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Commentary

Retrospective cohort study of 925 OAGB procedures. The UK MGB/OAGB collaborative group: A commentary

Although the mini gastric bypass/one anastomosis gastric bypass (MGB-OAGB) was described first in the 1990s as an efficacious and safe bariatric procedure [1], there has been limited uptake of this procedure, both in the UK and worldwide. Part of the reluctance stems from a perception that MGB-OAGB is associated with the development of oesophago-gastric (OG) cancer (despite a lack of evidence supporting this theory). There is also a view that this procedure is significantly malabsorptive and hence associated with complications akin to those seen with bilio-pancreatic diversion. The retrospective review of 925 patients undergoing MGB-OAGB in by Hussain et al. [2] therefore provides a timely summary of the actual outcomes of the MGB-OAGB achieved in specialist UK centres. Although this paper focussed on the management of complications after primary MGB-OAGB, one of the striking features is the apparently low incidence of complications after primary MGB-OAGB. The most common complication was diarrhoea and these cases were associated with biliopancreatic limb (BPL) lengths greater than 200cm. This correlates with work by Mahawar et al. who noted that longer BPL bypasses are associated with more complications and do not necessarily result in increased weight loss [3]. The evolving paradigm is that bypass procedures achieve weight loss mainly through neuro-hormonal effects on appetite, not due to 'restriction and malabsorption', and that a longer BPL length leading to malabsorption is neither necessary for weight loss nor desirable [4].

Although the results of this paper would suggest that MGB-OAGB should be offered more widely, these findings need to be interpreted with some caution. For a start, although authors have mentioned impressive weight loss after MGB-OAGB they have not detailed the impact of surgery on obesity-related co-morbidities. In addition all surgeons in this paper are, by definition, enthusiasts of the MGB-OAGB procedure and it is unclear whether their impressively low complication rate can be replicated in other non-specialist centres. Moreover the true rate of revisional surgery may be higher than the quoted rate due to the relatively short follow-up and the fact some patients may have undergone revision at other centres. Finally, this paper does not tackle the question of the putative long-term risks of OG cancer which, although not yet proven, is often mentioned by critics of this technique.

Nonetheless, this paper provides supportive evidence that the complication rates following MGB-OAGB appear low, and that in experienced hands the complications can be managed in a relatively straightforward manner. What remains unclear, and has not been addressed by this study, are the technical aspects of the MGB-OAGB (e.g. length and configuration of the pouch, length of the afferent and efferent limb) and their impact on weight loss, comorbidity resolution, weight regain and late complications. Whilst these questions do need addressing in future studies this paper does at the very least support the contention that MGB-OAGB can be delivered in the UK as safe, feasible bariatric procedure with a low complication rates and should therefore now be in the armamentarium of specialist surgical units as a standard bariatric option.

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