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INFORMATION SHEET

LAPAROSCOPIC SADI/S

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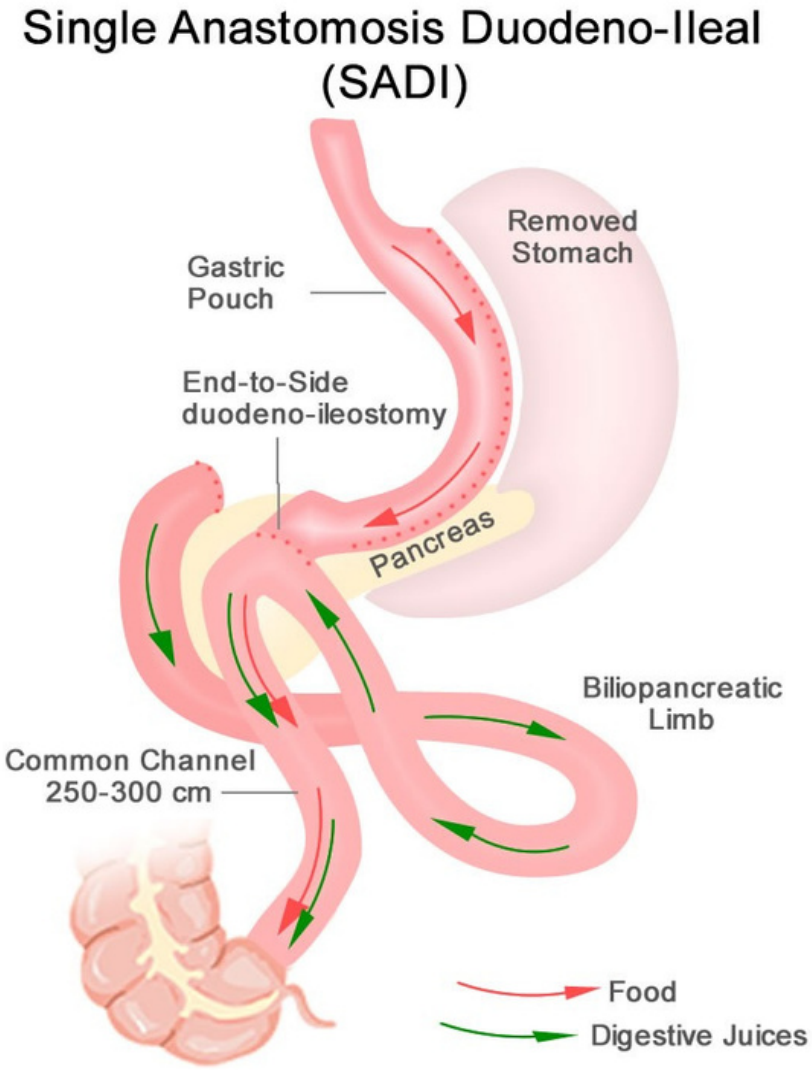
INFORMATION SHEET LAPAROSCOPIC SADI/S



You are considering undergoing a Laparoscopic Single Anastomosis Duodenoileal Bypass with or without Sleeve Gastroscopy for weight loss. The purpose of this information sheet is to provide you with the necessary information to make an appropriate and informed decision as to whether you wish to proceed with a Laparoscopic SADI.

The Laparoscopic SADI procedure involves make several small incisions through which laparoscopic instruments are inserted to perform the surgery. The procedure is designed to reduce the size of your stomach thus limiting the amount of the food that can be eaten at a meal. This new reduced stomach is then connected to the small intestine by a new anastomosis (join). These changes in your anatomy can result in a decrease in appetite and sometimes an aversion to certain types of foods.

This procedure is a combination of a restricted procedure (the Sleeve) and a malabsorptive procedure which limits your ability to absorb the food that you eat. This procedure is the strongest weight loss procedure performed in my practice. The malabsorptive aspect of this procedure requires you to take vitamins and supplements as directed by the Dietitian for the rest of your life. In addition, you need regular reviews and blood tests to check that you are absorbing sufficient minerals and vitamins. Failure to take the supplements or attend for regular reviews and blood tests, can result in mineral and vitamins deficiencies which can produce life changing complications and even increase your risk of dying. Thus, regular follow up is "ABSOLUTELY ESSENTIAL".

The procedure results in rapid weight loss which generally stabiles at about 18 months post surgery. In the initial post op period it can take some time for you to learn how your stomach behaves and you can have some issues with discomfort after eating and occasionally vomiting.

Following SADI you may experience an intolerance of certain types of food, usually fatty, greasy foods and/or diary products. You may also notice a change in your bowel habits with the tendency of more frequent looser motions. The body adapts to the change in your anatomy and these issues become less noticeable with time.

The SADI is the strongest bypass procedure that I perform. It is particularly beneficial for the super obese, that is, patients with a BMI greater than 50. It is particularly good for Diabetics and can be a suitable revisional procedure particularly for patients who have had a previous Sleeve Gastrectomy. Weight loss for the SADI averages between 65 – 75% of excess weight depending on the patient's starting BMI.

Please carefully weigh up the advantages and disadvantages of each bariatric procedure before you decide which one is your procedure of choice. Where appropriate I will make recommendation of which procedure you should consider as being the most appropriate for your medical condition.

EATING HABITS AND EXERCISE

Studies have shown that on average SADI patients lose their appetite for the first five months after surgery. It is important during this period you take the appropriate amount of calories, protein and vitamins in order to avoid feeling ill, weak and possible losing some hair. Your goal is to burn fat, not muscle, so taking in protein to maintain muscle bulk is very important. Your best chance of weight loss with the SADI is in the first nine months. To get the most out of your procedure take full advantage of the early period of lack of appetite to get into the right eating and exercising habits. Patients who fail to develop good dietary habits are more likely to regain weight in the longer term. If you go back to high calorie foods such as chips, cookies, and soft drinks and do not stay active, then even the best surgery will fail. Your bariatric procedure should be regarded as a tool to aid your weight loss. The importance of behavioural factors cannot be overemphasised. It is therefore very

important that you participate in our Patient Support Group as much as possible and seek dietary and psychological assistance whenever it is recommended or whenever you feel that you are struggling to achieve your goals. Studies have shown that patients who participate in patient support groups, and have their surgery carried out in the multidisciplinary environment, which we have in place at BIOS, achieve better results.

UNREALISTIC EXPECTATIONS

Weight loss with the Laparoscopic SADI can be very rapid. This ongoing weight loss can be psychologically addictive but ultimately it will slow down after six to nine months so it is best that you are prepared for this event. As has been stated previously, your best chance of weight loss is in the first few months, so this is the period when we recommend you begin your exercise regime. As you lose weight your exercise capacity will increase, making you feel better and fitter. The best average result from a laparoscopic SADI is 70% excess body weight over an 18-month period. Bear in mind, that the goal of surgery is to make you healthier, improve your life expectancy and decrease the problems suffered by obesity related diseases, it is not to get you down to your ideal weight. The more weight you have to start with, the more weight you will probably lose with surgery and our recommended dietary and exercise regime. Try not to get caught in the trap of comparing your weight loss with others.

If you are a woman you should avoid pregnancy in the first year postoperatively.

Periods of rapid weight loss are not the right time to be trying to get pregnant or trying to maintain and existing pregnancy. Also bear in mind that as you lose weight your fertility will increase and you are more likely to become pregnant. Female Laparoscopic SADI patients can and do get pregnant and with appropriate support from obstetricians, will have an uneventful pregnancy. Obviously it is important should you get pregnant, that you bring to your obstetricians attention as soon as possible the fact that you have had Laparoscopic SADI surgery.

To make your surgery technically as safe as possible we will start you on a VERY LOW CALORIE DIET for at least two weeks prior to surgery. This is designed to shrink your liver and reduce your risk of surgical complications. It also introduces you to the liquid dietary regime you will have in the postoperative period. If your liver is excessively large at the time of surgery, your procedure may be aborted and rescheduled for a later date.

Smoking is a serious problem for bariatric surgical patients. It increases your risk of pulmonary complication and blood clots regardless of the procedure you have performed. I strongly recommend that if you are a smoker, that you try and stop smoking prior to surgery. Even stopping smoking a week before surgery can be of benefit.

You will meet our anaesthetists at the time of your gastroscopy prior to your chosen bariatric procedure. This is done to make sure, as best as possible, that you are an

acceptable risk of anaesthesia. Anaesthetists may recommend further medical or cardiac investigations at that time. If this is the case your surgery will have to be postponed until these tests have been completed and evaluated by our anaesthetists. The pre- operative gastroscopy is designed, as stated previously, to introduce you to our anaesthetists but also to ensure that there are no other physical abnormalities, which would preclude you from having surgery. Bear in mind that after the operation, due to the change in anatomy, it will not be possible to access your bile ducts to remove gallstones using the endoscopic ERCP procedure. Surgery would be required to access bile ducts in the future.

General risks which apply to all abdominal surgery include but are not limited to the anaesthetic (greater in the morbidly obese), deep venous thrombosis (DVT), pulmonary embolism, death, infection, bleeding, pneumonia, heart attack, stroke, bowel obstruction, intra-abdominal abscess, damages to intra-abdominal organs, adhesions, wound infections and incisional hernias.

BLEEDING

It is unusual that you will need a blood transfusion as the risk of significant bleeding is less than 1%.

INFECTION

Any surgery carries a risk of infection. The most common types are wound infections, urinary infections and chest infections. More serious types are blood infections, abscess and peritonitis. Although fortunately rare, some of these infections can progress to death, even if the source of infection is corrected and appropriately treated.

CLOTS

Blood clots in the veins in the legs or pelvis (DVT) can migrate to the lung (pulmonary embolism – PE), which can be fatal. These can occur after any type of surgery, and the risk persists after surgery for up to three weeks. The risk of this type of complication after bariatric surgery is less than 1%. However, as it is such a serious complication and can result in sudden death, we take a number of steps to try and minimise the risks. You will be given injections to thin the blood, stockings to compress your legs and when you are asleep in the operating theatre, machines will be used to squeeze the blood from your legs. These machines continue to be used on the ward when you are in bed and we encourage you to get up and walk about the ward as soon as possible. The risk of DVT is about 1:200 and the risk of pulmonary embolism about 1:1000. If you are identified as being a high risk candidate, we may discharge you home on blood thinning injections for up to three weeks in an effort to minimise your risk.

CHEST PROBLEMS

Pulmonary complications such as pneumonia, aspiration and atelectasis (partial collapse of the base of the lungs) can occur after any type of surgery under general anaesthetic. The risk of this complication can be reduced by stopping smoking, early mobilisation after surgery and working with our physiotherapists with chest exercises and incentive spirometry.

INCISIONAL HERNIAS

Incisional hernias are common after open bariatric surgery but thankfully rare after laparoscopic bariatric surgery. The risk is approximately 1% and if they do occur they tend to be small and easily repaired at a later date.

SMALL BOWEL OBSTRUCTION

The small intestine can get blocked by twists around scar tissue (adhesion) inside the abdomen that can occur after surgery. The other less common cause of bowel obstruction is an internal hernia. These types of obstructions can occur at any time and can occur many years after surgery. The rate of bowel obstruction after a Laparoscopic SADI is less than 1%. If not treated appropriately and quickly, there is the risk of compromise to the bowels blood supply and if the bowel dies this can lead to perforation and serious complications or even death. Most obstructions after laparoscopic surgery can be successfully repaired laparoscopically.

WOUND INFECTION

These can occur with any type of surgery and even in clean surgery they occur in up to 5% of cases. They may require antibiotics, opening and drainage of the wound with packing. These wounds are then allowed to heal over a longer period of time with dressings as an outpatient. Patients who smoke are at increased risk of wound infection.

DAMAGE TO SPLEEN OR OTHER ORGANS

The spleen lies close to the upper portion of the stomach and can be injured during surgery. Fortunately it is very rare to injure the spleen during laparoscopic surgery and the rate is under 1%. If this was to happen you may require conversion to an open procedure and removal of the spleen. This will be avoided wherever possible. Pancreatitis is a rare but reported complication as is liver injury. These rarely require any surgical intervention.

BOWEL INJURY

Rarely the intestines or stomach can be injured at the time of surgery. If this occurs and is recognised, it will be repaired laparoscopically but the operation may be aborted at that point and rescheduled for a later date. If bowel injury was not recognised at the time then there is a risk of developing life-threatening peritonitis requiring further surgery and probable admission to Intensive Care.

DEATH

The mortality rate in gastric bypass is 1:1000. You should recognise that although we do everything possible to minimise the risk, it cannot be reduced to zero. By undertaking bariatric surgery you are exchanging your risk of decreased life expectancy from weight loss related illnesses, i.e. approximately four years for an Australia women, for a short term increase in your risk of death during and immediately after the operation. Although the procedure is carried out with keyhole surgery it is still major surgery and you and your family should realise that any complications of this procedure could result in death.

Risks, which apply particularly to laparoscopic SADI, include all of the above, but there are additional specific risks related to the procedure.

LEAK

The risk of a leak is about 1% and usually occurs in the first few days after surgery. This can lead to peritonitis, intra-abdominal abscess or even death. At the time of surgery a leak test is performed in the operating theatre to confirm that you do not have a leak before you are transferred to recovery. The key to successful management of a leak is early recognition and appropriate intervention. However, it is not always possible to demonstrate a leak with x-ray techniques and it may be necessary to take you back to theatre for further laparoscopic surgery because a leak is suspected but cannot be demonstrated. This is performed on the better safe than sorry basis. A leak at the anastomosis (where the stomach pouch is attached to the small bowel) is the most common cause for serious complications after laparoscopic SADI surgery. Treatment usually requires a return to the operating theatre, closure of the leak and insertion of drains. A feeding tube is also usually inserted directly into the bowel. These procedures are usually performed laparoscopically but it may be necessary for a more traditional open approach to be used. Typically in this situation, the patient requires admission to Intensive Care and may or may not require a period on a ventilator. Other complications can result from these leaks such as kidney failure requiring dialysis. It may be necessary to transfer you to a large teaching hospital for further care.

IT IS MY POLICY THAT IF I AM UNHAPPY WITH YOUR POST OPERATIVE RECOVERY, I WILL TAKE YOU BACK TO THEATRE FOR A LAPAROSCOPY. THIS MAY MEAN THAT YOU HAVE A 2nd PROCEDURE WHICH SHOWS NO ABNORMALITY. HOWEVER, STUDIES HAVE SHOWN THAT EARLY INTERVENTION FOR COMPLICATIONS PRODUCES THE BEST OUTCOMES.

FOR UNINSURED PATIENTS THIS WILL RESULT IN ADDITIONAL THEATRE AND ANAESTHETIC FEES.

INTRA-ABDOMINAL ABSCESS

Occasionally an abscess can develop without any evidence of leak. This may be due to some intra- abdominal fluid from the time of surgery becoming infected, and it usually presents 5 to 14 days postoperatively. This type of situation usually responds to antibiotic treatment but may require drainage of the abscess under x-ray control and occasionally further surgery, which is again usually performed laparoscopically.

STRICTURES

Any surgical join between pieces of gut can scar down causing a stricture. This usually occurs around 4–8 weeks post surgery. It can lead to difficulty eating with nausea and vomiting. It is usually treated with gastroscopy and balloon dilatation as a day case. In 80% of cases only one dilatation is necessary but a small number of patients may require two or more dilatations. Very rarely a further operative procedure is required to resolve this issue.

VITAMIN MINERAL DEFICIENCIES

As the laparoscopic SADI does involve a degree of alteration in the normal gut anatomy and some malabsorption, this can result in deficiency of a number of vitamins and minerals. It is therefore important that you take regular multivitamins and that you have your blood checked on a regular basis. It is possible for patients who are compliant with their diet and take supplements to develop vitamin deficiencies. The most common would be iron deficiency anaemia or deficiencies in calcium. More rarely vitamin B deficiency can occur along with vitamin A deficiency. We recommend that your GP perform regular blood tests to check for vitamin deficiency.

HAIR LOSS

It is not uncommon to have some thinning or loss of hair in the first few months after bariatric surgery. This is mainly temporary and is related to reduced protein intake.

HIATUS HERNIA

A hiatus hernia occurs when part of the stomach slips up through the diaphragm into the chest. It is very common in the obese patient and will probably have been noted at your gastroscopy. At the time of your SADI surgery your hiatus hernia may be repaired with simple sutures to the hiatus. Generally the symptoms associated with a hiatus hernia of heartburn and reflux responds best to weight loss rather than anti-reflux surgery.

GALLSTONES

There is an increased risk of developing gallstones after any weight loss surgery and obviously it is not possible to carry out an ERCP once you have had a SADI. This means that should you develop complications related to gallstones, you are more likely to require surgery. Whilst this surgery can usually be performed laparoscopically, there is a small risk that you would require an open procedure.

FAILURE TO LOSE WEIGHT

Although uncommon, it is possible to fail to lose weight after any bariatric procedure.

DIARRHOEA/CONSTIPATION

Some change in bowel habit is common after SADI. Diarrhoea, or loose motions can occur but generally improve with time.. Constipation is common after bariatric surgery, as patients tend not to drink enough liquid. As your liquid and fibre intake improves your tendency to constipation will settle. If necessary, a gentle laxative such as Movicol can be taken.

LARGE FOLDS OF SKIN

This is always a possibility with significant weight loss. There is no reliable way to determine before surgery how much or any this will occur in your case. Age, exercise, speed of weight loss, elasticity of skin all play a role. Plastic surgery procedures are available to correct excess skin problems and you can be referred to an appropriate plastic surgeon and the plastic surgeon also presents at our Patient Support Group.

Fertility

Weight loss surgery can increase fertility.It is recommended that pregnancy is avoided for 12-18 month post surgery.Gastric Bypass /SADI surgery can impair absorption of the oral contraceptive pill and therefore patients should consider implantable contraceptives or barrier method. This should be discussed with you GP or Gynaecologist.

CONVERSION

Whilst we will always attempt to complete your operation laparoscopically, as this is easier on you and certainly easier from a surgical point of view, it is occasionally necessary to convert to an open procedure. This is a rare procedure but obviously if it occurs will lead to prolonged time in hospital and a longer postoperative recovery.

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