BroadcastMed | Dr. Pullatt - long version

I'm Rana Pullatt.

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The duodenal switch operation is a weight loss procedure.

Among the many improved procedures for weight loss, this duodenal switch procedure is the most effective procedure for diabetic patients and for the super obese patients.

After the sleeve gastrectomy is performed, the liver retractor is placed and the ileocecal junction is identified.

Any adhesions of the omentum are taken down.

Once ileocecal junction is identified, the bowel is rotated in an anti-clockwise fashion.

At 125 centimeters, clips are placed to mark it.

We then move up another 150 centimeters and then tack the bowel to the omentum, taking care to visualize and orient the bowel properly with marking sutures.

Once this is done, the antrum is lifted straight up and the duodenum is dissected, both inferiorly and superiorly.

And once the duodenal resection is complete just lateral to the hepatoduodenal ligament, we then pass a Penrose drain to encircle the duodenum.

A good cuff of duodenum is obtained.

We then bring the bowel loop up.

And in a lot of cases, we don't have to divide the omentum or do any other technique, and we are able to get the bowel to reach the duodenum.

And care must be taken to start the anastomosis.

A running 2-0 Vicryl suture is used.

We excise the falciform ligament in some patients to improve the exposure to this area.

As can be seen, the posterior layer is placed very close to the mesenteric side, in order to give enough space for the anterior layer.

We then perform a single layer closure using an absorbable 2-0 Vicryl suture to complete the anastomosis.

This then completes the omega loop configuration of the duodenal switch, which will then be converted to a Roux-en-Y technique.

The loop duodenal ileostomy is visualized here.

Once the loop is complete, we then count backwards and come down to the clips that we placed at 125 centimeters from the ileocecal junction.

We then place some stay sutures.

In some patients, it is required.

In most patients, we don't need stay sutures.

Once this is done, we then use these and perform the ileoileostomy in a H-shaped fashion, using bidirectional firing of the stapler, as can be seen.

The bowel is rotated and the common entrotomy is closed in a transverse fashion.

We believe this gives very good aperture to the anastomosis as well as a very limited risk of narrowing.

The omega configuration is then converted to a Roux-en-Y configuration by dividing the bowel, [INAUDIBLE]

duodenal anastomosis.

An endoscopy is performed, as can be seen.

The anastomosis is examined and found to be hemostatic.

Inside to dissection of the duodenum can also be performed.

This is especially useful when reversing a gastric bypass when we can't afford to take the vasculature all the way down.

As can be seen, the duodenum is left in place and dissection between the duodenum and the pancreas is performed.

And the duodenum is divided.

Mesenteric closure is seen.

Using a nonabsorbable suture, the ileo-ileal mesentery is splayed, and it can be closed.

Petersen's space is best closed where during the performance of the loop duodenal ileostomy the transverse colon is lifted up and the defect is visualized by reflecting the loop duodenal ileostomy to the right of the patient, and the Petersen space is thereby closed.

We do not routinely do a gallbladder at the time of the surgery because we feel it adds to the length of this procedure in these super obese patients.

And we take them out as needed on a later time.

As can be seen, the longer duodenal cuff is seen, and the duodenal Ileal anastomosis is well visualized.

Sometimes, due to the extreme obesity of the patient, there are a couple of options that can be done to make the mesentery reach.

And one of them is the Retrocolic technique.

As can be seen, the [INAUDIBLE] is constructed and then the mesocolon is opened.

And even in the extremely obese patients, the loop is easily brought-- the limb is easily brought up to rest close to the duodenum.

Staple anastomosis is visualized in this.

And the common enterotomy is closed using a running absorbable suture. We have abandoned the Retrocolic technique and gone to the ligation of the right gastric artery in patients in whom the mesentery does not reach.

As can be seen, the antrum is lifted up and the duodenal cuff is then dissected til it appears to be adherent into the pancreas.

And once the cuff is dissected, the GDA is dissected and found.

As can be seen, the gastric duodenal artery is seen.

Once this is done, the duodenal cuff is encircled with the Penrose.

And with this in place, the stomach and the antrum are lifted up, and the right gastric artery is identified and ligated.

This gives a tremendous amount of mobility to the duodenal cuff off the sleeve.

And almost always we are able to anastemose, even in the super morbidly obese patients.

As can be seen, the anastomosis is [INAUDIBLE]..

This operation has the most amount of weight that a patient can lose.

It's a required form of treatment for these patients who then are able to get a level playing field as far as their metabolic disease is concerned, and it would be less frustrating for them.