



COMITATO SCIENTIFICO

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ANNI DI OAGB

MATURITÀ RAGGIUNTA? CORSO LIVE
SU TECNICA, GESTIONE, CURIOSITÀ E
SUL "PERCHÉ IO LO FACCIO COSÌ"

LATINA, Venerdì 27 Giugno 2025

Direttore del Corso: Prof Angelo Iossa
Presidente onorario: Prof Giuseppe Cavallaro



CONGRESSO REGIONALE
SICOB LAZIO

OAGB nel mondo... storia di un successo?

DR. FRANCESCO M. CARRANO

UOC CHIRURGIA GENERALE & BARIATRIC
CENTER CENTER OF EXCELLENCE
AOU SANT'ANDREA, ROMA



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Era un giovedì notte del settembre 1997...

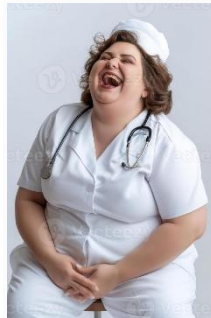
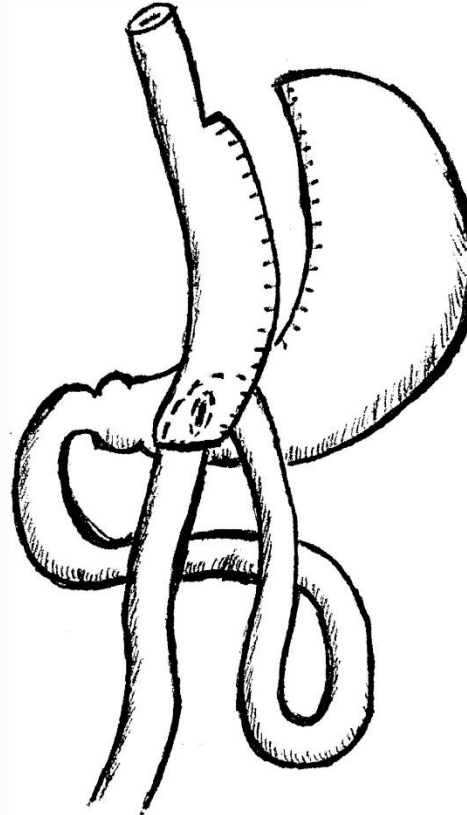
6 ferite da .357 magnum
addome → lesioni coda
pancreas, stomaco,
multiple anse intestinali



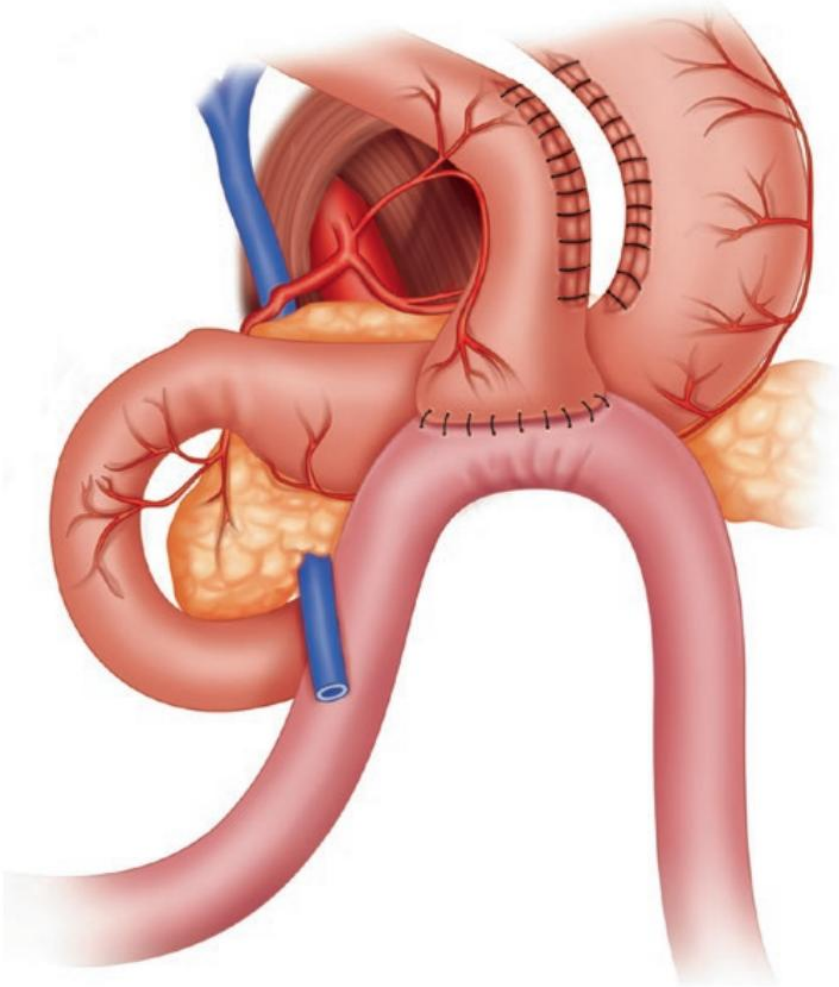
splenopancreasectomia
distale + Billroth II



Rutledge inventa il  Mini-Gastric Bypass e lo
esegue il mattino
successivo



Il Mini-Gastric Bypass MGB (RUTLEDGE, 1997)



- **Pouch gastrica:** dalla base della *zampa d'oca* fino a sx dell'angolo di His
- **Bypass intestinale:** ansa **ante-colica** di digiuno, 150–200 cm distale al legamento di Treitz
- **Anastomosi gastro-digiunale ampia:** parete posteriore della pouch ↔ bordo antimesenterico del digiuno
- Configurazione **termino-laterale** con suturatrice lineare da **45 mm**

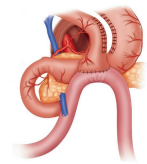
Perché “Mini”-Gastric Bypass?

- Anni '70-'80: moda “mini”, mini-laparotomia, ecc.
- Anni '90: mini-invasivo, mini-laparoscopia
- MGB = versione “semplificata” del RYGB → nome “mini”



Timeline OAGB

1997 – Concezione Mini-Gastric Bypass (MGB) da R. Rutledge



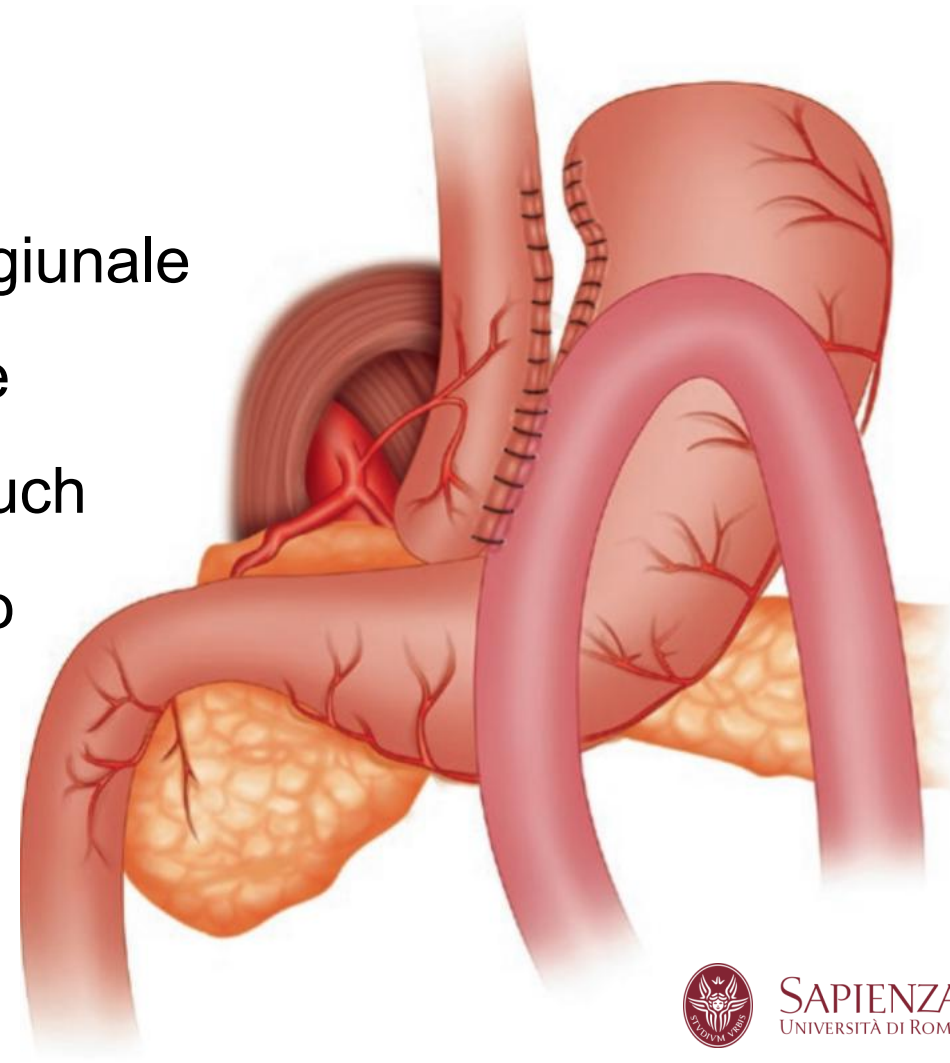
2001 – Prima casistica MGB (1 274 pazienti) pubblicata su Obesity Surgery

2002 – Prof. Carbajo modifica il MGB → nasce l'OAGB



La variante OAGB (Carbajo, 2002)

- **Configurazione latero-laterale** tra pouch e ansa digiunale
- Sutura “**anti-reflusso**” di 5–6 cm: avvicina il margine mesenterico del digiuno alla parete laterale della pouch
- Enterotomia nel tratto distale della pouch e sul bordo antimesenterico dell’ansa
- **Gastro-digiunostomia latero-laterale**



Timeline OAGB

2005 – Serie laparoscopica OAGB (209 pz) + risultati 2 410 MGB (6 anni)

2015 – MGB Conclave New Delhi e nascita MGB-OAGB International Club

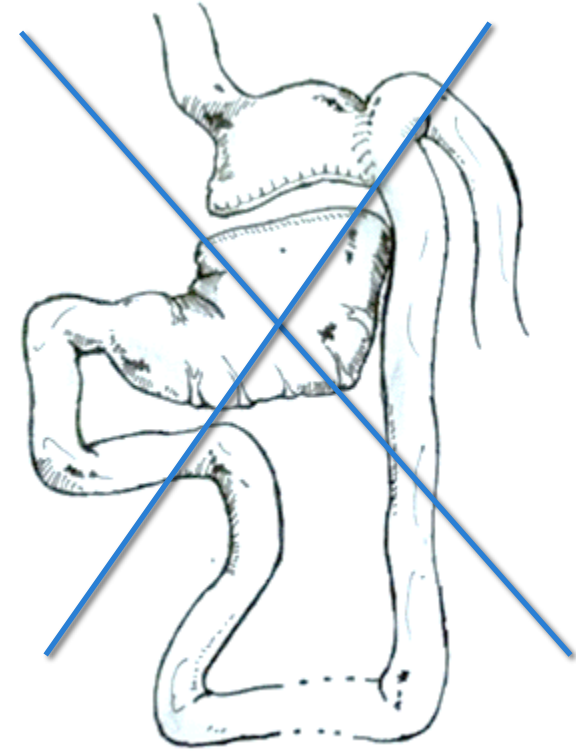
2018 – IFSO Position statement 

2021 – IFSO Position statement - update 

2023 – Approvazione ASMBS 

Critiche iniziali rivolte a Rutledge (fine anni '90)

- «Non asporti la **colecisti** → calcolosi post-bypass»
- «Il loop non è **retro-colico / retro-gastrico** → rischio reflusso»
- «È il vecchio bypass di **Mason** → porterà a **cancro gastrico**»
- «Billroth II provoca **neoplasie** dello stomaco»
- «Pouch e gastro-digiunostomia sono **troppo grandi** → pazienti non dimagriranno»



(Queste obiezioni furono poi confutate dai dati clinici a lungo termine)

BRIEF REPORT



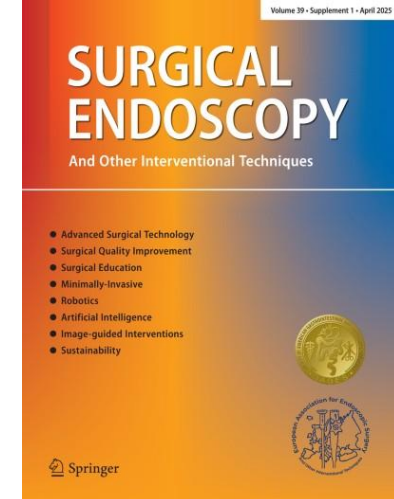
Gastric Cancer in One-Anastomosis Mini-gastric Bypass: Case Report and Systematic Review

Danilo Vinci^{1,2} · Antonio La Terra² · Emilio Manno³ · Giovanni Merola⁴ · Andrea Muratore²

Study	Year	Journal	Number of patients	Tumor location	Histology
Scozzari et al. [9]	2013	<i>Surgery for Obesity and Related Diseases</i>	4	1 gastric pouch 3 excluded stomach	Adenocarcinoma
Runkel M. et al. [10]	2019	<i>Chirurgia</i>	1	Gastroesophageal junction	Adenocarcinoma
Atarodi H. et al. [11]	2020	<i>Obesity Surgery</i>	1	Distal transverse colon	Adenocarcinoma
Karabacak U. [12]	2020	<i>Journal of Cancer Research and Therapeutics</i>	1	Gastric pouch	Adenocarcinoma
Aggarwal S. [13]	2020	<i>J Minim Access Surg</i>	1	Gastroesophageal junction	Adenocarcinoma
Parmar C. et al. [7]	2022	<i>Surgery for Obesity and Related Diseases</i>	2	Gastroesophageal junction	Adenocarcinoma
Mouawad C. et al. [8]	2024	<i>Journal of Gastrointestinal Cancer</i>	1	Gastro-jejunal anastomosis	Adenocarcinoma
Present case	2024	<i>Obesity Surgery</i>	1	Gastro-jejunal anastomosis	Adenocarcinoma

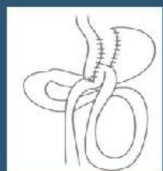
12 casi

E il reflusso?



Median follow-up = 4.2 years (range 1.1–6.9)

Cross-sectional study;
University-hospital based



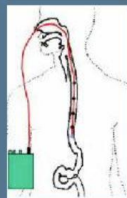
50 OAGB patients

- Impedance-24h-pH-metry
- High-resolution Manometry
- Gastroscopy

Results



Anastomositis: 38.0% ↑
Esophagitis: 34.0% ↑



LESP (mmHg) 29.6 ↔
Non-acid reflux: 46.3 ↑
Acid reflux: 10.3 ↓
DeMeester: 10.3 ↓



GIQLI 111.2
BAROS: 5.2

Conclusion:

This study has shown decreased rates of acid reflux and increased non-acid reflux after a mid-term outcome of primary OAGB patients.

Gastroscopy showed signs of chronic irritation of the gastrojejunostomy, pouch, and distal esophagus, even in asymptomatic patients.

2025



Risultati MGB a 5 anni - Rutledge

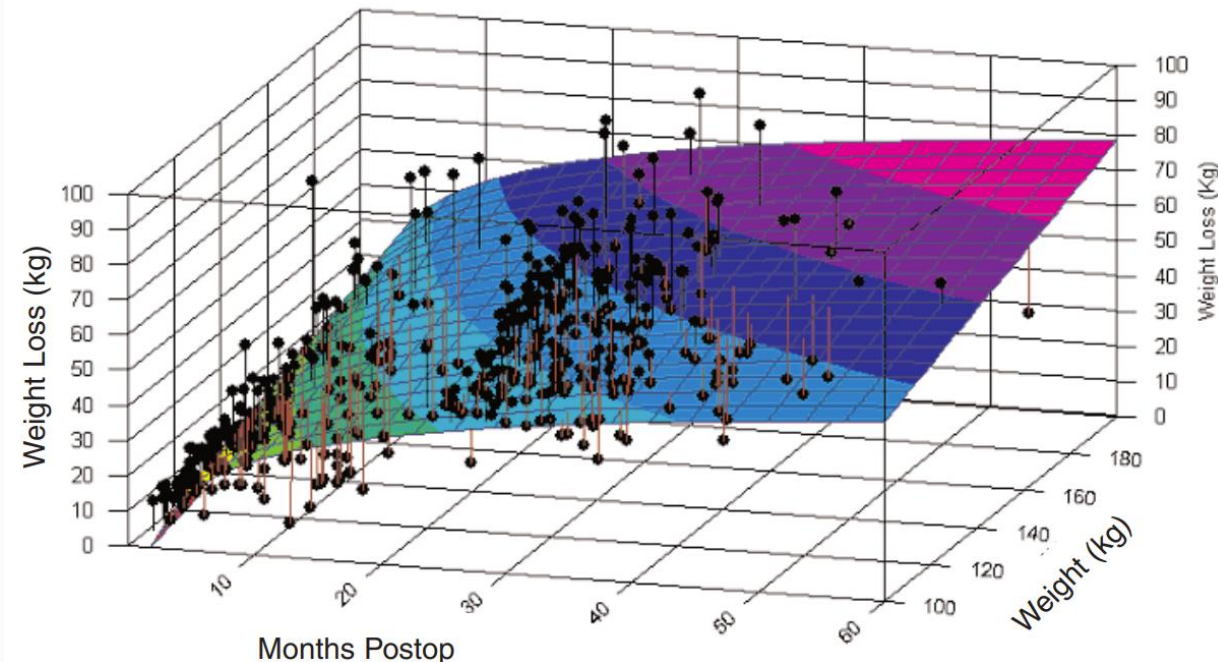
- **37,5 min** il tempo operatorio medio
- Degenza mediana **1 giorno**
- **0,08 %** mortalità 30 gg
- 5,9 % complicanze (leak 1,08 %)
- **Perdita peso: 80 %EWL** a 1 anno;
>95 % dei pazienti mantengono il risultato fino a 5 anni
(<5 % ripresa >10 kg)
- **Remissione comorbidità:** GERD 85 %, T2DM 83 %, OSAS 87 %, ipertensione 80 %, ipercolesterolemia 89%
- **Complicanze tardive:** ulcera/dispepsia 5,6 %, anemia sideropenica 4,9 %, malnutrizione 1,1 %

Obesity Surgery, 15, 1304-1308

Continued Excellent Results with the Mini-Gastric Bypass: Six-Year Study in 2,410 Patients

Robert Rutledge, MD, FACS; Thomas R. Walsh, MD, FACS, CPE

The Centers of Excellence for Laparoscopic Obesity Surgery (CELOS), Las Vegas, NV, USA



Risultati OAGB a 6-12 anni - Carbajo

- **Casistica:** 1200 pazienti (2002-2008), BMI medio 46 kg/m², età 43 aa; F 62 %, M 38 %
- **Tempi operatori:** 86 min primario · 112 min con procedure concomitanti · 180 min revisioni
- **Sicurezza:** conversioni 0,3 % · complicanze maggiori precoci 2,7 % · tardive 1 % · mortalità 0,16 %
- **Perdita di peso:** %EWL 88 % a 2 aa → 77 % a 6 aa → 70 % a 12 aa (BMI 46 → 26,6 → 29,9)
- **Remissione comorbidità:** DM2 94 % · ipertensione 94 % · dislipidemia 96 % · GERD 92 % · OSAS 90 % · steatosi 100 %
- **Re-interventi:** 1,3 % per complicanze; 0 % per fallimento
- **Follow-up disponibile:** 87 % a 6 aa · 70 % a 12 aa

OBES SURG (2017) 27:1153–1167
DOI 10.1007/s11695-016-2428-1

ORIGINAL CONTRIBUTIONS

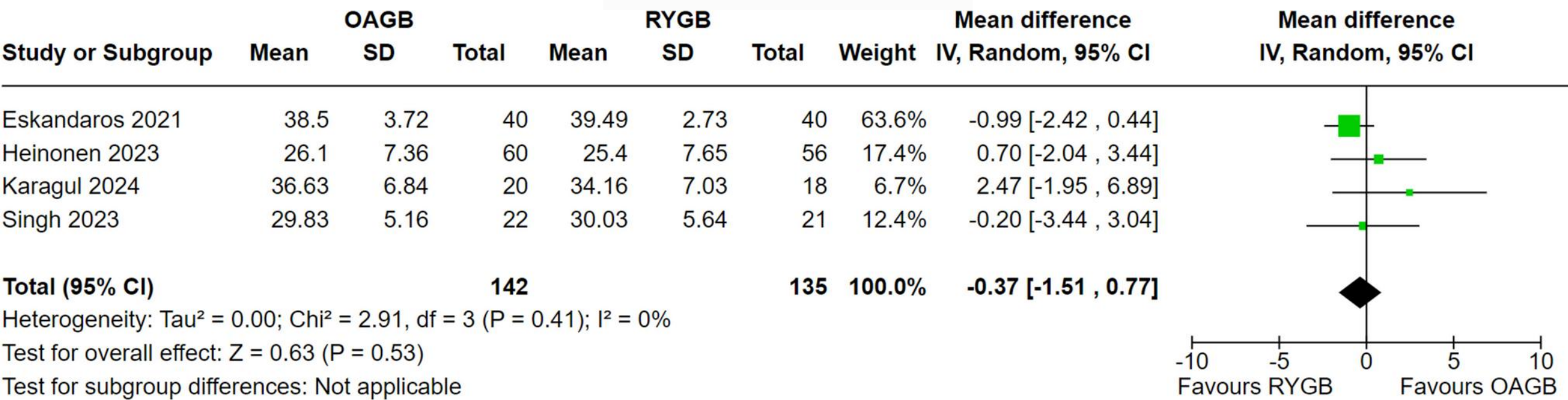
Laparoscopic One-Anastomosis Gastric Bypass: Technique, Results, and Long-Term Follow-Up in 1200 Patients

Miguel A. Carbajo¹ · Enrique Luque-de-León¹ · José M. Jiménez¹ ·
Javier Ortiz-de-Solórzano¹ · Manuel Pérez-Miranda¹ · María J. Castro-Alia¹



Risultati a 12 mesi

Ahmed Y, et al. March 2025



TWL% at 12 months

Risultati a 12 mesi

Ahmed Y, et al. March 2025

Study or Subgroup	OAGB		RYGB		Weight	Risk ratio M-H, Random, 95% CI
	Events	Total	Events	Total		
Delko 2024	1	36	1	38	3.5%	1.06 [0.07 , 16.25]
Fahmy 2018	4	20	0	21	3.2%	9.43 [0.54 , 164.62]
Karagul 2024	4	20	0	18	3.2%	8.14 [0.47 , 141.49]
Level 2020	1	9	0	19	2.7%	6.00 [0.27 , 134.43]
Robert 2024	27	66	14	76	84.2%	2.22 [1.28 , 3.87]
Salman 2023	7	31	0	31	3.3%	15.00 [0.89 , 251.77]
Total (95% CI)		182		203	100.0%	2.58 [1.55 , 4.30]

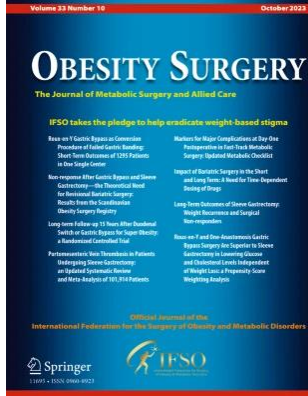
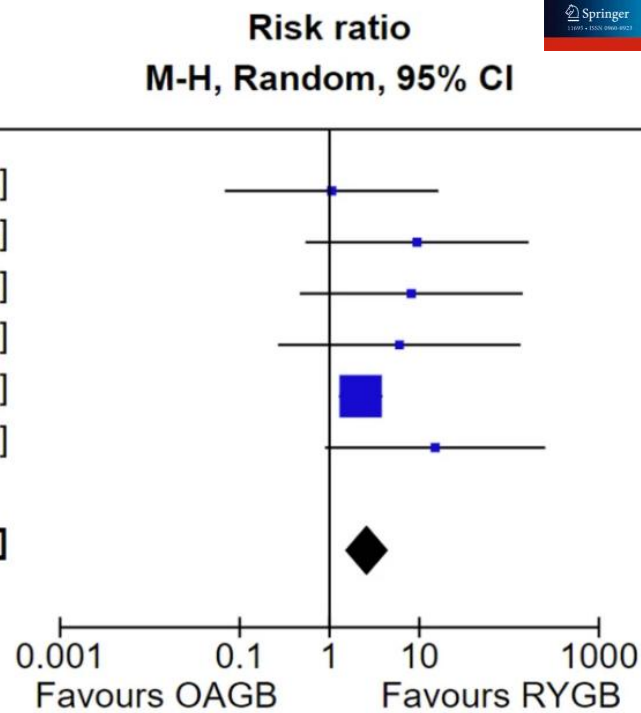
Total events: 44 15

Heterogeneity: Tau² = 0.00; Chi² = 4.30, df = 5 (P = 0.51); I² = 0%

Test for overall effect: Z = 3.65 (P = 0.0003)

Test for subgroup differences: Not applicable

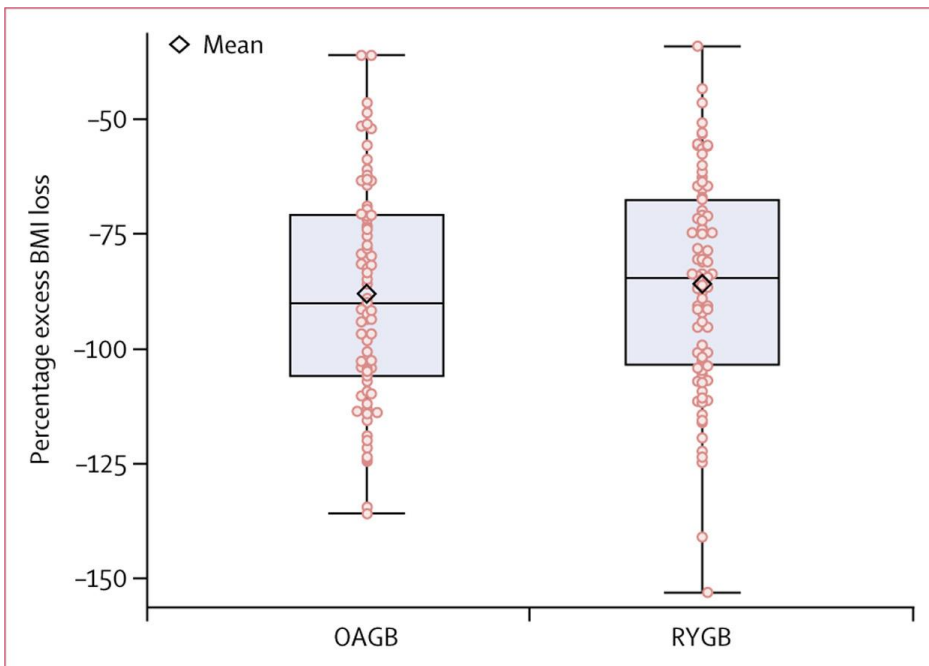
Incidence of de novo GERD



Risultati a lungo termine

Efficacy and safety of one anastomosis gastric bypass versus Roux-en-Y gastric bypass for obesity (YOMEGA): a multicentre, randomised, open-label, non-inferiority trial

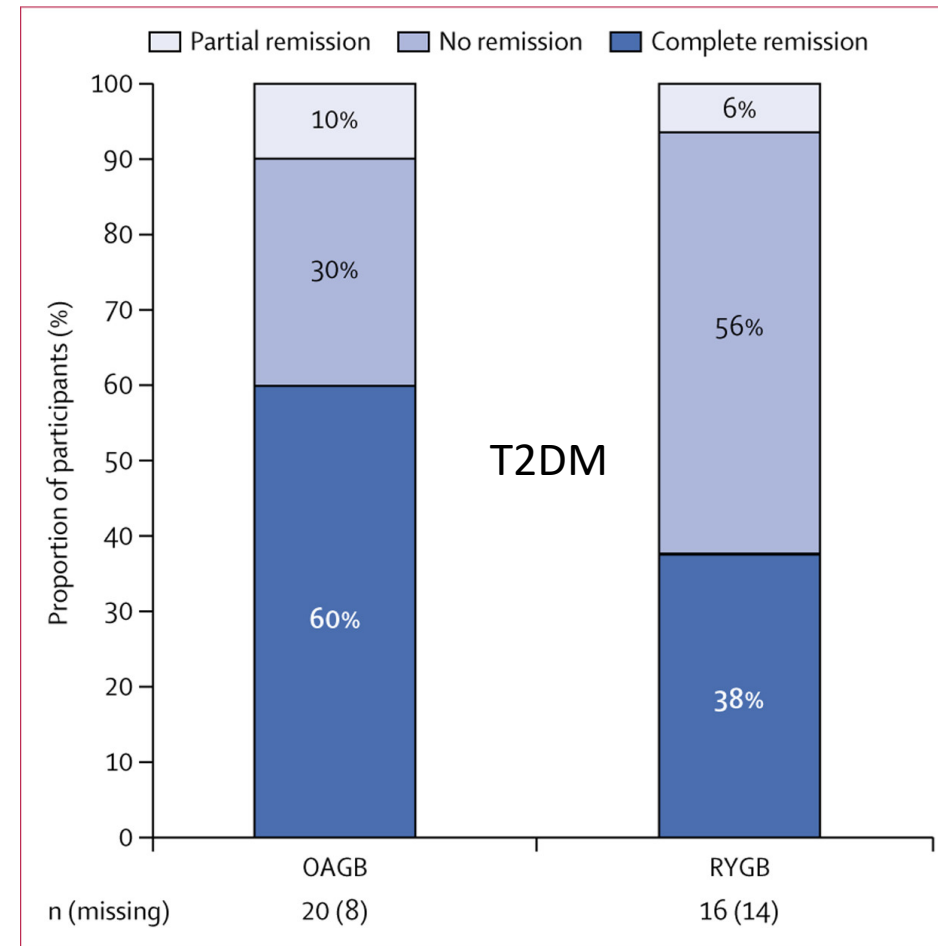
Maud Robert, Philippe Espalieu, Elise Pelascini, Robert Caiazzo, Adrien Sterkers, Lita Khamphommala, Tigran Poghosyan, Jean-Marc Chevallier, Vincent Malherbe, Elie Chouillard, Fabian Reche, Adriana Torcivia, Delphine Maucourt-Boulch, Sylvie Bin-Dorel, Carole Langlois-Jacques, Dominique Delaunav, Francois Pattou, Emmanuel Disse



“OAGB was not inferior to RYGB regarding percentage excess BMI loss at **5 years** with similar metabolic outcomes. The high rate of clinical gastro-oesophageal reflux disease after OAGB raises questions about its long-term consequences, which need to be further investigated”.

THE LANCET
Diabetes & Endocrinology

April 2024



IFSO UPDATED POSITION STATEMENT - 2021

De Luca, et al.

Recommendation of the IFSO OAGB Taskforce

1. OAGB should remain the official IFSO-approved identifier for this procedure. MGB and OAGB may be different operations in the mind of some authors, but both operations are similar as they both have a single gastro-jejunal anastomosis and furthermore, most studies report on an operation that is not a pure MGB or a pure OAGB, but rather a mixed technique. We have learned from other procedures (e.g., RYGB, BPD, DS) that it is essential to define each type of intervention under a single name. For these reasons, IFSO selected OAGB as the approved identifier for this procedure.
2. The outcomes from OAGB are promising in terms of short operative time, low perioperative complication rate, good weight loss and good comorbidities remission (T2DM, HTN, OSAS, and DL) and appear at least equivalent to other bariatric surgery procedures.
3. OAGB in the primary setting provides better weight loss, comorbidity reduction and fewer complications when compared to the outcomes when OAGB is performed as

a revisional procedure. Patients should be aware of these differences if undertaking OAGB as revisional procedure.

4. At this stage, bile reflux does not seem to be a major issue for patients who have undergone OAGB and there have not been increased reports of esophageal or gastric cancer. Due to the risk of under reporting and the time lag for carcinogenesis following OAGB, we recommend that patients should remain under the care of their multidisciplinary bariatric team and have regular endoscopic examinations as per the IFSO position statement on endoscopy [119].
5. While the data is currently lacking, long-term nutritional deficiencies due to the malabsorptive nature of OAGB procedures should be considered and patients should have at least an annual nutritional review and appropriate micro- and macronutrient supplementation. Long-term observational studies should be undertaken, potentially using national registries, to better understand nutritional requirements. Given that BPL length appears to be an important variable, RCTs are warranted to address this important issue.
6. The majority of the studies included in this review are case studies with <5 years follow up. In order to increase the body of evidence, patients should be encouraged to remain in long-term multidisciplinary care, and clinics should be encouraged to participate in registries, as well as longer-term follow-up studies, and possibly RCTs.

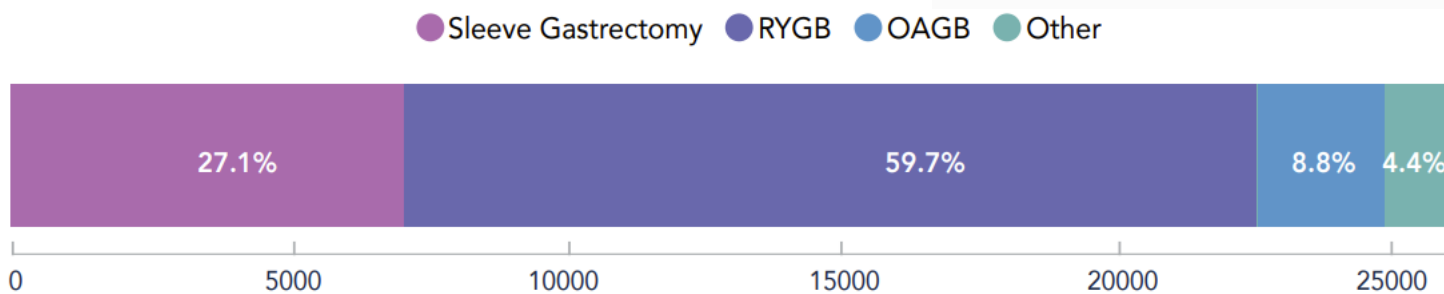
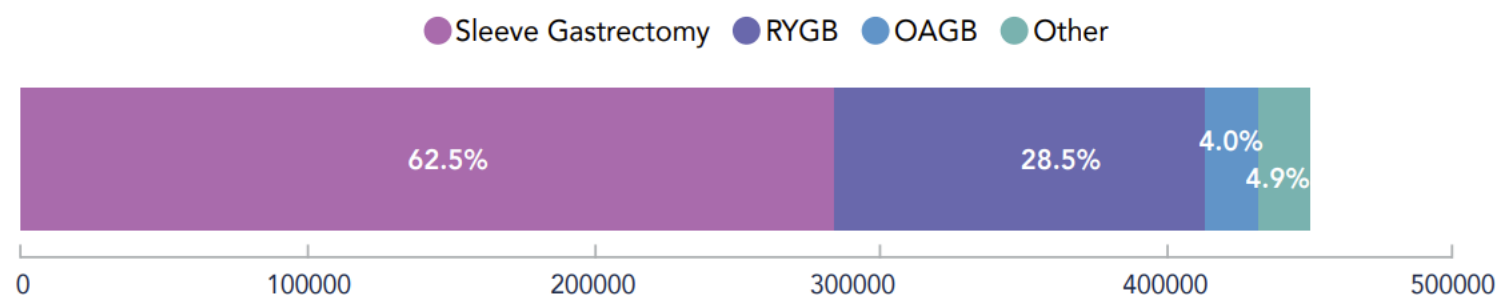


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OAGB nel mondo



≈ 20 000 OAGB/anno, trend in crescita (+35% vs 2020)



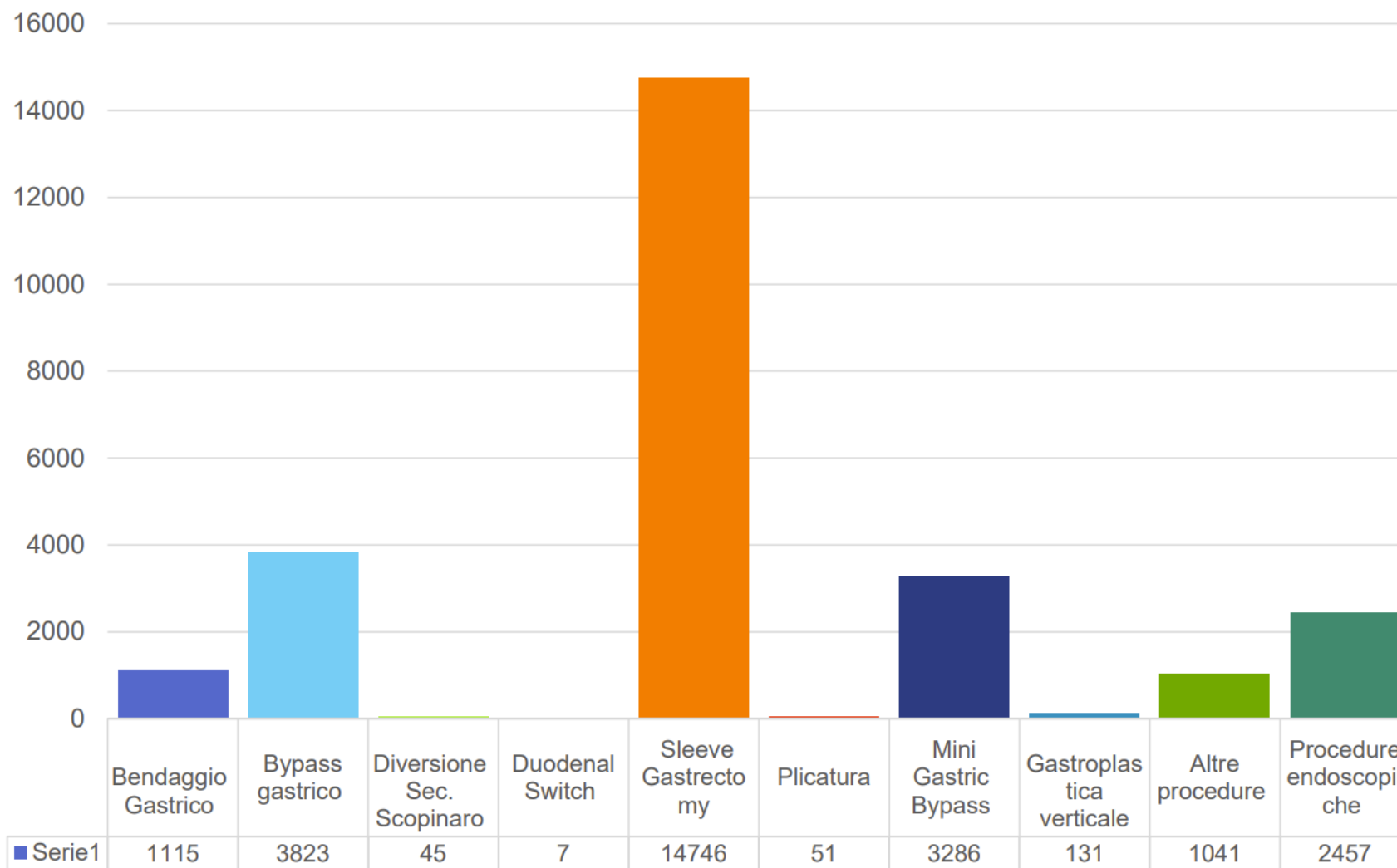
(Fonte: IFSO World Registry 2024)

OAGB



Tipologia delle procedure eseguite nel 2024

Totale **26.702** interventi



Dati Ufficiali SICOB - aggiornati al 21 gennaio 2024

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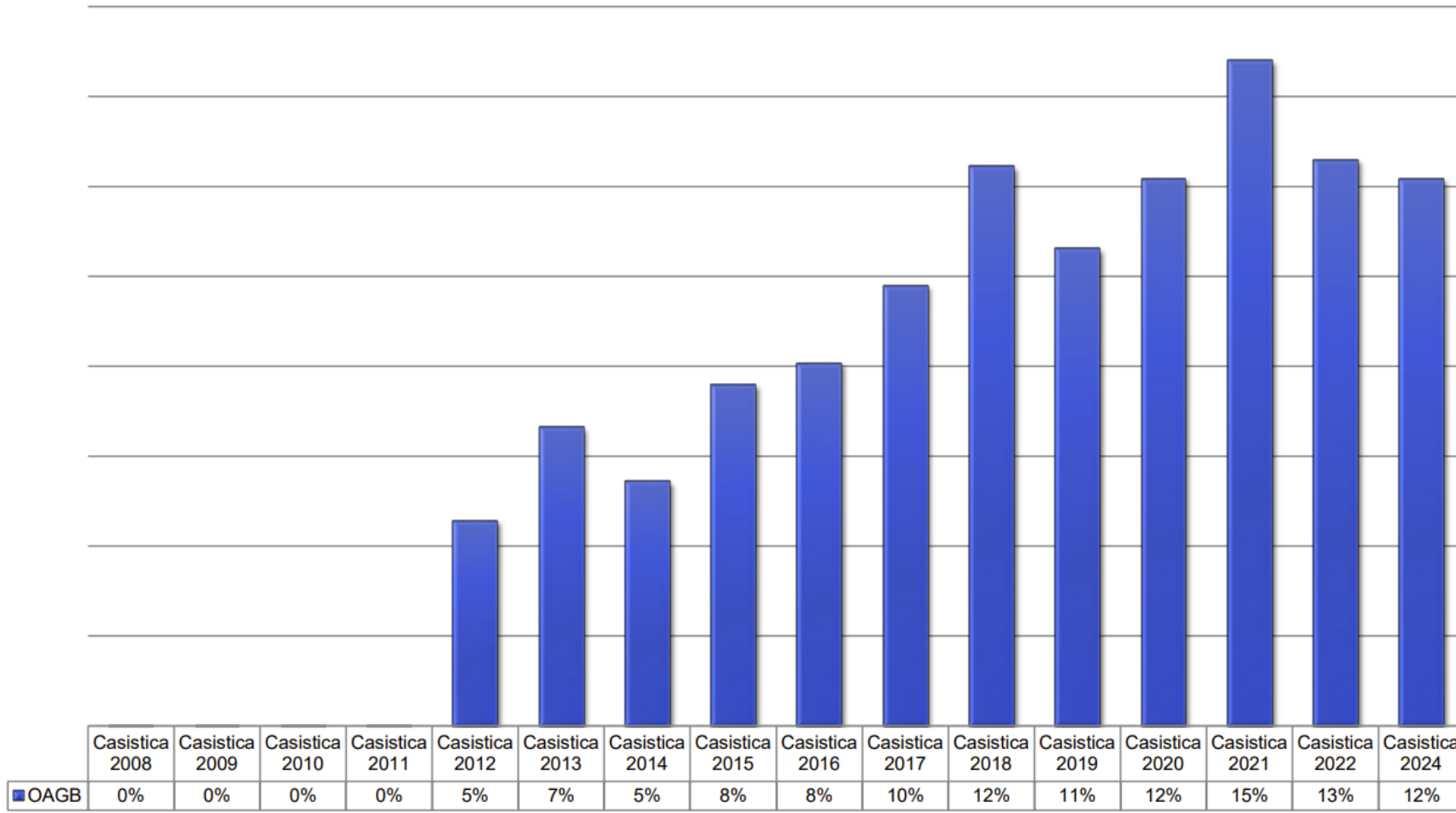


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OAGB Andamento Percentuale sul totale interventi



Dati Ufficiali SICOB - aggiornati al 21 gennaio 2024

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Grazie

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