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Laparoscopic Gastric Bypass Surgery

Introduction

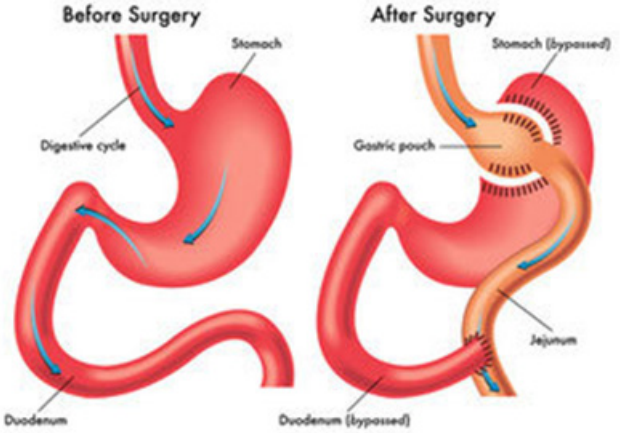
Overweight is also referred to as obesity the Gastric Bypass operation was developed in the 1960s and is still the most well-known and world-wide most widely performed surgery for the treatment of obesity in the Surgery, the stomach is cut at the very top and thus a small stomach pocket formed this magenta leads to a restriction of the food intake (called restriction) by the recording-me of the smallest food quantities, it comes to the stretching of the small stomach and Quickly to a feeling of satiety. In comparison to the Magenbanding, the food pulp is additionally diverted (bypass = redirection) To do this, the small intestine is separated after the duodenum and sewn as a bypass to the small stomach pocket further down the two small intestine legs are reunited; It thus leads to the diversion of the food pulp and thus to the temporary separation of food and digestive fluids bile resp. Abdominal saliva (digestive juices) are formed in the liver resp. In the Pancreas and arrive in the duodenum, where they with the Gastric acid and other substances from the Restmagen be mixed. From here the digestive juices get into the small intestine where they come into contact only at the lower small intestine seam with the food pulp in addition to the restriction a SOG Malabsorption (decreased or later onset digestion) which is compared to the Magenbanding to A greater weight loss leads to the dangers of the disease obese patients have an increased risk of developing various diseases, such as high blood pressure, diabetes, heart attack, heart congestion, joint ailments, gallstones and Venous problems their life expectancy is greatly reduced by the overweight and its consequences.

Prerequisites

The obese patient must have a body mass index (BMI) of 35 kg/m2 or above many sufferers also have sequelae of obesity such as blood glucose increase, blood fat Increase (Hyperlipidaema) and hypertension
(hypertension) In addition, the most well-known eating disorders are also evaluated: Big Eater, binge Eater (time-limited binge eating with loss of control), sweet eater (eating lots of sweets, rich in calories and fatty), Fat eater (Above average highfat food) especially the Binge Eater, sweet eater and fat eater speak well to the gastric bypass. The patient must have tried for 2 years through a conservative (non-surgical) therapy such as B nutritional counseling, behaviour-tenstherapie and physical activity to reduce his weight unfortunately, it is actually the case that conservatives Therapy trials in the long run usually fail.
The following clarifications must be carried out before the operation: often the PA-Tienen is primarily assigned to me as a Adipositaschirurgen you will be informed by me in detail about the whole procedure before, during and after the operation a further Examination is provided for specialized interns (SOG Adipositasabklärung) A ernährungsbera is very advisable even before the operation the consultation with a psychiatrist is indispensable especially for pre-existing mental problems before the Surgery, a gastric reflection and an ultrasound of the gallbladder are also performed. The Restmagen is no longer accessible after gastric bypass surgery for a stomach mirror, which is why it is very important to exclude any diseases in this area before preexisting stomach diseases (e.g. gastric ulcer, colonisation with A certain bacterium «Helicobacter pylori») can be treated before the operation the ultrasound is used for the exclusion of gallstones and for the determination of the liver size it is known that gallstones form in the case of heavy weight loss and these can also cause discomfort today I recommend the simultaneous Gallenblasenent-distance if the organ contains stones.

Surgical Technique

After the operation, however, only in the lower part of the intestine the food can be completely digested and absorbed into the blood surgical technique by 4-6 small cuts on the upper abdomen become so-called trocars and the camera optics for the laparoscopic operation Introduced by these trocars, long, fine instruments are pushed into the abdominal cavity the stomach is severed as well as the small intestine, a Dünndarmschlin-GE is connected to the reduced stomach and the small intestine is again Y-shaped further down. Sammengenäht.



Advantages of the method of laparoscopic gastric bypass is a recognized and very efficient weight reduction operation the patients can be distinguished by the combined principle of action (reduction of the MA-gene, restrictive component) and the Bypass method (Malabsorptive component) efficiently control your weight disadvantages of the method it is a technically difficult operation, as many seams must be made and the through-separation of the stomach must be laid very far above this is a region that has already Lean and particularly difficult to access in obese patients after the operation, there is the possibility of temporary deficiency conditions for iron, vitamin B, D and calcium. These elements need to be replaced of course about 20% of the patients undergoing surgery experience a so-called dumping this unpleasant reaction occurs when the patients take sugar in any form this then arrives very quickly in the Small intestine and binds there water the water is removed from the circulation and it comes to stalls with dizziness to collapse, including nausea, vomiting and trembling these symptoms disappear with time.
Initially, poorly digested food in the large intestine can lead to outages, similar to a drug ingestion of Xenical ®, as the non-fully digested fats can lead to equator-named fat chairs and through cases a bypass operation can No longer be undone in addition, the separated stomach part and the duodenum can no longer be viewed en-doskopisch with the mouth of the bile ducts.

Anesthesia

This operation is carried out in general anesthesia.

Complications

General Complications of operations such as infections (pneumonia), venous thrombosis and pulmonary embolism. Infringementtongues of organs and blood vessels are replaced by a standardized Surgical technique reduced to a minimum also today a quick and effective therapy of such problems is possible a rare but serious complication represents the injury of the gastric or esophagus wall this can cause abdominal skin inflammation and Abscess formation and must in most cases be remedied immediately by another procedure.
In the preparation on the stomach, due to the close anatomical relationship, it can rarely come to an injury of the spleen; Such a spleen injury usually leads to severe bleeding if such a spleen injury cannot be safely supplied, the spleen must be removed likewise, the newly created compounds

between the stomach and small intestine as well as the small intestine and small intestine can leak and the resultanht intestinal content can also lead to a severe abdominal skin inflammation The operation must be carried out openly, opening of the abdominal cavity by a large-need cut, there is a risk for a wound infection and for a hernia.

In the long-term course, after every intervention in the abdomen to adhesions/oneclamping and consequently to an intestinal occlusion, which at most may require a new intervention also, in the longterm course can be chronic Deficiency conditions or to a excessively weight loss, which can make a correction of the thigh lengths in a further intervention necessary.
The candidates for a surgical procedure for the treatment of their obesity have to be informed that the path will not be the same for everyone it can cause complications, it may also be necessary that a second surgery must be made, Be it to correct a complication or be it due to an insufficient weight loss due to the first selected surgical technique the mortality risk is approximately 1/900 to 1/1200 operations all patients are included, including patients with Weighing over 200 kg or already manifest heart disease.

Aftercare

With a gastric bypass require a lifelong and initially close after care in cooperation with the physician family doctor, the values of the defect must be determined so that one can be identified and corrected at an early stage.

Prognosis

The weight loss in this Method is expected to be between 60 – 90% of the overweight.

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