

## Algorithm for Failure after Laparoscopic Sleeve Gastrectomy

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### INTRODUCTION

Laparoscopic Sleeve Gastrectomy (LSG) represents nowadays the most common bariatric procedure. Weight loss failure and intractable severe reflux after primary LSG can necessitate further surgical interventions: Revised Sleeve Gastrectomy (ReSG), Roux-en-Y Gastric Bypass (RYGB), Duodenal Switch (DS) or Single Anastomosis Duodeno-Ileal bypass (SADI-S). Sleeve gastrectomy is a careful weight reduction strategy in which the stomach is diminished to about 15% of its unique size, by careful evacuation of an enormous part of the stomach along the more prominent bend. The outcome is a sleeve like structure. The system forever lessens the size of the stomach, in spite of the fact that there could be some dilatation of the stomach later on throughout everyday life. The strategy is for the most part performed laparoscopically and is irreversible [1].

Sleeve gastrectomy was initially proceeded as an adjustment to another bariatric strategy, the duodenal switch and afterward as the initial segment of a two-phase gastric detour procedure on very corpulent patients for whom the danger of performing gastric detour medical procedure was regarded excessively enormous. The underlying weight reduction in these patients was so fruitful it started to be researched as an independent procedure [2].

Sleeve gastrectomy is the most normally performed bariatric medical procedure worldwide. In numerous cases, sleeve gastrectomy is as successful as gastric detour medical procedure, remembering enhancements for glucose homeostasis before considerable weight reduction has happened. This weight reduction autonomous advantage is identified with the diminishing in gastric volume, changes in gut peptides and articulation of qualities engaged with glucose retention [3].

Laparoscopy is an activity acted in the midsection or pelvis utilizing little entry points (normally 0.5 cm-1.5 cm) with the guide of a camera. The laparoscope helps analysis or restorative intercessions with a couple of little cuts in the abdomen [4]. Laparoscopic medical procedure, likewise called negligibly obtrusive medical procedure (MIS), bandaid medical procedure or keyhole medical procedure, is a cutting edge careful strategy. There are various points of interest to the patient with

laparoscopic medical procedure versus the more typical, open strategy. These incorporate diminished torment because of littler entry points, decreased discharging and shorter recuperation time. The key component is the utilization of a laparoscope, a long fiber optic link framework that permits review of the influenced zone by winding the link from an increasingly inaccessible, however more effectively open area [5].

### DESCRIPTION

Laparoscopic medical procedure incorporates activities inside the stomach or pelvic depressions, while keyhole medical procedure performed on the thoracic or chest cavity is called thoracoscopic medical procedure. Explicit careful instruments utilized in a laparoscopic medical procedure incorporate obstetrical forceps, scissors, tests, dissectors, snares and retractors. Laparoscopic and thoracoscopic medical procedure have a place with the more extensive field of endoscopy. The first laparoscopic strategy was performed by German specialist Georg Kelling in 1901 [6].

### Sleeve gastrectomy medical procedure

The technique includes a longitudinal resection of the stomach beginning from the antrum at the point 5 cm-6 cm from the pylorus and completing at the fundus near the cardia. The staying gastric sleeve is aligned with a bougie. Most specialists want to utilize a bougie between 36 Fr-40 Fr with the strategy and the perfect surmised staying size of the stomach after the technique is around 150 ml [7].

Embraced by the International federation for the surgery of obesity and metabolic disorders and the American society for metabolic and bariatric surgery, sleeve gastrectomy is picking up prominence in kids and young people. Studies by Alqahtani and associates have discovered that sleeve gastrectomy causes enormous weight reduction in youngsters and youths matured 5 to 21 years. Moreover, they contrasted weight reduction and grown-ups and discovered practically identical weight loss. Recent reports from the gathering show that development advances unaffected after sleeve gastrectomy in kids more youthful than 14 years of age.

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Depression following the system has been noted in certain people. Another reaction is sleep deprivation. After this medical procedure numerous individuals can possibly rest when they take melatonin or dozing prescriptions [8].

58 patients out of 2177 sleeves (2.66%) were analyzed: 36 ReSG (62.07%), 12 RYGB (20.69%), 6 DS (10.34%), 4 SADIS (6.89%). The indication was: IWL for 29 patients (50%), WR for 19 patients (32.7%) and severe GERD for 10 patients (17.2%). The average time between the primary and revisional procedure was 37 months (9.94). We recorded 4 complications. Two stenosis after ReSG (5.55%) were managed both by endoscopic dilatation [9]. Two reoperations after DS (33.3%): 1 bowel obstruction 3 months after surgery managed by laparoscopy and 1 case of elongation of the common channel for severe hypo albuminemia 24 months after. No mortality was occurred. During the same period there were performed 30 ReSG, 3 DS, 2 SADIS and 6 RYGB. Due to incomplete data they were not included in the present study [10].

## CONCLUSION

All the patients who underwent a revisional surgery after LSG (2006-2015) were included in this study. The requirements for revisional surgery were the Insufficient Weight Loss (IWL), the progressive Weight Regain (WR) or symptomatic Gastro-Esophageal Reflux Disease (GERD). The indication, the time interval between the primary and revisional procedure, the complications and their management were analyzed. Our algorithm consists in: ReSG is indicated when large fundus is revealed on contrast studies, for GERD the procedure of choice is represented by RYGB, SADIS replace the DS.

## REFERENCES

1. Shi X, Karmali S, Sharma AM, Birch DW. A review of laparoscopic sleeve gastrectomy for morbid obesity. *Obes Surg.* 2010;20:1171-1177.
2. Himpens J, Dobbeleir J, Peeters G. Long-term results of laparoscopic sleeve gastrectomy for obesity. *Ann Surg.* 2010;252(2):319-324.
3. Baltasar A, Serra C, Perez N, Bou R, Bengochea M, Ferri L. Laparoscopic sleeve gastrectomy: A multi-purpose bariatric operation. *Obes Surg.* 2005;15(8):1124-1128.
4. Diamantis T, Apostolou KG, Alexandrou A, Griniatsos J, Felekouras E, Tsigris C. Review of long-term weight loss results after laparoscopic sleeve gastrectomy. *Surg Obes Relat Dis.* 2014;10(1):177-183.
5. Lalor PF, Tucker ON, Szomstein S, Rosenthal RJ. Complications after laparoscopic sleeve gastrectomy. *Surg Obes Relat Dis.* 2008;4(1):33-38.
6. Stenard F, Iannelli A. Laparoscopic sleeve gastrectomy and gastroesophageal reflux. *World J Gastroenterol.* 2015;21(36):10348.
7. Yehoshua RT, Eidelman LA, Stein M, Fichman S, Mazor A, Chen J, et al. Laparoscopic sleeve gastrectomy-volume and pressure assessment. *Obes Surg.* 2008;18(9):1083-1088.
8. Roa PE, Kaidar-Person O, Pinto D, Cho M, Szomstein S, Rosenthal RJ. Laparoscopic sleeve gastrectomy as treatment for morbid obesity: Technique and short-term outcome. *Obes Surg.* 2006;16(10):1323-1326.
9. Fuks D, Verhaeghe P, Brehant O, Sabbagh C, Dumont F, Riboulot M, et al. Results of laparoscopic sleeve gastrectomy: A prospective study in 135 patients with morbid obesity. *Surgery.* 2009;145(1):106-113.
10. Moy J, Pomp A, Dakin G, Parikh M, Gagner M. Laparoscopic sleeve gastrectomy for morbid obesity. *Am J Surg.* 2008;196(5):e56-e59.