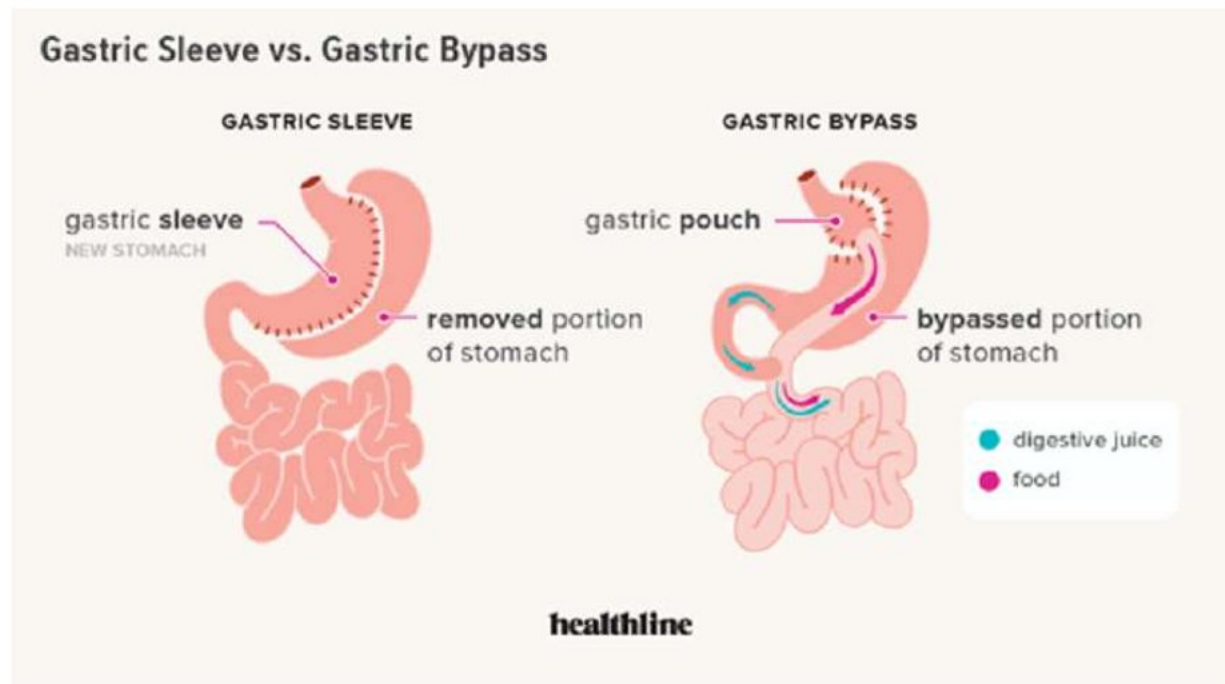


# ROBOTIC and LAPAROSCOPIC SLEEVE GASTRECTOMY at ANADOLU MEDICAL CENTER

Sleeve gastrectomy is a partial gastrectomy in which the majority of the greater curvature of the stomach is removed. In this operation we remove approximately 70 to 80 percent of the stomach, resulting in the creation of a narrow gastric tube.

The new (sleeve) stomach is small in its capacity (restriction) and has few remaining ghrelin-producing cells (appetite hormone).



Sleeve gastrectomy is technically easier to perform than the Gastric By-Pass. It is also safer as it reduces the risks of complications. It is the most commonly performed bariatric procedure in the world and in the United States.

## How is the procedure is performed?

Sleeve gastrectomy is performed under general anesthesia and can be done both laparoscopic and robotic. Both procedures are safe and reliable.

## Duration of Surgery/Procedure

Although it depends on the BMI of patients and can be different from one patient to another, laparoscopic sleeve gastrectomy takes about 45-60 minutes and robotic sleeve gastrectomy takes about 60-75 minutes.

## Anticipated Risks

### Bleeding:

Bleeding (0.3%-0.5%) can occur from the gastric or short gastric vessels during dissection of the greater curve. Most of the bleeding problems associated with Sleeve Gastrectomy (SG) occur from the staple line after transection of the stomach. The bleeding is most likely a result of the large staples used for the thick tissue in the distal stomach. Large staples are not adequate to seal small vessels. This has led many surgeons to reinforce the staple line by over-sewing, buttressing, or both.

### Gastric leaks:

Gastric leaks after SG are one of the most serious complications and can occur in up to 5.3 percent of patients. Reoperation with primary repair during the early postoperative course is the best option for a leak following SG.

Clinically stable patients may be able to undergo percutaneous drainage, antibiotic therapy, and parenteral nutrition until the leak is healed. Endoscopic therapy with the use of stents has been increasingly employed for management of leaks, but migration of the stents remains a problem. Early diagnosis, adequate drainage, and gastric decompression are the mainstay of treatment for leaks.

#### **Reflux:**

Gastroesophageal reflux after SG presents with classic symptoms such as burning pain, heartburn, and regurgitation. It can occur as an early and late complication. The first-line treatment is antireflux medical therapy. GERD unresponsive to antireflux medical therapy with no clear anatomic abnormalities, such as stoma stenosis or a hiatal hernia, can be effectively treated by conversion to RYGB.

#### **Stenosis:**

Narrowing or stenosis can create gastric outlet obstruction. The presentation varies depending on the severity of the obstruction and can include dysphagia, vomiting, dehydration, and the inability to tolerate an oral diet. Management of stenosis primarily consists of endoscopic dilation. If the area of stenosis is too long, surgical intervention may be necessary with conversion to an RYGB, gastric stricturoplasty, or resection with gastrogastrostomy.

#### **Success Rates**

My personal success rate is high.

I have not had any serious complication (leak, bleeding, stenosis etc.) yet.

**Recovery Process / Period:** About 7-10 days

**Days of Admission:** 2-3 days.

**Days of Stay in the Country:** About 7-10 days.

#### **Expected After Care**

We recommend dietitian and psychologist follow up to our patients for at least 2 years after surgery.

#### **Doctor experience with the Procedure**

My personal experiences for sleeve gastrectomy is more than 500 cases.

#### **Scientific References**

- 1) Lim RB, Blackburn GL, Jones DB. Benchmarking best practices in weight loss surgery. *Curr Probl Surg* 2010; 47:79.
- 2) Ferhatoglu MF, **Kartal A**, Filiz AI, Kebudi A. Comparison of New Era's Education Platforms, YouTube® and WebSurg®, in Sleeve Gastrectomy. **Obes Surg**. 2019 Jun 6. doi: 10.1007/s11695-019-04008-x
- 3) Benaiges D, Más-Lorenzo A, Goday A, Ramon JM, Chillarón JJ, Pedro-Botet J, Flores-Le Roux JA. Laparoscopic sleeve gastrectomy: More than a restrictive bariatric surgery procedure? *World J Gastroenterol*. 2015 Nov 7;21(41):11804-14.
- 4) azl Alizadeh R, Li S, Inaba CS, Dinicu AI, Hinojosa MW, Smith BR, Stamos MJ, Nguyen NT. Robotic versus laparoscopic sleeve gastrectomy: a MBSAQIP analysis. *Surg Endosc*. 2019 Mar;33(3):917-922

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