

**SUGSS**

Sydney Upper GI  
Surgical Society

PRINCIPAL SPONSOR

**Medtronic**



INTERCONTINENTAL  
SYDNEY DOUBLE BAY

# 2015 "Revision Bariatrics II" SUGSS MEETING

**Saturday 5 December, 2015**  
InterContinental Sydney  
Double Bay

## FINAL PROGRAM & ABSTRACTS

### VIDEOS AND CUTTING EDGE TECHNIQUES IN 2015

- Re-operative bariatric surgery – classification, indication and outcomes.
- Is sleeve gastrectomy the new gold standard in bariatric surgery?
- Management of complications after sleeve gastrectomy.
- Revision surgery for the 2nd, 3rd or 4th time – Have you really considered the risks?
- Diet and lifestyle behaviours that are proven to work post-operatively in the long-term.
- Why the gastric band should still be on the menu.
- The evidence – Which patients will benefit from the band.
- Sleeve volume and patient assessment for the failed sleeve.
- Resleeve, bypass and novel therapies for the failed sleeve.
- Long term data for the long tight Australian sleeve.
- Long term data for the mini-gastric bypass in NZ.
- How does the long tight sleeve compare to RYGB in Diabetes – a RCT.
- Video – Band to sleeve – how I do it.
- Video – Band to bypass – how I do it.
- Does hiatus hernia repair for GORD after sleeve work?

### INTERNATIONAL FACULTY

Raul Rosenthal, USA  
Michael Booth, NZ  
Colleen Cook, USA

### AUSTRALIAN FACULTY

Reza Adib	Reg Lord
Roy Brancatisano	David Martin
Tony Brancatisano	Charlie Mosse
Wendy Brown	Michael Talbot
Peter Cosman	Craig Taylor
George Hopkins	Nick Williams
John Jorgensen	Tim Wright
Ken Loi	

### CONVENORS

David Martin  
Michael Talbot

# WELCOME



Dear Colleagues

It is with great pleasure that we welcome you to the Annual Sydney Upper GI Surgical Society (SUGSS) meeting. This year we are again in beautiful Double Bay on the banks of the Sydney Harbour in pleasant early summer Sydney weather. Set in a boutique harbour side suburb, we are a stone's throw from both the CBD and stunning beaches and coves. SUGSS is the first active Upper GI group in Australia and continues to play an educational as well as an important representative role for Upper GI Surgeons in NSW. This has demonstrated not only the common interests of our group but the benefit of being an organised, co-operative and functional team when required.

To this end thank you for participating in this opportunity for fostering relationships, expanding your horizons

and socialising with colleagues, their families and our trainees, students and hospital teams. This year we return to revision bariatric surgery. The first SUGSS revision bariatric meeting two years ago was incredibly well attended and dealt with the failed band whereas this time around we look closer at the revision operations, including newer options such as the Single Loop Mini Bypass, how to select surgical revision options, videos of expert surgical techniques and ways to assess and treat failing or complicated sleeve gastrectomy.

We have put together an invigorating one day program, with an impressive list of International (US / NZ), Inter-State, Regional and Local speakers with challenging and novel topics and enough time to catch up with colleagues from near and far.

For Fellows, registrars and junior doctors, it will be a great opportunity, not only to keep abreast of cutting edge changes in surgery, but also to meet current and potential mentors and be stimulated to consider future fellowship and career opportunities.

Our event is conveniently placed on a Saturday and set again in the iconic, refurbished and very famous Double Bay InterContinental Hotel (think Michael Hutchence, John Travolta, Madonna, George Bush, David Gotley).

This year we have another fabulous harbourside conference dinner to follow (including prominent up and coming Member of Parliament and ex AMAQ president, Dr Christian Rowan, as our after dinner speaker) who will no doubt pique your interest and may provide you with some interesting insight and inspiration.

Lastly we wish to thank the valuable support that our sponsors contribute towards the success of this meeting, particularly our Principal Sponsor, Medtronic. Without our broad range of sponsors, this meeting would not be of the high calibre that we have come to expect and experience.

Welcome and enjoy!

David Martin and Michael Talbot

**SUGSS**  
Sydney Upper GI  
Surgical Society

**SUGSS (Sydney Upper Gastro-Intestinal Surgical Society) is the representative body for NSW Upper GI surgeons.**

**SUGSS recently represented this group of surgeons with the NSW government during the rationalisation of cancer services.**

The SUGSS' charter is to foster education and research for surgery of the Upper Gastrointestinal tract, encompassing the oesophagus, stomach, liver, biliary tract, and pancreas, as well as other areas such as endoscopy and hernia surgery with particular reference to the development of co-operative multi-centre studies and cross campus collegiality.

When called upon, it is also the collective voice of representation for these surgeons. SUGSS also has fostered close working relationships with the Upper Gastrointestinal Surgery contingent of the RACS (Royal Australian College of Surgeons), as well as with the ANZ Gastro-Oesophageal and Hepatobiliary Pancreatic Surgical Associations (ANZGOSA / ANZHBPA) and Obesity Surgical Society of Australia and New Zealand (OSSANZ).

The board members of SUGSS are: David Martin - Chair (Royal Prince Alfred Hospital/Concord Repatriation Hospital), Michael Talbot - Treasurer (St George Hospital), Steve Liebman (Royal North Shore Hospital) and Henry Pleass (Westmead Hospital). The Committee of Management includes Charbel Sandroussi (Royal Prince Alfred Hospital), Koroush Haghghi (St Vincent's and Prince of Wales Hospitals), Nick Williams (Wagga Wagga Base Hospital) and Peter Cosman (Liverpool Hospital).

It is the only local association for Upper GI surgeons in NSW and preceded by the ANZHBPA and ANZGOSA Associations. SUGSS hosts an Annual Meeting in Sydney which is very successful and well attended.



## INVITED SPEAKERS



**RAUL ROSENTHAL**  
USA

Cleveland Clinic Florida  
Weston, Florida

Dr Raul Rosenthal is a surgeon in Weston, Florida and is affiliated with Cleveland Clinic Florida. He received his medical degree from Universidad Nacional de Rosario Faculty of Medicine and has been in practice for 33 years. He is Chief of MIS and Bariatric Surgery and director of Fellowship in Minimally Invasive and Bariatric Surgery at Cleveland Clinic Florida. He is currently the Chairman of the Department of General Surgery and director of the General surgery Residency Program. Dr Rosenthal served on the Clinical Issues, Emerging Technologies, Institutional Relationships, and Education Committees of ASMBS.



**MICHAEL BOOTH**  
NEW ZEALAND

Waitemata District Health Board  
(North Shore and Waitakere Hospital)

Michael Booth is a general surgeon at North Shore, Auckland with an interest in bariatric surgery. He did a Fellowship performing mainly open Fobi pouch gastric bypass and as the laparoscopic revolution took hold joined the tidal wave! He has experience in banded bypass (Fobi Pouch), and banded loop gastric bypass.

Dr Booth also does gastric sleeve surgery and has experience in duodenal switch surgery. His other area of interest is in gallstone disease, and antireflux surgery in both obese and non-obese patients.



**COLLEEN COOK**  
USA

Bariatric Support Centers International  
West Jordan, Utah

An enduring inspiration for over 20 years as a successful weight loss surgery patient, Colleen Cook is here to educate, motivate and celebrate! Her company, Bariatric Support Centers International is known world-wide for leading the bariatric support community and assuring optimal outcomes. Colleen is also the founder and former chair of the National Support Group Network an Integrated Health Committee of the ASMBS. She has served on the National Advisory Board for the Walk From Obesity and currently serves on the Membership Committee for the Obesity Action Coalition

## SUGSS MEDTRONIC TRAVELLING FELLOWSHIP

### Medtronic \$5,000 SUGSS Medtronic Travelling Fellowship

A sincere thank you to Medtronic, who has been a long term partner and principal sponsor of SUGSS, for providing this Travelling Fellowship for this year's Meeting. Four papers were chosen and these will be presented during the "Medtronic Prize 2015 Presentation Talks" at the end of each session.

#### ELIGIBILITY

Open to consultants within their first 4 years of practice - fellows, registrars, and residents who are planning a career in Upper GI surgery, this scholarship is planned to facilitate travel to expedite the learning of new techniques and processes to which you would not normally be exposed.

#### ADJUDICATION

Nominees will be judged by a panel based on the quality of the planned presented paper and their plans for use of the travelling scholarship. Previous recipients have used their prize to support a visit of several renowned international units, often with concomitant international conference attendance.

#### ENTITLEMENTS

The prize winner will also be invited back to a future SUGSS conference to talk on their experiences and an associated Upper GI topic.



## GUEST SPEAKERS

### **Reza Adib**

**Brisbane Obesity Clinic, Brisbane**

Dr Reza Adib has depth of experience in laparoscopic surgery and obesity management and has studied in Australia, England, Scotland, France and Austria. This broad international background puts him in a unique position to understand and treat a wide range of people from a variety of backgrounds and environments.

### **Roy Brancatisano**

**Circle of Care, Sydney**

Dr Roy Brancatisano is a bariatric surgeon who trained in Sydney, where he achieved his surgical qualifications and fellowship of the Royal Australasian College of Surgeons in 1993. He has performed well over 3500 weight loss surgery operations, including laparoscopic gastric banding, gastric sleeve resections and gastric bypass. His expertise in advanced laparoscopic techniques has enabled him to improve the operation of gastric sleeve resection by completely over-sewing the staple line to reduce leaks and bleeding risks. In 2003, he founded the Institute of Weight Control and developed the 'Circle of Care' Program. The Circle of Care program arose in response to listening to patient's needs and experiences, and realising that they are better able to achieve their goals of weight control and a healthier lifestyle when supported by a team of health professionals, including physician, dietitians, psychologist and physiotherapists.

### **Tony Brancatisano**

**Circle of Care, Sydney**

Dr Tony Brancatisano is a bariatric physician, research scientist and assistant surgeon in laparoscopic surgery. He has worked in the area of bariatrics for over 10 years at the Institute of Weight Control in Sydney. He works in a busy clinic with over 2800 gastric band patients and over 1500 patients with gastric sleeves. He also oversees the management of the multidisciplinary team at the Circle of Care. Tony is the principle investigator of a number of multi centre clinical trials on new therapeutic devices for weight loss including the innovative vagal blocking neuromodulating device. He

has authored over 100 peer-reviewed journal articles, abstracts and book chapters, and is a guest reviewer for the journals: Surgery for Obesity and Related Diseases and Obesity Surgery. He is a full member of the Obesity Society of Australia and New Zealand and a founding member of the NFSI Obesity Management Network.

### **Wendy Brown**

**Monash University, Melbourne**

Professor Wendy Brown, MBBS (Hons), PhD, FRACS, FACS, is Chair of the Monash University Department of Surgery at the Alfred Hospital, Director of the Monash University Centre for Obesity Research and Education and Clinical Lead of the National Bariatric Surgery Registry. She works privately at the Avenue and Cabrini hospitals. Her sub-specialist interests are oesophago-gastric cancer, gastrooesophageal reflux disease and bariatric surgery. Her research interests include health outcomes from bariatric surgery, animal models of bariatric surgery and basic mechanisms underlying satiety. She is Immediate Past President of OSSANZ and President Elect of ANZGOSA, Deputy Senior Examiner in General Surgery for the RACS and Chair of the Scientific Board of IFSO.

### **Peter Cosman**

**St George Private Hospital, Sydney**

Peter Cosman concluded his undergraduate studies in Arts and Medicine at the University of Sydney in 1994. After completing his internship at Repatriation General Hospital, Concord in Sydney, he commenced surgical training at Westmead Hospital in 1996. He interrupted his training to undertake research at the University of Sydney in 2000, leading to the award of the degree of Doctor of Philosophy. He attained his specialist qualification from the Royal Australasian College of Surgeons in 2005, and completed further training as an upper gastrointestinal and pancreatic surgeon before commencing practice as a Visiting Medical Officer in South Western Sydney in 2007.

Since his appointment, he has been developing a practice that covers all aspects of upper gastrointestinal and pancreatic surgery, including surgery for cancer of the pancreas, oesophagus,

and stomach, surgery for complex gallstone problems and pancreatic diseases, surgery for weight loss, and surgery for gastro-oesophageal reflux and hiatus hernia. He also performs surgery for hernia, emergency surgery, and trauma surgery.

### **George Hopkins**

**Obesity Surgery, Brisbane**

Visiting Upper Gastrointestinal and weight loss surgeon Royal Brisbane & Womens' Hospital and Holy Spirit Northside Private Hospital; President of OSSANZ (Obesity Surgery Society of Australia and New Zealand). Most of Dr Hopkins' general surgical practice is now in the field of bariatric and revisional bariatric procedures. He is in private practice at the Chermiside Medical Complex and runs the Surgical Weight Management Clinic at the Royal Brisbane and Women's Hospital.

### **John Jorgensen**

**St George Private Hospital, Sydney**

Dr Jorgensen specialises in Upper Gastrointestinal Surgery (surgery of the oesophagus, stomach, pancreas, spleen and gallbladder) and Weight Loss Surgery with specific emphasis on laparoscopic (ie keyhole surgery).

### **Ken Loi**

**St George Obesity Surgery, Sydney**

Dr Ken Loi is a specialist Upper Gastrointestinal Surgeon with appointment at St George Public and Private Hospital, Kareena Private and Sutherland Public Hospital. He has performed more than 3,000 advanced laparoscopic surgeries including primary and revisional bariatric operations. He has studied extensively about Bariatric surgery since 2002 and advanced his experience from USA and Australia. Currently he holds the position of Honorary Treasurer of OSSANZ (Obesity Surgery Society of Australia and New Zealand) and also in Education and Training position in IFSO - International Federation of Obesity Society (Asian-Pacific chapter).

Ken Loi is a Consultant Upper GI and Bariatric Surgeon St George and Sutherland Hospital. Treasurer and executive of OSSANZ.

## Reg Lord

### St Vincent's Clinic, Sydney

Prof Reg Lord practices at St Vincent's Hospital, St Vincent's Private Hospital, and Macquarie University Hospital, all in Sydney. After training in general surgery at St Vincent's Hospital he spent more than five years at the University of Southern California, Los Angeles. At the University of Southern California he worked as a member of the team which first performed the sleeve gastrectomy operation for weight loss and was one of the first surgeons worldwide to perform laparoscopic sleeve gastrectomy, more than ten years ago.

Reg Lord is Head of Surgery at the Notre Dame School of Medicine, Sydney, Head of the Gastro-oesophageal Cancer Research Program at the St. Vincent's Centre for Applied Medical Research, adjunct Professor of Surgery at Macquarie University School of Advanced Medicine, conjoint Associate Professor at UNSW, and the immediate past chairman of the Sydney Upper Gastrointestinal Surgery Society.

## Craig Taylor

### Advanced Laparoscopic Surgeon, Sydney

Craig Taylor is an Upper GI trained Bariatric Surgeon from Sydney and has performed over 4,000 bariatric procedures. He is based at Concord, The Mater, and Sydney Adventist hospitals.

## Nick Williams

### Riverina Bariatrics, Wagga Wagga

Dr Nicholas Williams is an obesity, endocrine and upper GI surgeon working in Wagga Wagga, NSW.

He completed fellowships in hepatobiliary-pancreatic surgery at Royal North Shore Hospital in Sydney and Endocrine/Obesity surgery in Mexico City.

He works in a high volume regional bariatric surgical practice, with a special interest in bypass and revisional surgery.

His other main interest is in the safe provision of upper gastrointestinal malignancy surgery in the regional setting, and he is the discipline leader for surgery at the rural campus of the University of Notre Dame.

## Tim Wright

### Newcastle Obesity Surgery Centre

Tim is a general surgeon with a special interest in advanced laparoscopic surgery. He has been performing obesity surgery since 1997 and has extensive experience with all three common operations - gastric banding, sleeve gastrectomy and gastric bypass. He has also done many revision procedures from previous failed operations such as stomach stapling.



INTERCONTINENTAL  
SYDNEY DOUBLE BAY

## INTERCONTINENTAL SYDNEY DOUBLE BAY 33 Cross Street, Double Bay

Located in the picturesque seaside village of Double Bay, this intimate Sydney hotel offers luxury and privacy at its finest. Only minutes from the CBD of Sydney and 13kms from the airport, guests can enjoy the central location and village atmosphere of Double Bay with boutique shopping, cafes and the beach only a minute's walk from the hotel. At sunset, escape the city for stunning harbour views and a cocktail or two at our rooftop bar

Instantly feel at home in the elegant yet comfortable surrounds of this bayside retreat. Contemporary, stylish abodes all feature lofty windows which open out, allowing natural daylight to pour in, with vistas including the bay, leafy Double Bay village, or the hotel's French provincial courtyard.



## FREE WIFI

The code for internet for our event will be **SUGSS2015**

Just select 'Intercontinental' in the WIFI options. You will then be taken to your browser, then select 'Conference' and enter the code **SUGSS2015**.



## MORNING SESSION

0800-1020

### Revision Bariatrics - Overview

Chairs / David Martin and Charlie Mosse

🕒 0800-0900

Registration

🕒 0900-0905

President's Welcome

🎤 David Martin

🕒 0905-0910

Revision in surgery in Australia and New Zealand – scope of the problem

🎤 Ken Loi

🕒 0910-0925

Why bother – What is the cost of the 2nd, 3rd or 4th obesity operation?

🎤 John Jorgensen

🕒 0925-0950

Welcome to Miami. How we assess and manage bariatric failures at the Cleveland clinic. Re-operative bariatric surgery – classification, indication and outcomes

🎤 Raul Rosenthal / Keynote Speaker

🕒 0950-1005

Patient and diet factors in weight regain – what does the data show and what do we do about it?

🎤 Colleen Cook / Keynote Speaker

🕒 1005-1010

Prize Paper 1 Outcomes following revisional bariatric surgery: band, sleeve and bypass. A 10 years single centre study

🎤 Ali Riaz

🕒 1010-1020

Panel Discussion

🕒 1020-1050

Morning Tea – 30 minutes



## BRUNCH SESSION

1050-1230

### Sleeve and Bypass as Primary Operations

Chairs / Craig Taylor and Nigel Peck

🕒 1050-1055

A prospective study. Band vs sleeve – eating quality of life and weight loss

🎤 Tony Brancatisano

🕒 1055-1105

The role of the sleeve as a stand alone operation

🎤 Raul Rosenthal / Keynote Speaker

🕒 1105-1110

Does taking the Antrum make a difference? Longer term outcomes with the long tight ANZ sleeve

🎤 David Martin

🕒 1110-1115

Put a ring on it. Fixed ring sleeve video. Personal experience and the literature

🎤 Tim Wright

🕒 1115-1130

How does the long tight All Black Sleeve compare with Roux-en-Y gastric bypass in diabetics – a RCT

🎤 Michael Booth / Keynote Speaker

🕒 1130-1140

How I deal with leaks post sleeve gastrectomy – the Australasian perspective

🎤 Michael Talbot

🕒 1140-1150

Dealing with complications post sleeve gastrectomy – the American perspective

🎤 Raul Rosenthal / Keynote Speaker

🕒 1150-1200

Any role for the endobarrier?

🎤 Reg Lord

🕒 1200-1205

Prize Paper 2 Portal vein thrombosis in sleeve gastrectomy

🎤 Stephanie Tan

🕒 1205-1230

Panel Discussion

🕒 1230-1330

Lunch - 1 hour

## POST LUNCH SESSION

1330-1440

### Old & New Wonder Kids - The Single Loop "Mini" Bypass and The Gastric Band

**Chairs** / Tim Wright and John Jorgensen

🕒 1330-1340

**Video – How I do it and why it is becoming a preferred primary alternative**

🎤 **Nick Williams**

🕒 1340-1355

**"What I've Learnt". Long term outcomes (to 10 years) with the Mini Bypass (with a fixed ring) in New Zealand**

🎤 **Michael Booth** / Keynote Speaker

🕒 1355-1400

**Is there a risk of oesophago-gastric cancer 10, 20 or 30 years after the mini-bypass - what should we be telling our patients?**

🎤 **Peter Cosman**

🕒 1400-1410

**The mini bypass for failed sleeves and bands - an early experience, some warnings and a review of the literature**

🎤 **Reza Adib** / Keynote Speaker

🕒 1410-1425

**How to predict success with the band – what the data tells us. And why we should keep it on the menu**

🎤 **Wendy Brown** / Keynote Speaker

🕒 1425-1430

**Prize Paper 3 Meta-analysis; internal hernia after lap Roux-en-Y Gastric Bypass**

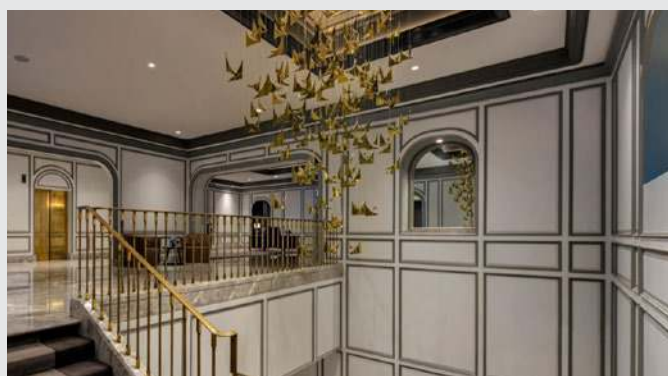
🎤 **Sashi Yelyuri**

🕒 1430-1440

**Panel Discussion**

🕒 1440-1510

**Afternoon Tea**



## AFTERNOON SESSION

1510-1700

### Revision Surgical Techniques and How to Assess and Manage the Failed Sleeve

**Chairs** / Michael Talbot and Wendy Brown

🕒 1510-1515

**Video – How I do it. Band to sleeve and outcomes**

🎤 **Craig Taylor**

🕒 1515-1520

**Video – How I do it. Band to sleeve and outcomes**

🎤 **Roy Brancatisano**

🕒 1520-1525

**Video – How I do it. One step band to RYGB and outcomes**

🎤 **George Hopkins**

🕒 1525-1530

**Video – How I do it. Band to fixed ring bypass**

🎤 **Michael Talbot**

🕒 1530-1540

**Ct Fizzogram, physiology and assessing the failed sleeve**

🎤 **Michael Talbot**

🕒 1540-1545

**Video – How I do it. Sleeve to RYGB and outcomes**

🎤 **George Hopkins**

🕒 1545-1605

**The role of the sleeve and bypass as revision operations. When I use them and video of technique**

🎤 **Raul Rosenthal** / Keynote Speaker

🕒 1605-1610

**Prize Paper 4 Hiatus hernia repair for GORD after sleeve**

🎤 **Pram Gunanayagam**

🕒 1610-1630

**Panel Discussion**

🕒 1630-1645

**Closing remarks**

🎤 **Michael Talbot**



# CONFERENCE DINNER / Saturday 5 December

## REGATTA RESTAURANT - 7pm 'til late

\*\*Seats are strictly limited\*\*

Coach departs the InterContinental at 6:45pm

Cost: \$ 0 per delegate (included in registration)  
\$ 120 per accompanying person  
(Unfortunately no children are permitted)

Includes: Gastronomical menu, accompanied by fine beverages. Return coach transfers from the InterContinental Hotel.

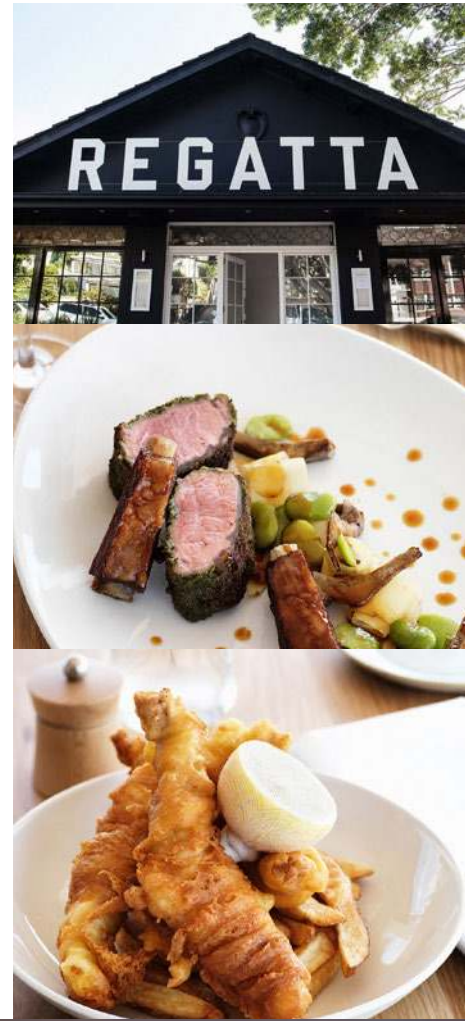
### 594 New South Head Road, Rose Bay

REGATTA Rose Bay is the current resident of one of Sydney Harbour's most iconic historical piers - now the Rose Bay Marina.

This Sydney harbour restaurant includes a contemporary, relaxed dining room and harbour-side bar offering a modern Australian menu with an emphasis on the very best seasonal produce, sustainable seafood and meat dishes.

The REGATTA team is led by Peter Nield, former General Manager at the Woollahra Hotel and award-winning Bistro Moncur, and Head Chef Claudio Morales, former Head Chef at Ash Street Cellar and Ivy's poolside Uccello.

**\*Please see the registration desk if you are no longer attending\***



### AFTER DINNER SPEAKER

#### Dr Christian Rowan

Queensland Member of Parliament, Physician, Private Hospital Medical Director and the immediate past president of the Queensland AMA.

Dr Rowan who was at the centre of the recent Queensland doctors dispute will be taking the gloves off and addressing Advocacy for Specialists in a potentially hostile future medical playing field and take us inside the inner sanctums of the government and politics.







## Patient and diet factors in weight regain – what does the data show and what do we do about it?

Colleen Cook, Bariatric Support Centers International

**Background:** Recommendations for dietary intake, eating behaviors, and physical exercise are typically made to post-bariatric patients yet little is known about which are most associated with weight loss success or failure over the intermediate- and longer-term. This study investigated whether adherence to specific guidelines provided by a bariatric support organization would be associated with intermediate to longer-term weight loss outcomes at 5 or more years post-surgery.

**Method:** Members of a bariatric support organization responded to an online survey assessing adherence to specific, research-based, behavioral recommendations based on previous research (Cook, 2012; Cook & Edwards, 1999). Of 535 initial respondents, 255 were at least 5 or more years post-surgery. From these, a final sample of 158 respondents was comprised of 117 (74.05%) reporting  $\geq 80\%$  EBWL who were defined as "Highly Successful" (HS) and 41 (25.9%) reporting  $< 40\%$  EBWL, who were defined as "Not Highly Successful" (NHS). These groups were compared on self-reported behaviors including: dietary intake, physical exercise, attendance at surgical follow-up visits, and participation in bariatric support groups.

**Results:** Participants averaged 51.7 ( $\pm 8.9$ ) years of age, 8.8 ( $\pm 4.2$ ) years post-surgery, and 96% female, 59% married, and 89% White. HS and NHS groups did not differ on demographic variables. Regarding dietary intake, HS group reported significantly higher rates of adherence to recommendations for diet ( $p < .001$ ); fewer total calories/day (1511.9kCals versus 2190.0kCals,  $p < .001$ ); higher %calories from protein (49% versus 36%;  $p < .001$ ); higher frequencies of eating protein first ( $p = .007$ ); and lower %calories from carbohydrates (31% versus 40%;  $p = .001$ ). HS group was significantly more likely to regularly weigh themselves ( $p < .001$ ); attend support groups ( $p = .002$ ); and take supplemental multivitamins ( $p = .029$ ), calcium ( $p = .004$ ), iron ( $p = .011$ ), and B12 ( $p = .001$ ). HS group was significantly less likely to graze ( $p < .001$ ); eat mindlessly ( $p < .001$ ); eat in front of TV ( $p = .002$ ); eat fast food ( $p < .001$ ); and eat high sugar foods ( $p < .001$ ). Groups significantly differed on patterns of drinking carbonated beverages ( $p = .02$ ) and caffeine ( $p = .005$ ). Finally, the HS group reported significantly more physical activity at least several times/week than NHS group ( $p < .001$ ). No significant differences found for ingestion of %calories from fat or the frequencies of eating at sit-down restaurants, drinking liquids with calories (e.g., protein drinks), or attending surgical clinic follow-up.

**Conclusion:** This study is one of the few studies to examine how the numerous recommended post-bariatric guidelines impact %EBWL in the intermediate to longer-term time-frame. Adherence to the majority of the guidelines recommended was found to be associated with weight loss success of greater than 80%EBWL. Adherence to such behaviors significantly distinguished patients with and without a high degree of success at 5 or more years after weight loss surgery.

## Medtronic Prize Presentation 1

### Outcomes following revisional bariatric surgery: band, sleeve and bypass. A 10 years single centre study

Ali Riaz, St George Hospital, Sydney

**Background:** The number of bariatric procedures being performed worldwide has hugely increased over the past two decades and this has led to revisional bariatric surgery being increasingly performed. However, revisional surgery has been associated with higher rates of complications, longer duration of procedures and poorer longterm outcomes. The ideal revision procedure remains unclear. The current study looks at our revision surgery cohort following primary Laparoscopic Gastric Band (LGB) and includes Re-LGB, Laparoscopic Gastric Sleeve (LGS) and Laparoscopic Roux en Y Gastric Bypass (RYGB) particularly with regards to weight loss, complications and resolution of symptoms.

**Methods:** Using our prospectively collected database we analysed 306 patients undergoing revisional bariatric surgery (LGB, LGS, LRYGB) from January 2004 - July 2015. The were divided into three groups: Group 1 included patients who had their LGB replaced by another LGB ( $n=84$ ), Group 2 included patients who underwent a LGS ( $n=77$ ) and Group 3 who had a revisional RYGB ( $n=144$ ). Patient demographics, reasons for revision surgery, complications, ongoing medical problems, BMI (before and after surgery) and medication changes were all analysed. Follow up was done with an upto date telephone survey or taken from a recent clinic visit.

**Results:** The study included 54 males and 252 females with a mean age, BMI and time prior to their primary LGB was 40.2 years (15-73), 44.6 $\pm$ 8.1 kg/m<sup>2</sup> and 31.2 $\pm$ 21 months. There was no statistical difference between the three groups. At the time of the revisional surgery Group 1 (LGB) had a significantly lower BMI compared to Group 2 (LGS) and Group 3 (RYGB) ( $P > 0.05$ ). After a mean follow up of 31.1 (0.3-123.1) months, Group 3 (RYGB) significantly reduced BMI compared to Pre-revision BMI and also compared to Group 1 and Group 2 ( $P > 0.05$ ).

The commonest reasons revisional surgery was due to inadequate weight loss/weight regain, gastric reflux and band issues (slippage, erosion, or failure), the majority of patients succeeded in overcoming the reason for revisional surgery however, 16 patients failed to improve (LGB  $n=9$  (11%), LGS  $n=3$  (3.5%) and RYGB  $n=4$  (5%).

Patients who had surgery for reflux/vomiting and obstructive symptoms ( $n=77$ , 25%), 15 continued to be symptomatic: Group 1 (LGB  $n=6$ ), Group 2 (LGS  $n=3$ ) and Group 3 (RYGB  $n=6$ ). Overall the complication rate was 6.1% ( $n=19$ ). Group 1 (LGB  $n=4$ , 5%), compared to Group 2 (LGS  $n=3$ , 4%) and Group 3 (RYGB  $n=12$ , 8.3%). There was no mortality during the study period.

**Conclusion:** Revisional surgery is safe and all three mainstay procedures could be considered. Our data shows that for maintenance of weight loss a RE-LGB is an option whereas if further weight loss is required then a LGS or a RYGB should be considered. The greatest weight loss is associated with RYGB.



## A prospective study. Band vs sleeve – eating quality of life and weight loss

**Tony Brancatisano**, Circle of Care, Sydney

**Background:** Few studies have compared the quality, frequency of eating and food tolerance amongst various textured foods between two restrictive bariatric procedures: adjustable gastric band (AGB) and sleeve gastrectomy (SG).

**Methods:** A quality of eating and hunger questionnaire (EHQ) was completed by 133 patients prior to their usual follow up care; 76 patients underwent AGB and 67 patients SG. The study type was prospective and cross sectional. Patients rated the frequency at which they consumed "easy" vs "challenging" foods, the amount and length of time for food consumption, frequency of regurgitation, and degree of satiety/fullness after a meal. Data is presented as median (interquartile range). Scores between bariatric procedures were compared using Mann-Whitney U test.

**Results:** The EHQ was completed by AGB patients at follow up of 76.5 months (27.3) and by SG patients at 11.8 months (7.5). Compared to AGB, SG produced the lowest cumulative score (78 vs 68, respectively,  $p < 0.001$ ), indicating improved food tolerance. SG patients ingested 'challenging foods' more frequently (score of 2; >2-3 times per week) vs score of 3 for AGB (< once per week;  $p < 0.0001$ ) with both groups consuming 'easy' foods equally (score of 3). Amount of food eaten was less for the SG than for the AGB (score of 2- one cup; 3-1 ½ cups, respectively;  $p < 0.0001$ ). Both groups rated degree of satiety/fullness equally (score of 2; pleasantly full). However, AGB patients regurgitated/vomited regularly (score of 2; < = once per fortnight) whereas SG rated it as 1 (never or rarely) ( $p < 0.0001$ ). The median EWL was 67.4% (26%) for SG and 47.1% (41%) for AGB.

**Conclusions:** Compared with long term follow up of AGB patients, the SG had improved quality of eating, tolerated a greater variety of textured foods with minimal if any symptoms, ate less food and equally satiated.

## The role of the sleeve as a stand alone operation

**Raul Rosenthal**, Cleveland Clinic Florida, Weston, Florida

**Background:** Laparoscopic sleeve gastrectomy (LSG) is an emerging surgical approach, but 1 that has seen a surge in popularity because of its perceived technical simplicity, feasibility, and good outcomes. An international expert panel was convened in Coral Gables, Florida on March 25 and 26, 2011, with the purpose of providing best practice guidelines through consensus regarding the performance of LSG. The panel comprised 24 centers and represented 11 countries, spanning all major regions of the world and all 6 populated continents, with a collective experience of >12,000 cases. It was thought prudent to hold an expert consensus meeting of some of the surgeons across the globe who have performed the largest volume of cases to discuss and provide consensus on the indications, contraindications, and procedural aspects of LSG. The panel undertook this consensus effort to help the surgical community improve the efficacy, lower the complication rates, and move toward adoption of standardized techniques and measures. The meeting took place at on-site meeting facilities, Biltmore Hotel, Coral Gables, Florida.

**Methods:** Expert panelists were invited to participate according to their publications, knowledge and experience, and identification as surgeons who had performed >500 cases. The topics for consensus encompassed patient selection, contraindications, surgical technique, and the prevention and management of complications. The responses were calculated and defined as achieving consensus ( $\geq 70\%$  agreement) or no consensus (<70% agreement).

**Results:** Full consensus was obtained for the essential aspects of the indications and contraindications, surgical technique, management, and prevention of complications. Consensus was achieved for 69 key questions.

**Conclusion:** The present consensus report represents the best practice guidelines for the performance of LSG, with recommendations in the 3 aforementioned areas. This report and its findings support a first effort toward the standardization of techniques and adoption of working recommendations formulated according to expert experience.

## How does the long tight All Black Sleeve compare with Roux-en-Y gastric bypass in diabetics – a RCT

**Michael Booth**, Waitemata District Health Board, (North Shore and Waitakere Hospital)

**Background:** Roux-en-Y gastric bypass is proven to be effective in the management of type 2 diabetes mellitus. Observational studies suggest similar diabetes remission rates may exist following sleeve gastrectomy, however only one other randomised trial has directly compared these two procedures.

**Methods:** Randomised, assessor and patient-blinded, single centre trial, evaluating the efficacy of laparoscopic silastic ring Roux-en-Y gastric bypass versus sleeve gastrectomy in 114 obese patients with type 2 diabetes mellitus. Mean ( $\pm$ SD) age of patients was 47 $\pm$ 8 years and 55% were female. Mean ( $\pm$ SD) BMI was 43 $\pm$ 7 kg/m<sup>2</sup> and glycated haemoglobin 8.0 $\pm$ 1.4%. 33 (29%) patients required insulin and 36(32%) patients had diabetes for >10 years duration. The 12-month end point was the proportion of patients with glycated haemoglobin <6% without pharmacological treatment.

**Results:** Of 114 patients, 96% completed 12 months follow-up. No significant difference was seen in achievement of this end point: 52% (29 of 56 patients) following gastric bypass and 49% (28 of 58 patients) following sleeve gastrectomy. Percentage weight loss was greater in gastric bypass versus sleeve gastrectomy group (27 $\pm$ 0.1% and 32 $\pm$ 0.1% respectively)  $p < 0.01$ . Reoperation was required in 5 patients following gastric bypass and 3 following sleeve gastrectomy.

**Conclusion:** At 12 months Roux-en-Y gastric bypass and sleeve gastrectomy achieved similar remission of type 2 diabetes. Greater weight loss was seen following gastric bypass. Further on-going study of these patients will provide longer-term outcomes.

## How I deal with leaks post sleeve gastrectomy – the Australasian perspective

Michael Talbot, St George Hospital, Sydney

**Background:** Endotherapy techniques to manage patients with upper gastrointestinal leaks and fistulae predominantly involve the use of self-expanding metal stents (SEMS). Adjuvant therapies such as application of endoscopic clips, use of glue or tissue plugs can be attempted if stents fail. This presentation describes a series of 22 sleeve gastrectomy patients in a larger series of 66 patients with oesophago-gastric leaks, perforations and fistulae.

**Methods:** Single-centre retrospective series. Since 2004 SEMS placement was used as the mainstay of upper GI leaks, including those occurring in sleeve gastrectomy patients. Since 2013, SEMS have been reserved only for uncontained leaks and internal drainage with endoscopically placed 7 french 7 cm pigtail catheters has been used in patients presenting with contained oesophago-gastric leaks, and as a "bail-out" in patients with fistulae after SEMS placement. In patients presenting with leaks after sleeve gastrectomy pneumatic dilation of the stomach to 30 mm at all endoscopy sessions is also performed.

**Results:** 22 patients were treated with successful resolution of leaks or fistulae in all (11) patients treated with a combination of internal drainage and/or 30mm dilation of the gastric tube. Of 12 patients treated initially with SEMS placement, 1 was converted to internal drainage after stent removal, one underwent roux-en-y anastomosis to a chronic fistula tract and one underwent resection of the stomach and intrathoracic anastomosis. The other patients treated with SEMS and external drainage had successful resolution of their fistulae although often at the expense of prolonged admissions with enteral or parenteral nutritional support. Compared with patients undergoing SEMS placement, patients those undergoing internal drainage were generally able to commence a fluid diet within a week of drain placement without fistula recurrence.

## Dealing with complications post sleeve gastrectomy – the American perspective

Raul Rosenthal, Cleveland Clinic Florida, Weston, Florida

**Background:** The rise of bariatric surgery has lead to an increasing number of reoperations for failed bariatric procedures. The reasons and types of these operations are varied in nature and remain to be defined.

**Methods:** A retrospective review of a prospectively collected database was conducted to identify patients who underwent laparoscopic revisional surgery for non-gastric banding-related bariatric procedures between 2001 and 2008.

**Results:** Of 384 secondary bariatric operations, 151 reoperative procedures were performed. Twenty-six vertical banded gastroplasties (17.2%), 2 mini-gastric bypasses (1.3%), 2 non-divided bypasses (1.3%), 1 distal Roux-en-Y gastric bypass (RYGBP; 0.7%), and 2 sleeve gastrectomies (1.3%) were converted to RYGBP. Three RYGBP (2%) and four jejunoileal bypass procedures (2.6%) were reversed secondary to malnutrition. One jejunoileal bypass (0.7%) and one biliopancreatic diversion (0.7%) underwent sleeve gastrectomies. Three pre-anastomotic rings were removed due to erosion (2%). Eleven pouch trimmings (7.3%), 16 redo gastrojejunostomies (10.6%), 5 redo jejunojejunostomies (3.3%), 36 remnant gastrectomies (23.8%), and 2 gastrogastic fistula takedowns (1.3%) were performed for pouch enlargements, strictures, and gastrogastic fistulas.

Thirty-six patients (23.8%) underwent a combination of these procedures. The major morbidity (13.2%) was related to leaks. Other complications included wound infection, intra-abdominal abscess formation, and trocar site hernias. The mortality rate was 2%.

**Conclusions:** Reoperative bariatric surgery is a complex and growing field in bariatric surgery. The indications for surgical reoperation can vary depending on the procedure and reason for intervention. Laparoscopy appears to be a feasible approach. Though safe, morbidity and mortality are significantly higher than in primary bariatric procedures.

## Medtronic Prize Presentation 2

### Portal vein thrombosis in sleeve Gastrectomy

Stephanie Tan, Royal Brisbane and Women's Hospital

**Introduction:** Sleeve gastrectomies are becoming a more popular form of bariatric surgery as weight loss is better and more rapid than the lap band<sup>1</sup>. Portal and mesenteric vein thrombosis is a relatively uncommon complication of a sleeve gastrectomy, with an incidence rate of 0.3-1%<sup>2,3</sup>. It can therefore be a difficult diagnosis, especially as the presenting symptoms are vague. However, there can be serious consequences as it can lead to bowel ischaemia necessitating resection. This paper will present the symptoms, risk factors, method of diagnosis, treatment and long term outcomes of patients who had portal vein thrombosis post sleeve gastrectomy.

**Method:** Retrospective data was collected from 5 bariatric centres across Australia.

**Results:** 5431 patients underwent a sleeve gastrectomy across 5 centres from February 2007 to June 2015. Of these, 15 (0.3%) had recognised portal vein thrombosis. Mean BMI was 42.2. 60% were female. 6 patients (40%) had previous history or family history of DVT. Their initial admission for the sleeve was uncomplicated with a mean admission length of 3.5 days. The mean time to re-presentation was 14 days with a presenting complaint of non specific abdominal pain. Diagnosis was most often established with a contrast CT. Treatment was non-operative with anticoagulation in all patients except one who required successive laparotomies and bowel resection. All patients discharged on therapeutic anticoagulation. 66% remained on anticoagulation from 3-6 months. 1 patient remained on warfarin for life given prior DVT/PE. Mean weight loss was 27% of body weight (7.5-66.3%). Nil mortality.

**Conclusion:** Portal vein thrombosis is a difficult diagnosis with potentially disastrous consequences. Patients typically present at least 7 days postoperatively with abdominal pain. Presenting complaint is non-specific and a high index of suspicion needs to be maintained.



## The mini bypass for failed sleeves and bands – an early experience, some warnings and a review of the literature

Reza Adib, Brisbane Obesity Clinic, Brisbane

Single anastomosis gastric bypass (mini gastric bypass) was initially described by Rutledge. The initial results were taken cautiously in United States and later established in at least one randomized trial in South East Asia. Later an adaptation of the procedure in Europe with sustainable good results attracted the attention of the rest of the bariatric surgical community to its current status around the world.

In Australia a gathering of bariatric surgeons recommended the consensus as single anastomosis gastric bypass to be preferably undertaken as a primary procedure and with more caution as revision procedure. In this small series we review some of early experiences and unexpected complications of mini bypass as a revision from laparoscopic sleeve gastrectomy and discuss the steps in management.

### Medtronic Prize Presentation 3

#### Meta-analysis; internal hernia after lap Roux-en-Y Gastric Bypass

Sashi Yelyuri, Concord Repatriation General Hospital, Sydney

**Introduction:** A proportion of bariatric surgeons do not close the peritoneal spaces during LRYGB. We systemically reviewed published studies to determine whether closure of mesenteric spaces during LRYGB is associated with a significant reduction in the incidence of re-operation for internal hernia (IH).

**Methods:** The review protocol was registered in PROSPERO, York (CRD42013006289) and adheres to PRISMA guidance. A comprehensive systematic review of literature was undertaken by searching Medline, Embase, Web of Science, Cochrane library and all relevant citations and references. No published randomised trial was identified; hence, study eligibility was extended to time-series that compared the incidence of IH before and after implementation of space-closure. Study quality, bias and outcomes were analysed by two independent reviewers.

**Results:** Systematic review of literature identified 2081 reports. There were 8 eligible studies; further, 9 studies reported IH after space-closure, 10 studies after non-closure and 12 studies were on other technical issues. Only 1 study explicitly reported length of follow-up separately for non-closure patients (mean 100 months) vs. closure (40 months). In total, spaces were not closed in 5880 patients vs. closure in 4878 patients. The length of follow-up was notably longer for non-closure patients vs. closure. Because of substantial inter-study variations, the data were not suitable for meta-analysis. The reported incidence of IH ranged from 3.35%-14.4% for non-closure vs. 0-2.0% with closure.

**Conclusion:** Within the limitation of sparse data, non-closure of peritoneal spaces appears to be associated with substantially increased incidence of IH. It seems clinically prudent to close all peritoneal spaces created during laparoscopic gastric bypass.

## How I do it: Band to sleeve and outcomes

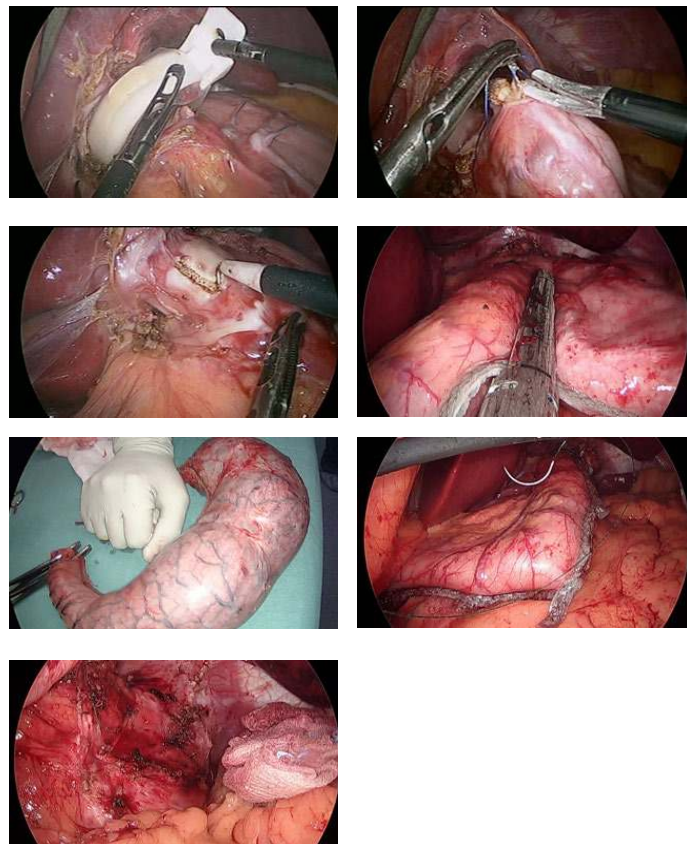
Craig Taylor, Advanced Laparoscopic Surgeon, Sydney

This video presentation demonstrates a laparoscopic two-stage conversion from adjustable gastric band to sleeve gastrectomy. Reasons for the conversion included inadequate weight control, food intolerance, or band related complications.

During the first stage, the gastric band was explanted, all suture material removed, gastric wrap taken down, and fibrous eschar excised. The sleeve gastrectomy was performed during the second stage after an interval of at least three months, achieving a 40Fr tubular stomach to the pylorus, taking care to avoid Incisura narrowing, complete resection of the fundus, and repair of any hiatal weakness or herniation.

85 consecutive patients underwent conversion over a 4 year period by a single surgeon. Patient weight pre-band, lowest with band, at band reversal, and at 12 and 18, and 30 months after sleeve were 125kg, 103kg, 120kg and 90kg, 90kg, 90kg respectively, indicating a loss of 63%EWL, which was maintained out to 30 months post sleeve. There was one complication (1.1%: unplanned splenectomy). There were no leaks, bleeds, venous thrombosis, or other morbidity, and no deaths.

In our experience sleeve gastrectomy after unsuccessful gastric banding is both safe and effective.



## Video – How I do it. One step band to RYGB and outcomes

George Hopkins, Obesity Surgery, Brisbane

**Background:** Revisional bariatric surgery has become more necessary for those who had laparoscopic adjustable gastric banding (LAGB) for various reasons. Previous studies have shown that conversion to Roux-en-Y gastric bypass (RYGB) can be effective and safe. This study will look at the outcome of patients who failed to lose weight post LAGB and underwent conversion RYGB.

**Methods:** All patients with a Body Mass Index (BMI)  $\geq$  45 who underwent a conversion LAGB to RYGB were included between the period of December 2008 and December 2011. Data on patients' demographic, operative detail, weight loss results, follow-up rate, and post-operative morbidity and mortality were collected.

**Results:** Forty-four patients were included. 80% of the patients had the procedure done as single-stage. The percentages of excess weight loss were 43% and 41% at 12 and 24 months, respectively. There was no mortality. Morbidity rate at <30-day period was 20.5% and 45.5% at 2 years.

**Conclusions:** Our study has shown improved and sustained weight loss result in patients who experienced inadequate weight loss post LAGB and subsequently underwent a conversion RYGB. The post-operative morbidity rates were higher compared to that of the primary bariatric surgery as expected. Long-term follow-up study is still required.

## How I do it. Band to fixed ring bypass

Michael Talbot, St George Hospital, Sydney

**Background:** Over a decade of revision bariatric surgery has led the author to accept that simple surgical solutions to weight regain after gastric band may lead to acceptably safe results, but disappointing long-term weight gain can still occur.

**Methods:** Due to the inability to predict who will fail and who will succeed with revision band-to-bypass procedures it has become routine to place a silastic ring of 7-7.5 cm size around the stomach when performing roux-en-y gastric bypass. A video presentation of the technique will be shown.

**Conclusions:** Addition of a fixed ring to a gastric bypass pouch adds little to the complexity of the surgery and does not appear to cause noticeable complications. To date, not patient with a banded revision bypass (nor banded primary bypass) has presented with significant weight regain after surgery.

## CT Fizzogram, physiology and assessing the failed sleeve

Michael Talbot, St George Hospital, Sydney

**Background:** Bariatric Surgery changes foregut anatomy in order to alter the physiology of eating. While weight-loss may lead to health improvements in some domains, this disruption of normal anatomy and physiology can lead to the development of gastrointestinal disease. When patients regain weight after sleeve gastrectomy it can be difficult to determine what role disordered anatomy and physiology have if promoting the eating behaviours that lead to weight regain.

**Methods:** Description of the anatomy and physiology of sleeve gastrectomy with a focus on newer modalities such as 3D CT and oesophageal physiology testing. Common endoscopic findings and interventions required when patients present with symptoms will be discussed.

**Results:** Barium radiology and diagnostic endoscopy has some utility in patients with weight regain after sleeve gastrectomy, but are likely insufficient in many. 3D CT and oesophageal physiology testing provide data that are often able to guide management.

**Discussion:** A number of patterns of deranged anatomy and physiology can be seen in patients with failing sleeve gastrectomy. Using knowledge gained through these tests can guide clinicians in the management of their patients.

## How I do it. Sleeve to RYGB and outcomes

George Hopkins, Obesity Surgery, Brisbane

**Purpose:** Sleeve gastrectomy (SG) has emerged as a reliable primary procedure for the management of morbid obesity in Australian and New Zealand. Complications and failure however are creating an ever increasing cohort of patients needing revisions. Our preference is conversion to Roux-en-Y Gastric Bypass (RYGBP).

**Methods:** Retrospective analysis of prospectively collected data from a single surgeon working in a large multidisciplinary bariatric centre. Indications for conversion, technical details, early morbidity, and weight loss data were assessed.

**Results:** Sixty patients were included. Median BMI pre-RYGBP was 38.2kg/m<sup>2</sup> (pre-SG 43.6kg/m<sup>2</sup>). The most common indication for surgery was inadequate weight loss following sleeve gastrectomy (51.7%). There was no mortality. Early morbidity was seen in 36.7% of patients; the most common complication was stricture of the gastro-jejunal anastomosis (7 patients). Median percentage Excess Weight Loss (%EWL) was 20%, 33%, 50%, 39% and 32% at 4-6 weeks, 3, 6, 12 and 24 months respectively after conversion to RYGBP.

**Conclusion:** RYGBP seems a rational choice for failed and complicated sleeve gastrectomy. The procedure is not without risk and a higher rate of preoperative complications needs to be anticipated.

## The role of the sleeve and bypass as revision operations. When I use them and video of technique

Raul Rosenthal, Cleveland Clinic Florida, Weston, Florida

**Background:** Laparoscopic adjustable gastric banding (LAGB) has a high incidence of long-term complications and failures. The best procedure to handle these failures and the optimal number of stages in such cases is still controversial. The aim of this retrospective study was to compare the results of conversions of LAGB to either laparoscopic sleeve gastrectomy (LSG) or laparoscopic Roux-en-Y gastric bypass (LRYGB) in failed LAGB using a single-stage approach.

**Methods:** All patients who underwent conversion from LAGB to either LRYGB or LSG between January 2005 and March 2012 were included in the study. Early and late complications were reviewed. The percentage excess weight loss (%EWL) between the two groups was compared at 3, 6, 12 and 24 months of follow-up.

**Results:** Fifty-nine patients, 11 men and 48 women, were included in the study. The most frequent indication was insufficient weight loss or weight regain (non-responders group), in 44 patients (75 per cent); 15 patients had a revision for complicated LAGB. The early complication rate in the non-responders group was 7 per cent (3 of 44 patients), compared



## ABSTRACTS / in order of sessions

with 13 per cent (2 of 15) in the complicated LAGB group. Mean(s.d.) %EWL in the non-responders group was 55(22) per cent in patients converted to LRYGB and 28(25) in those converted to LSG (P= 0.001).

**Conclusion:** LRYGB and LSG are both safe and feasible options for failed or complicated LAGB. In the non-responders group, %EWL was superior for conversion to LRYGB. The surgical morbidity rate was highest in patients having revision for band complications.

### Medtronic Prize Presentation 4

#### Hiatus hernia repair for GORD after sleeve

**Pram Gunanayagam**, Concord Repatriation General Hospital, Sydney

Introduction: Gastro-oesophageal reflux with hiatus hernia is a recognised consequence following laparoscopic sleeve gastrectomy (LSG). Definitive treatment for intractable post-operative reflux post sleeve often involves conversion to Roux-en-Y Gastric bypass (RYGB). This is a valid operation but carries inherent risks of short and long term sequelae including dumping, malabsorption and bowel obstruction. We have trialed more straightforward initial laparoscopic hiatus hernia repair, with associated oesophageal fixation and lengthening, following LSG, to treat reflux. We report early and intermediate outcomes (reflux, quality of life and satisfaction scores) using this approach.

**Methods:** Patients were identified from a single surgeon prospectively maintained database. The technique of revision hiatus hernia repair requires ensuring adequate abdominal oesophageal length, crural repair using anterior and posterior Ethibond sutures over a 32F Bougie and oesophageal fixation to the crura and fundopexy. Outcomes were measured using Visick, Health Related Quality of Life (HRQL) and satisfaction scores.

**Results:** 10 patients (8 females; 2 male) with median age 47.3 underwent revision laparoscopic hiatus repair at median 416 days following sleeve gastrectomy. There was no major procedural morbidity. Barium swallow confirmed hiatus hernia and/or reflux in all patients. The mean pre-revision Demeester score was 38.2. Post-operative HRQL improved (26 vs. 16.4) and Visick score improved (3.7 vs. 2.6). Six patients were satisfied. The remaining 4 patients had initial good satisfaction initially but developed recurrent symptoms later, and progressed to further revision surgery, at a median time from hiatus hernia repair of 531 days (364d - 1282d). Revision procedures were laparoscopic roux-en-Y gastric bypass (3) and laparoscopic Endostim insertion (1) with all patients reporting subsequent good satisfaction scores.

**Conclusion:** Laparoscopic hiatus hernia repair does not guarantee sustained resolution of reflux after sleeve gastrectomy but may provide a reasonable and less morbid initial alternative without jeopardising future surgical alternatives. Longer term results are awaited.



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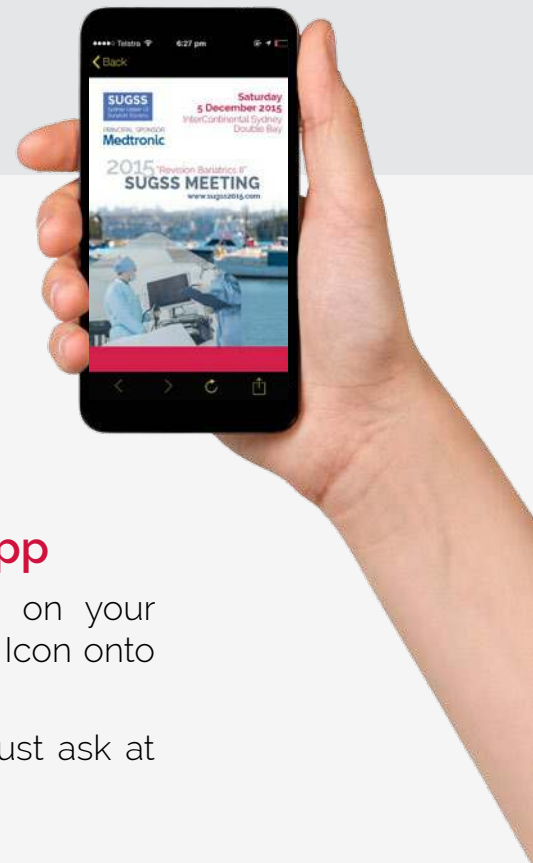


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