



Commentary

Commentary on 'retrospective cohort study of 925 OAGB procedures. The UK MGB/OAGB collaborative group'



Mini-One Anastomosis Gastric Bypass (MGB-OAGB) is becoming an attractive bariatric surgery, gaining more popularity worldwide. Recent studies have shown this operation to be more effective compared with the standard Roux-en-Y gastric bypass (RYGB) due to its shorter operative time, fewer short- and long-term complications, shorter length of stay, better excess weight loss (EWL) and better sustained EWL at least during mid-term follow-up, and less postoperative pain and other comorbidities [1,2].

It is also appealing as revision procedures (lengthening or shortening the biliopancreatic limb (BPL)), in case of inadequate or excessive weight loss, are easy to perform [3]. Moreover, should there be a need for reversal of the procedure, the Magenstrasse–Mill operation is possible; however, it is not completely without bariatric effects.

Despite most reports suggesting MGB-OAGB as an efficient and safe operation with a short learning curve, higher risk of symptomatic biliopancreaticoduodenal reflux and marginal ulcers following this operation is well documented. Furthermore, higher incidence of diarrhea, steatorrhea, and nutritional adverse events (such as iron deficiency anemia) in this group suggests the malabsorptive effects of this bariatric procedure. The length of the BPL has been implicated as a strong factor linked with malnutrition. However, there is still no consensus about the best length. Many studies have kept the length of the limb between 200 cm and 350 cm, whereas others have stressed that in order to avoid the nutritional risk the length of the BPL should not exceed 150 cm [4].

In this regard, a large case series study has considered a long BPL of more than 2 m as the main underlying cause of intractable diarrhea, confirming that reducing its length to 150 cm can help optimize the nutritional status [5].

This is while others have pointed out that a short BPL (less than 200

cm) is associated with a higher incidence of biliary reflux, because the more the afferent limb is shortened the more the bile would be concentrated. This is of great concern, as it is suspected to increase the controversial risk of gastric and esophageal cancers. However, a number of traits are added to this surgical technique to minimize these risks.

References

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