Variation of Laparoscopic Roux-en-Y Gastric Bypass Techniques and Dumping Syndrome assessment: a Survey of 80 Bariatric Surgeons and Endoscopists

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Background

Laparoscopic Roux-en-Y Gastric Bypass (RYGB) is the second most frequently performed bariatric procedure worldwide and one of its most frequent long-term complications is Dumping Syndrome (DS). Despite a dedicated consensus on the diagnosis and management of DS, published in 2020[1], great variability exists among physicians.

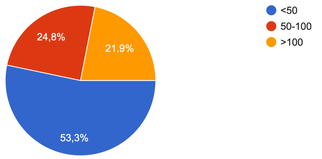
Methods

An anonymous 24-question survey was distributed by email and website (Websurg, IRCAD France) to all the subscribers bariatric surgeons and endoscopists from August to September 2023

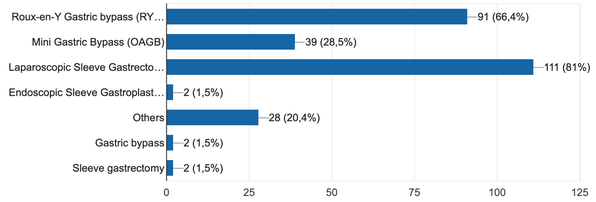
Results

A total of 143 subjects (137 surgeons, and 6 endoscopists) responded. Among surgeons, 46.7% perform at least 50 procedures per year and 66.4% of them routinely perform RYGB.

How many bariatric procedures do you perform per year?

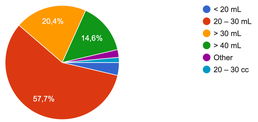


Which of the following procedures do you usually perform?

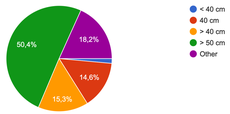


A wide variability was found in the main technical aspects of the surgical procedure: the volume of the gastric pouch, the length of the jejunal loop and the Roux limb.

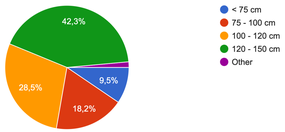
Which ideal volume do you look for when performing the gastric pouch during RYGB?



Starting at the ligament of Treitz, how long is the jejunal loop to create the biliopancreatic (BP) limb?



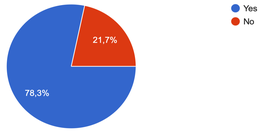
How many centimeters do you usually measure to create the Roux limb?



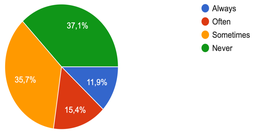
[1]*Scarpellini E et al. Nat Rev Endocrinol. 2020*

A multidisciplinary team preoperative evaluation and follow-up were reported by 89 % and 84% of the responders, respectively.
The frequency of DS after RYGB was reported as <20% in 70%, <40% in 24.4 % and >40% in 5.5% of cases. Only 15.6% of the responders routinely use mOGTT to confirm the diagnosis of DS, as recommended by guidelines, while 32.2% never used this diagnostic test. The limited use of the mOGTT could be related to low patient compliance, which in 65.5% of cases was evaluated <50%.

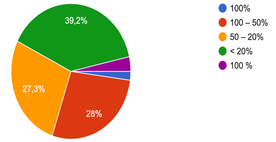
Do you differentiate between early and late dumping syndrome?



Do you confirm your diagnosis with MOGTT?



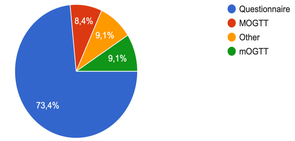
Based on your experience, how do you consider the compliance of your patient with MOGTT?



The most frequent first-line DS treatment was diet alone or in combination with drugs (mainly acarbose). Second-line treatment was endoscopic revision while surgical revision represented the third-line treatment, frequently performed after two failed attempts of endoscopic revision.
Six types of surgical procedures were reported with pouch revision (37.1%), distal RYGB (28.4%), and Biliopancreatic diversion/Duodenal switch (11.1%) being the most frequent.

Treatment efficacy was evaluated by DS questionnaires in 73.4.9% of cases, whereas by mOGTT only in 8.4%.

How do you usually control the efficacy of the DS treatment?



Conclusions

There are wide variations in the diagnosis and management of DS after LRYGB. Further consensus and guidelines are warranted to standardize patients' diagnostic and therapeutic algorithm.