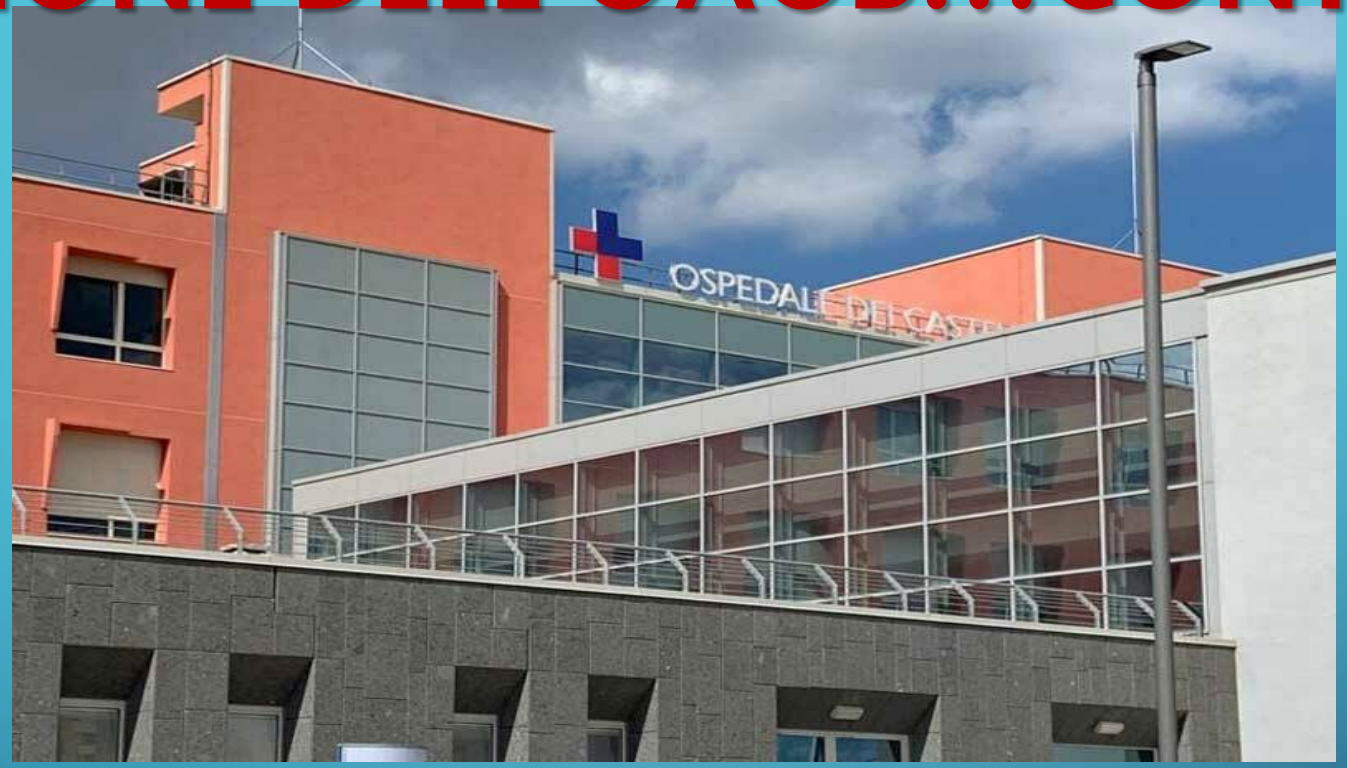
EVOLUZIONE DELL'OAGB…CONTROVERSIE



DOTT.SSA FRANCESCA ABBATINI MD,PHD

U.O.C. CHIRURGIA GENERALE E D'URGENZA OSPEDALE DEI CASTELLI,ARICCIA(RM)

DIRETTORE DOTT. ANGELO SERAO

SISTEMA SANITARIO REGIONALE
ASL ROMA 6

S.I.C.OB. Società Italiana di Chirurgia dell'OBesità e delle malattie metaboliche

LATINA

Obesity Surgery (2018) 28:303–312
https://doi.org/10.1007/s11695-017-3070-2

ORIGINAL CONTRIBUTIONS

The First Consensus Statement on One Anastomosis/Mini Gastric Bypass (OAGB/MGB) Using a Modified Delphi Approach

Kamal K. Mahawar[1] · Jacques Himpens[2] · Scott A. Shikora[3] · Jean-Marc Chevallier[4] · Mufazzal Lakdawala[5] · Maurizio De Luca[6] · Rudolf Weiner[7] · Ali Khammas[8] · Kuldeepak Singh Kular[9] · Mario Musella[10] · Gerhard Prager[11] · Mohammad Khalid Mirza[12] · Miguel Carbajo[13] · Lilian Kow[14] · Wei-Jei Lee[15] · Peter K. Small[1]

-101 OAGB/MGB experts from 39 countries
-55 statements in areas of controversy or variation
-consensus was achieved for 48/ 55 proposed statements

Expert Disagreement with the Committee Statements

Out of the 48 statements where consensus was achieved, experts agreed with 46 of the statements proposed by the committee. Two statements where a consensus of disagreement was reached have been clearly identified in Table 3. These are as follows.

(i) One anastomosis/mini gastric bypass (OAGB/MGB) is not a malabsorptive bariatric procedure (disagreed by 82.0% of the experts).

(ii) The standard length of the bilio-pancreatic limb should be 150 cm for all patients (disagreed by 82.0% of the experts).

No Consensus Achieved

Even after two rounds of voting, there was no consensus on 7 statements. These have been clearly identified in Table 3 and are as follows.

(i) One anastomosis/mini gastric bypass (OAGB/MGB) largely works similar to an RYGB in its mechanism of action (65.35% disagreed).

(ii) OAGB/MGB is an acceptable surgical option for suitable patients with severe gastro-oesophageal reflux disease (GERD) requiring daily medication (69.31% agreed).

(iii) OAGB/MGB is the preferred surgical option for suitable patients with severe psychiatric disorders because of the ease of reversibility (54.46% agreed).

(iv) OAGB/MGB is not recommended for patients with Barrett's oesophagus (66.34% agreed).

(v) Routine crural approximation is unnecessary for patients with a hiatus hernia (63.37% agreed).

(vi) Patients should be advised routine prophylaxis for gallstones with ursodeoxycholic acid for at least 6 months (64.36% disagreed).

(vii) Patients developing symptomatic GERD unresponsive to maximal medical therapy after OAGB/MGB can be offered surgical correction in the form of a Braun's anastomosis between afferent and efferent limbs (66.34% disagreed).

IFSO OAGB-MGB Consensus Meeting

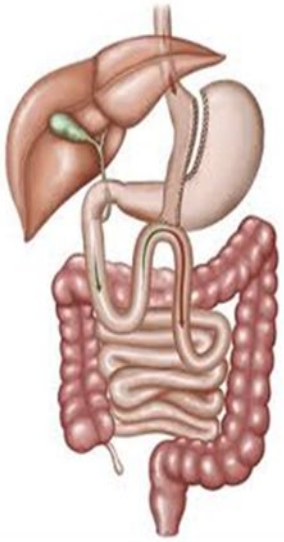
Obesity Surgery (2020) 30:1625–1634
https://doi.org/10.1007/s11695-020-04519-y

ORIGINAL CONTRIBUTIONS

Check for updates

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[1] · Jean-Marc Chevallier[2] · Kamal Mahawar[3] · Wendy Brown[4] · Lilian Kow[5] · Kevin P. White[6] · Scott Shikora[7] · IFSO Consensus Conference Contributors



The minimal recommended length of the gastric pouch should be…	No consensus Roughly 15 cm—46% As long as possible—54%
Total bowel length should always be measured for a safe and adequate OAGB-MGB.	No consensus Agree—41% Disagree—59%
Total bowel length should be measured for a safe and adequate OAGB-MGB whenever possible without adding risk to the patient.	No consensus Agree—62% Disagree—38%
Esophagitis grade C or D is a contraindication to OAGB-MGB.	No consensus Agree—67% Disagree—33%
The best way to choose the length of the biliopancreatic limb should be based on…[c]	No consensus A fixed length from the Treitz's angle—27% Patient's BMI—33% % Of the total bowel length—41%
When measurement of the total small bowel length is performed, the ideal percentage length for the biliopancreatic limb, as a percentage, should be…	No consensus <30%—17% 30–40%—68% >40%—15%
To avoid gastric pouch rotation, the gastroenterostomy should be done on its posterior wall or over the staple line, but not on the anterior wall of the gastric pouch	No consensus Agree—55% Disagree—45%
Which is your preferred place in the pouch to do the gastroenterostomy—the anterior wall, posterior wall or staple line?	No consensus Anterior wall—23% Posterior wall—59% Staple line—18%

statements. Numerous areas of non-consensus still remaine
even after this consensus activity.

Obesity Surgery (2024) 34:4541–4554
https://doi.org/10.1007/s11695-024-07563-0

REVIEW

MGB-OAGB International Club—Results of a Modified Delphi Consensus on Controversies in OAGB

Aparna Govil Bhasker[1,2] · Arun Prasad[3] · Sumeet Shah[4] · Chetan Parmar[5] · OAGB-M. G. B. Consensus Contributors[6]

10	IFSO consensus			OAGB Consensus R1		
	The minimal recommended length of the gastric pouch should be	Roughly 15 cm—46% As long as possible—54%	No consensus	The minimal recommended length of the gastric pouch should be	12-15 cm-7%, 15-18 cm-56%, more than 18 cm-36.3%	No consensus
				OAGB Consensus R2		
				The minimal recommended length of the gastric pouch should be	15-18 cm-45.2%, More than 18 cm-54.8%	No consensus
11	IFSO consensus			OAGB Consensus R1		
	Choosing a fixed length from the angle of Treitz can be considered a proper way to define biliopancreatic length	Agree 76% Disagree 24%	Consensus Achieved	Recommended length of the biliopancreatic limb must be	Upto 150 cm-9.9%, 150-200 cm- 68.1%, Tailored as per TBL-22%	No consensus
				OAGB Consensus R2		
				Recommended length of the biliopancreatic limb must be	Upto 150 cm-4.1% 150-200 cm- 65.8% Tailored as per TBL-30.1%	No consensus
				OAGB Consensus R3		
				Recommended length of the biliopancreatic limb must be: Results of Round 2- [≤ 150 cm-4.1%] [150 to 200 cm- 65.8%] [Tailored as per the total bowel length- 30.1%]	Upto 150 cm-2.9% **150-200 cm- 71%** Tailored as per TBL-26.1.1%	Consensus Achieved
12	IFSO consensus			OAGB Consensus R1		
	The best way to choose the length of the biliopancreatic limb should be based on	A fixed length from the Treitz's angle—27% Patient's BMI—33% % Of the total bowel length—41%	No consensus	Best way to choose the length of billio-pancreatic limb must be based on	As a % of TBL-31.9% BMI-41.8% Fixed length- 26.4%	No consensus
				OAGB Consensus R2		
				Best way to choose the length of billio-pancreatic limb must be based on	A fixed length from the Treitz's angle—26% Tailored as per the patient- 76%	Consensus Achieved
13	IFSO consensus			OAGB Consensus R1		
	Total bowel length should always be measured for a safe and adequate OAGB.	Agree—41% Disagree—59%	No consensus	Total bowel length must be measured in all cases	Agree: 30.8% Disagree: 69.2%	No consensus
				OAGB Consensus R2		
				Should it be mandatory to measure the total bowel length in all cases?	Agree: 32.9% Disagree: 67.1%	No consensus
				OAGB Consensus R3		
				Should it be mandatory to measure the total bowel length in all cases: Results of Round 2- [Yes: 32.9%] [No: 67.1%]	Agree 17.4% Disagree- 82.6%	Consensus Achieved
14	IFSO consensus			OAGB Consensus R1		
	Which is your preferred place in the pouch to do the gastro-enterostomy—the anterior wall, posterior wall or staple line?	Anterior wall—23% Posterior wall—59% Staple line—18%	No consensus	Gastro-enterostomy must be performed	Post wall- 47.3% On the staple line- 9.9% Ant wall- 6.6% Does not make any difference- 36.3%	No consensus
				OAGB Consensus R2		
				Does the position of gastro-enterostomy (anterior, posterior, on the staple line) make any difference to the outcomes?	Yes- 31.5% No- 68.5%	No consensus
				OAGB Consensus R3		
				Does the position of gastro-enterostomy (anterior, posterior, on the staple line) make any difference to the outcomes? Results of Round 2- [Yes: 31.5%] [No: 68.5%]	Yes- 14.5% No- 85.5%	Consensus Achieved
15				OAGB Consensus R1		
				Anti-reflux stitch between the afferent loop and gastric pouch is a necessary step	Agree- 44% Disagree- 56%	No consensus
				OAGB Consensus R2		
				Anti-reflux stitch between the afferent loop and gastric pouch is advisable?	Yes- 52.9% No- 47.1%	No consensus
16	IFSO consensus			OAGB Consensus R1		
	Hiatal hernia, no matter what size, is a contraindication to OAGB.	Agree- 9% Disagree- 91%	Consensus Achieved	Crural repair for hiatus hernia must be done in patients with	Type 2,3 and 4 hiatus hernias- 83.5%	Consensus Achieved
17	IFSO consensus			OAGB Consensus R1		
	The mesocolic-mesenteric (Petersen's) space should be closed to decrease the postoperative risk of internal hernia.	Agree- 29% Disagree- 71%	Consensus Achieved	Peterson's defect must always be closed	Agree- 25.3% Disagree- 74.7%	Consensus Achieved
18	IFSO consensus			OAGB Consensus R1		
	The best way to choose the length of the biliopancreatic limb should be based on	A fixed length from Treitz angle- 27% Patient's BMI- 33% % of the total bowel length- 41%	No consensus	The best way to "prevent" protein-energy malnutrition after OAGB is	Fixed BPL < 150 cm- 34.1% Tailored as per TBL- 65.9%	No consensus
				OAGB Consensus R2		
				The best way to prevent protein-energy malnutrition after OAGB is	Fixed BPL < 150 cm 27.4% Tailored as per patient- 72.6%	Consensus Achieved

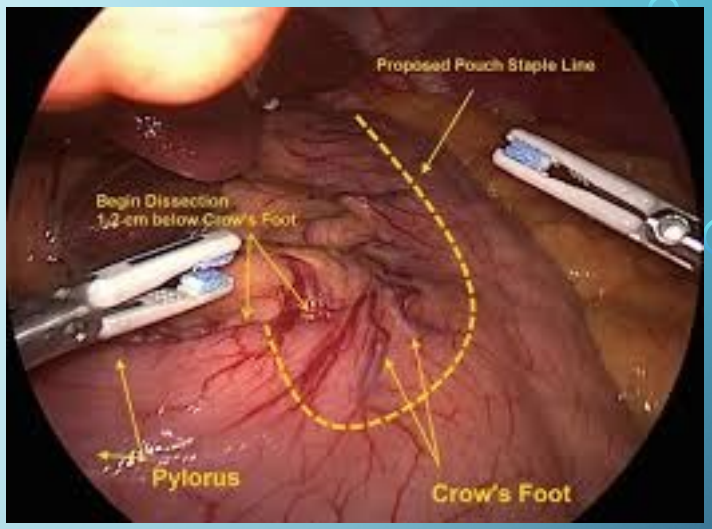
86 surgeons from 25 countries.
69.7% of the experts were from the Asia Pacific region, where OAGB is most commonly performed

Obesity Surgery (2021) 31:2453–2463
https://doi.org/10.1007/s11695-021-05276-2

ORIGINAL CONTRIBUTIONS

Areas of Non-Consensus Around One Anastomosis/Mini Gastric Bypass (OAGB/MGB): A Narrative Review

Mohammad Kermansaravi[1] · Amir Hossein DavarpanahJazi[2] · Shahab ShahabiShahmiri[2] · Miguel Carbajo[3] · Antonio Vitiello[4] · Chetan D. Parmar[5,6] · Mario Musella[4]



TASCA GASTRICA

1)Calibro della sonda oro-gastrica (32-50Fr)

2)Ingresso nel piccolo omento e prima staplerata: -1-2 cm distalmente alla zampa d'oca
- parte più bassa dell'incisura angularis fino a 5 cm dal piloro
- sopra la zampa d'oca

3)Lunghezza della tasca gastrica: argomento dibattutto 18cm?, 12-18 cm?, >15 cm?, Deve essere più lunga possibile, almeno 15 cm in quanto una tasca gastrica troppo corta predispone ad insorgenza di MRGE

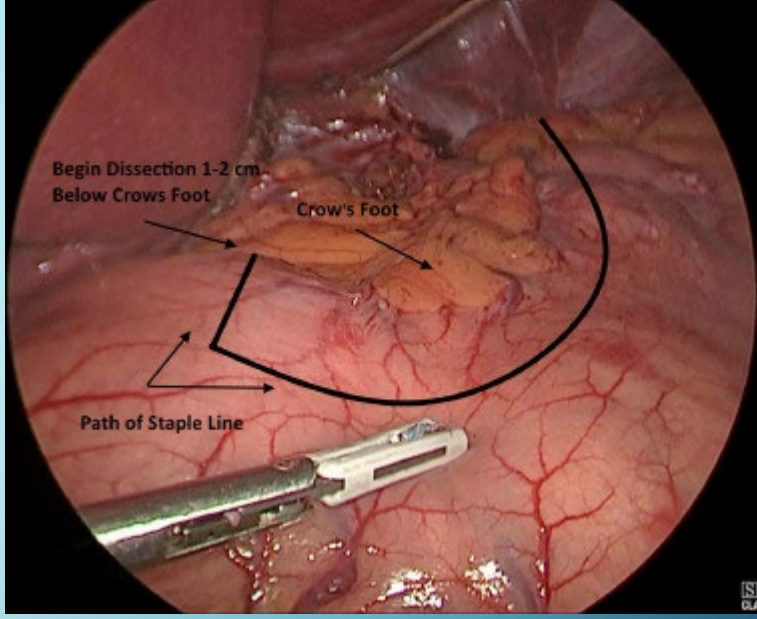
Obesity Surgery (2024) 34:4541–4554
https://doi.org/10.1007/s11695-024-07563-0

IFSO

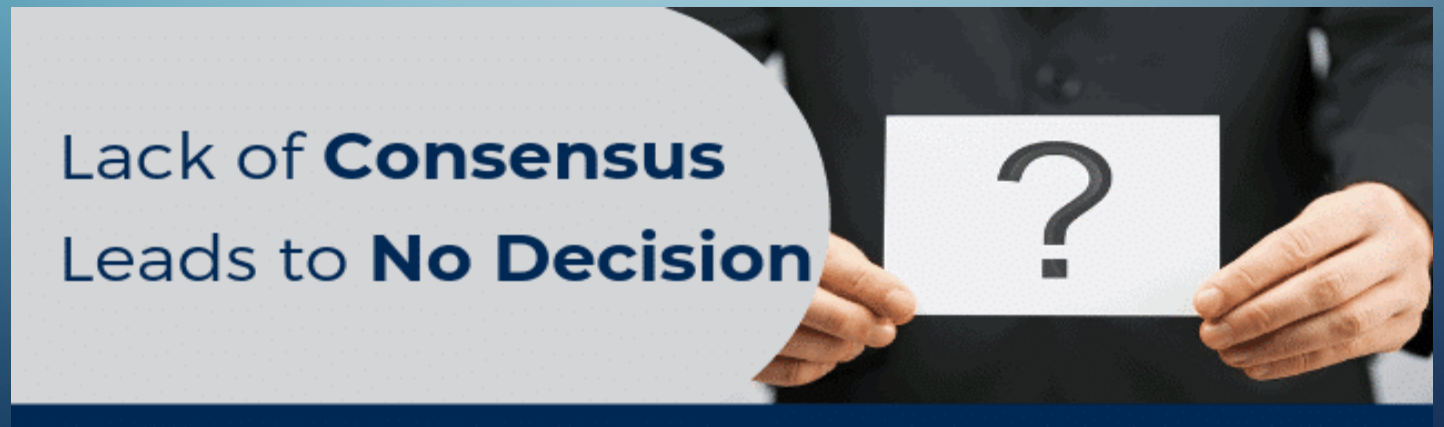
REVIEW

MGB-OAGB International Club—Results of a Modified Delphi Consensus on Controversies in OAGB

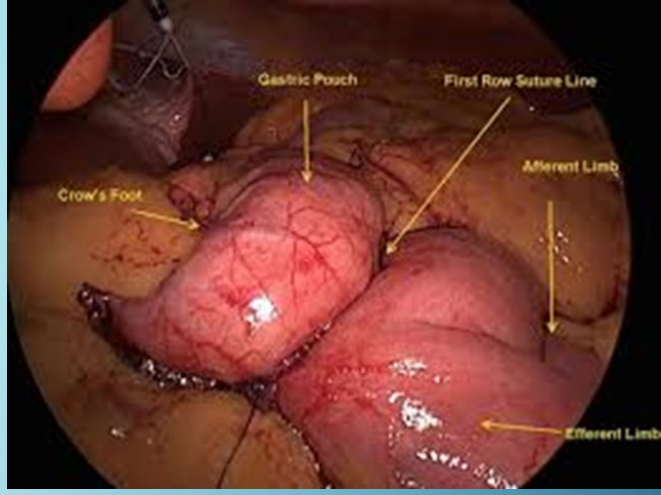
Aparna Govil Bhasker[1,2] · Arun Prasad[3] · Sumeet Shah[4] · Chetan Parmar[5] · OAGB-M. G. B. Consensus Contributors[6]



10	**IFSO consensus**			**OAGB Consensus R1**		
	The minimal recommended length of the gastric pouch should be	Roughly 15 cm—46% As long as possible—54%	No consensus	The minimal recommended length of the gastric pouch should be	12-15 cm-7%, 15-18 cm-56%, more than 18 cm-36.3%	No consensus
				OAGB Consensus R2		
				The minimal recommended length of the gastric pouch should be	15-18 cm-45.2%, More than 18 cm-54.8%	No consensus



ANASTOMOSI GASTRO-DIGIUNALE



- Suturatrice lineare + sutura in continua con materiale assorbibile
- Lunghezza anastomosi: 25mm, 40mm, 60 mm
- Sutura: preferenza del chirurgo (Vicryl 2-0, V-Loc 2-0, PDS 2-0), assorbibile materiale più utilizzato
- Anastomosi manuale
- Anastomosi sulla parete posteriore gastrica nella maggior parte dei lavori
- Qualche caso di anastomosi sulla parete anteriore

Areas of Non-Consensus Around One Anastomosis/Mini GastricBypass (OAGB/MGB): A Narrative Review
Mohammad Kermansaravi et al., Obesity Surgery (2021) 31:2453–2463

Obesity Surgery (2020) 30:1625–1634
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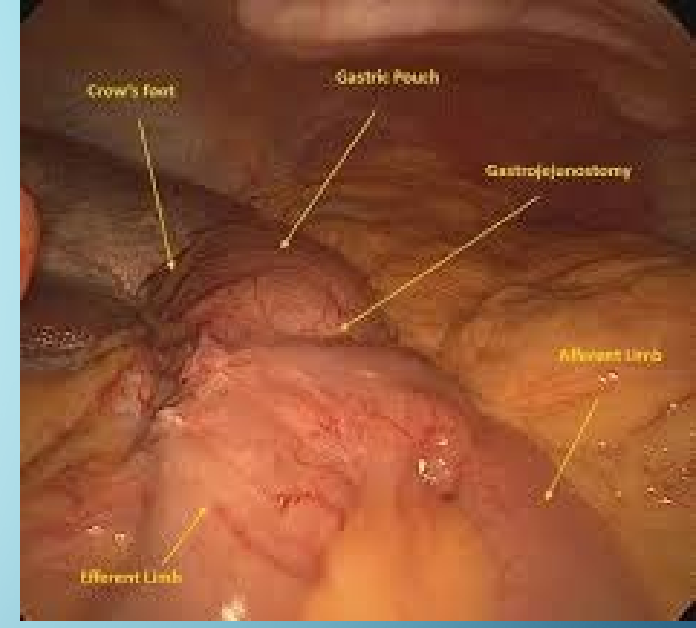
To avoid gastric pouch rotation, the gastroenterostomy should be done on its posterior wall or over the staple line, but not on the anterior wall of the gastric pouch	No consensus Agree—55% Disagree—45%
Which is your preferred place in the pouch to do the gastroenterostomy—the anterior wall, posterior wall or staple line?	No consensus Anterior wall—23% Posterior wall—59% Staple line—18%



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REVIEW

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OAGB Consensus R3		
Does the position of gastro-enterostomy (anterior, posterior, on the staple line) make any difference to the outcomes? Results of Round 2- [Yes: 31.5%] [No: 68.5%]	Yes- 14.5% No- 85.5%	Consensus Achieved

OAGB Consensus R2		
Anti-reflux stitch between the afferent loop and gastric pouch is advisable?	Yes- 52.9% No- 47.1%	No consensus

Obesity Surgery (2018) 28:303–312
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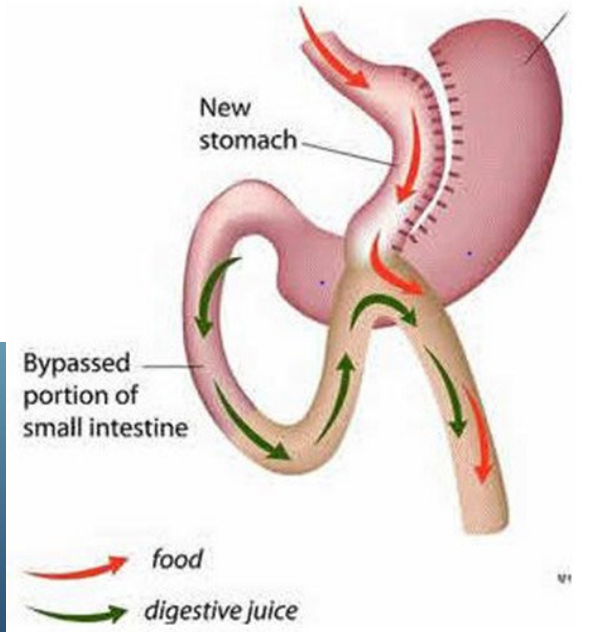
(i) One anastomosis/mini gastric bypass (OAGB/MGB) is not a malabsorptive bariatric procedure (disagreed by 82.0% of the experts).

(ii) The standard length of the bilio-pancreatic limb should be 150 cm for all patients (disagreed by 82.0% of the experts).



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Total bowel length should always be measured for a safe and adequate OAGB-MGB.	No consensus Agree—41% Disagree—59%
The best way to choose the length of the biliopancreatic limb should be based on…[c]	No consensus A fixed length from the Treitz's angle—27% Patient's BMI—33% % Of the total bowel length—41%
When measurement of the total small bowel length is performed, the ideal percentage length for the biliopancreatic limb, as a percentage, should be…	No consensus <30%—17% 30–40%—68% >40%—15%

MISURAZIONE DELLA LUNGHEZZA TOTALE DELL'INTESTINO TENUE

- MOLTO DIBATTUTA LA LUNGHEZZA DELL 'ANSA BILIO-PANCREATICA
- ANSA BILIARE DI 200 CM O PIU' LUNGA AUMENTA IL RISCHIO DI MALASSORBIMENTO E MALNUTRIZIONE PROTEICO-CALORICA E DOVREBBE ESSERE ESEGUITA DOPO MISURAZIONE DELL'INTERA LUNGHEZZA DI TENUE (Ramos AC, et al. 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. Obes Surg. 2020;30(5):1625–34.
- CARBAJO MISURAVA LA LUNGHEZZA DI TUTTO IL TENUE E CONFEZIONAVA L'ANASTOMOSI G-D CON LA PORZIONE CENTRALE.RACCOMANDANDO CHE LA LUNGHEZZA DELL'ANSA BILIOPANCREATICA DOVESSE ESSERE CUCITA IN BASE ALLE CARATTERISTICHE DEL PAZIENTE, UTILIZZANDO DAL 40 AL 60% DI TENUE, CHE POTREBBE ESSERE DIFFERENTE IN RELAZIONE AI VARI GRADI DI OBESITA' (Carbajo MA et al. Laparoscopic one-anastomosis gastric bypass: technique, results, and long-term follow-up in 1200 patients. Obes Surg. 2017;27(5):1153–67 Ruiz-Tovar J, CarbajoMA, Jimenez JM, et al. Are there ideal smallbowel limb lengths for one-anastomosis gastric bypass (OAGB) To obtain optimal weight loss and remission of comorbidities withminimal nutritional deficiencies? World J Surg. 2020;44(3):855)
- SOONG ET AL. RACCOMANDAVANO LA MISURAZIONE ROUTINARIA DI TUTTO IL TENUE, MANTENENDO L'ANSA COMUNE DI ALMENO 400 cm. PER RIDURRE L'INCIDENZA DI MALNUTRIZIONE SENZA COMPROMETTERE L'EFFETTO SULLA PERDITA DI PESO E SULLA RISOLUZIONE DEL DIABETE (Soong TC, Almalki OM, Lee WJ, et al. Measuring the small bowel length may decrease the incidence of malnutrition after laparoscopic one-anastomosis gastric bypass with tailored bypass limb. Surgery for Obesity and Related Diseases : official journal of the American Society for Bariatric Surgery. 2019;15(10):1712–8.)
- LA MISURAZIONE DI TUTTO IL TENUE NON E' SCEVRA DA RISCHI. AUMENTO DEI TEMPI OPERATORI E DEL RISCHIO DI LESIONI IATROGENE MISCONOSCIUTE SOPRATTUTTO IN PAZIENTI CON BMI ELEVATO
- NON ESISTE UN METODO PRECISO DI MISURAZIONE DELL'INTESTINO, CHE VARIA DA CHIRURGO A CHIRURGO (Genser L, al. Laparoscopic reversal of mini-gastric bypass to original anatomy for severe postoperative malnutrition. Langenbeck's Arch Surg. 2017;402(8):1263–70.)

Obesity Surgery (2024) 34:4541–4554
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12	**IFSO consensus**			**OAGB Consensus R1**		
	The best way to choose the length of the biliopancreatic limb should be based on	A fixed length from the Treitz's angle—27% Patient's BMI—33% % Of the total bowel length—41%	No consensus	Best way to choose the length of bilio-pancreatic limb must be based on	As a % of TBL- 31.9% BMI- 41.8% Fixed length- 26.4%	No consensus
				OAGB Consensus R2		
				Best way to choose the length of bilio-pancreatic limb must be based on	A fixed length from the Treitz's angle—26% Tailored as per the patient- 76%	Consensus Achieved
13	**IFSO consensus**			**OAGB Consensus R1**		
	Total bowel length should always be measured for a safe and adequate OAGB.	Agree—41% Disagree—59%	No consensus	Total bowel length must be measured in all cases	Agree: 30.8% Disagree: 69.2%	No consensus
				Should it be mandatory to measure the total bowel length in all cases?	Agree: 32.9% Disagree: 67.1%	No consensus
				OAGB Consensus R3		
				Should it be mandatory to measure the total bowel length in all cases: Results of Round 2- [Yes: 32.9%] [No: 67.1%]	Agree 17.4% Disagree- 82.6%	Consensus Achieved

ANSA BILIO-PANCREATICA

-LUNGHEZZA VARIABILE DA 100 A 400 cm, ANCORA DIBATTUTA

-LUNGHEZZA FISSA NON APPROPRIATA PER OBESI CON AMPIA VARIABILITA' DI BMI

-SCEGLIERE LA LUNGHEZZA IN BASE AL BMI

(LeeWJ,WangW, Lee YC, et al. Laparoscopic mini-gastric bypass: experience with tailored bypass limb according to body weight. Obes Surg. 2008;18(3):294–9.; Kermansaravi M, Pishgahroudsari M, Kabir A, et al. Weight loss after one-anastomosis/mini-gastric bypass-the impact of biliopancreatic limb: a retrospective cohort study. Journal of Research in Medical Sciences : the official journal of IsfahanUniversity of Medical Sciences. 2020;25:5.)

-NOUN ET AL. AUMENTAVANO LA LUNGHEZZA DELL'ANSA DI 10 cm → AD OGNI AUMENTO DI BMI SOPRA 40 (Noun R, Skaff J, Riachi E, et al. One thousand consecutive minigastric bypass: short- and long-term outcome. Obes Surg.2012;22(5):697–703.

-LEE ET AL., JAMMU ET AL., KERMANSARAVI ET AL ., 180 cm → 35-39 BMI

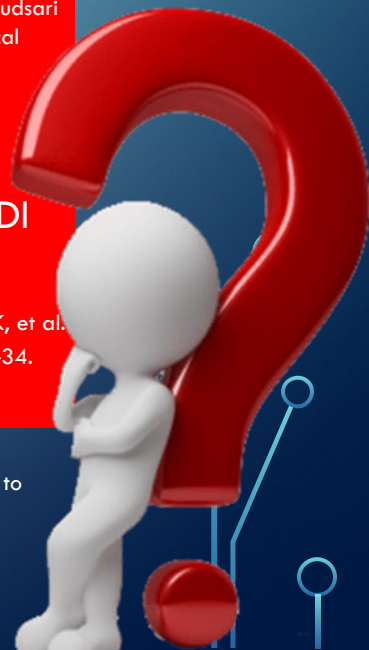
200 cm → 40-50 BMI

220 cm >50 BMI RIDUCENDO DI 10 cm LA LUNGHEZZA OGNI 5 AA SOPRA I 45 AA (Leeet al. Laparoscopic Roux-en-Y vs. minigastricbypass for the treatment of morbid obesity: a 10-year experience. Obes Surg. 2012;22(12):1827–34; Jammu GS, Sharma R. A 7-year clinical audit of 1107 cases comparing sleeve gastrectomy, Roux-En-Y gastric bypass, and minigastric bypass, to determine an effective and safe bariatric and metabolic procedure. Obes Surg. 2016;26(5):926–32.; Kermansaravi M, Pishgahroudsari M, Kabir A, et al. Weight loss after one-anastomosis/mini-gastric bypass-the impact of biliopancreatic limb: a retrospective cohort study. Journal of Research in Medical Sciences : the official journal of Isfahan University of Medical Sciences. 2020;25:5.)

- STESSI RISULTATI SULLA PERDITA DI PESO CON ANSA DI 150 cm e 200 cm (Boyle M, Mahawar K. One anastomosis gastric bypass performed with a 150-cm biliopancreatic limb delivers weight loss outcomes similar to those with a 200-cm biliopancreatic limb at 18 -24 months. Obes Surg. 2020;30(4):1258–64.)
- NO CONSENSUS SULLA PERCENTUALE DI LUNGHEZZA IDEALE DELL'ANSA BILIOPANCREATICA MISURANDO LA LUNGHEZZA DI TUTTO IL TENUE

-IFSO OAGB/MGB CONSENSUS RACCOMANDAZIONE: 30-40% DELLA LUNGHEZZA TOTALE DEL TENUE (Ramos AC, Chevallier JM, Mahawar K, et al. 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. Obes Surg.2020;30(5):1625–34.

-KOMEI ET AL. : ANSA BILIO PANCREATICA > 200 CM BYPASSANDO IL 40 % DI TENUE ASSOCIATA A MINORI DEFICIT NUTRIZIONALI CON SIMILE PERDITA DI PESO (Komaei I, Sarra F, Lazzara C, et al. One anastomosis gastric bypass-mini gastric bypass with tailored biliopancreatic limb length formula relative to small bowel length: preliminary results. Obes Surg. 2019;29(9):3062–70.)



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REVIEW

One Anastomosis Gastric Bypass (OAGB) with a 150-cm Biliopancreatic Limb (BPL) Versus a 200-cm BPL, a Systematic Review and Meta-analysis

Mohamed AbdAlla Salman[1] · Ahmed Salman[1] · Mohamed Moustafa Assal[2] · Mohammed Elsherbiney[3] ·

The total population number of the studies included in the current review was 2599:
1100 (42.3%) OAGBwith a 150-cm BPL
1336 (51.4%) OAGBwith a 200-cm BPL

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Table 1 The included studies and patients characteristics

Study	Boyle and Mahawar [15]	Omar et al. [16]	Pizza et al. [17]	Jedamzic et al. [19]	Slagter et al. [9]	Sam et al. [18]	Samuel et al. [14]	Bertrand et al. [20]
Year	2020	2021	2020	2020	2021	2022	2019	
Type of study	Retrospective analysis of the prospective hospital database							
Follow-up (months)	24	24	24	24	24	36	12	32.4–44.87
150-cm group (*n*)	118	171	60	11	172	171	178	392
200-cm group (*n*)	225	234	60	93	72	234	310	392
Both groups (*n*)	343	405	180	155	244	405	488	784
Females: *n* (%)	232 (67.6)	275 (67.9)	117 (65%)	111 (71.6)	199 (81.6)	275 (67.9)	327 (67)	598 (76.3)
Mean age	46.3±12.8	46 ± 10.98	35.2±9	45 ± 4.5	48 ± 11	46 ± 10.98	46.5±7.25	44±11.3
Baseline weight	137.6	139±29.96	119.9±28.9	128.5 (92–196)	124±17	139±29.96	NA	121±16, 120±16.6
Baseline BMI	48.39	49±8.14	44.93±7.56	45.1 (33.1–71.1)	44±4	49±8.14	44±2.75	43±3.6, 42.6±3.6
200-cm group EWL%	75±20.1	NA	61.2 ± 12.1	82.2 ± 24.8	75 (59–81)	76.46±20.1	68 (53–83)	76.8 ± 21.6
150-EWL% mean	74±22	NA	60.7 ± 16.1	63.2 ±17.0	83 (65–99)	75.02±21.35	67 (53–80)	75.5 ± 24.02
200-TWL% mean	36.1 ± 9.2	NA	41.8 ± 8.9	34.5 ± 9.4	34 (28–38)	36.15±9.19	NA	NA
150-TWL% mean	34 ± 9.8	NA	40.7 ± 9.4	33.1 ± 5.2	29 (23–36)	34.12±9.49	NA	NA
200-cm group	12 (46.2)	NA	5 (45.5)	NA	21 (68)	NA	NA	45 (48.4)
150-cm group	12 (46.2)	NA	5 (45.5)	NA	21 (68)	NA	NA	38 (50.7)
Diabetes mellitus improvement: *n* (%)								
200-cm group	24 (38)	NA	3 (30)	NA	2 (13)	NA	NA	NA
150-cm group	13 (50)	NA	2 (18.2)	NA	10 (32)	NA	NA	NA
Hypertension resolution: *n* (%)								
200-cm group	28 (33.7)	NA	17 (53.1)	NA	10 (48)	NA	NA	33 (21.9)
150-cm group	21 (42.9)	NA	18 (52.9)	NA	28 (49)	NA	NA	31 (22.3)
Hypertension improvement: *n* (%)								
200-cm group	24 (28.9)	NA	NA	NA	11 (52)	NA	NA	NA
150-cm group	11 (22.4)	NA	NA	NA	25 (42)	NA	NA	NA
Reoperation: *n* (%)								
200-cm group	2 (0.89)	NA	1 (1.67)	NA	NA	NA	NA	31 (7.9)
150-cm group	0 (0)	NA	2 (3.33)	NA	NA	NA	NA	16 (4.1)

This review found that 200-cm BPL displayed better weight loss outcomes with a significant difference in the TWL%.
There was comparable comorbidities remission.
Nutritional deficiency rates were higher in patients with a 200-cm BPL.

Significantly higher ferritin and folate deficiency rates were found in the 200-cm BPL group.
Considering a 200-cm BPL delivers a better weight loss outcome than a 150 –cm BPL, which is at the expense of a more severe nutritional deficiency.

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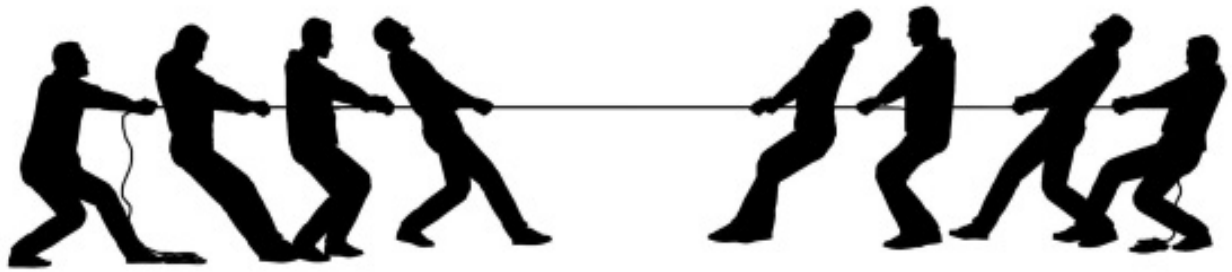
REVIEW

MGB-OAGB International Club—Results of a Modified Delphi Consensus on Controversies in OAGB

Aparna Govil Bhasker[1,2] · Arun Prasad[3] · Sumeet Shah[4] · Chetan Parmar[5] · OAGB-M. G. B. Consensus Contributors[6]

11	**IFSO consensus**			**OAGB Consensus R1**		
	Choosing a fixed length from the angle of Treitz can be considered a proper way to define biliopancreatic length	Agree 76% Disagree 24%	Consensus Achieved	Recommended length of the biliopancreatic limb must be	Upto 150 cm- 9.9%, 150-200 cm- 68.1%, Tailored as per TBL- 22%	No consensus
				OAGB Consensus R2		
				Recommended length of the biliopancreatic limb must be	Upto 150 cm- 4.1% 150-200 cm- 65.8% Tailored as per TBL- 30.1%	No consensus
				OAGB Consensus R3		
				Recommended length of the biliopancreatic limb must be: Results of Round 2- [≤ 150 cm- 4.1%] [150 to 200 cm- 65.8%] [Tailored as per the total bowel length- 30.1%]	Upto 150 cm- 2.9% **150-200 cm- 71%** Tailored as per TBL- 26.1.1%	Consensus Achieved



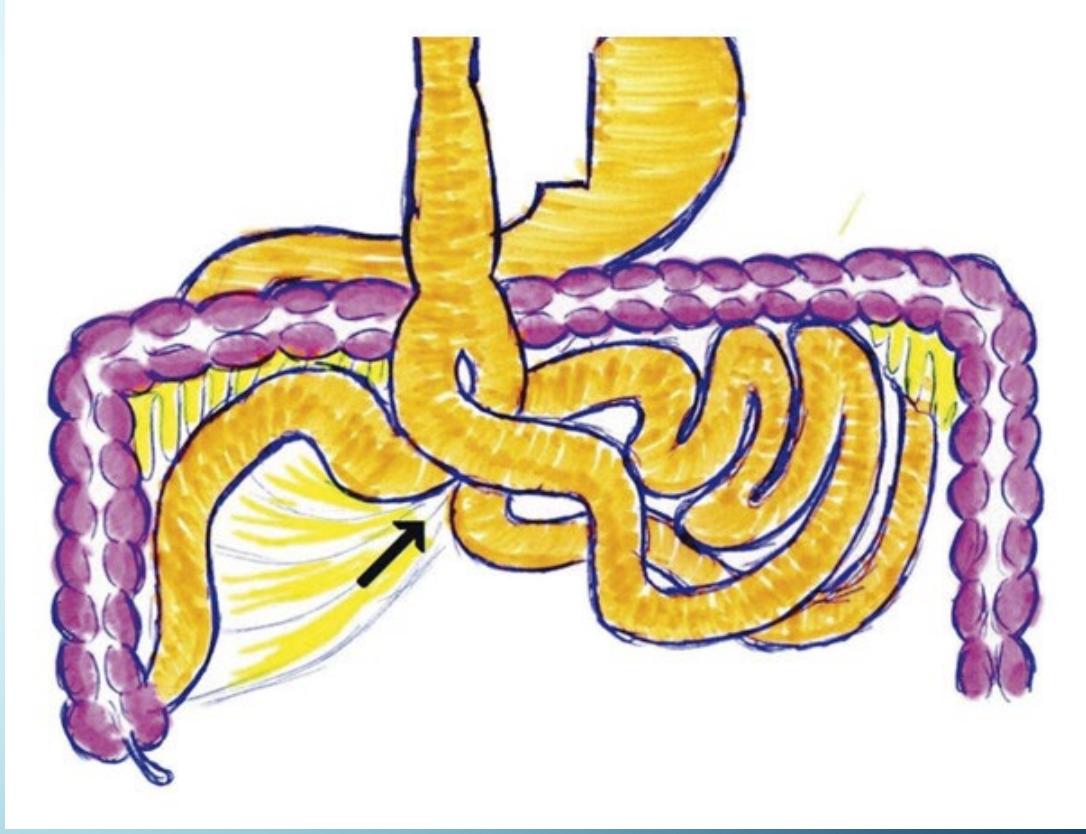
18	**IFSO consensus**			**OAGB Consensus R1**		
	The best way to choose the length of the biliopancreatic limb should be based on	A fixed length from Treitz angle- 27% Patient's BMI- 33% % of the total bowel length- 41%	No consensus	The best way to "prevent" protein-energy malnutrition after OAGB is	Fixed BPL < 150 cm- 34.1% Tailored as per TBL- 65.9%	No consensus
				OAGB Consensus R2		
				The best way to prevent protein-energy malnutrition after OAGB is	Fixed BPL < 150 cm- 27.4% Tailored as per patient- 72.6%	Consensus Achieved

SPAZIO DI PETERSEN

- *La maggior parte dei chirurghi sono d'accordo nel non chiudere lo spazio di Petersen, in quanto molto grande e meno probabilità di ernia interna rispetto al RYGBP.*

- *Rischio di ernia interna è di circa 1 /500 casi.*
  In letteratura sono descritti pochi casi di ernia interna dopo OAGB/MGB, la maggior parte dei chirurghi non chiude lo spazio di Petersen.

- *Uno studio di Mahawar et al. Mostra che solo il 18% dei chirurghi chiude lo spazio di Petersen durante OAGB/MGB; sebbene la sua chiusura previene il rischio di ernia interna, kinking, twisting e migrazione della pouch gastrica in torace*



Areas of Non-Consensus Around One Anastomosis/Mini Gastric Bypass (OAGB/MGB): A Narrative Review Mohammad Kermansaravi et al., Obesity Surgery (2021) 31:2453–2463

	IFSO consensus			OAGB Consensus R1		
	The mesocolic-mesenteric (Petersen's) space should be closed to decrease the postoperative risk of internal hernia.	Agree- 29% Disagree- 71%	Consensus Achieved	Peterson's defect must always be closed	Agree- 25.3% Disagree- 74.7%	Consensus Achieved

Obesity Surgery (2018) 28:303–312
https://doi.org/10.1007/s11695-017-3070-2

ORIGINAL CONTRIBUTIONS

The First Consensus Statement on One Anastomosis/Mini Gastric Bypass (OAGB/MGB) Using a Modified Delphi Approach

Kamal K. Mahawar[1] · Jacques Himpens[2] · Scott A. Shikora[3] · Jean-Marc Chevallier[4] · Mufazzal Lakdawala[5] · Maurizio De Luca[6] · Rudolf Weiner[7] · Ali Khammas[8] · Kuldeepak Singh Kular[9] · Mario Musella[10] · Gerhard Prager[11] · Mohammad Khalid Mirza[12] · Miguel Carbajo[13] · Lilian Kow[14] · Wei-Jei Lee[15] · Peter K. Small[1]

No Consensus Achieved

Even after two rounds of voting, there was no consensus on 7 statements. These have been clearly identified in Table 3 and are as follows.

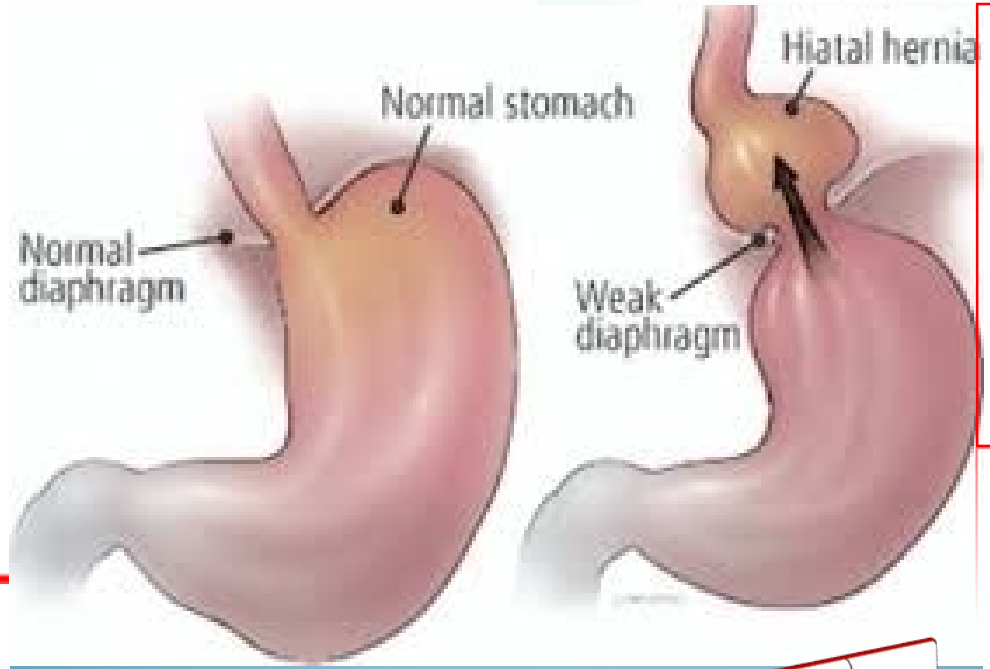
(i) One anastomosis/mini gastric bypass (OAGB/MGB) largely works similar to an RYGB in its mechanism of action (65.35% disagreed).
(ii) OAGB/MGB is an acceptable surgical option for suitable patients with severe gastro-oesophageal reflux disease (GERD) requiring daily medication (69.31% agreed).
(iii) OAGB/MGB is the preferred surgical option for suitable patients with severe psychiatric disorders because of the ease of reversibility (54.46% agreed).
(iv) OAGB/MGB is not recommended for patients with Barrett's oesophagus (66.34% agreed).
(v) Routine crural approximation is unnecessary for patients with a hiatus hernia (63.37% agreed).
(vi) Patients should be advised routine prophylaxis for gallstones with ursodeoxycholic acid for at least 6 months (64.36% disagreed).
(vii) Patients developing symptomatic GERD unresponsive to maximal medical therapy after OAGB/MGB can be offered surgical correction in the form of a Braun's anastomosis between afferent and efferent limbs (66.34% disagreed).

Obesity Surgery (2021) 31:2453–2463
https://doi.org/10.1007/s11695-021-05276-2

ORIGINAL CONTRIBUTIONS

Areas of Non-Consensus Around One Anastomosis/Mini Gastric Bypass (OAGB/MGB): A Narrative Review

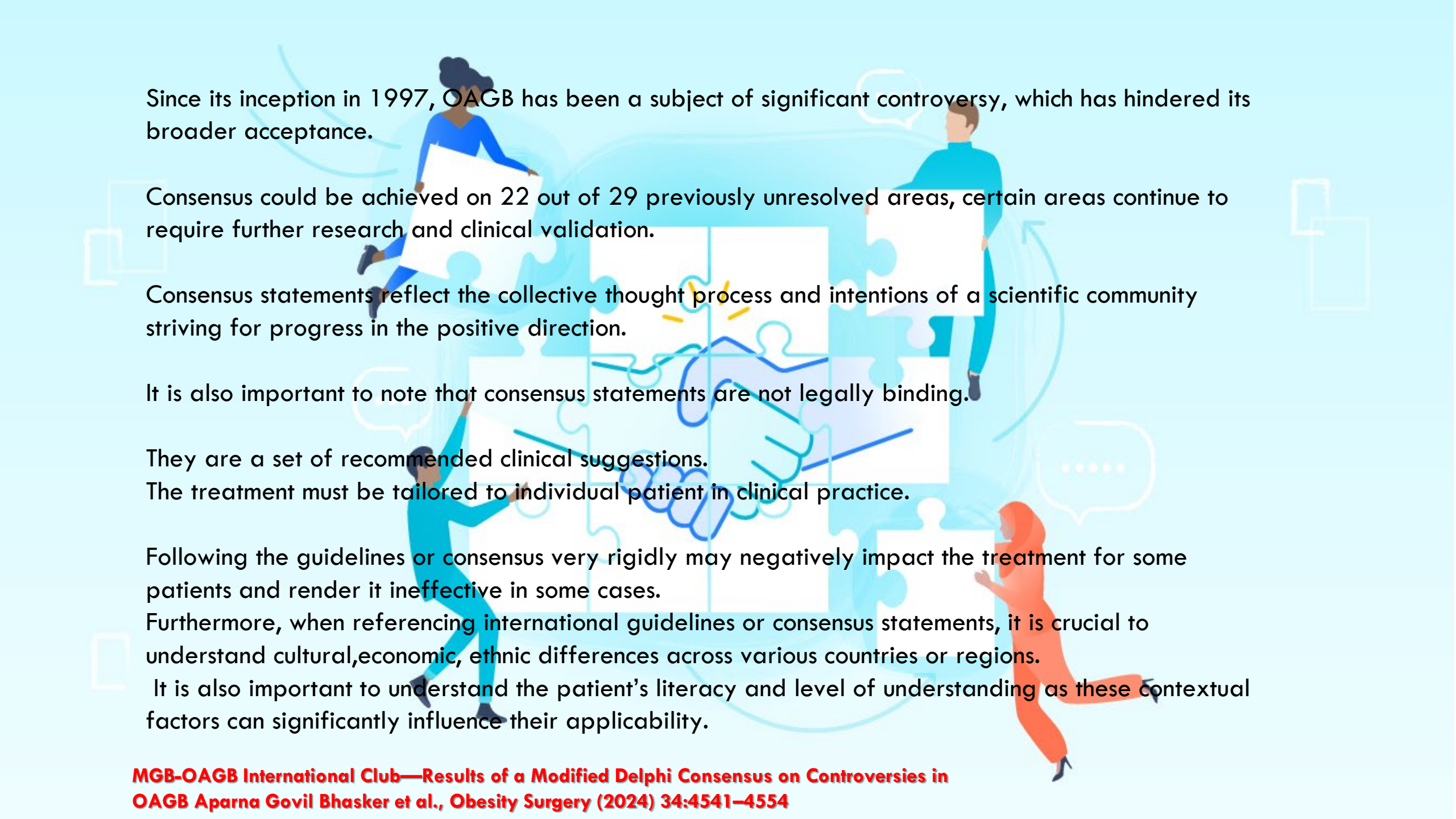
Mohammad Kermansaravi[1] · Amir Hossein DavarpanahJazi[2] · Shahab ShahabiShahmiri[2] · Miguel Carbajo[3] · Antonio Vitiello[4] · Chetan D. Parmar[5,6] · Mario Musella[4]



16	IFSO consensus	Hiatal hernia, no matter what size, is a contraindication to OAGB.	Agree- 9% Disagree- 91%	Consensus Achieved	OAGB Consensus R1	Crural repair for hiatus hernia must be done in patients with	Type 2,3 and 4 hiatus hernias- 83.5%	Consensus Achieved

Hiatal Hernia Repair

Although there is no any consensus around hiatal hernia (HH) repair during OAGB/MGB, it has been shown that the presence and size of HH are correlated with postop GERD symptoms, especially in moderate and large HH [44]. Hence, selective HH repair in large and giant size is recommended by some authors [8, 45, 46]. Deitel et al. suggested HH repair in presence of a large gastric fundus in HH [24]. It is also recommended to repair any HH during conversional Roux-en-Y gastric bypass after OAGB/MGB due to GERD symptoms [7]. "His angle" dissection and posterior crural closure and also Toupet's fundoplication with gastric remnant are recommended in such scenario [7, 45].



Since its inception in 1997, OAGB has been a subject of significant controversy, which has hindered its broader acceptance.

Consensus could be achieved on 22 out of 29 previously unresolved areas, certain areas continue to require further research and clinical validation.

Consensus statements reflect the collective thought process and intentions of a scientific community striving for progress in the positive direction.

It is also important to note that consensus statements are not legally binding.

They are a set of recommended clinical suggestions.
The treatment must be tailored to individual patient in clinical practice.

Following the guidelines or consensus very rigidly may negatively impact the treatment for some patients and render it ineffective in some cases.
Furthermore, when referencing international guidelines or consensus statements, it is crucial to understand cultural,economic, ethnic differences across various countries or regions.
It is also important to understand the patient's literacy and level of understanding as these contextual factors can significantly influence their applicability.

MGB-OAGB International Club—Results of a Modified Delphi Consensus on Controversies in OAGB Aparna Govil Bhasker et al., Obesity Surgery (2024) 34:4541–4554


THANK
YOU
FOR
YOUR
ATTENTION