

COMPARISON TABLE FOR VARIOUS WEIGHT LOSS SURGERY PROCEDURES

Type of Operation	VBG	Lap Band
Modality of Weight Loss	Restrictive	Restrictive , ½ ounce stomach (15cc)
Description	A silastic ring is used to create a small pouch of stomach.	An adjustable silicone constricting band is place completely around the very top part of the stomach creating a very small pouch.
Long term success	Poor Only 26% of patients maintain >50% of excess weight ¹	No long term studies yet available. At best should be similar to VBG.
Complications Non Surgical	21% Vomit more that once a week. 14% have heartburn ¹ Binging and purging very common secondary to pain.	89% of patients have at least one side effect. Nausea and Vomiting 51% Heart Burn 34% Need for re-operation or removal as high as 25% ¹⁷
Opinion	Poor long term results with VBG. ²	Actually not a new idea and was abandoned years ago. Some top surgeons in the field feel its resurgence will give bariatric surgery a bad reputation. ¹⁸
Summary	A restrictive operation with poor long term track record and numerous complications.	Restrictive procedure with no long term studies. Preliminary results disappointing. ¹⁹
Long term dietary modification	Extremely poor diet- Patients are not able to consume any solids since it plugs the opening at the silastic ring.	The same as VBG
Nutritional Supplement Individual patients requirements may differ. May also differ among physicians.	Multi vitamin, Iron, Calcium For life	The same as VBG

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Type of Operation	RNY, Gastric Bypass, Roux-en-Y, LAP, RNY	Duodenal Switch, BPD-DS, Distal Gastric Bypass with DS
Modality of Weight Loss	Restrictive 1-3 ounce stomach	Restrictive and Malabsorptive
Description	A very small pouch of fundus connected to a limb of small bowel. Pyloric Valve bypassed.	Sleeve gastrectomy, with ~8ounce pouch. Pyloric valve functional. The bilio-pancreatic secretions are kept separated from food to limit absorption except the last ~75cm of small bowel.
Long term success	Average 60-70% Peak results 18-24 months ^{3,4,5,6} >30% regained >15% or lost <50% ⁷	Above Average 70-80% excess weight loss reported over long term follow up. ^{8,9,10,11,12}
Complications Non Surgical	68.8% “continued” problem with vomiting, 42.7% plugging of the gastric pouch outlet. ¹³ 12% stenosis & 12% ulceration, with over all stomach complication in 20%. ¹⁴ Up to 76% of Patients develop Dumping Syndrome, with no association between severity of Dumping Syndrome and weight loss. ¹⁵	Fat soluble vitamin deficiency- Rarely seen with adequate dietary supplements, in addition to a normal healthy diet. Protein malabsorption- again with healthy well balanced diet far less common than seen in VBG or RNY patients with stenosis or who only consume high sugar/calorie drinks.
Opinion	“Gold standard” with frequent complications and hospital visits for patients ⁸ .	Technically a difficult operation to perform. Division of the post pyloric duodenum is a difficult step and could be dangerous in an inexperienced hand.
Summary	A restrictive procedure rendering a patient to a very limited diet, with significant complications. Long term results acceptable.	The best surgical solution available for treatment of Morbid obesity. Allows a patient to lead a normal life with normal dietary intake of meals in smaller volume, without the side effect of dumping syndrome, continued vomiting, plugging, etc.
Long term dietary modification	Significant dietary restriction. The unhealthiest diet after any weight loss surgery. Meat intolerance in majority of Pt. ¹⁶ Patients resort to high calorie drinks because can not tolerate “regular” meals	Most balanced diets tolerated well with no adverse effects. Patients tolerate “normal” diet.
Nutritional Supplement <small>Individual patients requirements may differ. May also differ among physicians.</small>	Multivitamin, Iron, B12, Calcium for life	Multivitamin and Calcium for life.

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- ¹⁹ Doherty C, Maher JW, Heitshusen DS., "Long term data indicate a progressive loss in efficacy of adjustable silicone gastric banding for the surgical treatment of morbid obesity", *Surgery*, 2002, Oct.;132(4):724-8
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- ¹² Marceau P; Hould FS; Potvin M; Lebel S; Biron S, Biliopancreatic diversion (duodenal switch procedure), *European J Gastroenterology Hepatology* 1999 Feb;11(2):99-103.
- ¹³ Mitchell JE, Lancaster KL, Burgard MA, Howell M, Krahn DD, Crosby RD, Wonderlich SA, Gonsell BA, Long-term Follow up of patients' Status after Gastric Bypass, *Obesity Surgery*, August 2001,11(4) 464-468.
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