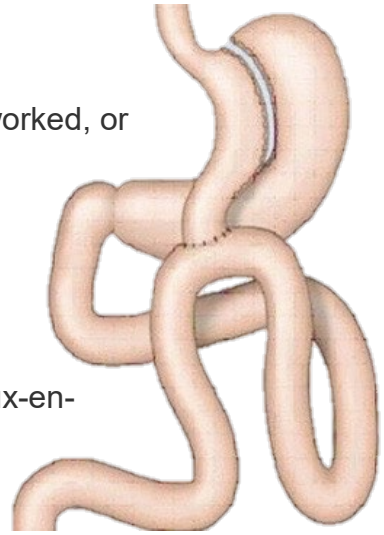
Royal Berkshire
NHS Foundation Trust

One anastamosis (mini) gastric bypass surgery

This leaflet explains what a 'one anastamosis (mini) gastric bypass' also known as OAGB surgery involves, including risks and benefits. If you have any questions, please feel free to discuss them with your Bariatric Team.

What is OAGB?

One anastomosis gastric bypass surgery (OAGB) is a weight loss procedure which is considered when diet and exercise have not worked, or when you have serious health problems because of your weight.



How does it work?

It works by decreasing the amount of food you can eat at one sitting and by altering the gut hormones that affect appetite and satiety (feeling full). It combines some of the properties of the Roux-en-Y gastric bypass (RYGB) and the sleeve gastrectomy (Sleeve).

The operation

The surgeon staples the upper part of the stomach to create a long narrow pouch, similar to the top three quarters of a sleeve gastrectomy. This pouch is then joined to a loop of small intestine so that a section of the small bowel is bypassed. When eating, food passes into this small pouch and then directly into the small intestine, bypassing most of the stomach and a section of the small bowel which alters the production of specialized gut hormones that control appetite and hunger. This leads to a decrease in appetite and a change in taste and food preferences away from fatty, sugary foods and also often reduces cravings and thoughts about food.

The operation is performed under a general anaesthetic meaning you will be asleep during the procedure. One anastomosis gastric bypass is done using keyhole (laparoscopic) or robotic surgery and usually takes about 2 hours. You will usually be able to go home 1-2 days after your operation but it can take up to 4-6 weeks to make a full recovery.

Advantages

- Weight loss starts from the time of surgery.
- It is unusual for a patient not to lose a significant amount of weight – you can expect to lose roughly 60 – 75% of your excess weight over two years.
- The average excess weight loss over the first three years is similar to that of a RYGB and generally much higher than a gastric band.
- It can help with remission if type 2 diabetes meaning that many patients can come off or reduce their medication straight after the operation.

Disadvantages

- The operative risks are higher than procedures not involving stapling of the stomach and/or bowel such as the gastric band.
- The OAGB may make symptoms of acid reflux worse and therefore, may not be suitable for patients with underlying bad acid reflux.
- The surgery, hospital stay and recovery time are similar to that of a Sleeve and RYGB but are longer than for a gastric band.
- It will be necessary to take long-term regular iron, calcium, multivitamin and B12 supplements after the surgery and there is a slightly higher risk of malnutrition than with the Sleeve or RYGB.
- If you eat sugary foods it can make you feel faint and sweaty. This is called ‘dumping syndrome’.

Side effects and risks

As with any major surgery, gastric bypass is associated with potential health risks, both in the short term and long term. For most people, the benefits in terms of losing excess weight are much greater than any disadvantages. In order to make an informed decision and give your consent, you need to be aware of the possible side-effects and the risk of complications.

Side effects

Side-effects are the unwanted but mostly temporary effects of a successful treatment, for example, feeling sick as a result of the general anaesthetic.

- Afterwards, you are likely to have some bruising, pain and swelling of the skin around the healing wound(s) for a few days.
- You may feel or be sick after eating, especially if you try to eat too much.
- A condition known as dumping syndrome can occur from eating too much sugar. While it isn’t considered a serious health risk, the results can be very unpleasant. Symptoms can include vomiting, nausea, weakness, sweating, faintness, and, on occasion, diarrhoea. This acts as a deterrent from eating the wrong types of food.
- After the operation you will need to take tablets daily containing iron, calcium and certain vitamins, as well as, have 3-monthly vitamin B12 injections.

Risks of the operation

Complications are when problems occur during or after the operation. Most people aren’t affected. Being very overweight increases the risk of complications following any operation.

Possible risks include:

- Chest or other infection. You will be given antibiotics during the operation to reduce the chance of getting an infection.
- Injury to bowel, blood vessels or adjacent organs (oesophagus, liver, spleen).
- Anastomotic or staple line leak or stricture (see below).

- Blood clots in the legs (deep vein thrombosis – DVT) with the risk of a clot passing into the lung (pulmonary embolism – PE). Blood thinning injections are used to help prevent DVT, and you will have these daily for at least two weeks after your operation.
- Reaction to the anaesthetic or medication.
- Complications with your heart, breathing or blood circulation.
- In fewer than 1 in 500 patients, the surgery may need to be converted from the keyhole approach to the traditional open surgical approach. This means making a bigger cut on your abdomen. This is only done if it's impossible to complete the operation safely using the keyhole technique.

The table below summarises the risks specific to having a OAGB procedure:

Risk	**What does this mean?**	**How is it treated**
Death	The risk of death from a OAGB is 1 in 1000. The most common cause of death is a blood clot in the lung (pulmonary embolism) or problems arising from a leak in one of the joins made during the surgery.	
Gastrointestinal tract leak	Leak from where the stomach and the small intestine are connected or stapled. The risk of this is about 1 in 100.	In case of small leaks, a drain may be placed by x-ray. However, with larger leaks patients require emergency surgery (laparoscopic or open) to wash out the area of the leak and place drains.
Bowel obstruction	Bowel blockages can be caused by scar tissue in the abdomen or kinking of the bowel. This can happen early after surgery but also late (months to years) after surgery This occurs in between 2 to 4 out of every 100 patients.	An emergency operation may be necessary.
Stricture	Excessive scar tissue formation can occur where the stomach pouch is connected to the bowel. This occurs in around 2 out of every 100 patients.	A stricture may be treated by endoscopy and balloon dilatation. This procedure involves inserting a tube (endoscope) through the mouth into the stomach, passing a balloon down the tube to the area of stricture, and inflating the balloon to dilate (stretch) the scar tissue.

Risk	What does this mean?	How is it treated
Ulcer	An ulcer may develop in the area where the new stomach pouch is connected to the small bowel. An ulcer occurs in 2 out of every 100 patients.	Ulcers are typically diagnosed by an upper endoscopy examination. They are treated by long-term use of an anti-ulcer medication.
Gallstones	Up to a third of all patients will develop gallstones during rapid weight loss.	Patients with symptomatic gallstones may require an operation to have the gall bladder removed (cholecystectomy).
Chronic abdominal pain	About 1 in 200 patients develop chronic abdominal pain or nausea after surgery.	Very rarely, patients may require reversal of the surgery.
Bleeding at operation or damage to other organs in the abdomen	Bleeding occurs in around 2 out of every 100 patients.	In rare cases, either endoscopic or further surgery may be needed to stop the bleeding.
Failure to lose weight	Ten out of every 100 patients do not lose the desired amount of weight or regain some weight. This may typically occur 2-3 years after surgery.	Most of weight regain is due to failure to follow the prescribed diet or lack of exercise. Patients who ‘graze’ on food all day or constantly eat to the point of stretching their stomach pouch may re-gain weight. Also, patients who do not exercise regularly may not achieve their goal weight.

Contacting us

To contact the Bariatric Team via Centre for Diabetes and Endocrinology, telephone: 0118 322 8109 /8811. Or email the Bariatric Specialist Nurse at katharine.hallworth-cook@royalberkshire.nhs.uk

To find out more about our Trust visit www.royalberkshire.nhs.uk

Please ask if you need this information in another language or format.

RBFT Centre for Diabetes and Endocrinology (Bariatric Surgery)
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