Dear Colleague,

It is our special honor to invite you to participate in the 4th International Alpine Obesity Surgery Expert Meeting to be held in Saalfelden, Austria, March 12th to 16th, 2006. We will provide an excellent overview of major topics related to progress in the laparoscopic treatment of morbid obesity. Leading experts will build the framework of this conference.

By learning from our experience, we will place major emphasis on sufficient discussion time during scientific sessions. The meeting will take place in the luxury Congress Hotel Brandlhof, which is located in a magnificent area with wellness and many sport facilities.

We are very much looking forward to welcoming you in Saalfelden, Austria.

Karl Miller, MD, Symposium Director

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Welcome Reception – Sun. March 12, 6:00 pm
Scientific Program – Mon.-Wed. March 13, 14, 15
(Farewell Party – March 15, 7:30 pm)
Workshop program & Social Program

Main Topics
- Controversies – Case Reports
- Physiology of Weight Loss
- Bariatric Surgery in Children and Adolescents
- Technical Details – an Update
- Reoperative bariatric surgery
- Two-Step Procedures
- Patient Safety – Center of Excellence
- Insurance and Patient Coverage
- Complications and Challenging problems
- Failed Bariatric Surgery: What to do

Venue
The Congress Hotel, Village Brandlhof, is situated in Salzburg County in the middle of Austria, 40 minutes by car from the Airport Salzburg, Wolfgang Mozart Amadeus.

Information and Registration
Gabriele Wesely
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www.obesity-online.com/Expertmeeting

Administration
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Local Scientific Committee
- Austrian Society for Obesity Surgery, under the auspices of IFSO
- Ludwig Boltzmann Institute for Gastrointesinal and Experimental Surgery, Salzburg, Austria
- Gastroenterologie and experimentelle Chirurgie, Salzburg
- Salzburg Obesity Academy Foundation

Official Language: English

Hotel Reservations
All reservations will be processed and confirmed via internet:
www.obesity-online.com/Expertmeeting
Rates and specific requests for hotel categories received after December 31, 2005 cannot be guaranteed.
Background: Two stage BPD/DS in patients at high risk for obesity surgery was introduced by Gagner. Considering BIB to be the least invasive method to obtain temporary weight loss, we have adopted the strategy of implanting this device as first line treatment in view of a three stage procedure: BIB (6 months) followed by Laparoscopic Sleeve Gastrectomy (LSG) and finally DS. This is a report of the clinical outcome obtained by this approach.

Methods: 12 patients (3M, 9F) mean age 36.4 (22-49 yrs) mean BMI 63.9 (47.4-79.5) mean weight 162.8 kg (130-191), mean BWL 73.3 (34.9-112.8) entered this study. 12 co-morbidities were diagnosed preoperatively: hypertension (33%), hypercholesterolemia (25%), diabetes (16.6%), sleep apnea (8.3%), osteoarthritis (8.3%) and gastro-esophageal reflux (8.3%). BIB was implanted under conscious sedation and endoscopic assistance. 1 month after BIB removal, weight was 142 kg (120-176), EWL% 21.1, and 9/12 co-morbidities were resolved. LBPD/DS was performed at mean BMI 46.9 (35.4-57.8), mean weight 124.2 kg (115-137), EWL% 39.7 (21.4-50.8) and 11/12 co-morbidities were resolved. At time of LSG (1 month after BIB removal), mean BMI was 54.6 (43.7-62.2), mean weight 142 kg (120-176), EWL% 21.1, and 9/12 co-morbidities were resolved. LBPD/DS was performed at mean BMI 46.9 (35.4-57.8), mean weight 124.2 kg (115-137), EWL% 40.2 with 2 remaining co-morbidities. Both LSG and LBPD/DS were performed without laparotomic conversion and postoperative complications.

Results: 1 out of 12 patients experienced balloon intolerance resolved by endoscopic removal 40 days post BIB. At time of LSG (1 month after BIB removal), BMI was 54.6 (43.7-62.2), mean weight 142 kg (120-176), EWL% 21.1, and 9/12 co-morbidities were resolved. LBPD/DS was performed at mean BMI 46.9 (35.4-57.8), mean weight 124.2 kg (115-137), EWL% 40.2 with 2 remaining co-morbidities. Both LSG and LBPD/DS were performed without laparotomic conversion and postoperative complications.

Conclusion: BIB sharply reduces the weight and the co-morbidities of candidates to the two stage LBPD/DS.
Bariatric surgeons in India are in evolution, and to-day surgery is performed by only a few surgeons. The procedure of choice at most laparoscopic centres is LAGB. In some selected cases, the choice of surgery is Roux-en-Y gastric bypass.

MAJOR HIATAL HERNIA AFTER LAP-BANDING: SURGICAL TREATMENT (VIDEO)
Jerome Dargent. Polyclinique de Rillieux, Rillieux-la-pape, France.
Background: Hiatal hernia and/or gastroesophageal reflux are often deemed an important issue before bariatric surgery, particularly in case of laparoscopic gastric banding. It may be an important issue postoperatively as well.

Methods: A 62-year-old woman patient with an initial BMI of 41 has been operated on with a Lap-band in September 2001. Preoperative upper GI endoscopy showed no sign of hiatal hernia or reflux. Postoperative course went uneventful, and the weight loss was satisfactory, with minor disturbance and a good quality of life.

An urgent reoperation was performed in September 2004 for acute anterior slippage. The band was removed. Then chest radiograph, upper GI barium swallow, and CT-Scan showed the presence of a very large intra-thoracic hiatal hernia. Although there was no actual symptom, we performed the cure of this hernia through laparoscopy in February 2005

Results: Postoperative course was uneventful. Current excess weight is 45%. A video will be presented.

Conclusions: This case suggests that even without a prior hiatal hernia, Lap-banding may eventually cause a disruption of the esophageal crus. Preoperative assessment of the GE junction could be pointless, but its status is definitely a long-term issue in bariatric surgery.

A PROGRESSIVE UNDERSTANDING OF OBESITY AS REFLECTED IN CARTOONS IN MAGAZINES
Mervyn Deitel. OBESITY SURGERY Journal, Toronto, Canada.

Massively obese individuals have been the subject of cartoons in magazines, which reflect perceptions of obesity by the public. The cartoons have often indicated prejudice without sympathy. A review was undertaken of the attitudes to severe obesity as reflected in cartoons in 4 popular magazines (PB, NY, P, MM) from library archives, comparing 1980-1983 with 1997-2000. The magazine study found 14 cartoons in 1980-1983 and 36 cartoons in 1997-2000 related to obesity. These indicate a progressive awareness of the ramifications of obesity by society, its causes, and the serious sequelae of severe obesity. The cartoons also reflect a progressive understanding of the impact on the obese individual and the psychological difficulties endured by the obese. The later cartoons show an awareness of the serious comorbidities of obesity and the medical and surgical treatments.

FACTORS IN THE PROGRESSIVE WORLDWIDE OBESITY EPIDEMIC
Mervyn Deitel. OBESITY SURGERY Journal, Toronto, Canada

Obesity (BMI >30) has been accelerating throughout the developed and developing world in the past 25 years. This was originally attributed to genetic causes, but the rapidity indicates that the major cause is lifestyle change. The world has become mechanized, where individuals are sedentary and spend hours at the computer. Even minor activities have become unnecessary. We use the remote control to lift the garage door. We travel by automobile, and no longer walk distances. We take the elevator for more than one floor. At the same time, the food industry has mechanized, where individuals are sedentary and spend hours at the computer. Even minor activities have become unnecessary. We use the remote control to lift the garage door. We travel by automobile, and no longer walk distances. We take the elevator for more than one floor. At the same time, the food industry has

Bariatric surgery, but also symptomatic patients for GERD in whom a high incidence of gastroesophageal reflux disease (GERD) has been observed. Follow-up studies after gastrectomy for benign disease suggest that procedures associated with duodenogastric reflux lead to increased risk of gastric stump carcinoma after 15-25 years. Roux-en-Y gastrojejunoanastomosis is associated with less pouch gastritis and should be accompanied by a lower risk of carcinoma, but long follow-up studies are lacking. While biliopancreatic reflux appears common in the distal stomach after bypass, more data are needed on long-term histologic changes. Reports of cancer of the esophagus and the stomach after bariatric surgery represent only about 20 cases. This may, however, reflect insufficient follow-up, under-reporting, or the effect of surgical pre-screening.

Conclusions: The risk factors gathered by the bariatric patients underline the need to detect potential precancerous conditions before surgery. Candidates for postoperative endoscopic surveillance could include patients with a >15 year history of gastric surgery, but also symptomatic patients for GERD in whom a high incidence of Barrett's metaplasia has been reported.

WHY APPLY A BAND IN THE GASTRIC BYPASS OPERATION FOR OBESITY
MAL Fobi. St. Mary Medical Center, Long Beach, CA, USA.

Background: The short-limb gastric bypass operation is the gold standard in bariatric surgery because it has been used for >35 years by many surgeons with well known outcome. This operation has a significant failure rate due to inadequate weight loss in a significant subset of patients and weight regain in another significant subset of patients. Placing a band that controls the