

4th International Alpine Obesity Surgery Expert Meeting, Sunday March 12 - Wednesday March 15, 2006, Saalfelden, Austria

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

Krankenhaus Hallein,
Buergermeisterstr. 34,
A-5400 Hallein, Austria
Tel: +43-6245-799-360

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

e-mail: office@obesity-online.com

www.obesity-online.com/Expertmeeting

Administration

Internet Consulting Medical GmbH
Gabriele Wesely, Tel: +43-664-4027645
E-mail: g.wesely@sbg.at
Buergermeisterstrasse 34
A-5400 Hallein, Austria

Local Scientific Committee

- Austrian Society for Obesity Surgery, under the auspices of IFSO
- Ludwig Boltzmann Institute for Gastrointestinal and Experimental Surgery, Salzburg, Austria
- Gastroenterologie und 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.



SCIENTIFIC COMMITTEE

S Kriwanek, Austria
F Aigner, Austria

FACULTY 2006

A Alvarez (Argentina)
L Angrisani (Italy)
M Anselmino (Italy)
A Baltasar (Spain)
R Baker (USA)
D Birk (Germany)
GB Cadiere (Belgium)
JM Chevallier (France)
P Chowbey (India)
F Daout (France)
J Dargent (France)
M Deitel (Canada)
S DeRoover (Belgium)
S Dexter (England)

JL Dulucq (France)
G Fielding (Australia)
M Fried (Czech Republic)
MAL Fobi (USA)
M Foletto (Italy)
M Gagner (USA)
JM Gileardin (Belgium)
JW Greve (The Netherlands)
E Hell (Austria)
U Hesse (Germany)
K Higa (USA)
J Himpens (Belgium)
E Hoeller (Austria)
D Krawczykowski (France)
T Lafullarde (Belgium)
L Lanstberg (Israel)
W Lechner (Austria)
L Lemmens (Belgium)
K Maksymowicz (Austria)

H Nehoda (Austria)
D Nocca (France)
T Olbers (Sweden)
N Ott (Austria)
P Pattyn (Belgium)
W Pories (USA)
G Prager (Austria)
T Rogula (USA)
N Scopinaro (Italy)
C Stroh (Germany)
M Suter (Switzerland)
H Tigges (Germany)
Ph Topart (France)
GCM Van Hout (The Netherlands)
B Van Ramhorst (The Netherlands)
R Weiner (Germany)
H Weiss (Austria)
AM Wolf (Germany)

Weather: Generally mild temperatures for winter activities. Check weather on internet.

CONGRESS HOTELS: Hotel / night / person €100

1. **Brandlhof** (Congress Hotel)
2. **Sporthotel Maria Alm** (15 minutes from the Congress Hotel)
3. **Schoerhof** (5 minutes from the Congress Hotel)

ONLINE REGISTRATION: www.obesity-online.com/Expertmeeting

Registration Fee €220. No Registration fee for accompanying persons.

ABSTRACTS IN ALPHABETICAL ORDER OF 1ST Author

BIOENTERIC INTRAGASTRIC BALLOON (BIB®) REDUCES THE OPERATIVE RISK OF LAPAROSCOPIC SLEEVE GASTRECTOMY (LSG) FOR CANDIDATES TO BILIOPANCREATIC DIVERSION WITH DUODENAL SWITCH (LBPD/DS) IN TWO STAGES

Luigi Angrisani, Vincenzo Borrelli, Monica Giuffrè, Michele Lorenzo, Francesco Persico, Carlo Paolo De Angelis, Melania Battaglini, Monica Ciannella, Giuseppe Capece, Carmine Fonderico. *Unit of Endoscopic Surgery, "S. Giovanni Bosco" Hospital, "Federico II" University of Naples, Naples, Italy.*

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 EW%186.8 (115.4-261.4) 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 LSG was performed on a 40 French oro-gastric bougie and bovine pericardial strips (Peri-Strips Dry®) was used for staple-line reinforcement. LBPD/DS was planned 1 month after weight loss plateau.

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), 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.

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 PROGRESSING 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 developed low-cost, high-caloric, low-protein, fast foods. Larger sized portions have made these attractive. Children are playing computer games instead of being active. Obesity, with secondary

diseases of diabetes, high blood pressure and high serum lipids, is appearing in adolescents. The current youth may become the first generation of humans who will not live as long as their parents. Obesity exists throughout North America, Europe, the Middle East, and now the Asia-Pacific region where industrialization and a sedentary lifestyle have developed.

The World Health Organization (WHO) in January 2004 approved the international guidelines to overcome "globesity"; the passage was delayed for a number of months by the USA which felt that food intake and exercise are a personal responsibility. However, many measures are under way in the USA, mainly on a state-by-state basis, to thwart increasing obesity. The WHO is disseminating recommendations, and the measures of the European Union will be enforced shortly. To thwart the epidemic requires available regular physical activity, labeling nutritional content, education, control of junk food advertising, and governmental action and incentives. This is very important for children, now that both parents tend to be at work during the day. The recent passage of the "Cheeseburger Bill" in the USA will not be helpful. There is widespread fear that the obesity epidemic cannot be reversed.

CANCER RISK AND BARIATRIC SURGERY

Arnaud De Roover, Claude Desaive, Olivier Detry, Carla Coimbra, André Scheen, Pierre Honoré, Michel Meurisse. *Department of Abdominal Surgery, CHU, ULG, Liège, Belgium.*

Background: While potential surgical and metabolic complications have been well defined after bariatric surgery, the risk of cancer in this population remains ill-defined.

Methods: We report 2 cases of gastric cancer, a B-cell lymphoma of the distal stomach after gastric bypass and a GIST after vertical banded gastroplasty, which illustrate the delay in diagnosis that results from the procedure and from the negligence of upper gastrointestinal symptoms often present in this population.

Results: High BMI *per se* is a risk factor for adenocarcinoma of the esophagus. The risk for this cancer in the bariatric surgery population is further emphasized by the high incidence of gastroesophageal reflux disease (GERD), in particular after restrictive procedures. 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 gastrojejunostomy 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