL CONTRIBUTIONS

Management of Acute Gastric Remnant Complications After Roux-en-Y Gastric Bypass: a Single-Center Case Series

Pouya Iranmanesh[1] · Naveen V. Manisundaran[1] · Kulvinder S. Bajwa[1] · Nirav C. Thosani[1] · Melissa M. Felinski[1] · Erik B. Wilson[1] · Shinil K. Shah[1,2]

Published online: 11 March 2020

Table 2 Type of complication, management, and outcomes

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7
Type of gastric remnant complication	Perforated ulcer	Bleeding	Perforated ulcer	Perforated ulcer	Necrosis	Bleeding	Bleeding
Type of management	Laparoscopic modified Graham's patch repair	Balloon enteroscopy and hemostasis with metallic clips	Laparoscopic modified Graham's patch repair	Open modified Graham's patch repair and gastrostomy tube	Laparoscopic remnant gastrectomy and laparoscopic-assisted endoscopy	Proton pump inhibitors	Balloon enteroscopy and hemostasis with metallic clips
Postoperative complication	None	None	None	New onset atrial fibrillation, pleural effusion	None	None	None
Length of hospital stay (days)	12	5	3	8	4	3	3

Obesity Surgery, **8**, 283–288

Modern Surgery: Technical Innovations

1998

The Surgical Technique of the Fobi-Pouch Operation for Obesity (The Transected Silastic Vertical Gastric Bypass)

Mathias A. L. Fobi MD, FACS; Hoil Lee MD[1]

Center for Surgical Treatment of Obesity, Bellwood General Hospital, Bellflower; [1]Cedars Sinai Medical Center, Los Angeles, CA, USA

Formation of gastrostomy with banded site

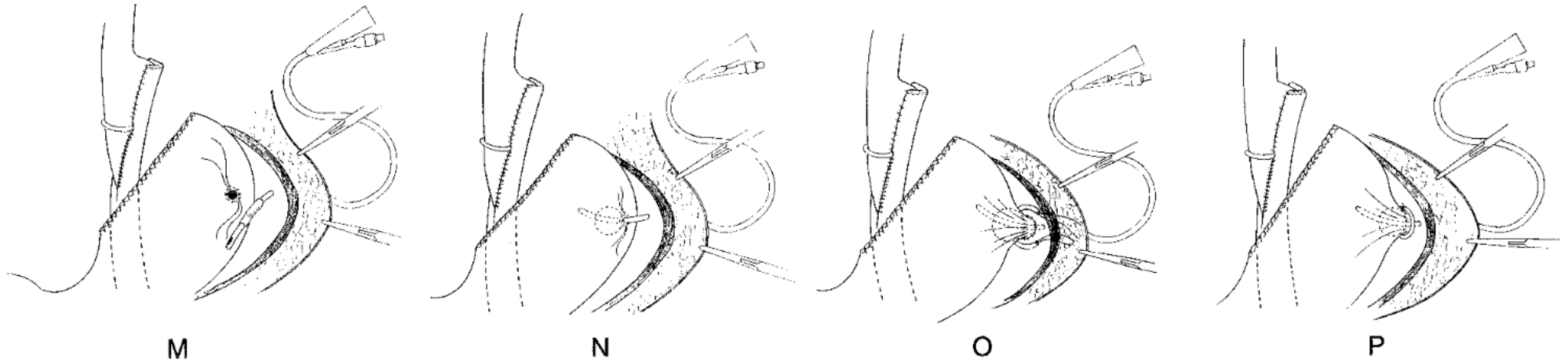


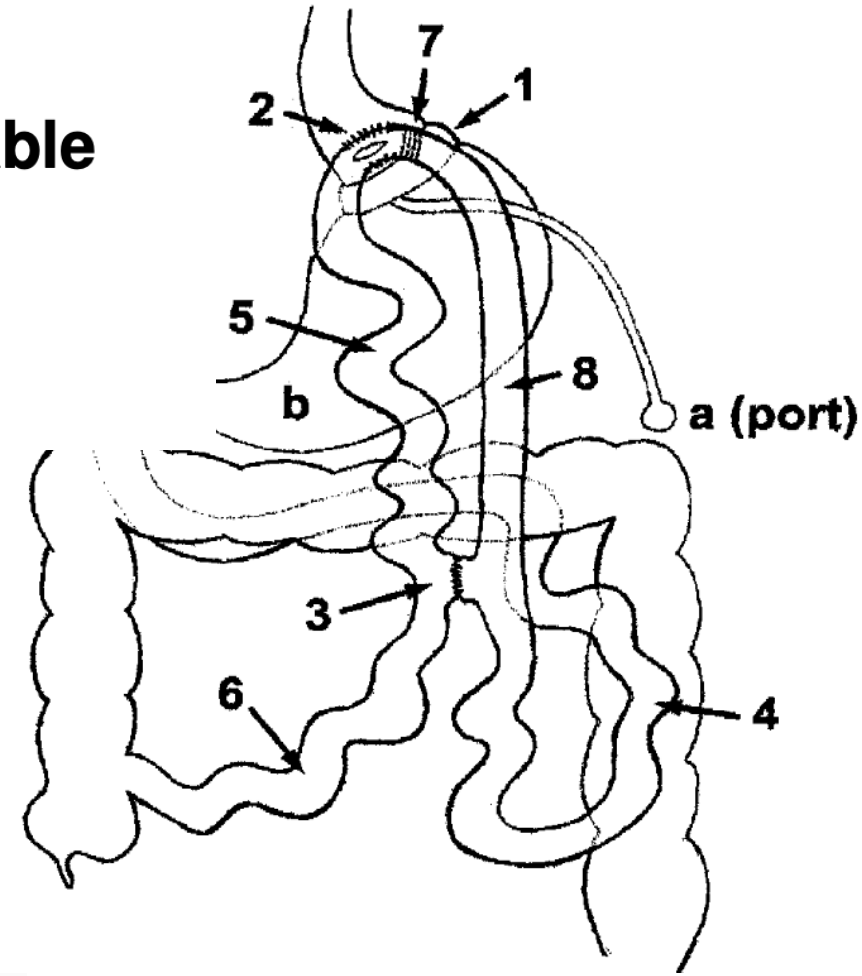
Figure 1. A–D, the Roux-en-Y limbs, E–H, the proximal banded pouch; I–L, the gastro-enterostomy; M–P, the gastrostomy and marker.

Obesity Surgery, **12**, 876-880

Modern Surgery: Technical Innovation

Functional Gastric Bypass with an Adjustable Gastric Band

Francesco Furbetta, MD; Giancarlo Gambinotti, MD

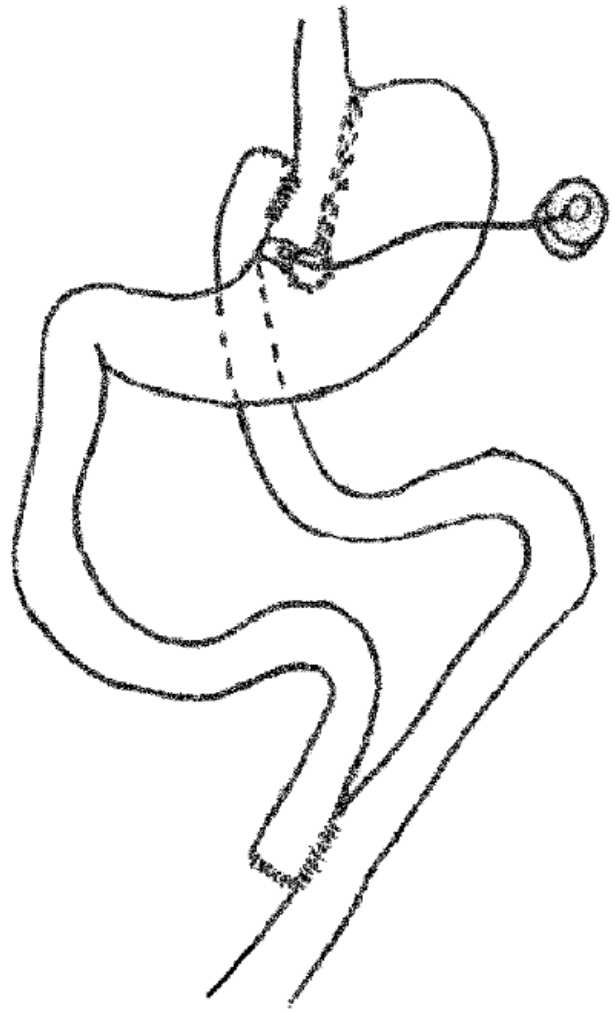


Obesity Surgery, **13**, 788-791

A Functional Roux-en-Y Gastric Bypass to Avoid Gastric Exclusion: 1-Year Results

Stefano Cariani, MD; Giovanni Vittimberga, MD; Sergio Grani, MD; Andrea Lucchi, MD; Manuela Guerra, MD; Enrico Amenta, MD

Dipartimento di Scienze Chirurgiche ed Anestesiologiche, Centro Studi di Terapia Chirurgica dell'Obesità Patologica, Università degli Studi di Bologna, Italy

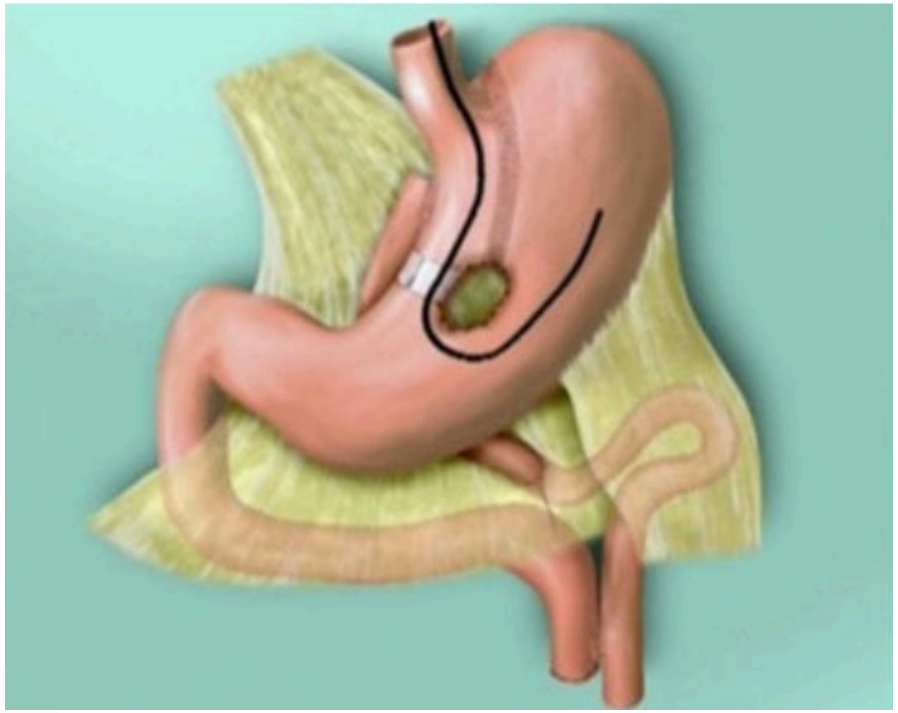


Obesity Surgery, 17, 1312-1318

Three-Year Results of Roux-en-Y Gastric Bypass-on-Vertical Banded Gastroplasty: an Effective and Safe Procedure which Enables Endoscopy and X-Ray Study of the Stomach and Biliary Tract

Stefano Cariani, MD; Enrico Amenta, MD

Dipartimento Emergenza/Urgenza, Chirurgia Generale e dei Trapianti (prof. B. Cola), Unità Operativa semplice di Terapia Chirurgica dell'Obesità Patologica (prof. E. Amenta), Azienda Ospedaliero-Universitaria di Bologna, Italia



Mozzi E, Lattuada E, Zappa MA, et al. Failure of gastric bypass following several gastrointestinal hemorrhages. Obes Surg. 2010;20:523–5.

Lesti G, Tidona V, Lanci C, et al. Bypass gastrico laparoscopico con fundectomia e stomaco esplorabile secondo Lesti. Tecnica e follow-up a sei anni. Ospedali D'Italia. 2009;15:440.

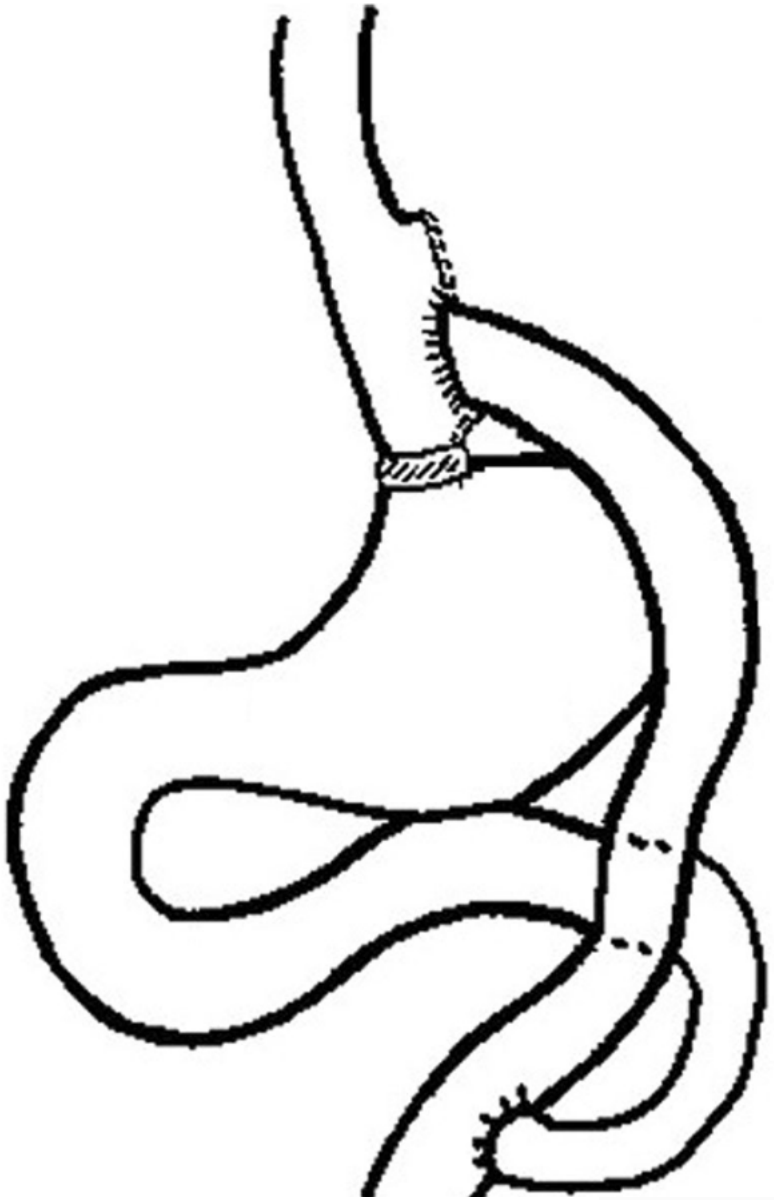
Lucchese M, Cariani S, Amenta E, et al. Other bariatric procedures. In: Angrisani L, editor. Bariatric and metabolic surgery. Berlin: Springer; 2016. p. 195–206.

OBES SURG (2017) 27:2145–2150
DOI 10.1007/s11695-017-2620-y

ORIGINAL CONTRIBUTIONS

Vertical Gastric Bypass with Fundectomy: Feasibility and 2-Year Follow-Up in a Series of Morbidly Obese Patients

Marco Antonio Zappa[1] · Alberto Aiolfi[1] · Cinzia Musolino[1] · Maria Paola Giusti[1] · Giovanni Lesti[2] · Andrea Porta[1]



Chronaiou A, Tsoli M, Kehagias I, et al. Lower ghrelin levels and exaggerated postprandial peptite YY, glucacon-like peptide-1 and insulin responses after gastric fundus resection in patients undergoing roux-en-Y gastric bypass: a randomized clinical trial. Obes Surg. 2012;22:1761–70.

postoperative leak rate compared to the circular stapler [23]. It has been proven that the gastric fundus plays a significant role on ghrelin secretion and metabolism. Ghrelin physiology is characterized by a rise during fasting periods and a rapid postprandial fall. In obese patients, fasting ghrelin levels are elevated and dynamics are altered with a missing postprandial inhibition [24–26]. The reductions of ghrelin secretion together with its serum concentration are achieved after the vertical gastric bypass with fundectomy [27].

Fundectomy and Ghrelin

Obesity Surgery (2020) 30:3046–3053
https://doi.org/10.1007/s11695-020-04650-w

ORIGINAL CONTRIBUTIONS

Impact of Functional Laparoscopic Gastric Bypass with Fundectomy and Gastric Remnant Exploration (LRYGBfse) on Patients' Quality of Life: Trajectory and 5-Year Follow-up Result

Giovanni Lesti[1] · Davide Bona[2] · Andrea Sozzi[2] · Francesco Lesti[1] · Gianluca Bonitta[2] · Marco Antonio Zappa[3] · Alberto Aiolfi[2]

Published online: 12 May 2020

The overall procedure-related morbidity rate was 1.1% (95% CI 0.4–2.3%). In two patients, the postoperative course was complicated by gastric anastomosis bleeding successfully managed with endoscopic clipping. In another patient, a significant intra-abdominal bleeding occurred and an emergent laparotomy was performed without finding the source of bleeding. In two cases, a postincisional trocar site hernia required a laparoscopic revision, respectively, in the 8th and 61st postoperative days. In two other cases, a small bowel intestinal occlusion related to an internal hernia required a laparoscopic revision 7 and 174 days after the index operation. No anastomotic leak, venous thromboembolism, pulmonary complications, or surgical site infections were observed. The median postoperative in-hospital length of stay was 4 days (range 2–10) and median ICU length of stay was 1 (range 1–2). None of the patients required postoperative mechanical ventilator assistance. The overall mortality was 0% (95% CI 0.0–0.4%).

Table 3 Body mass index (BMI) and percentage of total body weight loss (%TBWL) and excess weight loss (%EWL) at baseline and different follow-ups

	BMI (kg/m^2)	%TBWL	%EWL
Baseline	46.2 (9.8)	------	------
1-year follow-up	29.4 (5.9)	33.6 (4.7)	75.5 (15.1)
2-year follow-up	28.3 (4.7)	33.9 (4.2)	80.3 (12.4)
3-year follow-up	28.9 (5.2)	33.7 (5.0)	77.8 (14.3)
5-year follow-up	30.2 (6.2)	31.4 (5.9)	74.2 (16.9)

Table 4 Gastrointestinal Quality of Life Index (GIQLI). Comparisons were made for each follow-up point compared with baseline. No statistically significant differences were found comparing 1-, 2-, 3-, and 5-year follow-up results. Values are reported as median (IQR). *GI symptoms*, gastrointestinal symptoms

	Baseline	1-year	2-year	3-year	5-year
GIQLI total score	80.5 (14.9)	108.7 (19.9)*	113.8 (17.1)*	114.6 (15.5)*	106.9 (17.7)*
GIQLI subscores					
GI symptoms	52.4 (14.0)	63.1 (15.3)*	61.2 (15.1)*	59.9 (13.7)*	57.7 (13.8)*
Physical function	7.8 (3.3)	18.2 (6.3)*	23.2 (6.1)*	23.8 (4.1)*	20.5 (7.6)*
Emotional function	7.6 (3.4)	14.8 (5.5)*	15.9 (5.3)*	14.1 (4.8)*	13.4 (4.8)*
Social function	8.6 (3.7)	12.3 (5.8)*	14.2 (6.5)*	14.4 (5.8)*	12.7 (4.5)*
Medical treatment	2.8 (1.4)	3.2 (1.1)*	3.3 (1.2)*	3.4 (0.9)*	3.0 (1.5)**

*p value > 0.001; **p value = 0.024.

Table 3 Body mass index (BMI) and percentage of total body weight loss (%TBWL) and excess weight loss (%EWL) at baseline and different follow-ups

	BMI (kg/m^2)	%TBWL	%EWL
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2-year follow-up	28.3 (4.7)	33.9 (4.2)	80.3 (12.4)
3-year follow-up	28.9 (5.2)	33.7 (5.0)	77.8 (14.3)
5-year follow-up	30.2 (6.2)	31.4 (5.9)	74.2 (16.9)

Lesti-Zappa

ANDAMENTO DEI PARAMETRI ANTROPOMETRICI DEI 153.689 PAZIENTI INSERITI DAI CENTRI

numero di accessi nazionali 185.574

Selezionare la tipologia di intervento da consultare: By pass gastrico

FOLLOW UP	NUMERO CASI	PESO			BMI			EWL		
		MED	MIN	MAX	MED	MIN	MAX	MED	MIN	MAX
Ricovero	**26.996**	**118,52**	50,00	276,00	**43,61**	14,14	158,00	**0,00**		8,54
3 mesi	**8.956**	**96,49**	47,00	217,00	**35,73**	17,86	73,48	**37,26**	-800,00	736,36
6 mesi	**16.730**	**90,53**	47,00	235,00	**33,30**	14,77	79,15	**48,66**	-1.200,00	741,30
12 mesi	**14.744**	**82,39**	47,00	210,00	**30,32**	16,98	71,75	**62,25**	-1.080,00	736,75
18 mesi	**5.092**	**79,38**	49,80	177,20	**29,41**	17,30	66,12	**66,66**	-720,00	1.240,00
2 anni	**11.081**	**79,90**	43,00	213,00	**29,39**	16,80	68,10	**66,23**	-750,00	731,95
3 anni	**5.243**	**81,04**	46,00	175,00	**29,85**	16,54	62,81	**64,97**	-320,00	500,00
4 anni	**3.541**	**81,83**	49,90	189,00	**30,23**	17,53	64,21	**62,86**	-640,00	742,86
5 anni	**5.514**	**82,46**	50,00	185,00	**30,31**	17,34	69,42	**62,27**	-1.150,00	766,67
6 anni	**1.538**	**84,22**	50,00	210,00	**31,19**	17,08	54,66	**59,25**	-171,43	633,33
7 anni	**1.141**	**84,77**	50,00	168,00	**31,44**	18,31	64,81	**58,72**	-114,29	566,67
8 anni	**842**	**86,21**	47,00	189,00	**31,94**	17,99	65,92	**57,15**	-142,86	143,87
9 anni	**544**	**85,34**	50,00	163,00	**31,82**	17,30	56,63	**56,37**	-151,35	116,13
10 anni	**460**	**86,55**	50,00	175,00	**31,72**	17,07	56,50	**56,32**	-116,13	121,43
11 anni	**227**	**86,70**	50,00	134,50	**31,97**	19,05	52,70	**56,67**	-103,23	114,81
12 anni	**209**	**86,19**	50,00	180,00	**32,10**	19,70	58,11	**55,73**	-219,35	325,00

RYGB

S.I.C.OB.

OBES SURG (2013) 23:131–139
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OTHER

Unexpected Changes in the Gastric Remnant in Asymptomatic Patients after Roux-en-Y Gastric Bypass on Vertical Banded Gastroplasty

Luca Leuratti · Massimo Pierluigi Di Simone · Stefano Cariani

Results The endoscopy of the remnant stomach was technically easy and already showed on macroscopic examination 90 % cases of gastritis (41.2 % mild, 49 % severe) with tendency of severity in the distal stomach part. Histological analysis detected 39.2 % of active gastritis, 50.6 % of quiescent gastritis, 7.8 % of intestinal metaplasia, and 3.9 % of lymphoma-like gastritis.

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Gastric cancer after gastric bypass with fundectomy: The possibility for early diagnosis

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A B S T R A C T

Introduction: Roux-an-Y gastric bypass (RYGP) is one of the most important bariatric procedures and its results are well known in terms of weight loss and comorbid improvement. The major limitation of this technique is the difficult exploration of the excluded stomach and duodenum. Some Authors are performing the gastric bypass with fundectomy and, according to Literature, it is feasible and effective, with major advantage of explorable gastric pouch.

Presentation of case: We report the case of a 54-year-old woman affected by obesity (BMI 49 kg/m^2). After a pre-operative multidisciplinary evaluation and gastroscopy, she underwent a laparoscopic RYGB with fundectomy in October 2016.

One year after surgery she contacted the department for vomiting, pyrosis and weakness.

Thanks to the characteristics of the surgical technique it was possible to easily perform an OGD that detected an antral ulcer. The byopsy revealed a gastric adenocarcinoma.

A degastroresection was performed and the istological finding was a gastric adenocarcinoma pT1b N0 G3.

Discussion: Early diagnosis is essential in gastric tumors to ensure a good prognosis and the gold standard is performing gastroscopy with biopsies.

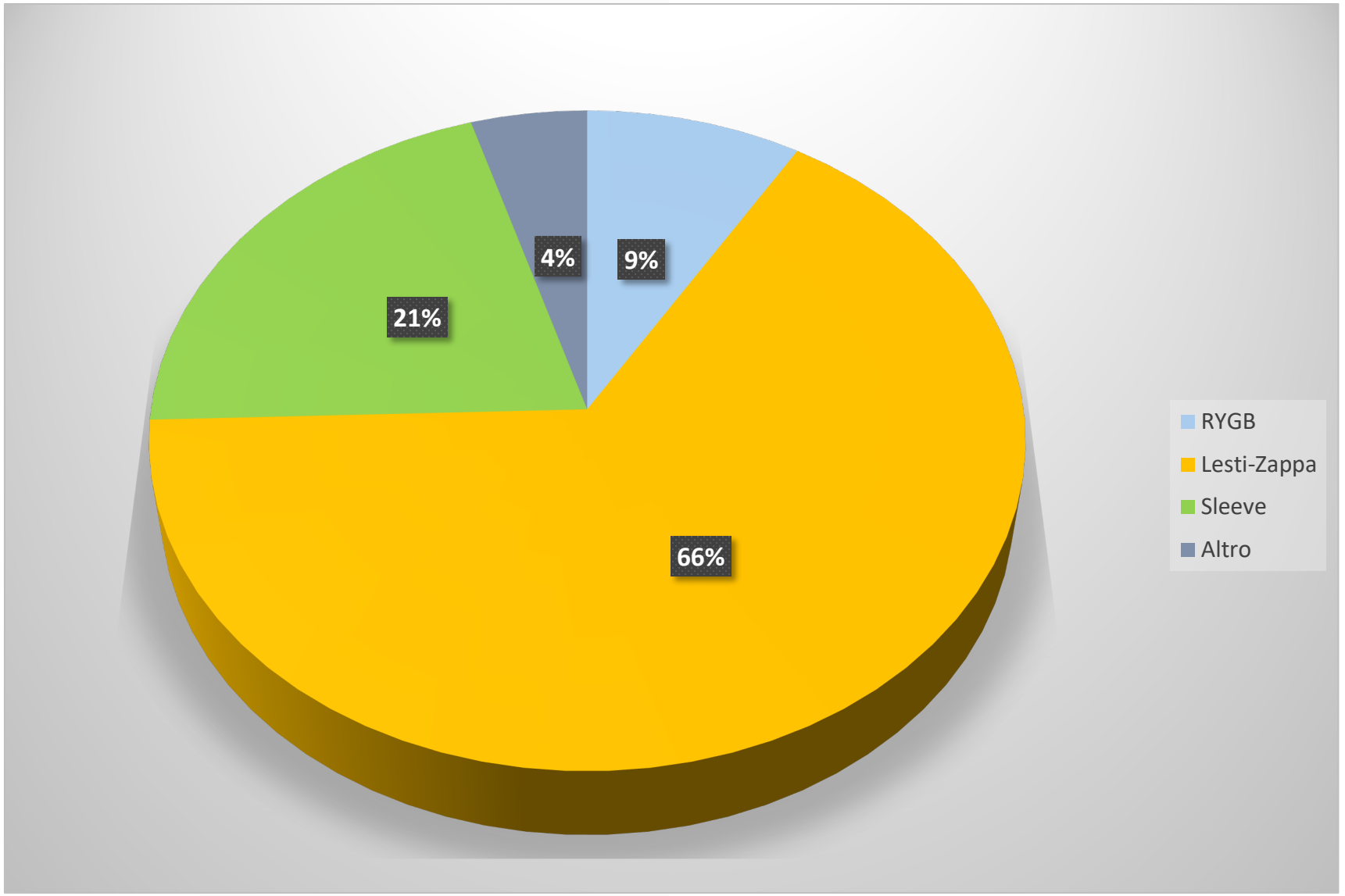
With the standard technique is very challenging to perform an OGD and the cancer stage is likely to be advanced at diagnosis, with a bad prognosis for the patient.

Conclusion: From the clinical case described and the analysis of the Literature, the advantages of this technique are clear, allowing for an easy endoscopic evaluation of gastric walls with the possibility of diagnosing early stage tumors with a better outcome for patients.

SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale della Romagna

Chirurgia Generale Riccione

Da luglio 2021 a Dicembre 2023: **149 interventi**



Chirurgia Riccione: bypass gastrico con fundectomia e stomaco esplorabile

-maggio 22 –dicembre 2023: **98 interventi**
-(78 F, 20 M)
-eta media 46
-72 primo intervento, 26 redo
-BMI medio pre 41.77
-peso medio pre 115 kg
-degenza media 3 gg
-tempo operatorio medio: 131 minuti
-1 conversione
-EW preop 57 kg
EWL 1 mese 16.4
EWL 3 mesi 32.9
EWL 6 mesi 49.8
EWL 1 anno 57.7

Solo primo intervento **72 pz**

EWL 1 mese 17
EWL 3 mesi 33.1
EWL 6 mesi 49.7
EWL 1 anno 56.4

Chirurgia Riccione: bypass gastrico con fundectomia e stomaco esplorabile

Complicanze < 30 gg. 5/98 (4.9%)

- -1 deiscenza sutura verticale
- -1 torsione anastomosi piede d'ansa (reintervento)
- -2 insufficienza resp acuta al risveglio
- -1 inf accesso trocar
- -1 ernia ombelicale strozzata

Complicanze >30 gg 2/98 (2%)

- 1-ernia interna Petersen a 1 anno
- 1-nausea

Readmission

- <30 gg 8/98 (7.8%) (3 dolore addomianle, 1 febbre, 1 suboccl, 1 deiscenza sutura verticale, 1 disidratazione, 1 necrosi omentale)
- >30 gg 2/98 (2%) (nausea, ernia di Petersen)

ERABS

-no SBG
-no CV
-no drenaggi di routine
-mobilizzazione nel pomeriggio
-dieta semiliquida alla sera dell'intervento
-RX TD in 1 POD (solo a scopo documentale…)
-dimissione al pomeriggio di 2 POD
-consulto telefonico tutti i giorni fino al 1 controllo ambulatoriale in 7 POD

Bypass gastrico con fundectomia e stomaco eplorabile

vantaggi

-stomaco, duodeno e via biliare esplorabili (pz giovani!)
-calo ponderale > RYGB
-risultati in termini di risoluzione comorbilita e qualita di vita uguali o superiori rispetto a RYGB
-complicanze e mortalita non superiori al RYGB

svantaggi

-tecnicamente piu complesso
-tempo operatorio piu lungo
-costi superiori rispetto al RYGB (piu ricariche e benderella)

Perché non preferirlo al RYGB?


S.I.C.OB.
XXXII CONGRESSO
NAZIONALE SICOB
23 - 25 MAGGIO 2024
GIARDINI
NAXOS

Grazie