Does it really work?

Between 200 and 300 bypasses are performed per year around Australia. The majority of patients are able to achieve around 85% of excess weight loss. It is a preferred option when revision surgery is required, such as when a Gastric Band or Sleeve fails to achieve adequate weight loss.

Operative Risks

For any operation there are risks, and in particular there is a risk of infection, bleeding and injury. The overall risk of major complications is 5%, higher in revision surgery. The most common major surgical complication is staple line leak and this occurs in 2 to 5 % of cases. The most common outcome is no complications or a minor problem that will pass such as wound infection (5%).

More Information

Gastric Bypass surgery is very effective. However it is important to consider the other options, namely Gastric band and Sleeve Gastrectomy. Information on each of these can be found on our website or in other information sheets including *A guide to Weight Loss Surgery*.

This brief information sheet is best considered a reference to be used in conjunction with discussions with your surgeon.

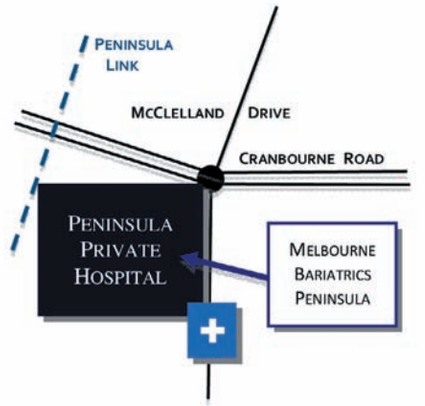
To discuss weight loss surgery including Gastric Bypass surgery with Mr Geoffrey Draper please discuss this with your GP and obtain a referral.

MELBOURNE BARIATRICS
PENINSULA

Mr Geoffrey Draper MBBS, FRACS
Bariatric, Laparoscopic and General Surgeon

Consulting at
Peninsula Private Hospital

Operating at
Peninsula Private Hospital
Beleura Private Hospital
Epworth Eastern



MR GEOFFREY F DRAPER MBBS, FRACS
MELBOURNE BARIATRICS PENINSULA

PHONE 97707189

PENINSULA PRIVATE HOSPITAL, SUITE 14
525 MCCLELLAND DRIVE, FRANKSTON VICTORIA 3199

info@melbournebariatrics.com.au
melbournebariatrics.com.au

MR GEOFFREY F DRAPER MBBS, FRACS
BARIATRIC, LAPAROSCOPIC AND GENERAL SURGEON

LAPAROSCOPIC GASTRIC BYPASS

to achieve the greatest weight loss

A guide to Gastric Bypass

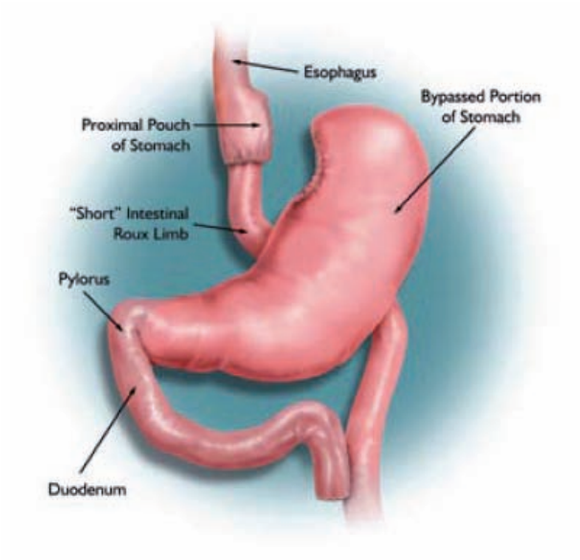
MELBOURNE BARIATRICS
PENINSULA

Laparoscopic Gastric Bypass

to achieve the greatest weight loss

Introduction

These operations include Roux-en Y Gastric Bypass (RYGBP) and Mini Gastric Bypass (MGP) among others. This information sheet refers to RYGBP as bypass. Involving a number of irreversible operative features, bypass achieves weight loss by decreasing the volume the stomach can hold (while leaving the extra stomach in place) and diverting food away from the part of the bowel that absorbs fat and sugar as well as important other nutrients. By decreasing food volume and the ability to absorb calories bypass will achieve major weight loss, usually around 85% of excess weight. However, there are problems such as "dumping", malabsorption and excessive weight loss. Also, bypass has a relatively high complication rate at around 5%.

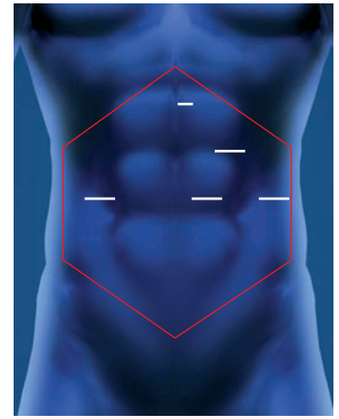


Highlighted stomach in the upper abdomen.

Although there are operations that can achieve even greater weight loss, these other operations are seldom performed in Australia for a number of reasons, particularly excessive weight loss and malnutrition. And so for most situations the bypass is considered the operation for the greatest weight loss. Sometimes it can be performed as a 2 stage operation, the second stage being done once significant weight loss has occurred, if this remains necessary. When previous weight loss surgery fails to achieve adequate weight loss or when complications occur after surgery, bypass is often the preferred operation.

The operation

Five small (5 to 15mm) incisions are made in the wall of the abdomen and long thin instruments introduced through them including a camera. The inside of the abdomen can then be visualised and manipulated. A small amount of the stomach is separated off by passing a stapler, creating a short, pocket shaped, pouch like stomach. The remaining stomach is left in place. The bowel is then divided and rejoined in such a way so as to divert food from the stomach to a part of the bowel further along that is not efficient at absorbing fat and sugars. There are numerous joins required. This operation should be considered irreversible.



The incisions allow the insertion of a camera, a liver retractor and instruments to grasp structures, cut and staple. The wound most likely to become infected is the left lower incision.

White Lines indicate the five usual incision sites.

When being performed for revision purposes, there is often scar tissue from the previous operation. This makes the operation more difficult and therefore higher risk and potentially the operation will be slightly modified to maximise safety. Sometimes this will mean the operation is done in 2 stages. Eg stage 1 removal of gastric band, stage 2 (months later) gastric bypass. Quite often there is a slight distortion of the stomach (Hiatus Hernia) near where the bypass is to be made and so this is repaired if present. The operation takes 90 to 120 minutes, usually requires four nights in hospital post operatively and two weeks convalescence.

"Dumping" and "malabsorption guts"

These are unpleasant experiences caused by food leaving the stomach being diverted to a new part of the bowel. With a bypass, if one eats large amounts of sugar or fat, there can be sensations of sweatiness, faintness, bloating and diarrhoea. To avoid these, patients need to try to eat smaller meals with a variety of foods.

Excessive weight loss and malnutrition

These can sometimes occur, especially if patients are not suitably monitored. Regular review by the weight loss surgery team and blood tests are required. The most common nutritional problems are Vitamins and iron, but there are others we need to monitor as well. Only very rarely is modification surgery required to prevent further weight loss.