In the first century AD, during the reign of Nero, Christianity struggled in its infancy; many movies have been made regarding this, including a 1951 release entitled “Quo Vadis?” Peter (before his Sainthood) had a vision in which he asked God, “Quo vadis?”, or “whither thou goest?”

Like in the early days of Christianity, the surgical treatment of morbid obesity, whose time has come, is at a crossroads, at which point I think we need to ask ourselves “Quo vadis?”, or where are we now, how did we get here, and where do we go from here? The manner in which we answer these questions may very well determine the future of bariatric surgery and its availability to those in desperate need of our services.

The Operations
The jejuno-ileal bypass was first introduced in the early 1950s, but because of rather severe side-effects, it was virtually abandoned many years ago. In the mid 1960s, the loop gastric bypass followed, but this procedure also was fraught with hazards, because of the possibility of bile reflux esophagitis, potential malignant degeneration over the years, leaks due to tension on the gastrojejunal anastomosis, and afferent limb closed loop obstruction of the bypassed stomach, so that it was abandoned in favor of the Roux-en-Y gastric bypass (RYGBP), pioneered by Drs. Mason and Ito in 1967. This procedure has proven to this day to be the measuring stick for the surgical treatment of morbid obesity. Many surgeons believed that this was merely a totally restrictive procedure. Thus, following Dr. Mason’s lead, we began experimenting with various types of gastroplasties and gastric banding procedures, and his vertical banded gastroplasty is still being performed frequently. However, because of superior weight loss with RYGBP, the majority of the ASBS membership today is doing some form of gastric bypass, or more extensive and malabsorptive versions thereof. In general, the more malabsorptive the procedure, the greater the weight loss and the higher the risk. Therefore, RYGBP would seem to be a reasonable compromise.

Bariatric surgeons appear to be in a race to discover the operation which will produce the most weight loss with the least amount of patient effort, seemingly de-emphasizing the potentially higher risk. We should continue to ask ourselves, “is the benefit worth the risk?”, particularly when we consider our relatively non-compliant patient population.

Should the patient with poor weight loss following a restrictive procedure be offered a revision? I’d say yes, as I have had reasonable success in converting restrictive procedures to the RYGBP, with results similar to my primary RYGBP experience. From 1979 to 1986, I did various gastroplasties – horizontal, diagonal, and vertical. Many returned after regaining significant weight, and earlier on I would re-do the gastroplasty. In 1986, I began converting these people to RYGBP. I found that the morbidity rate as well as the maintained weight loss at 1 and 2 years was considerably better. This was further confirmed in a study that I presented 2 years ago in Memphis.

Does the same hold true with failed RYGBP? Fox, Fobi, and Sugerman found a 15-25% long-term complication rate with severe protein malabsorption when RYGBP was converted to more distal procedures. Therefore, is the extra 9-14 kg weight loss worth the risk of doing these proce-
dures? Probably so, if all our patients returned for follow-up and followed our recommendations. However, some patients will not be compliant no matter what we do.

Perhaps my experience is different from most, but about 40% of the patients who call and make appointments to see me, spending about 30 minutes of my office staff’s time, fail to keep their introductory clinic appointment. Not only that, but when I looked at my 10-year postoperative data several years ago, 49% of patients were lost to follow-up. Following mail-outs and phone calls day-and-night, including Sunday nights, we were still only able to reach 51% of our patients. Thus, if we recommend that patients with distal RYGBP, biliopancreatic diversion, and duodenal switch take an extra 60-90 grams of supplemental protein daily forever, there are occasional problems because some of these people do not listen, do not understand, or simply disappear in our extremely mobile society.

At 1-year follow-up, which in my experience is 83%, there is an increase in alkaline phosphatase and iron deficiency anemia in many patients, indicating that many are not taking their calcium supplements and multivitamins with iron, although I continue to insist that they do. This experience has made me re-think the concept of the much more malabsorptive procedures in my practice. I have now done eight conversions from proximal to distal gastric bypass, and my enthusiasm is similar to that of Fox, Fobi, and Sugerman; I have had to convert three of the eight back to standard RYGBP, because of protein malabsorption and severe pretibial edema approaching anasarca. I suggest that if we are going to do malabsorptive procedures beyond RYGBP, we each need our own set of selection criteria and a bariatric surgery center which will follow our patients indefinitely.

Extensive malabsorptive procedures are performed on the assumption that patients will continue to fail less malabsorptive procedures, primarily due to non-compliance. I recently saw one of my patients who had my standard RYGBP 2 years ago, at which time she was 182.5 cm (6’1”) in height and weighed 227 kg (500 lbs) with a BMI of 74. As you can see today, she weighs a svelte 90 kg (200 lbs), with a BMI of 27 (Figure 1). Granted, this is rare, but she uses a treadmill twice a day and swims three times a week. She indeed is unusual, but with intensive counseling and pre- and postoperative encouragement to buy into their treatment, why should most of our patients not do just as well, and why should we coddle those who do not?

Open or Laparoscopic?
In spite of the fact that the laparoscopic approach has been supported and encouraged by many experts in the field, they all agree that there is a significant “learning curve”, and better results will occur with time and experience. However, as more primary laparoscopic surgeons enter the bariatric surgery field and intend to be part-time bariatric surgeons, is it truly germane to say that the laparoscopic approach will ultimately be the only way to go?

I have answered that question for myself after comparing my data, that of standard open RYGBP, with the laparoscopic results of Schauer, DeMaria and Sugerman, Higa, and Wittgrove and Clark. Comparing laparoscopic to open, I concluded that the laparoscopic RYGBP (LRYGBP) costs approximately $5,000 per case more than standard open RYGBP, relative to longer OR time at $1,250 per hour and equipment cost (lap is four