Overview of Laparoscopic Sleeve Gastrectomy (LSG).

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Sleeve gastrectomy (SG) has been a simpler bariatric operation, which shows good resolution of co-morbidities and provides excellent weight loss. Laparoscopic SG was initially performed for high-risk patients (in 2000) to enable increased safety for both operations. However, indications for SG as a primary procedure have been increasing. The Third International Consensus Summit for SG was held in New York City, Dec 2-4, 2010, to evaluate techniques and results.
Methods: A questionnaire was filled out at the Second ICSSG March 19-22, 2009 in Miami Beach and compared to the recent one in NYC in 2010.
Results: Findings are based on 106 questionnaires, representing a total of 14,776 SG. In 86.3%, SG was intended as the sole operation and 81.9% of the surgeons reported no conversions from a laparoscopic to an open SG. Mean ± SD %EWL: 1 yr 60.7 ± 15.6, 2 yrs 64.7 ± 12.9, 3 yrs 61.7 ± 11.4, 4 yrs 64.6 ± 10.5, >4 yrs 48.5 ± 8.7. Bougie size was median 34.0 Fr., (range 16-60). The dissection commenced 5.0 ± 1.4 cm (median 5.0, range 1-10) proximal to the pylorus. Staple-line was reinforced in 65.1%; of these, 50.9% over-sew, 42.1% buttress and 7% do both. Post-op, a high leak occurred in 1.5% and a lower leak in 0.5%, hemorrhage in 1.1%, splenic injury in 0.1%, and later stenosis in 0.9%. Post-op GE reflux (~3 months) was reported in 6.5% (range 0-83%). Mortality was 0.2 ± 0.9% (total 30 deaths in 14,776 patients). This year, 5 years results showed a mean of 50% EWL, a higher result than with gastric banding, but comparisons with gastric bypass are still pending. Conclusion: SG for morbid obesity should be recognized as a primary operation.