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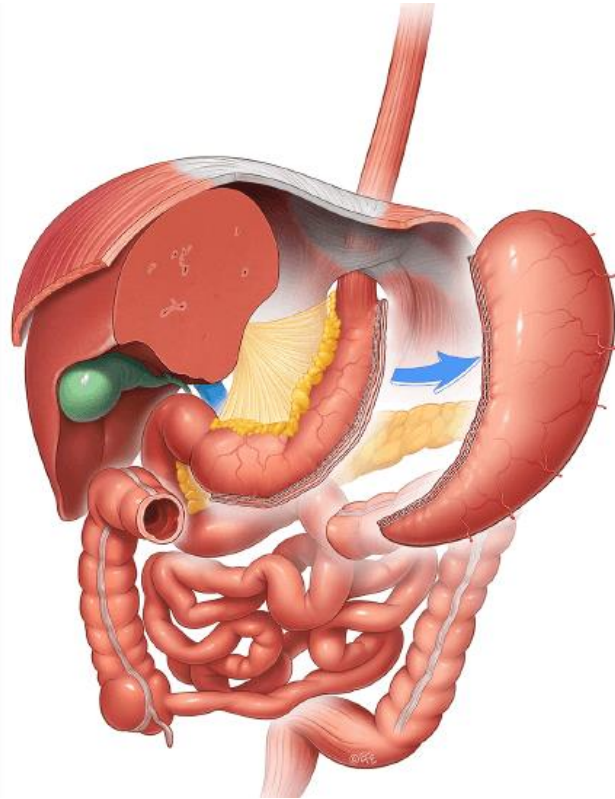
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RGE IN PAZIENTI SOTTOPOSTI A SADIS E A TRANSIT BIPARTITION

PIERO GIUSTACCHINI

CENTRO DIPARTIMENTALE DI CHIRURGIA ENDOCRINA E
DELL'OBESITÀ, U.O.C. CHIRURGIA ENDOCRINA E METABOLICA,
FONDAZIONE POLICLINICO UNIVERSITARIO AGOSTINO
GEMELLI IRCCS, ROMA

SLEEVE GASTRECTOMY



Obesity Surgery
<https://doi.org/10.1007/s11695-025-07859-9>



REVIEW

The Early Days of Laparoscopic Sleeve Gastrectomy: A Narrative Review

Eduardo Lemos de Souza Bastos^{1,2}

OBES SURG (2014) 24:71–77
DOI 10.1007/s11695-013-1046-4



ORIGINAL CONTRIBUTIONS

Sleeve Gastrectomy and Development of “De Novo” Gastroesophageal Reflux

Giannattia del Genio · Salvatore Tolone · Paolo Limongelli · Luigi Bruscano · Antonio D'Alessandro · Giovanni Docimo · Gianluca Rossetti · Gianfranco Silecchia · Antonio Iannelli · Alberto del Genio · Federica del Genio · Ludovico Docimo

Obesity Surgery

Table 2 Data on the evolution of LSG throughout the IFSO Global Registry reports

	Publication, year	Sleeve (%)	Leading procedure, %
1 th IFSO Global Registry [49]	IFSO webpage, 2014	19.3	RYGB (70.7)
2 th IFSO Global Registry [50]	IFSO webpage, 2016	40.7	RYGB (49.4)
3 th IFSO Global Registry [52]	Obes Surg, 2018 [51]	43.6	RYGB (46.3)
4 th IFSO Global Registry [53]	IFSO webpage, 2018	45.9	Sleeve
5 th IFSO Global Registry [55]	Obes Surg, 2019 [54]	58.6	Sleeve
6 th IFSO Global Registry [56]	IFSO webpage, 2019	50.2	Sleeve
7 th IFSO Global Registry [57]	IFSO webpage, 2021	61	Sleeve
8 th IFSO Global Registry [58]	IFSO webpage, 2022	62.5	Sleeve
	Obes Surg, 2024 [59]		



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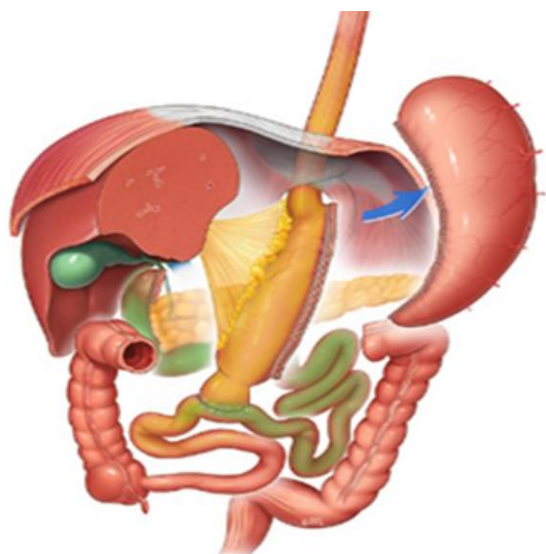


Original article

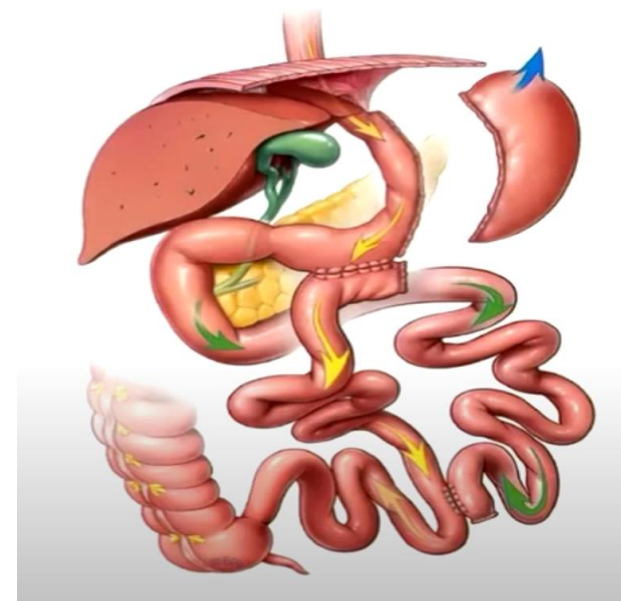
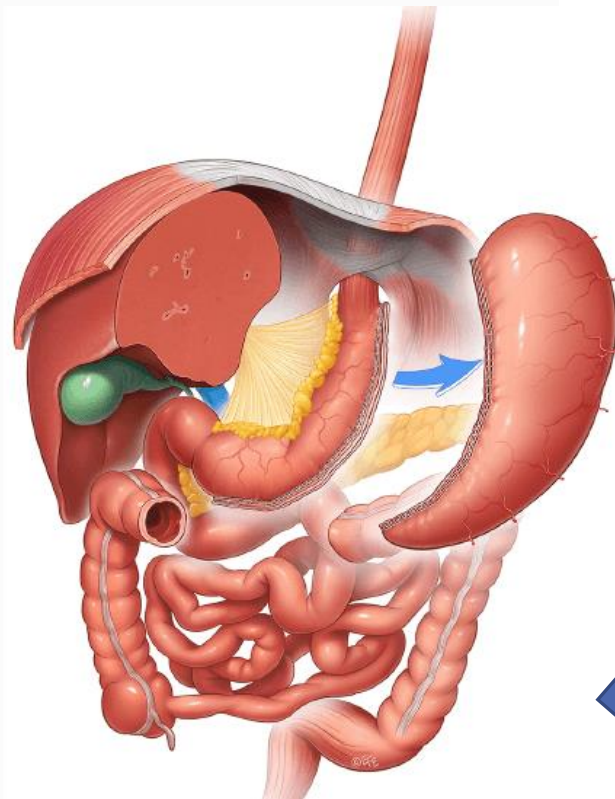
Esophageal adenocarcinoma after sleeve gastrectomy: actual or potential threat? Italian series and literature review

Alfredo Genco M.D. ^a, Lidia Castagneto-Gissey M.D. ^a, , Michele Lorenzo M.D. ^b, Ilaria Ernesti M.D. ^c, Emanuele Soricelli M.D. ^d, Giovanni Casella M.D. ^a

2007



2004





SADI-S, state of the art. Indications and results in 2024: a systematic review of literature

Livia Palmieri¹ · Francesco Pennestri^{2,3} · Marco Raffaelli^{2,3}

Updates in Surgery

Table 7 Improvement or resolution of comorbidities (

Study	T2DM		Arterial hyperten- sion		Dyslipidemia		OSAS		GERD	
	Resolved*	Improved*	Resolved*	Improved*	Resolved*	Improved*	Resolved*	Improved*	Resolved*	Improved*
Sánchez-Pernaute, 2010, [2]	96%	4%	91%	9%	10%	0%	N/A	N/A	N/A	N/A
Sánchez-Pernaute, 2013, [6]	95%	5%	N/A	N/A	63%	27%	N/A	N/A	N/A	N/A
Sánchez-Pernaute, 2014, [9]	89%	11%	60%	30%	40%	60%	N/A	N/A	N/A	N/A
Sánchez-Pernaute, 2015, [4]	71.6%	28.4%	52%	44%	89%	11%	N/A	N/A	N/A	N/A
Torres, 2017, [19]	75.8%	24.2%	63.8%	36.2%	95%	5%	N/A	N/A	N/A	N/A
Sánchez-Pernaute, 2020, [10]	94%	6%	56%	44%	N/A	N/A	N/A	N/A	N/A	N/A
Sánchez-Pernaute, 2022, [20]	38%	62%	78%	22%	N/A	53%	97%	3%	N/A	N/A
Pennestri, 2022, [21]	34%	17%	28%	2%	N/A	N/A	64%	5%	N/A	N/A
Marincola, 2023, [22]	87%	23%	65%	19%	N/A	N/A	83%	7%	N/A	N/A
Ospina Jaramillo, 2023, [23]	100%	0%	70%	30%	100%	0	25%	75%	N/A	N/A
Hu, 2024, [24]	100%	0%	62%	N/A	100%	0%	N/A	N/A	28%	62%
Banfiore, 2017, [25]	100%	0%	27%	22%	51%	23%	N/A	N/A	N/A	N/A
Zhang, 2024, [26]	0%	50%	N/A	N/A	0%	33%	N/A	N/A	N/A	N/A
Gebelli, 2022, [8]	96%	N/A	92.3%	N/A	76%	N/A	90.7%	N/A	N/A	N/A
Dijkhorst, 2018, [27]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Bashah, 2020, [28]	62%	38%	50%	0%	N/A	N/A	N/A	N/A	43%	14%
Gallucci, 2024, [29]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

N/A not available; *: % of patients

17 Studi

OSAS. GERD was reported only in two studies with a resolution rate of 28% and 43%, respectively.



The Efficacy and Safety of Laparoscopic Single-Anastomosis Duodeno-ileostomy with Sleeve Gastrectomy (SADI-S) in Mid- and Long-Term Follow-Up: a Systematic Review

Ali Esparham¹ · Samira Roohi¹ · Soheil Ahmadyar¹ · Amin Dalili² · Hengameh Anari Moghadam¹ · Antonio José Torres³ · Zhamak Khorgami^{4,5,6} 

10 Studi

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Abstract

This systematic review of 10 studies aimed to investigate the mid- and long-term results of duodeno-ileostomy with sleeve gastrectomy (SADI-S) according to the PRISMA guideline. Related articles, which reported outcomes of laparoscopic SADI-S with follow-up ≥ 3 years, were selected and analyzed. The percentage of excess weight loss (EWL) was 70.9–88.7%, and 80.4% at 6, and 10 years, respectively. The more common late complications were malabsorption (6.3%) and gastroesophageal reflux disease (GERD) (3.6%). The remission rates of hypertension, diabetes, GERD, obstructive sleep apnea, and dyslipidemia were 62.9%, 81.3%, 53.2%, 60.9%, and 69.7%, respectively. In conclusion, SADI-S is a safe and effective surgical technique with durable weight loss and a high rate of comorbidity resolution in mid and long term.



BMI tra 50 e 60 Kg/m²

Duodenal Switch vs. Single-Anastomosis Duodenal Switch (SADI-S) for the Treatment of Grade IV Obesity: 5-Year Outcomes of a Multicenter Prospective Cohort Comparative Study

Jordi Pujol Gebell¹ · Claudio Lazzara¹ · Amador García Ruiz de Gordejuela¹ · Mario Nora² · Ana Marta Pereira² · Andrés Sánchez-Pernaute³ · Javier Osorio¹ · Lucia Sobrino¹ · Antonio J. Torres García³

Table 1 Baseline and 5-year outcomes after each procedure. Data are expressed as number of patients (%) or median

	Preoperative			Postoperative 5y		
	DS n = 43	SADI-S n = 44	p	DS n = 37	SADIS n = 36	p
Gender						
Female, n (%)	34 (79.1)	31 (70.4)	0.209			
Age, year mean (SD)	46.6	43				
Weight, kg (SD)	138.6 (±13.4)	139.3 (±16.1)	0.203	80.3 (±14.7)	89.2 (±15.8)	0.024
BMI (SD)	52.5 (±2.9)	52.9 (±2.6)	0.222	30.6 (±4.9)	33.3 (±5.2)	0.023
Comorbidities, n (%)						
T2D	14 (32.4)	14 (32.3)	1			
T2D remission				13 (92.8)	12 (85.7)	0.572
Insulin	1 (2.3)	2 (4.5)	0.556			
Insulin retirement				1 (100)	2 (100)	1
HTN	21 (50)	27 (61)	0.654			
HTN remission				20 (95.2)	23 (85.1)	0.174
OSA	12 (28.2)	15 (35.3)	0.516			
OSA remission				9 (75)	11 (73.3)	0.719
cPAP	11 (25)	8 (17.5)	0.412			
cPAP retirement				9 (81.8)	5 (62.5)	0.666
DLP	17 (39.4)	15 (35.5)	0.799			
DLP remission				13 (76.4)	11 (73.3)	0.561
GERD	20 (47)	15 (35.5)	0.556			
GERD remission				12 (60)	7 (46.6)	0.952
Vomits				1 (2.5)	2 (5.2)	

DS duodenal switch, SADI-S single-anastomosis duodeno-ileal with sleeve, BMI body mass index, SD standard deviation, T2D type 2 diabetes, HTN hypertension, DLP dyslipidemia, OSA obstructive sleep apnea, GERD gastroesophageal reflux disease

Bold font indicate a $p < 0.05$

Table 2 Short- and long-term complications after hypoabsorptive bariatric surgery

	DS, n = 43	SADI-S, n = 44	p
Short-term complications, n (%)	5 (11.6)	5 (11.8)	0.582
Hemoperitoneum			
Intraluminal bleeding	1 (2.3)		
Duodeno-ileal anastomosis leak	1 (2.3)		
Duodenal stump leak			
Abdominal abscess	1 (2.3)		
Needed of blood transfusion	2 (4.7)		
Clavien-Dindo ≥ IIIA	2 (4.7)		
Hospital stay (days)	4 (±3.1)		
30-day readmission rate	1 (2.3)		
Long-term complications, n (%)	3 (7)		
Internal hernia	1 (2.3)		
Diarrhea	2 (4.7)		
Alkaline reflux	-		
Malnutrition	-		
Mortality	-		

Two patients in the SADI-S group experienced GERD caused by documented bile reflux and needed surgical conversion to DS, even though the preservation of the pylorus should play a protective effect against this potential complication of loop reconstructions. Other SADI-S series did not report any case of clinically significant bile reflux [15, 27]. It is possible that pylorus denervation due to excessive duodenal dissection could favor sphincter incompetence and therefore be the root cause of bile reflux following SADI-S. Also, biliary reflux previous to surgery due to pylorus incompetence might be another reason for these cases. Patients with previous biliary reflux should be selected to a Roux-en-Y reconstruction.



Bile Reflux After Single Anastomosis Duodenal-Ileal Bypass with Sleeve (SADI-S): a Meta-analysis of 2,029 Patients

Ray Portela¹ · Katie Marrerro² · Ahmet Vahibe¹ · Carlos Galvani³ · Helmuth Billy⁴ · Barham Abu Dayyeh⁵ · Benjamin Clapp⁶ · Omar M. Ghanem¹ 

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Abstract

Background Single anastomosis duodenal-ileal bypass with sleeve (SADI-S) is a novel bariatric surgery modified from the classic biliopancreatic diversion with duodenal switch (BPD-DS). These surgical modifications address most BPD-DS hurdles, but the risk of bile reflux may hinder SADI-S acceptance. We aimed to evaluate the event rate of bile reflux after SADI-S.

Methods PubMed, ScienceDirect, Cochrane, Web of Science, and Google Scholar were used to search English articles between 2008 and 2021 by two independent reviewers using the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA). The risk of bias was assessed using Newcastle–Ottawa Scale and the JBI tool. Event rates were meta-analyzed using Comprehensive Meta-Analysis (CME) V3.

Results Out of 3,027 studies analyzed, seven were included. Studies were published between 2010 and 2020. Six out of 7 studies were retrospective. Three studies had a low risk of bias, three studies had a moderate risk of bias, and one had a high risk of bias. The mean follow-up was 10.3 months. The total number of patients was 2,029, with 25 reports of bile reflux, resulting in an incidence of 1.23%, with an event rate of 0.016 (95% CI 0.004 to 0.055).

Conclusions Bile reflux has not been demonstrated to be problematic after SADI-S in this meta-analysis. Further long-term studies are needed.

RESEARCH



One-Anastomosis Gastric Bypass (OAGB) vs. Single Anastomosis Duodeno-Ileal Bypass (SADI) as revisional procedure following Sleeve Gastrectomy: results of a multicenter study

Pierpaolo Gallucci¹ · Giuseppe Marincola¹ · Francesco Pennestri^{1,2} · Priscilla Francesca Procopio^{1,2} · Francesca Prioli¹ · Giulia Salvi^{1,2} · Luigi Ciccoritti¹ · Francesco Greco¹ · Nunzio Velotti³ · Vincenzo Schiavone³ · Antonio Franzese³ · Federica Mansi³ · Matteo Uccelli⁴ · Giovanni Cesana⁴ · Mario Musella³ · Stefano Olmi^{4,5} · Marco Raffaelli^{1,2}

Table 2 Comparative analysis of intraoperative and postoperative data of all patients who met the inclusion criteria: OAGB (n = 126) vs SADI (n = 42)

Variable	OAGB N = 126	SADI N = 42	p-value
Approach			0.014
Laparoscopic (n, %)	126 (100%)	40 (95.2%)	
Robotic (n, %)	0	2 (4.8%)	
Post-operative ICU (n, %)	4 (3.2%)	0	0.573
Post-operative hospital stay, days (median, IQR)	4 (3 – 4)	2 (2 – 3)	0.001
30th day post-operative complications (n, %)	16 (12.7%)	0	0.015
Reoperation (n, %)	4 (3.2%)	0	0.243
Pneumonia (n, %)	1 (0.8%)	0	0.563
Bleeding (n, %)	9 (7.1%)	0	0.045
Deep vein thrombosis (n, %)	2 (1.6%)	0	0.411
Gastric stump leakage (n, %)	1 (0.8%)	0	0.563
Anastomotic leakage (n, %)	3 (2.4%)	0	0.313
Mid-term complications (n, %)	40 (31.7%)	1 (2.4%)	0.001
Internal hernia (n, %)	4 (3.2%)	0	0.243
Twisting of small bowel (n, %)	4 (3.2%)	1 (2.4%)	0.793
Anastomotic ulcer (n, %)	9 (7.2%)	0	0.045
Anastomotic stenosis (n, %)	8 (6.3%)	0	0.075
Malnutrition (n, %)	1 (0.8%)	0	0.563
RoW at 2 years follow-up (n, %)	6 (4.8%)	0	0.338
GERD (n, %)	7 (5.5%)	0	0.194
Converted to RYGB (n, %)	32 (25.4%)	0	0.001

OAGB One-Anastomosis Gastric Bypass; SADI Single Anastomosis Duodeno-Ileal Bypass; SD standard deviation; IQR 75% interquartile range; SG Sleeve Gastrectomy; RoW recurrence of weight; GERD gastroesophageal reflux disease; ICU intensive care unit; RYGB Roux-en-Y Gastric Bypass

Table 4 Intraoperative and postoperative outcomes between OAGB group (n = 42) and SADI group (n = 42) after propensity matching score analysis

Variable	OAGB N = 42	SADI N = 42	p value
Approach			0.152
Laparoscopic (n, %)	42 (100%)	40 (95.2%)	
Robotic (n, %)	0	2 (4.8%)	
Post-operative ICU (n, %)	4 (9.5%)	0	0.041
Post-operative hospital stay, days (median, IQR)	4 (4–5)	2 (2–3)	0.001
30th day post-operative complications (n, %)	3 (7.1%)	0	0.241
Reoperation (n, %)	0	0	1
Pneumonia (n, %)	0	0	1
Bleeding (n, %)	3 (7.1%)	0	0.241
Deep vein thrombosis (n, %)	0	0	1
Gastric stump leakage (n, %)	0	0	1
Anastomotic leakage (n, %)	0	0	1
Mid-term complications (n, %)	9 (21.4%)	1 (2.4%)	0.007
Internal hernia (n, %)	1 (2.4%)	0	0.314
Twisting of small bowel (n, %)	1 (2.4%)	1 (2.4%)	1
Anastomotic ulcer (n, %)	2 (4.8%)	0	0.262
Anastomotic stenosis (n, %)	2 (4.8%)	0	0.262
Malnutrition (n, %)	1 (2.4%)	0	0.314
RoW at 2 years follow-up (n, %)	1 (2.4%)	0	0.314
GERD (n, %)	1 (2.4%)	0	0.314
Converted to RYGB (n, %)	7 (16.7%)	0	0.006

OAGB One-Anastomosis Gastric Bypass; SADI Single Anastomosis Duodeno-Ileal Bypass; SD standard deviation; IQR 75% interquartile range; SG Sleeve Gastrectomy; RoW recurrence of weight; GERD gastroesophageal reflux disease; ICU intensive care unit; RYGB Roux-en-Y Gastric Bypass



Single Anastomosis Duodeno-ileostomy (SADI-S) Versus One Anastomosis Gastric Bypass (OAGB-MGB) as Revisional Procedures for Patients with Weight Recidivism After Sleeve Gastrectomy: a Comparative Analysis of Efficacy and Outcomes

Moataz Bashah^{1,2} • Ammar Aleter¹ • Jawher Baazaoui¹ • Ayman El-Menyar^{3,4}  • Antonio Torres⁵ • Asaad Salama¹

42 SADI Vs 49 OAGB

- **2016-2017 solo interventi di revisione**
- **F-UP 1 aa**
- **SADI 57% risoluzione o miglioramento GERD post-SG**

Reflusso biliare	0% Vs 6%
De novo GERD	0% Vs 6%
Ulcera marginale	0% Vs 6%



Long-Term Results of Single-Anastomosis Duodeno-ileal Bypass with Sleeve Gastrectomy (SADI-S)

Andrés Sánchez-Pernaute¹  · Miguel Ángel Rubio Herrera² · Natalia Pérez Ferré² · Carlos Sáez Rodríguez¹ · Clara Marcuello² · Clara Pañella¹ · Leyre Lopez Antoñanzas¹ · Antonio Torres¹ · Elia Pérez-Aguirre¹

A frequent concern after sleeve-based operations is the development of gastroesophageal reflux disease. We found advanced esophagitis in only 8.3% of the cases submitted to upper gastrointestinal endoscopy, which is a significantly lower proportion than could be expected, and we attribute it to the wider sleeve gastrectomy associated with the procedure.

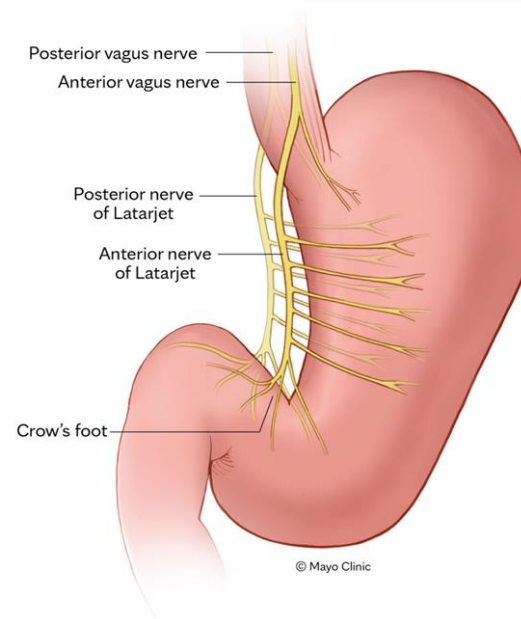
Only one patient was submitted to reoperation for pathologic gastroesophageal reflux disease (GERD) along with a hiatal hernia; reduction of the hernia and a Hill's procedure with hiatoplasty was performed. An upper gastrointestinal endoscopy was performed in 36 cases at a mean time of 6 years from the SADI-S. Most of the patients (72%) had a normal endoscopy. Grade A esophagitis was present in 5 cases (14%), and grade C or D in 3 patients (8.3%).



Single Anastomosis Duodenoileostomy with Sleeve: A Comprehensive Review of Anatomy, Surgical Technique, and Outcomes

Kamal Abi Mosleh¹ · Amanda Belluzzi¹ · Noura Jawhar² · Katie Marrero³ · Mohammad Al-Kordi¹ · Karl Hage¹ · Omar M. Ghanem¹

Fig. 3 Innervation of the stomach



Innervation

The left vagus nerve is situated on the anterior surface of the gastric region, while the right vagus nerve lies posteriorly (Fig. 3). The vagus nerve plays a crucial role in gastric motility, somatostatin secretion, and regulation of gastric acidity [26]. Preserving the distal branches of the left vagus nerve during antral preservation offers several advantages:

- Reduced risk of post-operative leak [26–28].
- Maintenance of normal gastric emptying and reduced postprandial discomfort [29].
- Reduced frequency of gastroesophageal reflux disease [30].

In principle, the vagus nerve is unlikely to get injured during the SADI-S procedure.

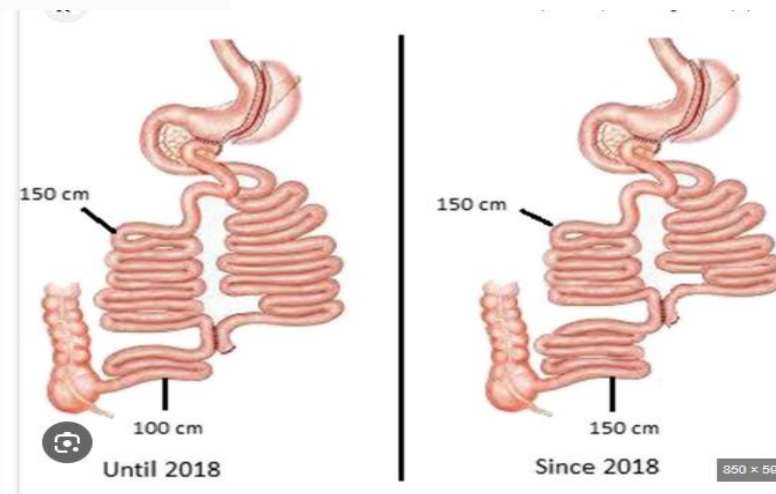
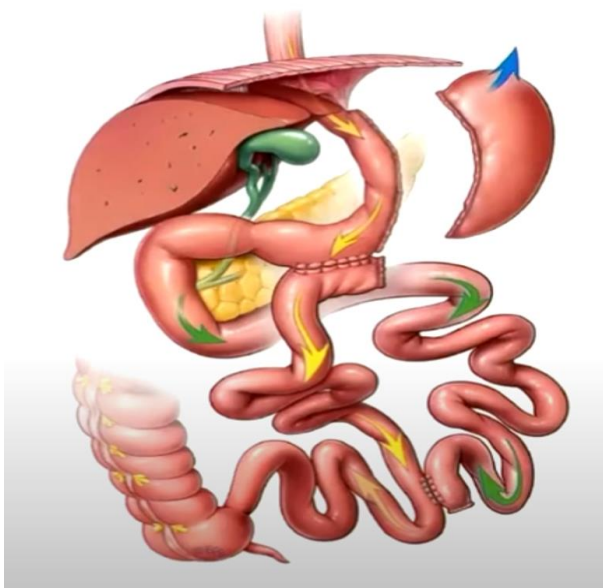


- **Meno pressione perché sleeve più «morbida» (soprattutto nelle redo)**
- **No commistione con reflusso biliare**



2004

SLEEVE GASTRECTOMY WITH TRANSIT BIPARTITION





The Protective Effect of Transit Bipartition and Its Modification Against Sleeve Gastrectomy-Related Esophagitis in a Rodent Model

Meng Wang¹ · Jason Widjaja¹ · Ponnie Robertlee Dolo¹ · Libin Yao¹ · Jian Hong¹ · Xiaocheng Zhu¹

Conclusion

Transit bipartition may protect the distal esophagus from the histological changes associated with esophagitis. We also described a modified form of transit bipartition, SG-PTB; however, we did not find a significant benefit in SG-PTB compared to SG-TB. Clinical studies are needed to confirm the anti-reflux effects of transit bipartition.

Fig. 1 Graphical demonstration of the three surgical models. a Sleeve gastrectomy (SG), b SG with transit bipartition (SG-TB), and c SG with proximal transit bipartition (SG-PTB)

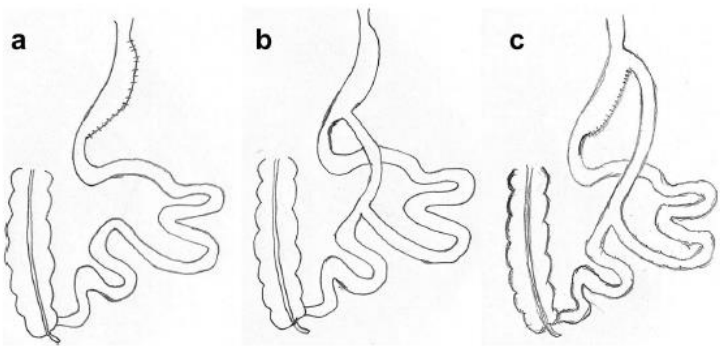
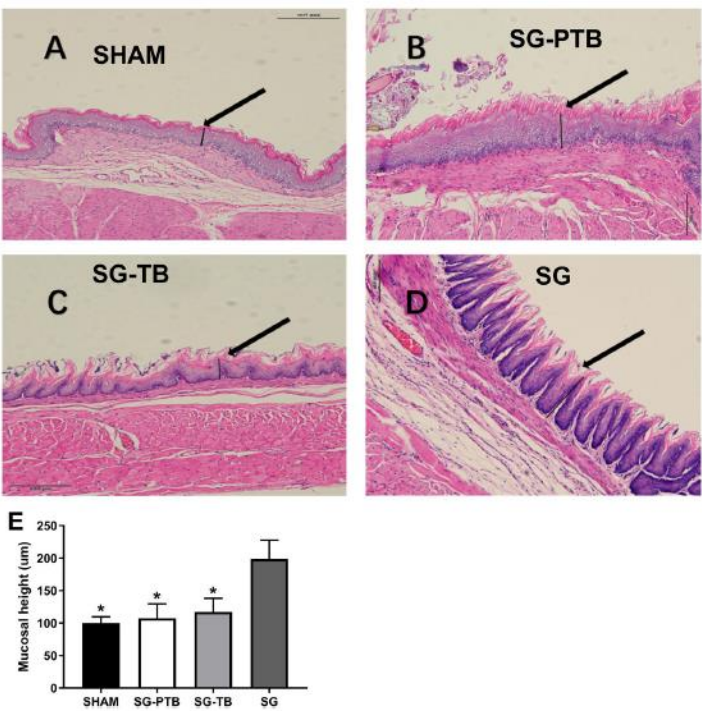


Fig. 5 Hematoxylin and eosin (H&E) histology (×100) in A SHAM, B SG-PTB, C SG-TB, and D SG. E shows the quantitative mucosal height observed through the histology. The black line (near the arrow) demarcates the mucosal length being measured. SG-PTB, sleeve gastrectomy with proximal transit bipartition; SG-TB, sleeve gastrectomy with transit bipartition; SG, sleeve gastrectomy



Sleeve Gastrectomy With Transit Bipartition

A Potent Intervention for Metabolic Syndrome and Obesity

Sergio Santoro, MD,* Luis Carlos Castro, MD,† Manoel Carlos Prieto Velhote, MD, PhD, FACS,‡
Carlos Eduardo Malzoni, MD, FACS,* Sidney Klajner, MD, FACS,* Leandro Perandin Castro, MD,†
Arnaldo Lacombe, MD,* and Marco Aurélio Santo, MD, PhD‡

Annals of Surgery • Volume 256, Number 1, July 2012

Methods: A total of 1020 obese patients with body mass index (BMI) ranging from 33 to 72 Kg/m² underwent SG and TB (SG + TB). TB creates a gas-

the predominant presenting symptom, along with some mostly left-sided abdominal distension. Postoperatively, 3 cases (0.5%) had a hiatal hernia corrected by a hiatoplasty due to severe reflux. Approximately 35% of patients were taking a daily or occasional proton-pump inhibitor for heartburn. In relation to the frequency of bowel

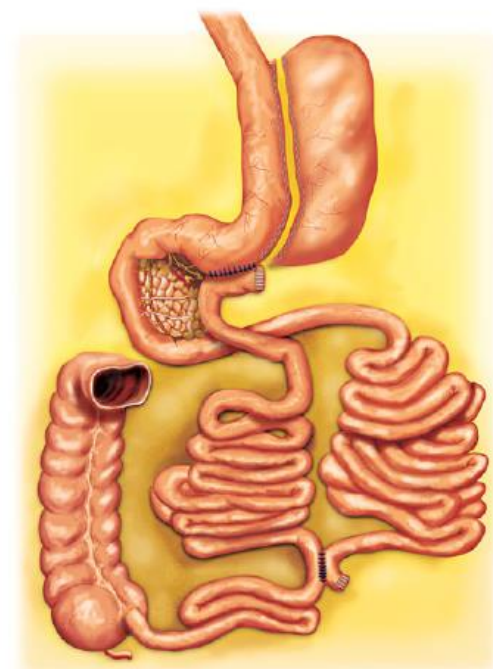


FIGURE 1. Didactic scheme of sleeve gastrectomy with transit bipartition.

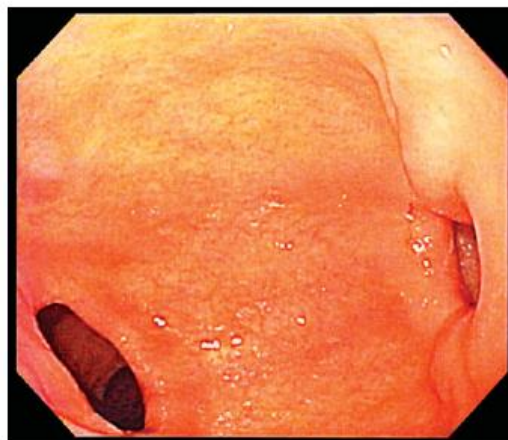


FIGURE 4. Late endoscopic view of the gastric antrum. Observe the pylorus at the right side and the gastroileal anastomosis at the lower left corner.

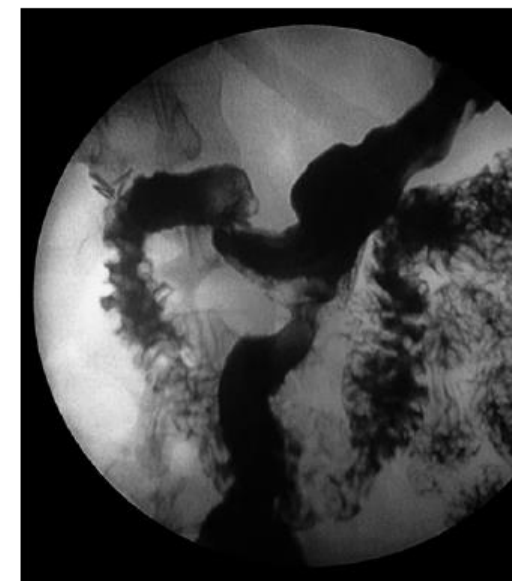


FIGURE 2. Late radiographic aspect of SG + TB. Observe that a part of the contrast media empties through the duodenum. The gastroileal anastomosis is very well shown.



Sleeve gastrectomy with transit bipartition in a series of 883 patients with mild obesity: early effectiveness and safety outcomes

Muzaffer Al¹ · Halit Eren Taskin²

Surgical Endoscopy (2022) 36:2631–2642 2635

Table 1 Patient demographics

	Mean (± SD)	Range
Age, yrs	51.8 (9.0)	24.0–77.0
Height, m	1.66 (0.10)	1.43–1.94
Absolute wt, kg	94.3 (15.7)	63.0–170.3
BMI, kg/m ²	34.1 (5.0)	28.0–57.8
Excess BMI, kg/m ²	9.1 (5.0)	3.0–32.8
Diabetes duration, yrs	12.4 (6.1)	4.0–37.0
	<i>N</i>	%
Females	516	58.5
Smokers	196	22.2
BMI groups	–	–
≥ 28.0– < 30.0 kg/m ²	211	23.9
≥ 30.0– < 35.0 kg/m ²	327	37.0
≥ 35.0 kg/m ²	345	39.1
Preoperative meds	–	–
OAD	822	93.3
Insulin	776	87.9
Comorbidities	–	–
T2DM	883	100.0
Hypertension	406	46.0
Hyperlipidemia	203	23.3
Hypertriglyceridemia	425	48.1

BMI body mass index, OAD oral antidiabetic medicine, T2DM type 2 diabetes mellitus

Table 2 Weight and body mass evolution through 12-month follow-up

	Preop <i>n</i> = 883 Mean (± SD) 95% CI	1 mo <i>n</i> = 883 Mean (± SD) 95% CI	3 mo <i>n</i> = 883 Mean (± SD) 95% CI	6 mo <i>n</i> = 809 Mean (± SD) 95% CI	9 mo <i>n</i> = 746 Mean (± SD) 95% CI	12 mo <i>n</i> = 646 Mean (± SD) 95% CI
Weight, kg	94.3 (15.7) 93.3, 95.3	86.5 (14.6) 85.5, 87.4	81.8 (13.5) 80.9, 82.6	78.6 (12.6) 77.7, 79.4	76.6 (11.9) 75.8, 77.5	75.6 (11.5) 74.7, 76.5
Total weight loss, %	–	8.3 (3.0) 8.1, 8.5	13.2 (4.1) 12.9, 13.5	16.3 (5.1) 15.9, 16.6	18.4 (5.7) 18.0, 18.8	19.8 (6.0) 19.4, 20.3
Body mass index, kg/m ²	34.1 (5.0) 33.7, 34.4	31.2 (4.7) 30.9, 31.5	29.5 (4.3) 29.2, 29.8	28.3 (3.8) 28.1, 28.6	27.7 (3.6) 27.4, 27.9	27.2 (3.4) 26.9, 27.5
Total body mass index loss, kg/m ²	–	2.8 (1.1) 2.7, 2.9	4.6 (1.7) 4.5, 4.7	5.6 (2.2) 5.5, 5.7	6.4 (2.5) 6.2, 6.6	6.9 (2.6) 6.7, 7.1

Overall follow-up rate 73.2% at 12 months

Table 6 Complications

	<i>n</i> (%)	Resolution
Early (1 mo. of surgery)		
Hernia at port sites	2 (0.2)	Repaired laparoscopically at 6 mo. w/prolene mesh
Bleeding (requiring reoperation or transfusion)	12 (1.4)	10/12 issues treated conservatively; 2 had bleeding controlled laparoscopically on postoperative day 1
Intestinal sub occlusion	15 (1.7)	All treated conservatively in hospital for 10 days
Symptomatic atelectasis	3 (0.3)	Resolved at 6 mo. with conservative treatment
Acute crises of urolithiasis	3 (0.3)	1 underwent cholecystectomy; 2 treated w/urodeoxycolic acid
Early incisional dehiscence	1 (0.1)	Early incisional repair under local anesthesia
Diarrhea	25 (2.8)	Treated conservatively and with probiotics
Foul-smelling stools	15 (1.7)	–
Late		
Marginal ulcer	3 (0.3)	Developed marginal ulcers after 12 mo. follow-up; treated conservatively
Anastomotic stenosis	10 (1.1)	Stenosis at gastroileal anastomosis at 6 mo. follow-up; 8 successfully treated w/balloon dilatation; 2 reoperated and anastomosis revised (1 open, 1 lap)
Late-onset gastrointestinal bleeding	1 (0.1)	Patient on anticoagulants w/gastrointestinal bleed seen at 6 mo. follow-up; treated by endoscopic clipping at antrum
Mortality	0 (0.0)	–
Total # complications = 90		
Total <i>N</i> = 883		
Overall complication rate = 10.2%		

NO GERD



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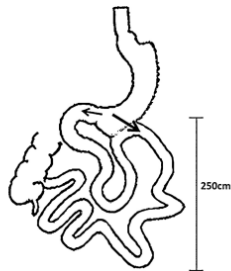
International Journal of Surgery Case Reports

journal homepage: www.casereports.com

Laparoscopic sleeve gastrectomy with loop bipartition: A novel metabolic operation in treating obese type II diabetes mellitus

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International Journal of Surgery

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Retrospective Cohort Study

Single anastomosis sleeve jejunal (SAS-J) bypass as a treatment for morbid obesity, technique and review of 1986 cases and 6 Years follow-up. Retrospective cohort

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Table 3
The effect of SAS-J bypass on weight loss, comorbidities.

Variable	Preoperative No = 1294		One year Postoperative No = 1294		Value
					% of improvement P value
Diabetes	327 (25.3%)	on OHA ^a 233	5 (0.4%)	98.5%	<0.0001
Hypertension	402 (31.1%)		29 (2.2%)	93%	<0.0001
Hyperlipidemia	547 (42.3%)		17 (1.3%)	96.8%	<0.0001
Sleep apnea	182 (14%)		0	100%	<0.0001
GERD	100 (7.7%)		11 (0.9%)	89%	<0.0001
HbA1c	6.4 ± 1		4.7 ± 0.4		<0.0001
BMI	44.7 ± 4.5		27 ± 2		<0.0001
%TWL			39 ± 7		
%EWL			87% ± 8%		
Insufficient weight loss			2 (0.15%)		
1ry Infertility			Preoperative 11	2 years Postoperative 4	<0.0001
				64%	

^a OHA: Oral Hypoglycemic Agents, P-Value is significant when < 0.05%.



The Bipartition

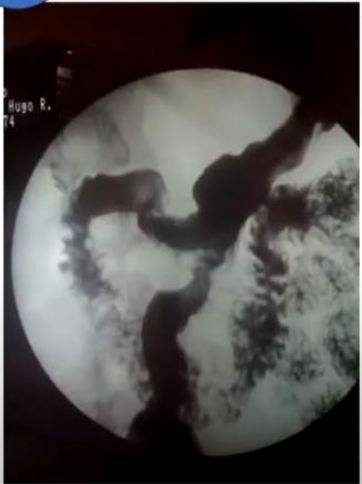
GERD is improved
by 3 mechanisms



1

The Bipartition

It Keeps the stomach
in the right position

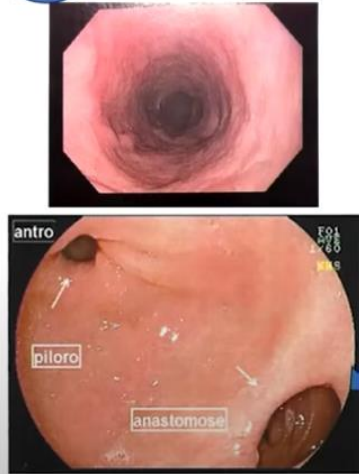


NO coiling!

2

The Bipartition

The bipartition is a
Gastric Drainage



3

The Bipartition

Substantial weight loss is important to
relieve GERD



BMI



Venezia

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Grazie