

**“BARIATRIC SURGERY AND THE OBGYN PATIENT: A GUIDE FOR CLINICIANS”**

THOMAS A. STELLATO, MD  
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**New gastric bypass procedure deserved mention**

I enjoyed Dr. Stellato’s article on bariatric surgery and the ObGyn patient, but I was disappointed that he did not address mini-gastric bypass (MGB). I also thought more information could have been provided on electrolyte replacement and dietary requirements for pregnant patients.

I am an ObGyn nurse who has undergone the MGB procedure. I went from a BMI of 40 with comorbidities to a normal BMI (weight loss of 130 lb) without comorbidity. I am 1 year postoperative, and my weight has stabilized at 131 lb. I also worked for a bariatric surgeon who performs the MGB. I believe it will become the “gold standard,” replacing the Roux-en-Y gastric bypass (RYGB).

The MGB is performed laparoscopically (with five incisions) and usually completed within 45 to 60 minutes. Typically, there is no ICU stay, and patients return home the next day. Unlike the RYGB, no organ removal is required. Reduction of the stomach pouch resembles the separation in the Magenstrasse and Mill procedure, and intestinal bypass is done with a loop of approximately 6 feet, without removal of intestine. The entire procedure is reversible.

Although the MGB has some of the same potential complications as the RYGB, they are less likely to occur. The most common one to occur immediately postop is anastomotic leakage. The MGB has all the advantages of the RYGB with fewer side effects such as reflux. In fact, gastric reflux is markedly reduced with the MGB, thanks to the shape of the new stoma. Dietary restrictions are few,



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and are necessary only during the first few postoperative weeks. Weight usually stabilizes in 12 to 18 months, but a few patients may continue losing weight for 24 months. There is a low incidence of weight increase with the MGB, unlike the RYGB.

I look forward to seeing more articles from OBG MANAGEMENT on the care and management of bariatric obstetric patients.

**Penny Grechus, RN**  
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**» Dr. Stellato responds:  
Mini-gastric bypass lacks long-term follow-up**

*I appreciate Ms. Grechus’s reading of my article and congratulate her on aggressively improving her health through bariatric surgery. Bariatric operations vary in their rate and degree of success, but they are only a tool and will rarely be of benefit without a compliant, responsible patient.*

*I did not include the MGB in my discussion of bariatric surgery because the article was intended to be an overview of the subject, not encyclopedic in nature. However, I would like to correct several points of misinformation in Ms. Grechus’s letter:*

- Ms. Grechus asserts that the MGB differs from the RYGB in that “no organ removal is required.” But construction of the Roux limb in the RYGB entails no removal of intestine or any other organ
- She states that the MGB is reversible. The RYGB is similarly reversible. In either case, however, complete reversal would necessitate a major operation
- She also states, “gastric reflux is markedly reduced with the MGB, thanks to the shape of the new stoma.” In reality, the RYGB is considered to be the optimal treatment for gastroesophageal reflux disease (GERD) in the morbidly obese patient. The small gastric pouch has been shown to contain negligible gastric acid, and peristalsis in the Roux limb prevents bile reflux as well. In theory, the anatomy of the MGB, with its loop gastrojejunostomy (as opposed to the construction of a Roux limb), raises concerns about bile reflux in these patients
- She states, “there is a low incidence of weight increase with the MGB, unlike the RYGB.” There is no evidence to support this statement; the RYGB is considered the “gold standard” because of its long-term success. As noted above, this success still depends on a compliant and responsible patient
- The suggestion that an ICU stay is mandatory after RYGB is incorrect. Only a minority of programs mandate an ICU stay after RYGB. In our program, ICU utilization was 5% despite the fact that patients’ BMIs ranged from 36 to 87!

*I certainly agree with Ms. Grechus that the MGB is a simpler procedure to perform and consequently would require a shorter operation.*

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Nevertheless, the RYGB is considered the “gold standard” bariatric operation because of its success and the opportunity to critically evaluate this operation over decades. Ms. Grechus’s suggestion that the MGB will “become the ‘gold standard,’ replacing the Roux-en-Y gastric bypass” is somewhat premature. Few studies have critically evaluated the MGB, and long-term follow-up is inadequate. As evidence, I offer the most recent medical coverage policy of CIGNA, which states:

The mini-gastric bypass has been proposed as a bariatric surgery method. The controversial procedure is performed laparoscopically and is similar to the Roux-en-Y technique except that, after the

division of the stomach, a jejunal loop is created and anastomosed to the gastric pouch. Complications include biliary reflux and esophagitis. Evidence supporting the use of the mini-gastric bypass is in the form of small case series (Rutledge, 2001) and one small randomized open comparison of the procedure to [laparoscopic] RYGB (Lee, et al, 2005). The authors reported similar efficacy in terms of excess weight loss (EWL) at 2 years. However, longer-term follow-up with regard to the risk of complications is recommended by the investigators. There is insufficient evidence in the published, peer-reviewed scientific literature to support the safety and efficacy of the mini-gastric bypass.<sup>2-4</sup>

*I congratulate Ms. Grechus on her successful weight loss and commend all patients who challenge themselves to reverse the devastation of morbid obesity. The bariatric approach can be life saving when all other resources have failed.*

### References

1. Hallowell PT, Stellato TA, Petrozzi MC, et al. Eliminating respiratory intensive care unit stay after gastric bypass surgery. *Surgery*. 2007;142(4):608-612.
2. Rutledge R. The mini-gastric bypass: experience with the first 1,274 cases. *Obes Surg*. 2001;11(3):276-280.
3. Lee WJ, Yu PJ, Wang W, Chen TC, Wei PL, Huang MT. Laparoscopic Roux-en-Y versus mini-gastric bypass for the treatment of morbid obesity: a prospective randomized controlled clinical trial. *Ann Surg*. 2005;242(1):20-28.
4. CIGNA Medical Coverage Policy Number 0051. Subject: Bariatric Surgery. June 15, 2009. Page 14. [http://www.cigna.com/customer\\_care/healthcare\\_professional/coverage\\_positions/medical/mm\\_0051\\_coveragepositioncriteria\\_bariatric\\_surgery.pdf](http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0051_coveragepositioncriteria_bariatric_surgery.pdf). Accessed May 5, 2010.

## Instant Quiz



### Considering these statements about the 25OH vitamin D level:

- a circulating 25OH vitamin D level >30 ng/mL is thought to represent an adequate vitamin D level
- a level <20 ng/mL is thought to represent vitamin D deficiency
- a level between 20 and 30 ng/mL is thought to represent vitamin D insufficiency

### What do you conclude about these assertions regarding the United States population?

1. Approximately 90% of adults who have darkly pigmented skin have a 25OH vitamin D level <30 ng/mL. **True? False?**
2. Approximately 95% of African-American women who are mothers have a 25OH vitamin D level <30 ng/mL. **True? False?**
3. In autumn and winter, the mean cord blood level of 25OH vitamin D in newborns of an African-American mother is about 20 ng/mL. **True? False?**

See page 31 for the answers.

