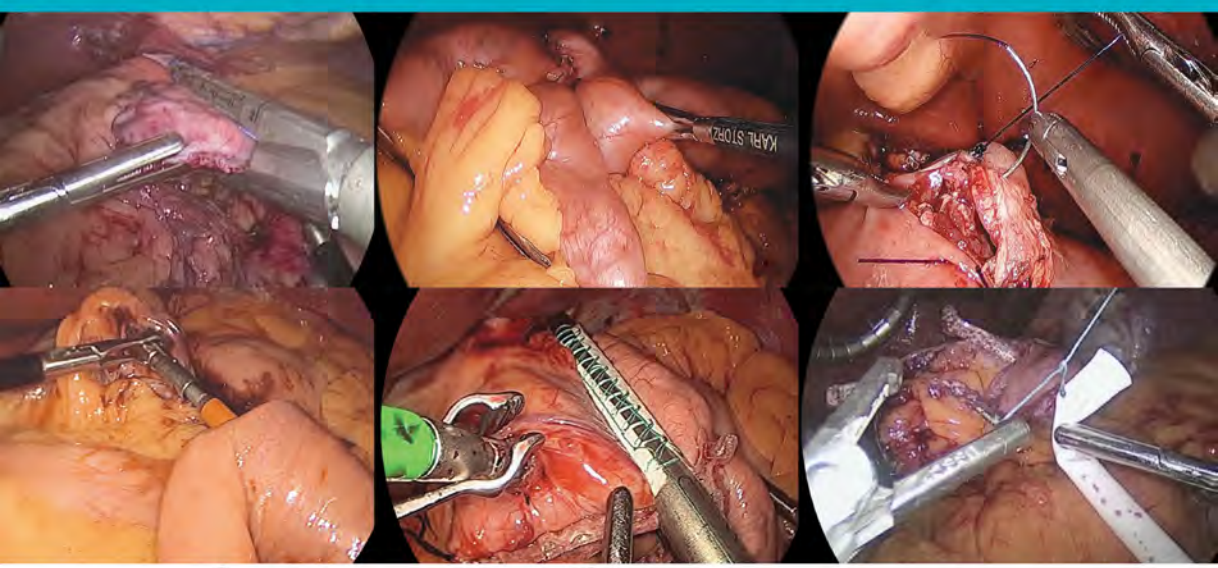
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# Video Atlas of Laparoscopic Surgery

## *Volume* 1

## Bariatric Surgery

Rana C Pullatt MD MS MRCS FACS



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*Foreword*
**Robin P Blackstone**
**MD FACS**

Includes Interactive
DVD-ROM
Containing 9 Videos
Including SIPS by Mitch Roslin
Duration 58 minutes

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# 3 Laparoscopic Antecolic Antegastric Bypass

*Rana C Pullatt*

## OPERATIVE PROCEDURE

The patient is positioned supine with both arms out. An incision is made one open hand span width from the xiphoid process and two fingerbreadths to the left off the midline. This incision is deepened and the fascia is grasped with an Adair clamp. Pneumoperitoneum is introduced through a Veress needle to a pressure of 15 mm Hg. A 12 mm trocar is introduced through this. Diagnostic laparoscopy is performed. Alternatively in extremely obese patients a visual entry is done using a 12 mm trocar in the left subcostal region at Palmer's point using a visiport. A 5 mm trocar is placed just below the right costal margin in the anterior axillary line to introduce the liver retractor; alternatively the liver retractor can be placed just below the xiphoid process. A 5 mm trocar is placed on the right side just below the right costal margin at the mid clavicular line. A 12 mm trocar is placed one hand width below that, slightly to the right side of the 5 mm trocar. Two other trocars are placed in the left side. One 12 mm trocar is placed in the left subcostal margin in the mid clavicular line. Another 5 mm trocar is placed one hand width below the 12 mm trocar. The angle of His is visualized and dissected. The left gastric artery is visualized. A small gastric pouch is created by transecting the stomach at the level of the second gastric vessel about 5 cm from the GE junction. The mesentery of the stomach is taken with the stapler. A green load is used for thick male stomachs and a blue load is usually used for female stomachs. The first fire of the stapler is done with staple line reinforcement. A small L shaped pouch is thus created based on the lesser curvature. Once complete division of the stomach is accomplished, the posterior side of the gastric pouch is cleared off the fat and mesentery for an appropriate area for anastomosis. The greater omentum is split if needed (Fig. 1). It is our observation that in most cases the splitting of the greater omentum is redundant and can be omitted, thereby not having the added expense of a harmonic scalpel. The ligament of Treitz is identified and the bowel is followed for 50 cm. A loop of

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bowel 50 cm distal to the ligament of Treitz is then brought up without tension to approximate the gastric pouch. A gastrotomy is then performed on the posterior side of the gastric pouch and a jejunotomy is performed. Once this is done a gastrojejunal anastomosis is performed using a single fire of the linear stapler at 35 mm (Fig. 2). Once this is done a 34 French Gastric Lavage tube is advanced through the gastric pouch into the jejunum stenting the anastomosis.The common enterotomy is then closed in two layers over this tube with a 2-0 Vicryl. Once this is accomplished the bowel is divided as it enters the gastrojejunal anastomosis creating a biliary limb and an alimentary limb. About 100 cm distal on the alimentary limb the biliary limb is plugged back in to create a Roux-en-Y configuration. This is done in a side-to-side fashion after jejunotomies are performed utilizing a single fire of the linear stapler with a white load. The common enterotomy is closed with another fire of the stapler with a blue load; alternatively the common enterotomy can be closed with a 2-0 Vicryl. The mesenteric defect is closed using a 2-0 silk suture (Fig. 3). Petersen's space is closed using a 2-0 silk suture (Fig. 4). The gastrojejunal anastomosis is checked with an endoscope for hemostasis and an air leak test. This completes the procedure. Patient positioning and trocar position is illustrated in Figures 5 and 6.

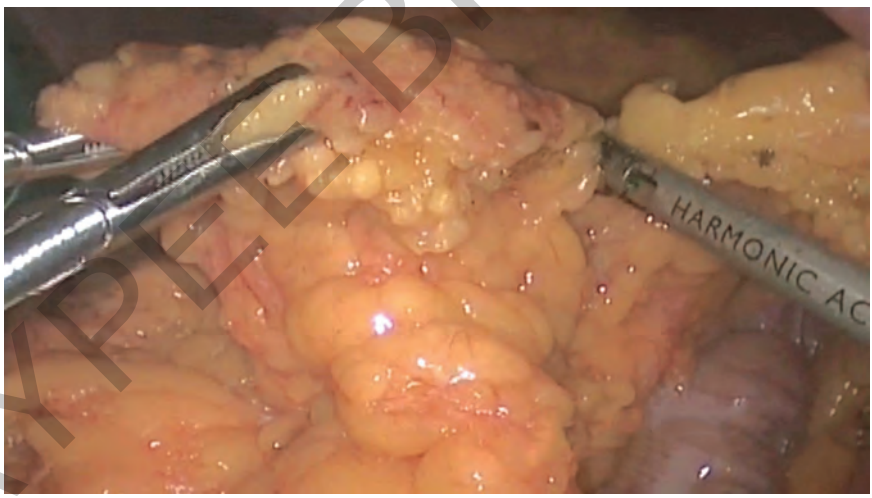



**Fig. 1:** Splitting greater omentum to allow passage of Roux limb.

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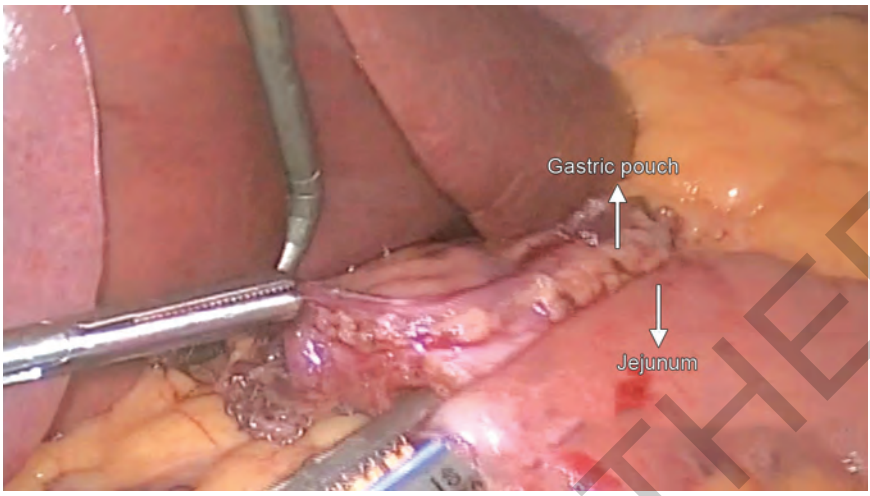



**Fig. 2:** Creation of gastrojejunal anastomosis using linear stapler.



**Fig. 3:** Closure of jejunojejunal mesenteric defect.

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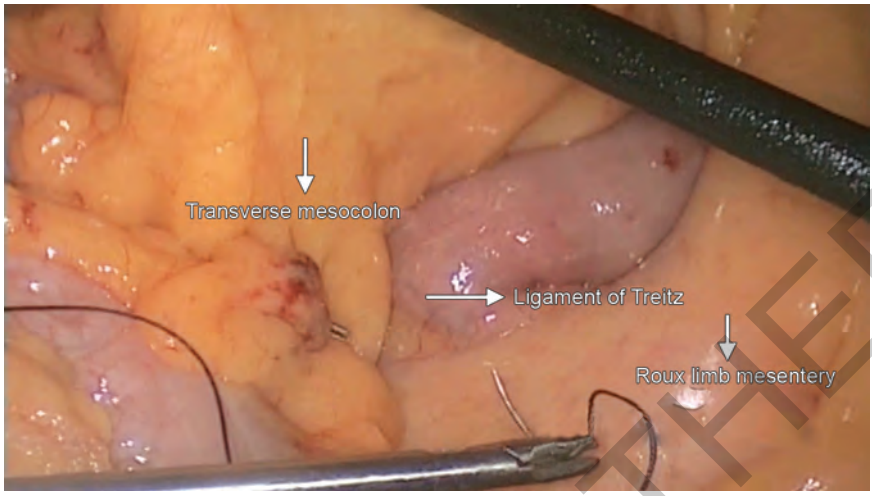



**Fig. 4:** Closure of Petersen's space.

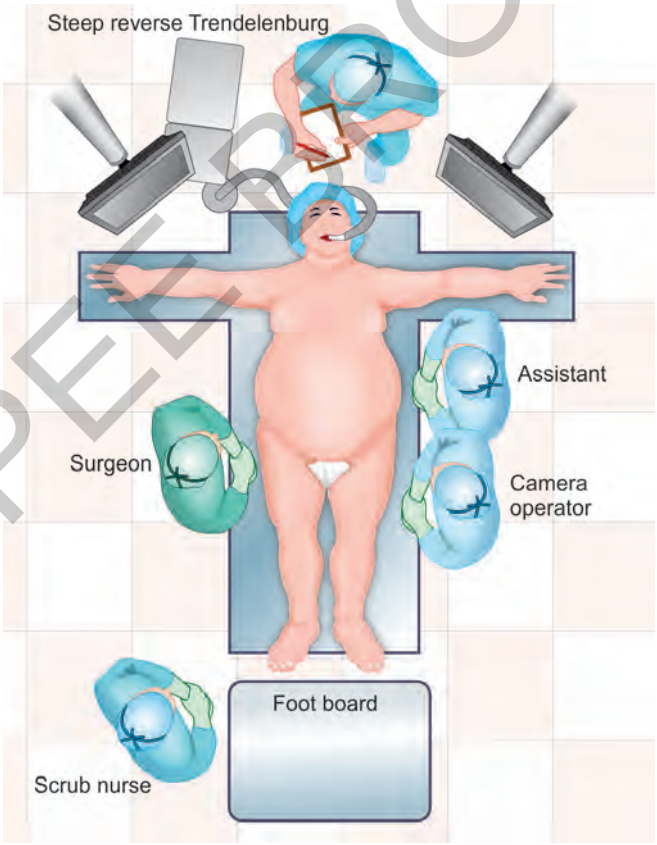



**Fig. 5:** Surgical positioning of patient.

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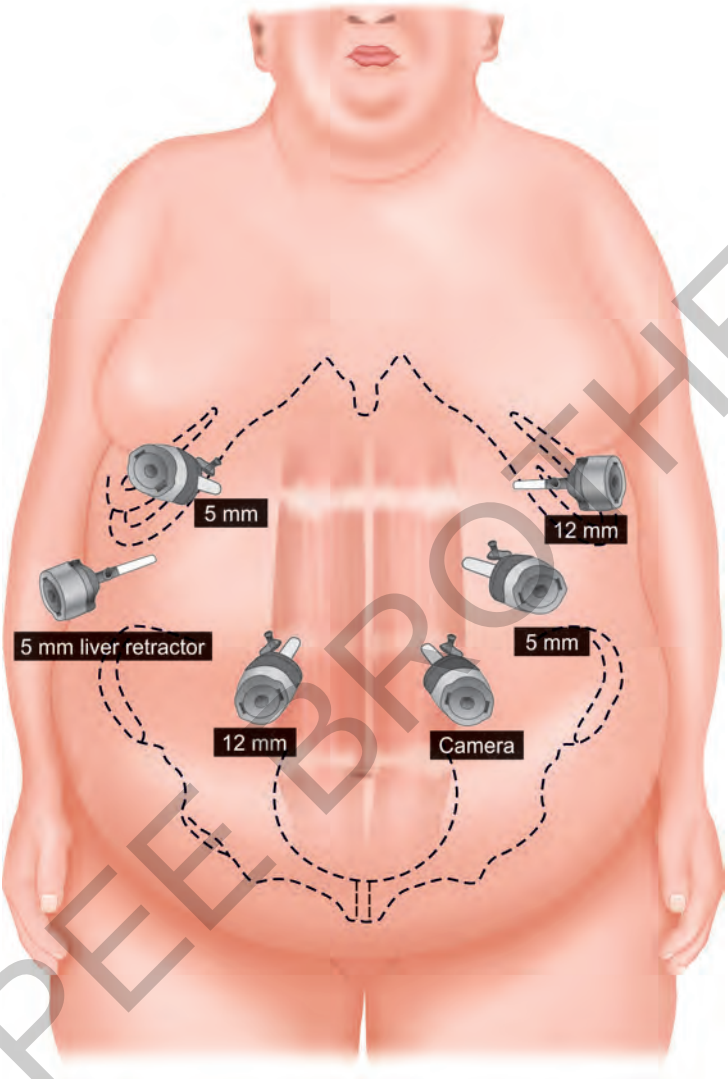



**Fig. 6:** Trocar position.

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# Video Atlas of
# Laparoscopic Surgery
# Bariatric Surgery

This *Video Atlas of Laparoscopic Surgery—Bariatric Surgery* focusing on bariatrics is aimed at students, residents, fellows and practicing surgeons with interest in metabolic and bariatric surgery. All mainstream bariatric operations are described in great detail. The operative videos are expertly edited and provide extensive guidance for the novice bariatric surgeon and helpful tips that can improve outcomes for an experienced surgeon. This atlas is the culmination of technical improvements made over several thousand bariatric procedures performed by experienced bariatric surgeons. Internists and physicians with interest in obesity and bariatric medicine will find the atlas helpful in understanding the anatomy of these procedures. Port positions and patient positioning is explained in the brochure enabling surgeons to perform these complex procedures with good outcomes. Our hope is that over the years, this atlas will prove to be the gold standard for teaching and improving techniques in bariatric and metabolic surgery.



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