

Introduction: The aim of this study was to determine the effects of the adjustable gastric band (AGB) on esophageal motility in patients who present for removal of the AGB.

Methods: A retrospective review of the 23 consecutive patient charts at Mount Sinai Hospital, New York, NY. High resolution esophageal manometry with impedance testing was performed after AGB removal in majority of patients while the rest had manometry with the AGB still in place. The age, sex, BMI, comorbidities, symptoms of dysphagia and food intolerance and manometry results were analyzed.

Results: 15/23 were female, the average age was 46 years and the average initial BMI was 42.1. 17 patients had GERD, 3 patients had dysphagia and 7 patients had significant food intolerance and 6 presented with inadequate weight loss. While 14 of the patients underwent manometry after removal of the band, 9 underwent manometry with the AGB present. 10 / 23 patients (43%) had significant dysmotility - ineffective peristalsis > 40% swallows. The AGB was removed in 17/23 for insufficient weight loss, significant gastroesophageal reflux, dysphagia or food intolerance. A revisional procedure was performed in 11 patients out of 17 (sleeve - 4, gastric bypass - 7). 6 of the 17 patients are waiting for the esophageal dysmotility to improve or resolve prior to revisional surgery.

Conclusion: There is significant prevalence of esophageal dysmotility in patients who present for removal of AGB.

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SLEEVE RESECTION OF THE GASTRO-JEJUNOSTOMY AND POUCH: OUTCOMES AFTER REVISION OF ROUX-EN-Y GASTRIC BYPASS

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Introduction: Significant weight regain or inadequate initial weight loss occurs in approximately twenty percent of patients after gastric bypass (GBP). This represents a difficult group of patients to treat and no standard surgical approach has been widely accepted. Options include pouch and/or stoma revision, limb length modification, and banding of the gastric pouch. We present our experience with “sleeving” the bypass.

Methods: A single institution, prospective, clinical database was retrospectively queried for patients who underwent “sleeve resection of the gastro-jejunosotomy and pouch” (SRGJP) as revision of GBP for inadequate weight loss or weight regain. Our technique involves resection of the “candy cane” jejunal limb and the lateral portions of the gastro-jejunosotomy, and pouch over a small (30-34 Fr) intraluminal bougie. The staple line is then imbricated with a permanent suture. Patients are managed per our standard post op bariatric protocol. We evaluated weight loss, complications and readmissions.

Results: Between 2011 and 2014 sixty-six patients, 94% female, average age 45 ± 9.84 underwent SRGJP from 3-16 years after their initial GBP. Average BMI at initial bariatric surgery was 54.6 ± 8.33 kg/m². Average BMI and weight at time of revision was 44.3 ± 7.79 kg/m² and 263.4 \pm 52.69 lb. respectively. Average

weight loss and percent excess BMI loss were 28.8 lb and 36.4% ($p=0.008$) at 6 months and 30.1 lb and 34.3% ($p=0.006$) at 12 months respectively. There was no statistical difference in weight loss or percent excess BMI loss at 6 vs. 12 months ($p=0.91$). There were 5 readmissions (7.6%), 1 leak (1.5%), and 4 patients required blood transfusion (6.1%).

Conclusion: SRGJP is a viable option for revision of gastric bypass. Weight loss is comparable to banding the gastric pouch. Complications are slightly higher than after primary GBP but are within acceptable limits.

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WEIGHT LOSS AFTER CONVERSION FROM LAPAROSCOPIC BAND TO LOOP DUODENAL SWITCH

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Objective: The Laparoscopic Lap Band is designed to be an adjustable laparoscopically placed gastric restriction device for treatment of severe obesity. While majority of patients achieves good outcomes with Lap Band, there is subset of patients who experiences complications or fail to lose sufficient weight after banding procedure. The purpose of this study was to access the outcomes of patients who had failed Lap band and were converted to Loop Duodenal Switch, in terms of their weight loss.

Method: We evaluated all from June 2013 to March 2015, with failed Lap band who were laparoscopically converted to Loop Duodenal Switch. Indication for conversion included- 1) Failed weight loss, 2) Failed weight loss with band slippage, 3) Lap Band causing esophageal obstruction and dysphagia, 4) Failed lap band with inability to tolerate adjustments, 5) Lap band causing severe abdominal pain. All the surgeries were done by one surgeon at one institution. We followed their intraoperative and postoperative complications and length of stay. Change in BMI between pre-op and post op follow up was evaluated.

Result: Among 15 patients (mean age- 46.53 ± 10.27 years) who underwent revision surgery, the mean BMI before the Loop Duodenal Switch was 46.15 kg/m² (range=29.33-82.73, SD-12.87) and the mean weight was 286.75 pounds (range=181.70-661.900, SD-116.69), mean revision operative time was 93.71 mins (range=65-125 mins), mean hospital stay was 3.67 days (range=1-15). The morbidity of the re-operation was 40 %: 3 abdominal Hematoma and 3 wound infections. No long term complications and no deaths were recorded. Mean excess weight loss was 30.76% with mean excess BMI lost of 38.55% at 3 months, 43.69% with 55.128% at 6months, 72.79% with 91.66% at 12 months and 98.65% with 124.13% at 18 months respectively.

Conclusion: Laparoscopically revision from Lap Band to Loop Duodenal Switch is safe and is a more effective alternative to gastric bypass who have failed Lap Band procedure. Revision to Loop Duodenal Switch in this subset of patients is technically challenging but if performed in the hands of experienced surgeon, can result in superior weight loss and better quality of life in shorter time period than other treatment options.