There is generally believed to be a close correlation between weight-loss success and patient well-being with aggressive follow-up, especially during the first year after surgery when patient monitoring is most critical. At these visits, weight loss is monitored, and patients are evaluated for overall health, vitamin levels, medication titration, activity levels, dietary habits, bowel function and hydration status.

After the first postoperative year, patients are seen less frequently, generally once or twice a year.

However, at these visits, patients should be assessed for nutritional deficiencies, appropriateness of their diet, weight maintenance, the presence of symptoms and overall health. Any potential deviation from what is expected from the bariatric team raises a red flag and often signals a problem that would be addressed by the multidisciplinary team following the patient. Commonly these are simple reversible and manageable issues such as dietary non-compliance or lack of physical activity that could be appropriately addressed, bringing the individual back on track, so to speak.

Despite bariatric surgery being “the only treatment that has been proven to be effective over the long term for most patients with clinically severe obesity” (NIH consensus conference statement, 1991), weight loss failure occurs in approximately 20 to 25 percent of patients. Few failures can be traced to technical errors. In most cases as stated above, dietary non-compliance or behavioral changes are to blame. In these cases, patients chronically overeat and/or abuse calorie-dense foods, candies or sweets. Patients may present with chronic vomiting, an increasing appetite, an increasing meal capacity and gradual weight gain. Most will also have abandoned exercise.

The treatment for someone who fails a bariatric procedure is controversial. Revision is an option, but carries a higher morbidity than the original procedure. Many surgeons would opt to revise the prior procedure and to convert to a more radical operation. However, there are no publications to support that shrinking a dilated pouch or revising a dilated anastomosis will lead to renewed weight loss. Limb lengthening is also poorly studied. Although dramatically decreasing the common
channel, thus enhancing the malabsorbptive component of the operation, will likely succeed in achieving weight loss, it may do so at increased nutritional risk.

Restapling after gastrogastric fistula would also be likely to succeed in renewed weight loss. However, because most failures are due to dietary non-compliance and/or behavioral changes, no procedure guarantees success. The decision to revise or perform other kinds of so-called “rescue procedures” should be carefully analyzed and individualized for each patient.

References
