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Re-do surgery: come, quando e perchè

Paolo Bernante

DIMEC

Centro di chirurgia metabolica e dell'obesità

ARTICLE IN PRESS

ELSEVIER

Surgery for Obesity and Related Diseases ■ (2026) 1–9

SURGERY FOR OBESITY AND RELATED DISEASES

Original article

International expert consensus on definitions and management of weight recurrence and suboptimal response after metabolic and bariatric surgery: a Delphi study

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Table 2
Items achieving highest consensus (≥90% agreement) in Round 2

Item	Dimension	Round 2 consensus (%)
Decisions about management of surgical nonresponse/recurrent weight gain should be individualized for every patient	Conservative management	100
If comorbidities recur OMMs should be considered	Conservative management	100
The presence of co-morbidities (metabolic COMs e.g. T2DM, OSA, MASLD, dyslipidemia, HTN) should be considered when deciding whether an OMM should be initiated	Conservative management	100
Is it appropriate for endocrinologists to prescribe OMMs in patients with recurrent weight gain after surgery?	Conservative management	100
The management starts with a comprehensive assessment that includes dietary patterns, physical activity level, and psychological disorders	Conservative management	97.3

Revision/conversion has a higher morbidity compared to primary bariatric surgery so medical obesity treatment options should be considered before surgical therapies in patients with recurrent weight gain after surgery

Certain anatomical causes of recurrent weight gain after primary bariatric surgery should be corrected with revisional surgery

team evaluation		
A comprehensive nutritional evaluation is essential for the evaluation of surgical nonresponse/recurrent weight gain	Diagnostic methods and assessment	97.3
Is %TWL a good measurement of response?	Quantitative thresholds	94.6
Careful inspection of prescribed medications taken is necessary for the evaluation of surgical nonresponse/recurrent weight gain	Risk factors and predictors	100
The level of perceived stress and mood over the past 6 mo to 1 yr should be assessed in relation to surgical nonresponse/recurrent weight gain	Risk factors and predictors	94.6
Problematic alcohol use is a contributor to surgical nonresponse/recurrent weight gain	Risk factors and predictors	94.6
Maladaptive eating behavior (grazing, loss-of-control eating, binge eating) are contributors to surgical nonresponse/recurrent weight gain	Risk factors and predictors	94.6
Poor follow-up is a contributor to surgical nonresponse/recurrent weight gain	Risk factors and predictors	94.6
Revision/conversion has a higher morbidity compared to primary bariatric surgery so medical obesity treatment options should be considered before surgical therapies in patients with recurrent weight gain after surgery	Surgical interventions	94.6
Certain anatomical causes of recurrent weight gain after primary bariatric surgery should be corrected with revisional surgery	Surgical interventions	91.9
A uniform definition of recurrent weight gain is helpful to select appropriate treatment modalities	Terminology and definitions	97.3
There is no uniformly recognized definition of "recurrent weight gain" after MBS	Terminology and definitions	94.6

OMM = obesity management medication; T2DM = type 2 diabetes mellitus; OSA = obstructive sleep apnea; MASLD = metabolic dysfunction-associated steatotic liver disease; HTN = hypertension; GERD = gastroesophageal reflux disease; OBGYN = obstetrician-gynecologist; OM = obesity medicine specialist; PCP = primary care physician; GJA = gastrojejunal anastomosis.

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Obesity Surgery (2026) 36:988–994
https://doi.org/10.1007/s11695-025-08426-y

IFSO

RESEARCH

Check for updates

Phenotyping of Patients Seeking Third or Higher-Order Metabolic Bariatric Surgery

Michal Zaichyk-Segal[1,2] · Orit Yogev[3] · Chaya Chweiger[3] · Galit Goldzak-Kunik[3] · Roni Elran-Barak[1] · Shiri Sherf-Dagan[4,5]

Key Points

- Third or higher-order MBS are increasingly performed worldwide.
- Patients seeking repeated MBS often present with complex surgical histories.
- Weight loss outcomes were less favorable after secondary vs. primary MBS.
- High prevalence of psychopathology was observed in this unique population.

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1. Resezione incompleta del fondo

Obesity Surgery
https://doi.org/10.1007/s11695-020-04718-7

IFSO

LETTER TO THE EDITOR

Cascade Stomach as a Risk Factor for Incomplete Resection of the Gastric Fundus in Laparoscopic Sleeve Gastrectomy: a Point of Technique

Paolo Bernante [1,2,3] · Francesca Balsamo [1,2,3] · Matteo Rottoli [1,2,3] · Andrea Sciannamea [1,2,3] · Massimo P. Di Simone [1,2,3] · Antonio Iannelli [4,5,6] · Gilberto Poggioli [1,2,3]

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1. Resezione incompleta del fondo

Obesity Surgery, **16**, 1327-1330

Feasibility of Laparoscopic Sleeve Gastrectomy as a Revision Procedure for Prior Laparoscopic Gastric Banding

Paolo Bernante, MD[1]; Mirto Foletto, MD[2]; Luca Busetto, MD[3]; Fabio Pomerri, MD[4]; Francesco Francini Pesenti, MD[5]; Maria Rosa Pelizzo, MD[1]; Donato Nitti, MD[2]

There are also some risks in performing the sleeve gastrectomy near the gastric fundus. The tissue is thicker due to the fibrous capsule around the band, and transecting stomach at this point could result in either poor union with leakage or poor healing because of decreased blood supply. As a result, the optimal sleeve gastrectomy may be impaired by shifting the transection plane too laterally.

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2. Ernia jatale misconosciuta/non trattata

SLEEVE SU PREGRESSO BGR

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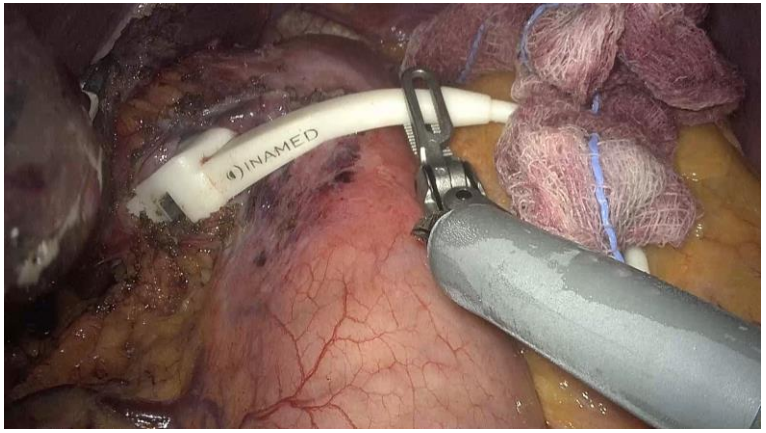

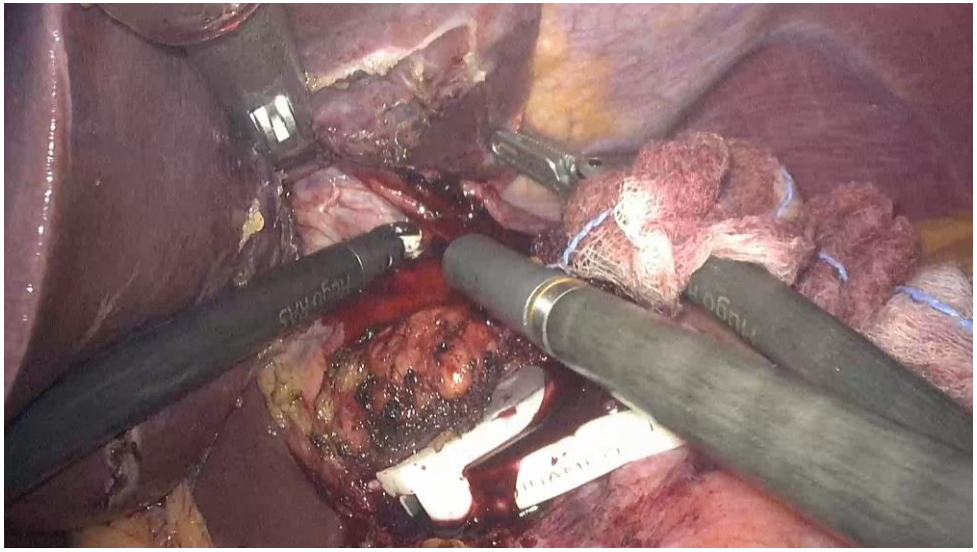

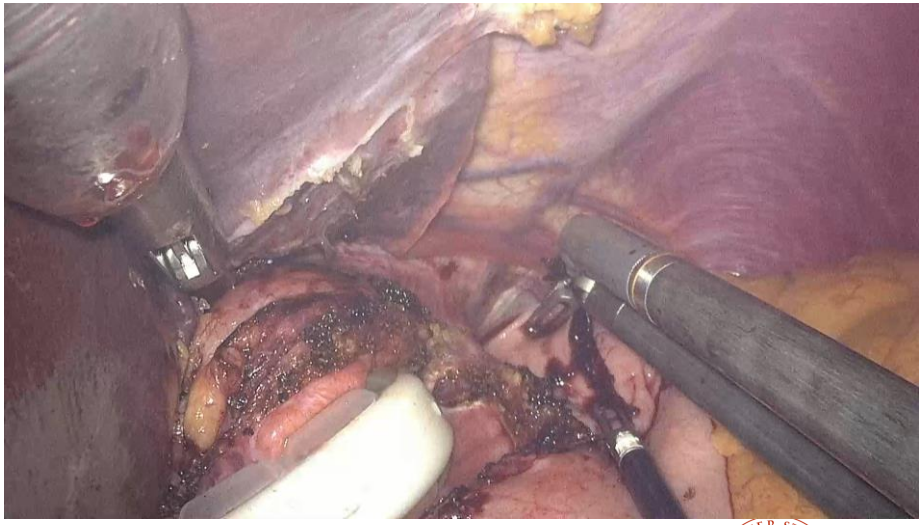

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SLEEVE POST BGR

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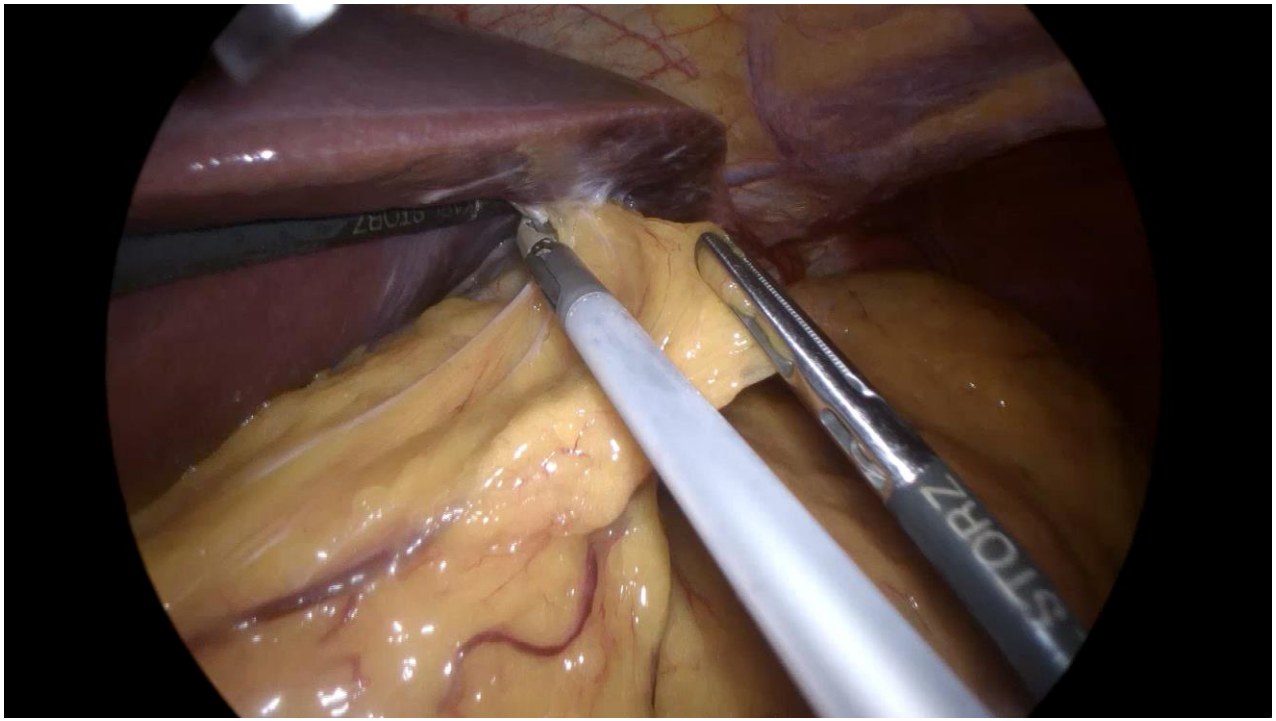
ERNIAZIONE TRANS-IATALE SLEEVE GASTRECTOMY



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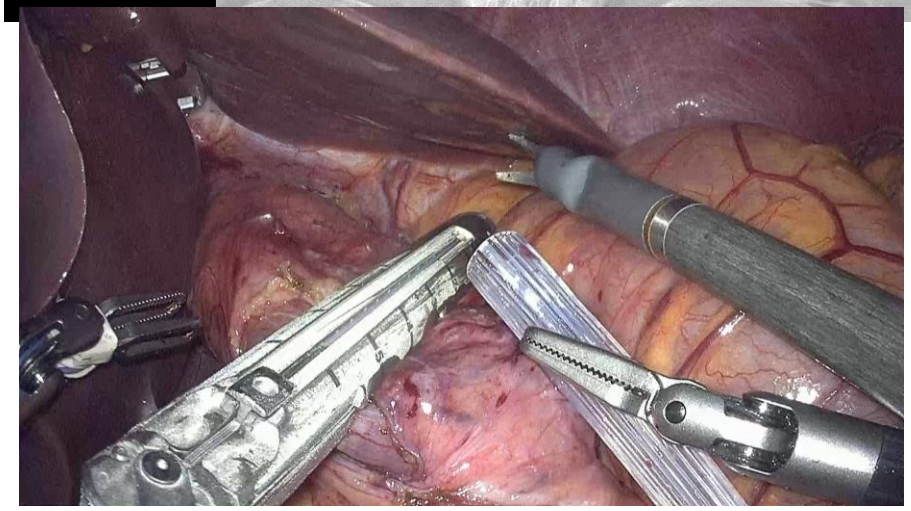
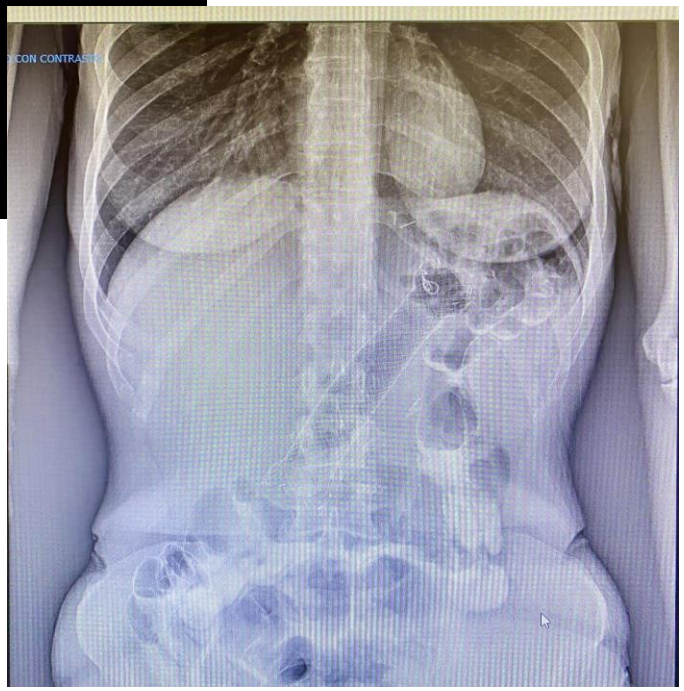
3. Stenosi angolare/twisting/kinking

If upper GI series demonstrates true obstruction, endoscopic or surgical intervention is required. A 2013 review of 717 patients found symptomatic gastric stenosis in 5 patients (0.69%). Four of the five patients were successfully managed with endoscopic dilation, while one patient failed endoscopic treatment and underwent conversion to a Roux-en-Y gastric bypass [34].





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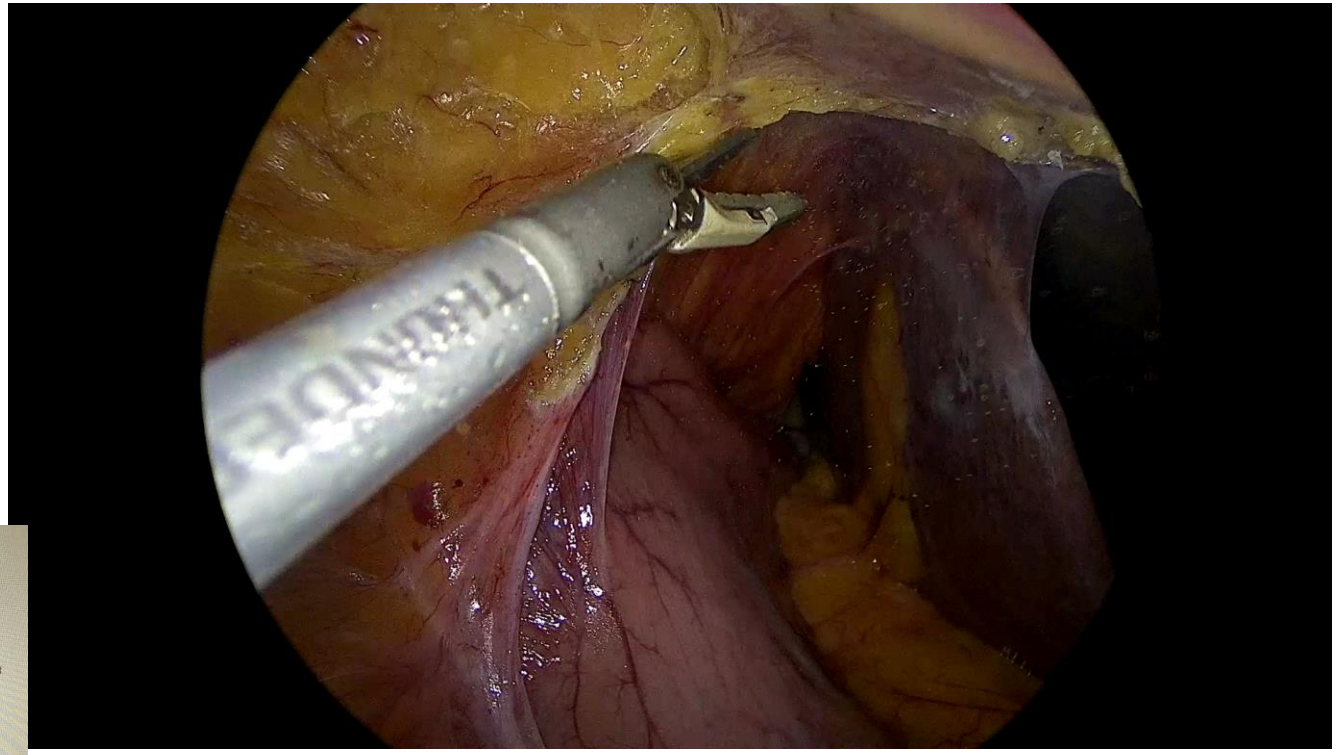
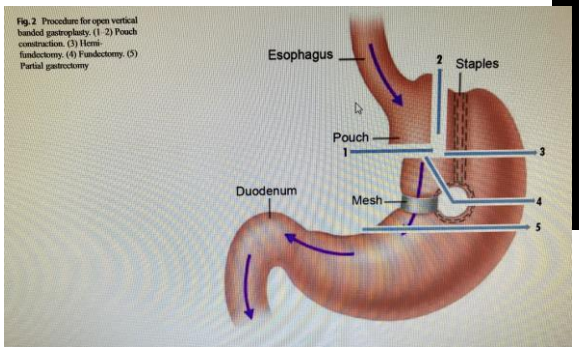
PREGRESSA GPV LAPAROTOMICA





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Endoscopic ultrasound-guided stented gastro-gastrostomy for strictured vertical banded gastroplasty
Balsamo F, Pagano N, Rottoli M, Di Simone MP, Sciannamea A, Poggioli G, Bernante P.
[1]Surgery of the Alimentary Tract, [2]Gastroenterology Unit, Sant'Orsola Hospital
Centre for the Study and Research of Surgical Treatment for Morbid Obesity
Alma Mater Studiorum University of Bologna, Italy
www.unibo.it

POLICLINICO DI SANT'ORSOLA

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BOLOGNA BARIATRIC

RESTAURAZIONE DA PREGRESSA ILEAL FOOD DIVERSION DI CONVERSIONE DA GASTROPLASTICA VERTICALE SEC. MASON

Sciannamea A, Balsamo F, Rottoli M, Garelli S, Pagotto U, Poggioli G, Bernante P.

CONCLUSIONI

- Anche se in letteratura non è ancora presente una **standardizzazione** ufficiale sui tempi chirurgici dei reinterventi, la nostra esperienza suggerisce che questa in realtà potrebbe essere possibile.

Il «ritorno all'anatomia originaria» ne costituisce uno step fondamentale

- Il reintervento deve essere inteso come una tra le strategie valide disponibili all'interno di un più ampio percorso terapeutico per la cura dell'obesità insieme alla terapia **farmacologica, nutrizionale e psicologica**; non deve assolutamente essere considerato come il risultato esclusivo di un fallimento della procedura primaria

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Credits:

Paolo.bernante@unibo.it