



SICOB FALL MEETING
LIVESURGERY
28 - 29 OTTOBRE 2024
MILANO, FONDAZIONE CARIPLO

Presidenti del Congresso P. Gentileschi, M. A. Zappa
Segreteria Scientifica E. Galfrascoli, M. P. Giusti

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TECNICHE E RISULTATI DELLA SASI

PROF. PAOLO BERNANTE

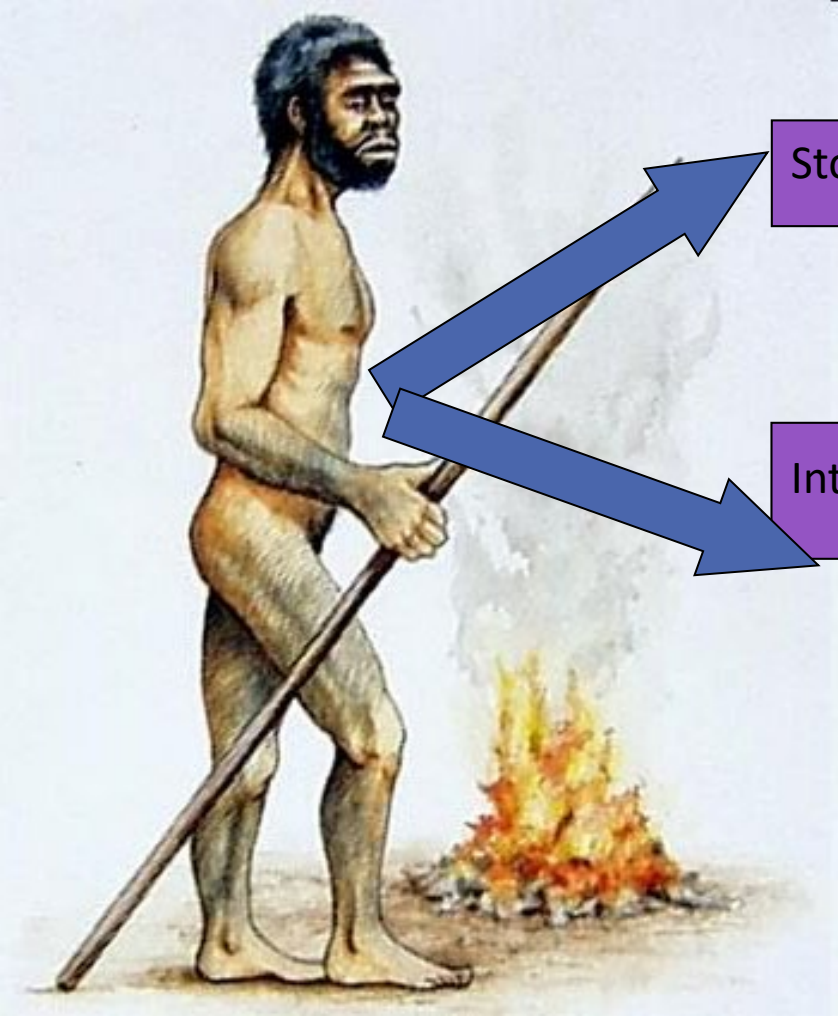
DIMEC

ALMA MATER STUDIORUM UNIVERSITA' DI BOLOGNA

CENTRO DI CHIRURGIA METABOLICA E DELL'OBESITÀ

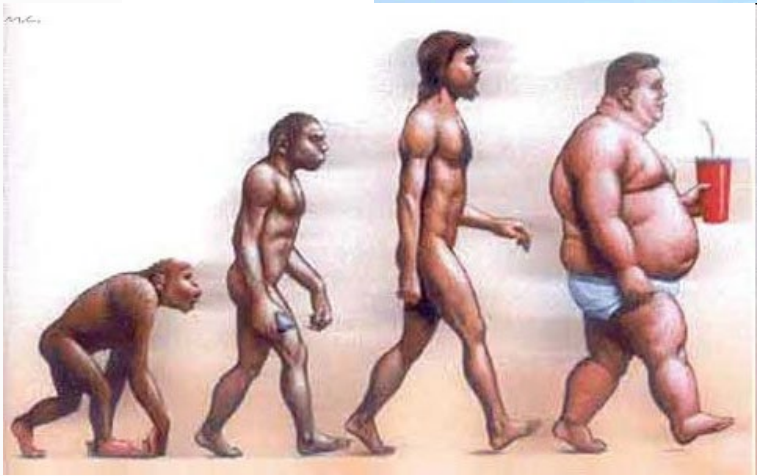
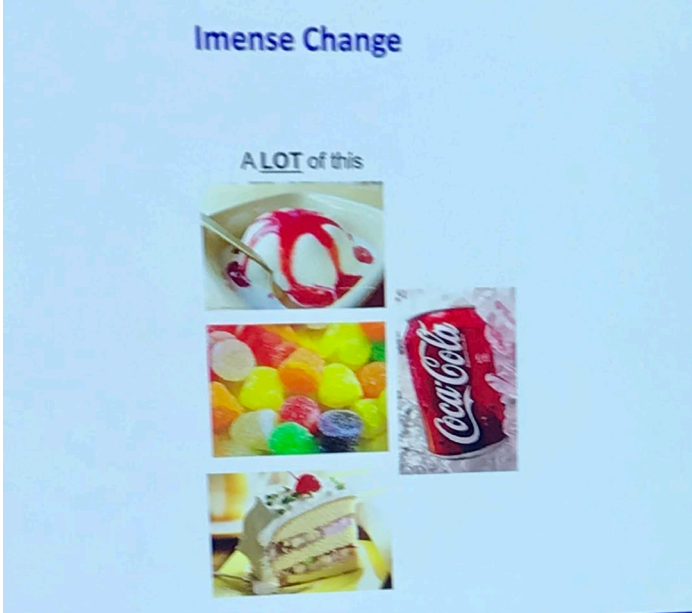
IRCCS POLICLINICO DI SANT'ORSOLA

“OTTIMO PER LA CARESTIA INDIFESO DALL’ABBONDANZA”



Stomaco troppo grande?

Intestino troppo lungo?



- Sérgio Santoro
- Manoel Carlos Prieto Velhote
- Carlos Eduardo Malzoni
- Fábio Quirino Milleo
- Sidney Klajner
- Fábio Guilherme Campos

Preliminary results from digestive adaptation: a new surgical proposal for treating obesity, based on physiology and evolution

Hospital Israelita Albert Einstein and Hospital da Polícia Militar, São Paulo, and Hospital Vicentino, Ponta Grossa, Paraná, Brazil

R Pais, FM Gribble et

Normal post-prandial physiology

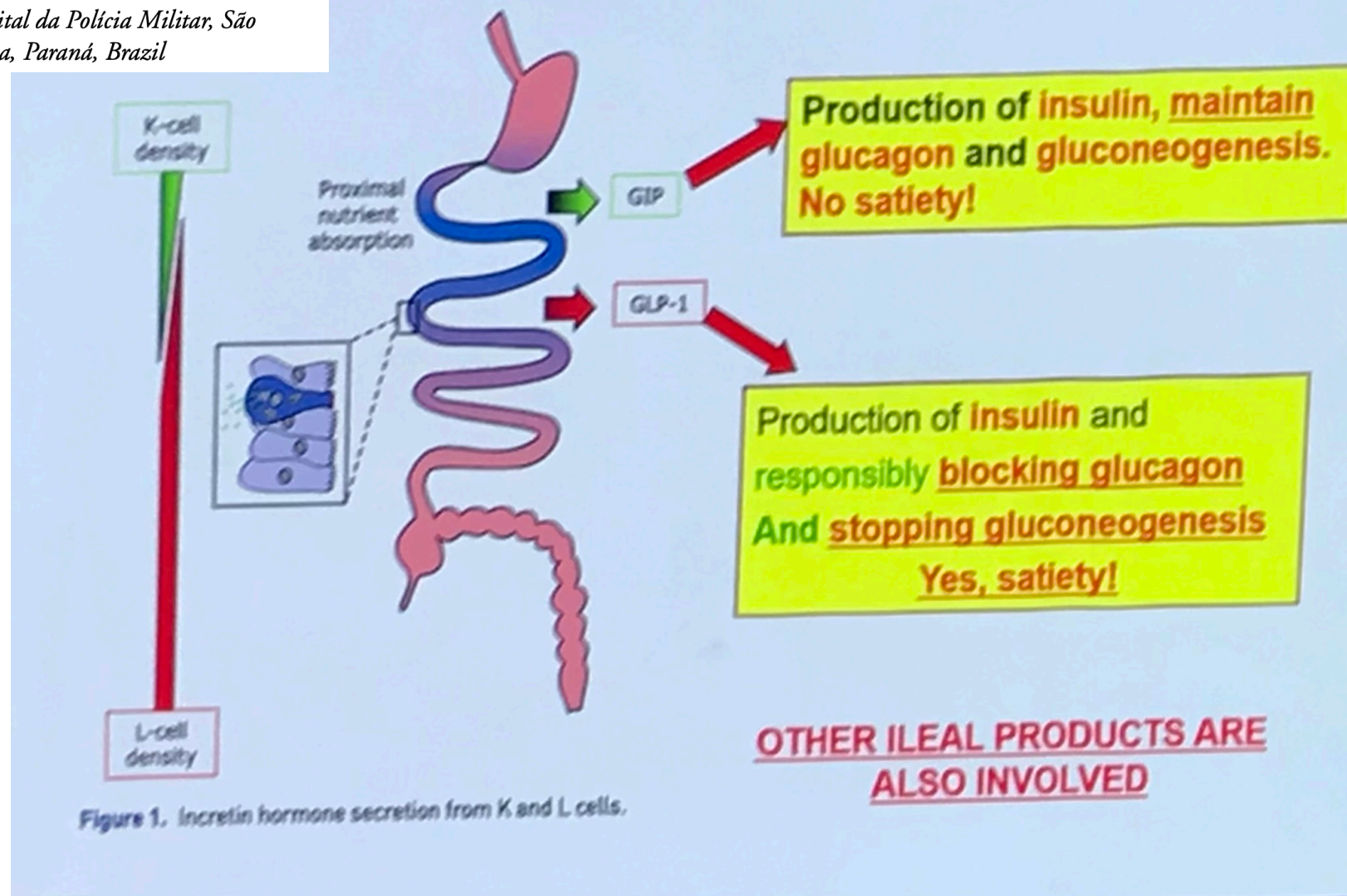


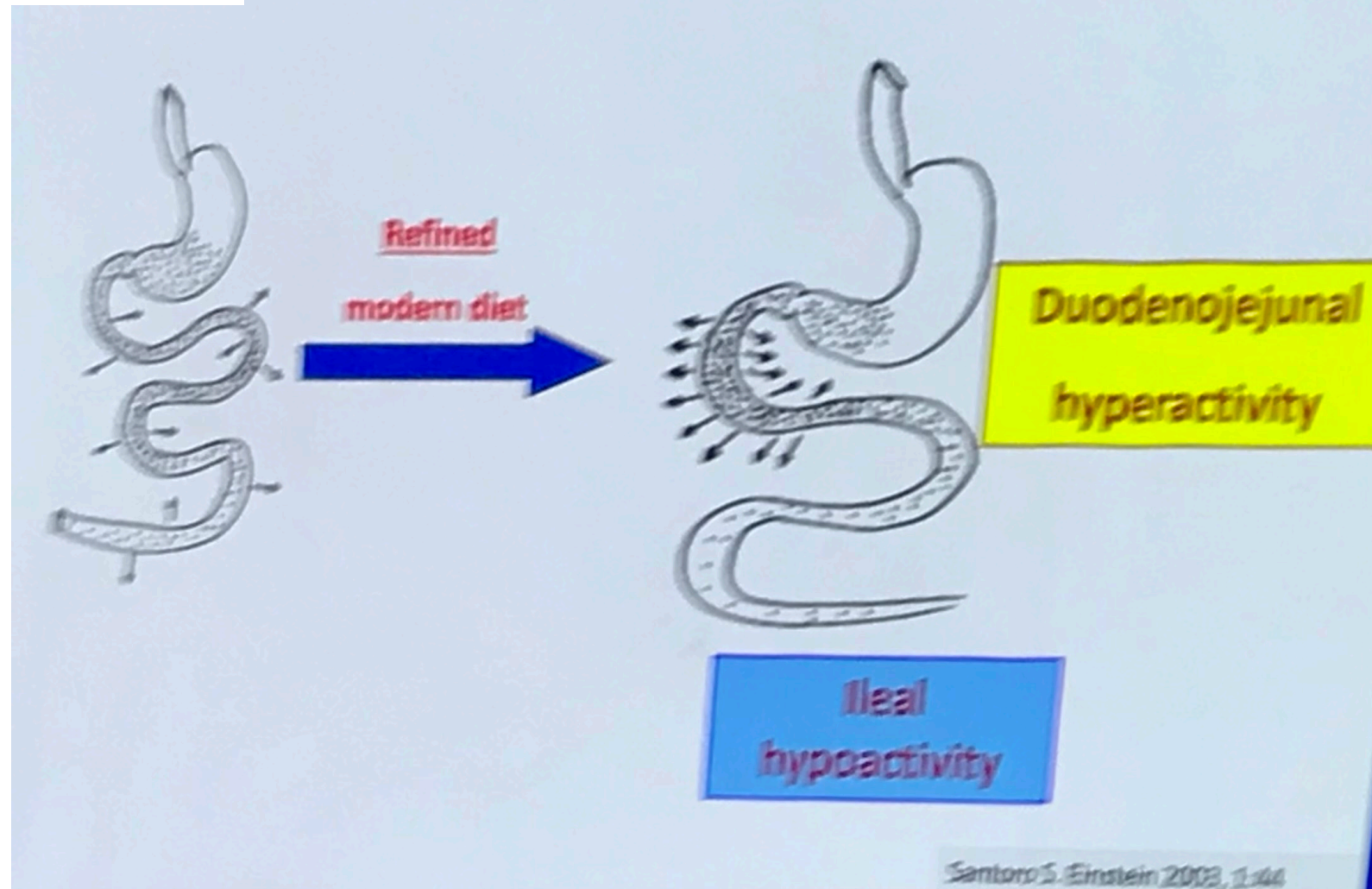
Figure 1. Incretin hormone secretion from K and L cells.

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Obesity and Metabolic Syndrome The Proximal-Distal Imbalance Theory



- Sérgio Santoro
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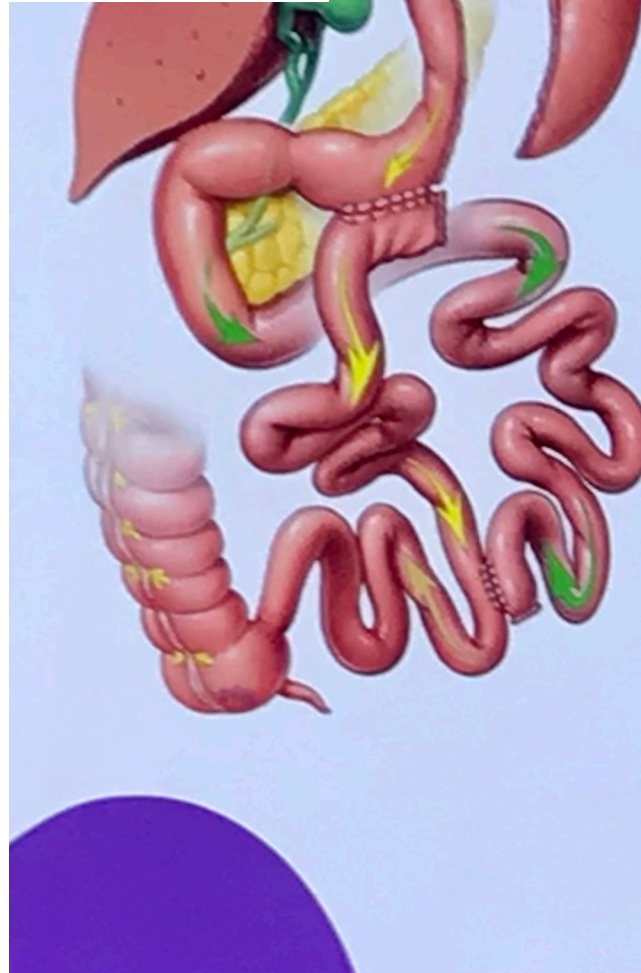
Hospital Israelita Albert Einstein and Hospital da Polícia Militar, São Paulo, and Hospital Vicentino, Ponta Grossa, Paraná, Brazil

**Distal absorption
and
Ileal hypertrophy
are new objectives
in Metabolic Surgery**

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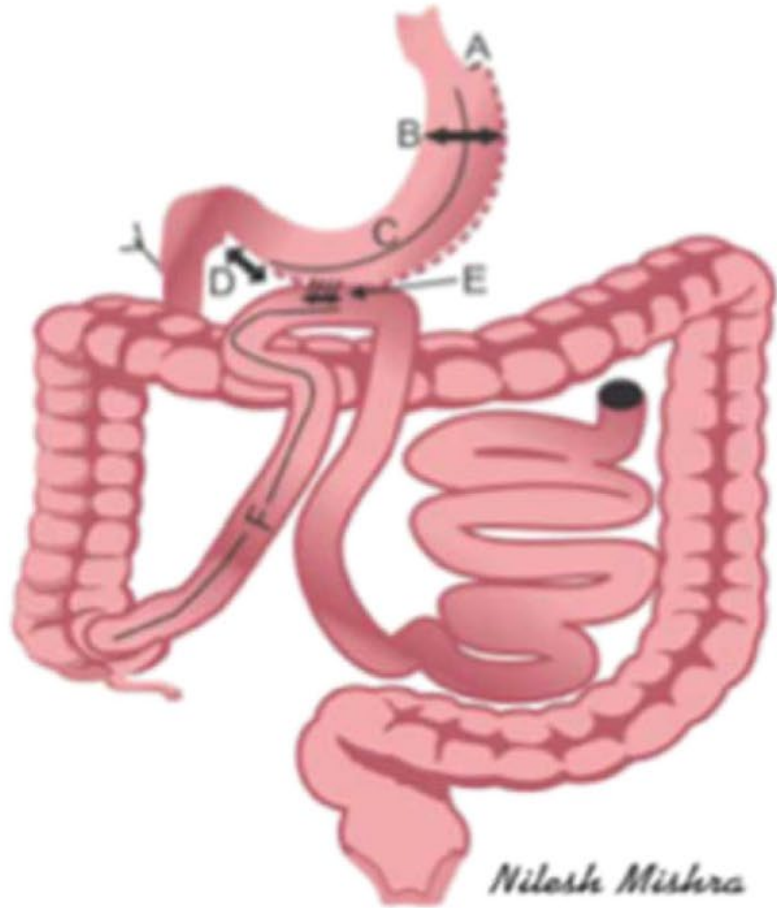
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The Bipartition

- Weight loss similar to DS
- But a lot simpler and safer
- Very high resolution of T2DM
- No excluded segments
- All limbs are alimentary
- No significant malabsorption
- Functional Restriction (instead of mechanical)
- Immediate ileal nutritive stimulus
- Full endoscopic access
- Keeps the stomach in position
- Lowers intra-gastric pressure
- Endoscopic adjustments



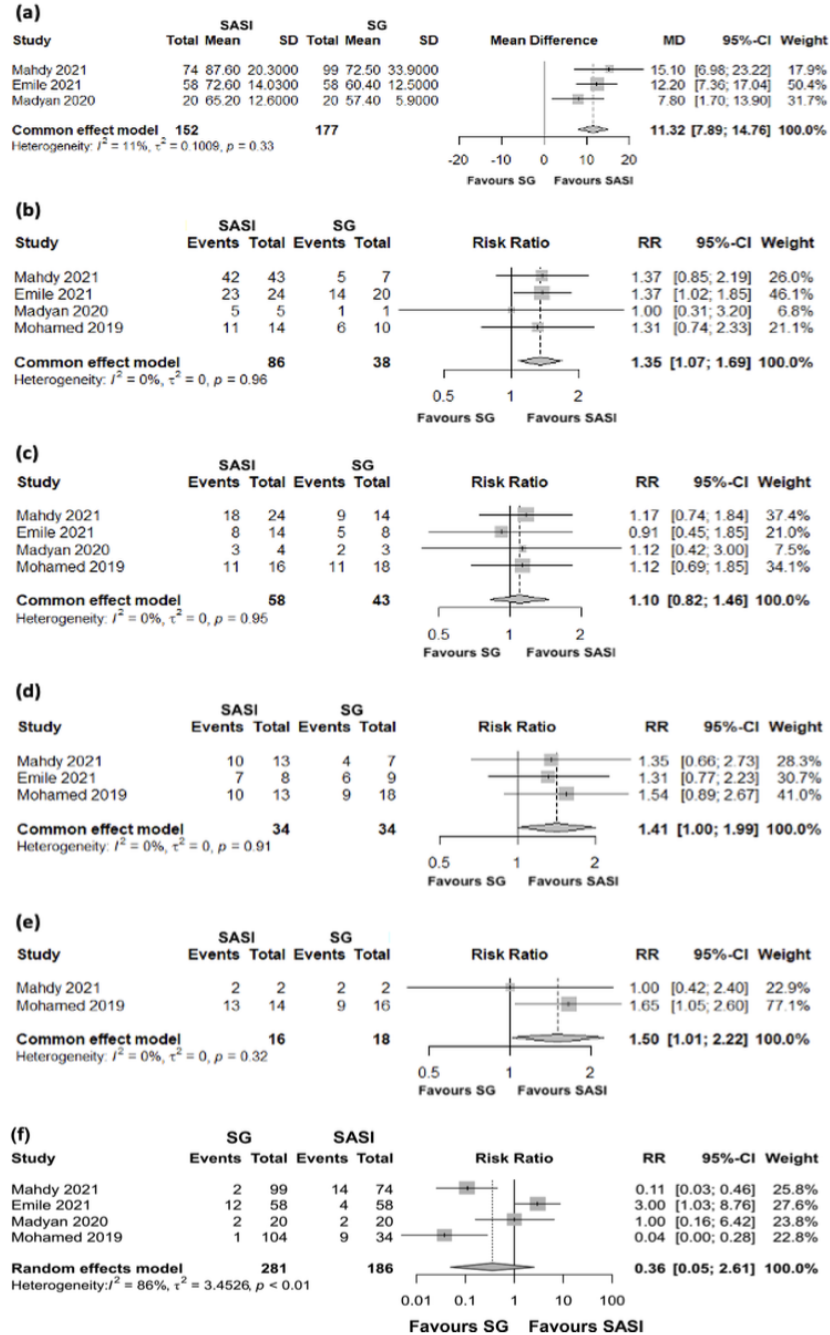
A = 2-3 cm	Distance of sleeve transection from esophagogastric junction
B = 3-4 cm	Use 50-60 Fr bougie to size sleeve width
C = As is	Length of sleeve
D = 2-6 cm	Distance from pylorus
E = 3 cm	Width of gastroileal anastomosis
F = 300 cm	Length of gastroileal limb
V = 150-250 cc	Volume of sleeve (approx.)

Single-Anastomosis Sleeve with Ileal Bypass (SASI)

Fig. 10 Single-anastomosis sleeve with ileal bypass (SASI)

- AKA**
- Laparoscopic sleeve gastrectomy with loop bipartition
 - Laparoscopic sleeve gastrectomy with loop gastroileal bypass
 - Laparoscopic sleeve gastrectomy with transit loop bipartition

Fig. 2 Forest plots of the comparison between SASI and SG; (a) %EWL, (b) T2DM, (c) HT, (d) DL, (e) OSA, and (f) complications



SASI vs SLEEVE

%EWL

T2DM

Hypertension

Dyslipidemia

OSAS

Complications

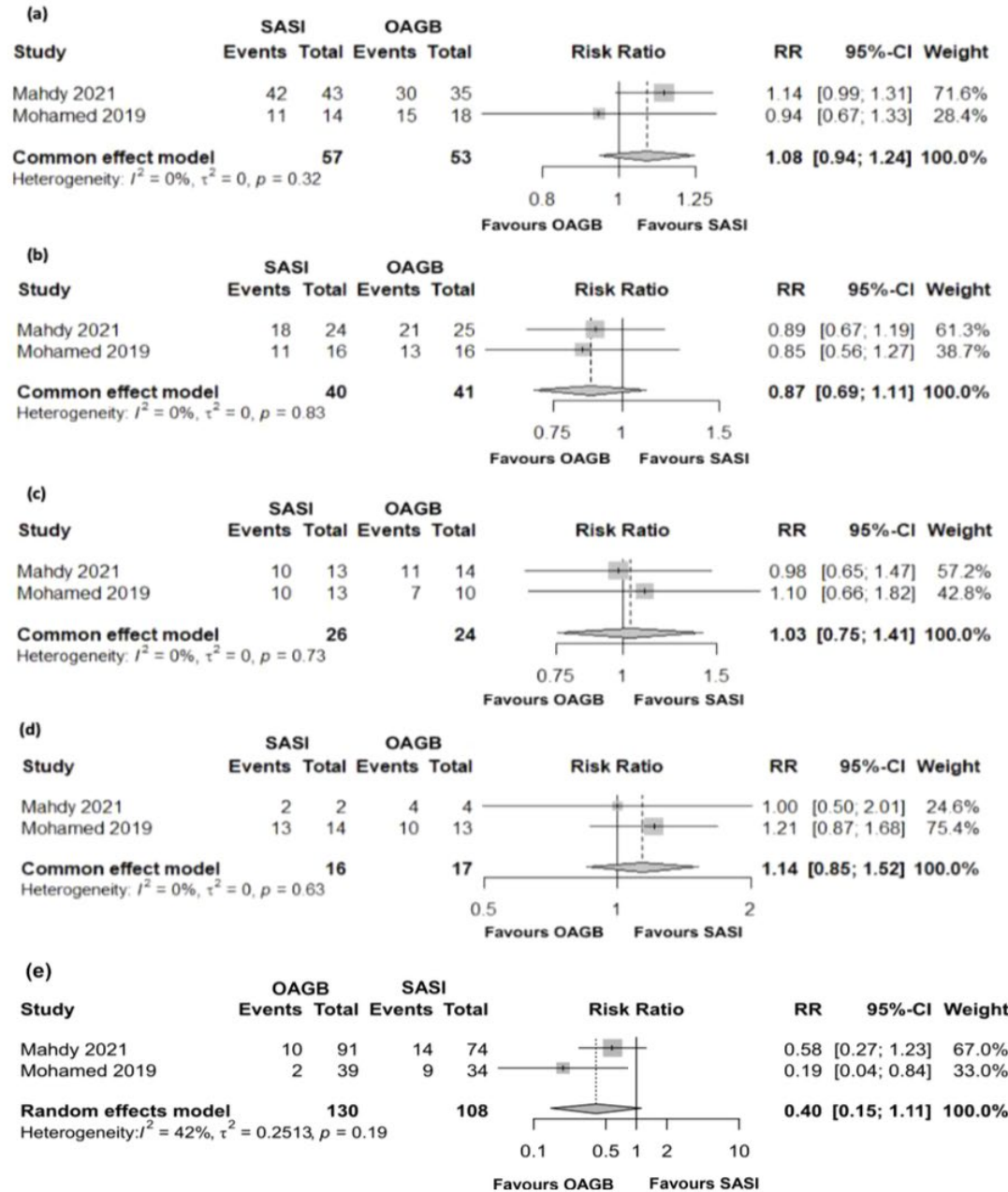
SYSTEMATIC REVIEW

Efficiency and safety of single anastomosis sleeve ileal (SASI) bypass in the treatment of obesity and associated comorbidities: a systematic review and meta-analysis

Carolina Rodrigues Oliveira¹ · Hugo Santos-Sousa^{1,2} · Maria Pinho Costa¹ · Filipe Amorim-Cruz⁵ · Raquel Bouça-Machado⁶ · Jorge Nogueiro⁷ · Fernando Resende^{1,2} · André Costa-Pinho^{1,2} · John Preto² · Eduardo Lima-da-Costa² · Silvestre Carneiro^{1,7} · Bernardo Sousa-Pinto^{1,3,4}

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SASI vs OAGB



T2DM

Hypertension

Dyslipidemia

OSAS

Complications

Langenbeck's Archives of Surgery (2024) 409:221
<https://doi.org/10.1007/s00423-024-03413-w>

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Fig. 3 Forest plots of the comparison between SASI and OAGB; (a) T2DM, (b) HT, (c) DL, (d) OSA, and (e) complications

TECHNICAL VARIATIONS AND RESULTS

Length of the common limb, which varied between 200 and 350 cm

Size of the gastro-ileal anastomosis, which was 3–4 cm

Gastro-ileal anastomosis proximal to the pylorus, which ranged between 3 and 6 cm

A longer biliopancreatic limb was associated with greater improvement in HT

A larger anastomosis size was associated with higher weight loss and a decrease in HT due to food diversion from the gastric pouch to the ileum, leading to an increase in the malabsorptive effect

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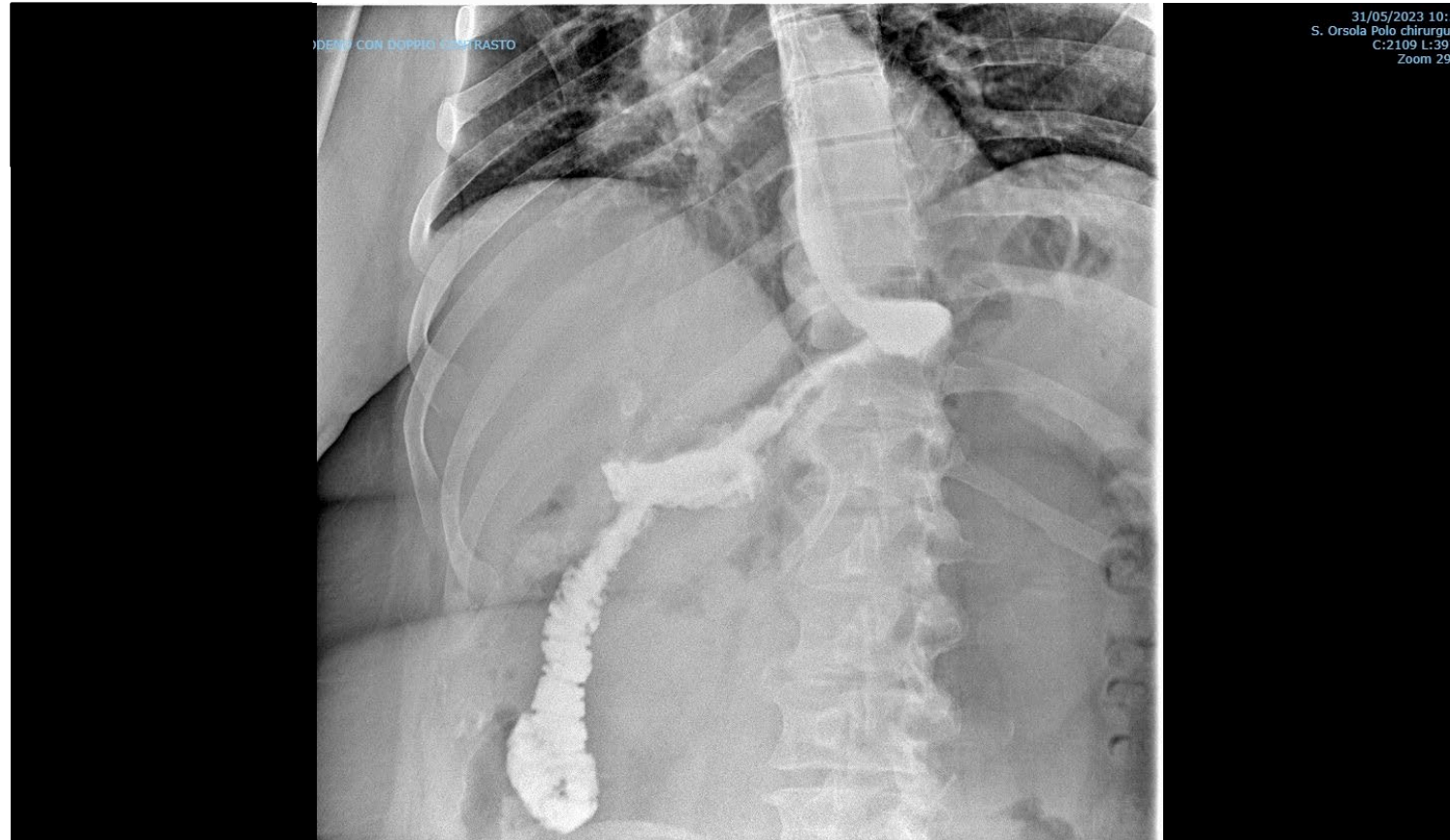
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ESPERIENZA PERSONALE: CONVERSIONE DA SLEEVE A SASI

ANEDDOTICA (2 CASI)

INDICAZIONI: WEIGHT REGAIN + GASTRITE CRONICA ATROFICA CON METAPLASIA INTESTINALE



ESPERIENZA PERSONALE: CONVERSIONE DA SLEEVE A SASI

Caso 1	
3/2015 sleeve gastrectomy	Kg 190 BMI 59,37
2016 nadir ponderale	Kg 136
5/2023 weight regain: SASI	Kg 151
5/2024	Kg 141

Caso 2	
5/2016 sleeve gastrectomy	Kg 158 BMI 57,34
4/2018 nadir ponderale	Kg 100
11/2022 weight regain: SASI	Kg 126
3/2023	Kg 109

Single anastomosis sleeve ileal (SASI) bypass as a primary and revisional procedure: a single-centre experience

Natalia Dowgiałło-Gornowicz, Kamil Waczyński, Kinga Waczyńska, Pawel Lech

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Videosurgery Miniinv 2023; 18 (3): 510–515

DOI: <https://doi.org/10.5114/wiitm.2023.128021>

The short- and medium-term effectiveness of SASI may be satisfactory. It may be an effective and safe method for the treatment of obesity. SASI may be an effective method of revisional bariatric surgery performed for GERD. **However, it had poor outcomes in revisional bariatric surgery performed for weight regain.**

TAKE HOME MESSAGE

- EFFICACE E SICURA COME PROCEDURA PRIMARIA (NB SLEEVE PIU' AMPIA)
- RISULTATI NON SODDISFACENTI IN TERMINI DI CALO PONDERALE COME CONVERSIONE POST-SLEEVE ??
- POCHI STUDI DI CONFRONTO CON RYGB
- DA STUDIARE L'INCIDENZA DELLE IPOGLICEMIE REATTIVE (LATE DUMPING) ??
- PROPOSTA RACCOLTA DATI MULTICENTRICA (paolo.bernante@unibo.it)



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