I chose to have bariatric surgery because I have struggled with yo-yo dieting for probably 25 years, and I've also had quite a few health issues. I had been doing research on the different types of bariatric surgery for several years, to be honest, and once I found out about the sleeve gastrectomy, I knew that was exactly what I needed. I can't even begin to tell you how wonderfully my life has changed in the past year. My health problems have pretty much disappeared. No Type II diabetes. My sugar level is completely normal. I have not taken any high blood pressure medicine. I have not used my sleep apnea machine since the day of the surgery. I just feel better. I cannot tell you how my self-confidence has improved. I would highly recommend this surgery to anyone that struggles with problems in their diet. Anybody that has struggled with losing weight, gaining weight or maintaining the weight loss that they've had. Like I say, it is not a magic bullet. It's not something that you automatically have, and then, you can just do whatever you want for the rest of your life. You still have to be careful because you can put the weight back on.

What you've just seen and heard is just one example of some of the many success stories coming out of the Halifax Weight Loss Surgery Program. Good evening and welcome to the OR webcast coming to you live from Daytona Beach, Florida. I'm your host Dr. Scott Klioze. I am joined this evening by my guest panel, my panel of experts. To my immediate left is Dr. Harry Black, the patriarch of our Bariatric Surgery Center. And the guy on the hot seat this evening is Dr. Joel Sebastian. Welcome gentlemen.

Thank you.
Thank you.

I'm going to start with Dr. Harry Black. Dr. Black, as I said before, you've been with the Halifax system for about 20 years, and about 10 years ago, you decided to go to the administration, and you said guys we need some sort of bariatric program.
That's right. I was asked to be a local HMO, Florida Healthcare Plans, because they wanted their patients taken care of, here, locally. We started going through the process of setting up a real program. Other surgeons had done bariatric surgery before, but not in the program standpoint, having everyone else on board as a team, as far as the medical doctor, the nutritionist, the exercise specialist, the psychiatrist.

And, we put together the team that has lasted until now, and it's only grown under Dr. Sebastien's tenure. That's right he kind of came over and ran with that ball. He did. He did.
It's great to see it grow like that. I assume that you've seen a lot of progression in the field of bariatrics over the past 10 years.
Absolutely. The gold standard is the laparoscopic roux-en-y gastric bypass, which is another procedure we can talk about during this one, maybe. And then, the laparoscopic gastric band, which we've actually done a procedure live before. And then, progressing to the this gastric sleeve that's done laparoscopically as well.

Well, I got to tell you. I just heard a statistic. It was on the news the other day, and they were talking about -- they were ranking the states by health, and Florida, out of 50 states, ranked number 33. So, we are well established in the lower 50th percentile, and the biggest health problem we have is weight and all the health-related risks associated with weight.
Yes.
I can tell you in our own department, in radiology, we used to have a scanner that could accommodate patients up to 450 pounds. As you know, being on the trauma service, we had patients that we couldn't fit into our scanner ---
We couldn’t fit into scanner (multiple speakers). That’s right. Absolutely.
So, now we have a scanner that can accommodate patients at 650 pounds.
That’s right.
Are they still growing?
They are.
That’s going to be a problem. I’ll have to get a CT scanner. Alright. I want to move on to Dr. Sebastien over there in the OR. Welcome Dr. Sebastien.
Thank you. As Dr. Klioze said, I am Dr. Joel Sebastien, and today, we are going to be performing laparoscopic vertical sleeve gastrectomy here at Halifax Health. Our team that’s going to be involved in the surgery - - at the head of the table is our nurse anesthetist, Kim White; directly across from me is my first assistant, Lucy Marks; and to my right is our scrub tech, Jillian Chambrey; and last but not least, our circulating nurse, Paul Karat. Together, we do these procedures, and it runs smoothly with a team such as this one.
Okay, Joel, now, you’ve been at Halifax Health since 2004. You’ve, basically, as Dr. Black was saying, took that ball and ran with the bariatric program. You are the man to go to. The protégé. We got our old silverback sitting over here next to us. He doesn’t do too much of this anymore, you’re kind the guy, right?
Yes. I perform the majority of the procedures here at Halifax Health, and like Dr. Black mentioned, we provide three surgeries: the laparoscopic roux-en-y gastric bypass, the laparoscopic adjustable gastric band and the laparoscopic vertical sleeve gastrectomy.
Perfect, and we’re going to go over just about all those in a little here. But first, kind of show us what the setup is that you have right there.
Well, we got things started in set up. We placed our trocars, these are the instruments through which we pass our working instruments. And if we go to the inside, it will show you a little of the surface anatomy at this point. Right here we have the stomach. We will be taking out a majority of the stomach, about 80%.
We’ve already retracted the liver, and you see a lot of fat around here and the spleen back here. But, this - - spleen is back there, yes. But this is where we will be working, right here.
Okay, good. I’d like to cue up that first video just to kind of reiterate what Dr. Sebastien has done to this point, and I think the videos are very helpful to kind of show the general audience what we are trying to accomplish. If we can get that up and running, we’ll show how Dr. Sebastien got to this point. Basically, we see our corpulent model here, and Dr. Sebastien marked out place right on the abdomen, and those will be evident when you see these little incision marks. Through those incisions, we are going to insert these trocars, and the trocars are the access for Dr. Sebastien’s surgical instruments. You take out the inner stylet, and you are going to have the access, and you will be able to blow up that abdomen, and basically, see the inside because you can put CO2 through the ports and the ports themselves will keep the air in. If we can look back at me real quick here, I can show you an example of one of these ports.
This is what it looks like, right here. This is what Dr. Sebastien inserts, and you can see there is an inner stylet, and this is actually blunted. So, when Dr. Sebastien goes into the little incision, this is designed so it will go through the abdominal wall but won’t perforate the bowel, or the liver, so on and so forth. I guess if you push hard enough, Dr. Black it would go through there.
You can certainly push it through anything in the abdomen.
You could do that, but they are designed to go to the abdomen safely, and then, once it’s in, this part comes out, and this is the access that you run the instruments through. So, that’s where we’re at right now. Alright, so, why don’t we go ahead and see what Dr. Sebastien is doing back in the OR. And kind of explain what’s happening there?
So, I started a little dissection. What we do, we remove the - - the crux of this operation is removing about 80% of the stomach along the greater curve. What we do is we start our dissection about 4 cm - - 4 cm to 5 cm from the pyloris, that’s this thick musculature right here on the stomach. We see the transition into the first portion of the intestines, the duodenum. So we measure about approximately 4 to 5 cm, and that’s where we actually start our dissection. What we are trying to do is to take down the blood supply along the greater curvature of the stomach and mobilize the stomach in its entirety along the greater curve, and then start dividing it.
Alright, I want to show another video. If we can cue that up, and it’s basically going to kind of give you an overview of what Dr. Sebastien is doing inside the peritoneal cavity. So, when we get that up and running, it’s also going to show us the normal course of the food material as it goes through the abdomen.
So, we’ve got our instruments going in. It shows you the esophagus, the stomach, the large intestine. What you are going to see now is the normal pathway of food. It comes down the esophagus, it goes into
the stomach, and then, it passes into the small bowel, as you see, right here. As soon as it goes into the small bowel, you start resorbing nutrients. So, this is the process of digesting your food, and what's important is that stomach, as it distends up, it starts to send signals to the brain, and it informs the patient that they're full. The satiety center. Is that correct, Dr. Black?

That's correct, absolutely.

Okay, so what we are trying to do is make patients feel full sooner than later, and you can eat fast enough to, basically, outstrip that whole sensory feedback mechanism. And I know that because I have done it myself. When I was a younger man, I could eat through that to a point where I was nauseated.

Absolutely.

So, what Dr. Sebastien is going to try to do is reduce the volume of that stomach to try to get those signals coming to the brain sooner with this particular procedure.

That's right.

Correct. How are you doing over there in the OR, Joel? Do you maybe want to show us.

Good. We got into the space behind the stomach, called lesser sac, and now we’ve taken down the branches of blood vessel along the greater curvature. We are using a harmonic scalpel in my right hand, over here. That's an instrument that coagulates and vibrates, and it coagulates and divide the blood vessels as we go along. This is revolutionized laparoscopic surgery, this instrument here.

It really has. It's made a difference in virtually every procedure we do laparascopically and makes something like this dissection very possible where it would not have been before this.

Let me ask you guys something. Were these ever done, open? Or has this always been a laparascopic procedure? I am talking about any of the bariatric-type procedures.

They started off being open. The roux-en-y gastric bypass, there’s been different iterations of different procedures over the years, but the roux-en-y gastric bypass, which actually staples off about 95% of the stomach and then bypasses part of the small intestine, was done open for years and years before the laparoscopic procedure was put into place.

Well, I can tell you guys, I mean, since the advent of this laparoscopic-type procedure, I have seen some of Joel's patients, some of your patients, Harry, and they'll tell me I am going to go see Dr. Sebastien, I'm going to get my bypass done next week. And, I will see them at the soccer field one Saturday the next game, they are back at the soccer field.

It's amazing isn't it.

And people in the hospital for a day or two after even some of these very, very large procedures, and the minimally invasive surgery has made just a huge difference in that.

Right. That is absolutely fantastic stuff. Now, I want to talk - - Joel, is it alright if I just talk about the resorption of the food material again. Do you have some time, or is there anything you want to show us at this point.

Go.

When people ingest food, like we said before, that gets into the stomach, it gets resorbed almost immediately as soon as it goes into the small bowel. And feel free to interject at any point, Dr. Black. I'm good.

As soon as I say something incorrect, you just jump right in there. So there’s two different types of mechanisms that we are looking for when we do a bypass. There’s either a restrictive process, which we talked about before, where you minimize the pouch, the size of the stomach itself. There’s another component called malabsorptive, and the malabsorptive is basically when you bypass some of the small bowel, and you prevent some of the nutrients from actually getting resorbed.

From being resorbed, that's right.

So, I would assume there’s consequences of each one. They truly restrictive, or solely restrictive, is basically going to preserve the resorption of the nutrients through the bowel. If you have a combination of the above, I would also assume that there are going to be some nutritional deficiencies that you may have to contend with.

That's right. That's one of the biggest problems with the roux-en-y gastric bypass is the malnutrition. The patients who undergo that procedure must take bariatric vitamins the rest of their lives, and they have to be monitored periodically for deficits in vitamins and minerals because of the absorption lack.

Okay. And this procedure, just to, again, to reiterate, this is only restrictive. We are not are doing any kind of malabsorptive procedures.
That’s right. The food still maintains its normal course through the stomach, except it’s a very much smaller stomach, but there is no malabsorption. Which is one the best benefits of this procedure is that there is no malabsorption in it. You may not lose as much weight, initially, or over a long period of time, but you don’t have the malabsorption problems.

That brings up another interesting point. Some patients may be looking at this, or potential patients, and say you know I’ve really tried to lose weight. I’ve tried every other mechanism. I can’t do it. I want to have this procedure done so that I can keep eating as much as I want to eat - - Won’t happen.

Why is that? What’s the deal, here? What’s the process of getting to the point of surgery?

Well, the truth about the surgery is that any of these surgical procedures are basically a tool that allow patients to learn how to eat differently and to exercise differently. Once they are able to lose a lot of weight over a relatively short period of time, say a few months to a year, then, they are able to learn the process of maintaining that weight by eating differently. It’s not a matter of being able to eat everything you want to every again. It’s a matter of eating the way you should in the first place, and this is a tool to be able to do that.

You know, I think that’s the absolute key, and I deal with patients with peripheral vascular disease who don’t eat right, and they’ll come into me and they say, “You know what, I don’t eat anything, and I can’t lose weight.” And, I am sure you’ve heard the same thing. Absolutely impossible.

Until you start keeping track.

It defies every law of thermodynamics. You can’t create matter out of pure nothingness, unless you’ve learned how to photosynthesize, you can’t do that, right?

That’s correct.
And we don’t photosynthesize. No one I know can photosynthesize at this point in time. What I found as I became older, an adult, and had a little trouble with my own weight is that it was difficult to find where my appropriate weight was. And this whole process of taking in energy, storing it in fat, right down here in your storage tank, is a long, arduous process. It takes a while to put it on, and it takes a long time to take it off.

Exactly.

And, I think where my patients fall into problems is when they expect to starve themselves for one day, and, basically, they get on the scale at the end of the day, and they are like, “I haven’t lost anything, this is ridiculous. I can’t diet.” And that’s where they just lose interest.

Over a period of time, and, certainly, there’s a lot of different diets. People get interested in one diet or the other diet, South Beach or the Atkins diet, and they’ll lose a certain amount of weight, and then, as soon as they go off that diet, then it all comes back. And then people are looking at the bariatric diet.

That’s exactly right.

Being the bariatric surgery diet, and it’s really not that. It’s a lifestyle change, and what this procedure does is allow somebody who has struggled with that and has more than 100 pounds to lose, in most cases, the opportunity of changing their lifestyle.

So, the team, the bariatric team that goes through this process brings the patient in. They counsel them on how to eat, right?

Exactly.

And they have to be willing to dedicate themselves to the program.

That’s right.

They have to follow the diet, and they have to reduce their caloric intake. And, I think, of everything that’s done, I mean, the surgery is great because it helps with the process, but that learning experience is probably paramount.

Oh absolutely, and that’s where the success of this program really comes in is that the patients are very prepared for surgery. By the time they get to the operating room, they’ve already been through this whole process with the whole team, from anywhere from two to six months, where they’ve learned how to exercise differently and eat differently and gained a lot of knowledge about their own nutrition and their bodies.

And I just want to make one more statement here, and we’ll move on. Joel, how are you doing? Anything interesting?

Doing good. We just about separated the vasculature along the greater curve. Now we are going to look at the hiatus, check for any hiatal hernias, and we’ll be stapling soon.
Okay, good. Let me know when you are ready for all that, and we’ll go on to the next animation. In the interim, I just want to talk about caloric intake. You know, right now, you see the numbers. The average caloric requirements for an adult, they use that magical 2,000 kilocalories per day.

Yes.

If you look at one pound of fat. One pound of fat actually can provide 3,500 kilocalories, alright. So, let’s say you are requiring 2,000 kilocalories a day. If you reduce your intake by 500, which means you are taking in 1,500, it will take you one week to lose one pound. That is safe weight loss.

That is safe weight loss.

You can’t expect not to eat anything in one day and lose 10 pounds. That’s not the way our body works. No. Nor take a diuretic and make - -

That’s right. That’s just water. That’s exactly right.

This tank takes time to go away, and if you lose one pound per day, you are going in the right direction, and you can’t be discouraged because you’ve only lost one pound in a week. That’s just the beginning.

That’s right.

This is not a sprint, you are actually in a marathon, correct?

Exactly, and it’s a lifestyle change.

I saw one of my marketers in my own practice turned me on to this, and I am sure there are plenty of examples out there, something called FitDay.com, www.fitday.com, where he actually maps out what he eats. And, it’s interesting because you will see over time that he will plateau in his weight, and then, it will drop for a couple of days.

That’s perfectly normal.

And then, it plateaus again, and then he uses some of those fat reserves. The trend is down, but there are times for four or five days at a time, even though he hasn’t changed his intake, that he doesn’t lose any weight, and that’s what patients need to understand. That this is not an immediate one-to-one response, I didn’t eat today I am going to be lighter tonight.

Exactly, and that’s one of the things that draws people to the bariatric surgery because it does provide a more-rapid weight loss. I mean, people can lose 100 pounds or more in less than a year, which is absolutely an astounding amount of weight to lose when you think about it.

We’re going to see an example of that a little bit later. We’ve got a patient coming on. It’s going to be great stuff. I am going to ask a couple of questions. Joel, you let me know, again, when you are ready.

Kelsey asked, does a patient lose their appetite after having the gastric sleeve surgery?

Yes. Yes.

In a majority of cases, patients lose their appetite. They have to remind themselves to eat following this procedure. That’s one of the nice things about the procedure. You know you mentioned that it’s a restrictive operation. Yes, you don’t have the malabsorption with this operation that you have with some of the operations out there, but you have a physiological affect that we’re seeing now where patients, through some neuro-hormonal effects, they lose weight. The metabolic rates increase and that allows them to lose weight, and the hunger, like you mentioned, about 80% or 90% of patients subjectively aren’t hungry enough to remind themselves to eat.

That’s good. That’s the goal of the whole program is to try to curb that appetite, and I think the hardest part with weight loss is know where you’re supposed to be. Maintenance is much easier than repair, and if you’ve got to go through and actually get to that - - I never knew what my appropriate weight was supposed to be until I got down to it, and I felt good about it, you know, and so, now, maintenance. Every now and then I fall off that diet wagon. I gain a little bit of weight, but I know if I control myself for a couple of days, that I will see a response within a week.

And it’s that knowledge that makes a big difference.

It’s the knowledge is paramount. Does this surgery, we already said, curb the patient’s hunger. Why do you inject CO2, Dr. Black?

In order to be able to see. If Dr. Sebastien let all the carbon dioxide out of the abdomen right now, you would see the camera collapse, and you wouldn’t be able to see anything at all. So, we’re actually just using carbon dioxide as an inert gas that does no harm. It’s a natural gas. We breathe out CO2 as part of our natural daily breathing, and it allow us to be able to see very well. It makes a big cave for us in the abdomen.

You know at our last OR webcast, one of the callers asked why don’t we use oxygen because the body uses oxygen. The problem is your using that electrical equipment in there and the patient will actually explode. That’s not good for anyone, right?
That’s actually happened before, not in laparoscopy, but in other surgical procedures where somebody had the oxygen, and, yes, it can cause an explosion.

Yes, we don’t want to see that. So, CO2 is used because it’s inert, it doesn’t explode and it’s a naturally occurring gas in the body.

And it causes absolutely no harm.

And it doesn’t cause any harm. So, that’s an excellent question. Excellent question. We actually have Carlos, from Mexico, what are the differences in weight loss time and surgical risk between the gastric sleeve and the gastric band? Which is the surgical procedure you prefer most?

Well, let me answer the first part of that, and I’ll let Dr. Sebastien answer the second part of that. Good enough.

You lose weight faster with the gastric sleeve, and there is a longer-term weight loss with the sleeve than the band. And it’s really in between the roux-en-y gastric bypass and the band as far as the amount of weight you can lose and the amount of weight that you keep off over a longer period of time. It is very successful and probably better for many people than the band, although the band is more widely accepted. This is a relatively new procedure for bariatric surgery. It’s only been around several years. There’s about 70 studies now that show that it’s effective, and it’s starting to catch on a little bit as far as an alternative to the other two. The gold standard is the roux-en-y gastric bypass. The band has been around. It was in Europe probably 12, 15 years ago, and also down in South American. And, as far as the sleeve is concerned, it’s been just in the last four to six years.

How you doing Joel?

Good. Stomach is fully mobilized now, you can see, we could flip it around, and now, we’ll start stapling. This is a marker to me to let me know about five — — This is where I will begin my stapling on the stomach. Joel, where is the esophagus? Coming down from which end there? Can you point that out? The top and the bottom.

Way up to the right.

It’s up here.

Okay.

We can’t see it, it’s in the hiatus — —

That’s the general vicinity. Okay. And so the bowel is going to be down and to the left relative to our to our current position.

What was that?

The bowel, the duodenum.

The small intestines?

Right.

The is the beginning of the small intestines, right here, the duodenum.

And that’s the gallbladder behind it.

Right there. The gallbladder.

Very cool stuff.

Pancreas underneath here.

Alright. Do we have time to cue up that video before you staple, or is he ready to go?

Yes. You can.

Alright, why don’t we cue up that third video on the gastric sleeve, and we’re going to kind of show everyone what the anatomy is. Again, this what it looks like before we actually do any kind of revision to the stomach itself. The food stuff passes through the stomach right into the small intestine, and starts getting resorbed. What Dr. Sebastien is going to do at this point in time is he is going to shorten that stomach. He’s going to make it smaller, and he’s going to do that using this gastric sleeve, and the stapling gun that we are going to demonstrate here in a moment. That whole partitioned portion of the stomach is the removed. Correct?

That’s right.

Just like in the video, right there. And, what you’re left with is an abbreviated stomach, and the idea is as the foodstuff comes back down it stretches that stomach earlier and makes you feel full earlier.

It does.

If you here, you see, what we’re doing right now, we’re passing a bougie. This is essentially the sizer, and we divide the stomach along this sizer so we know essentially how big we are making the stomach. You know there’s different bougie — — there’s different theory on what size you make it. Whether you make it
really small bougies of 32s or really big bougies of 50s. Most people use between 32 and 50. I tend to do all mines through around a 36 French Bougie.

And the bougies is inside the patient's mouth going into the stomach.

That's correct.

Right, and that's what you see that lying along my stapler, right here.

Alright, and that's the staple gun you've got around the stomach right now.

Right. The best place to staple it in - - it's a Ethicon product, it's a stapler that divides and cuts at the same time. It puts three rows of staples on each side and cuts in the middle. On my staple, we have a seam guard, which helps decrease bleeding and increase the burse, so will decrease our leak rate. These instruments make this operation a lot safer operation.

These are amazing instruments, and I have had, preparing for this particular presentation, I have had the opportunity to use some of these. Emily from Ethicon J&J is going to give us one to demonstrate to our audience here, but you couldn't do this without the stapler.

Not laparascopically, that's for sure. I mean, you could do it, but it would very tedious and have a high complication rate if you had to do it by hand. The key here, somebody asked a question here about is there a risk of infection? And that was Haley. Is there high risk of infection with this surgery, but because of what we use, probably not, right? There is a risk of infection with any surgery, but it's not a high risk. It's rare to have a surgical infection after this procedure. It can happen, but it's rare.

Okay. Alright.

So, now we are going to do our first firing. We placed our bougie, it looks good. The first firing -- one of the key things with stapling, especially down here, this is the thickest portion of the stomach, so we use a thicker, higher staple height here. This area, right here, this angle, we try not to get too close to that, about 2 cm or so, to prevent strictures, obstruction at a later point. Key thing when you first firing down her along the antrum of the stomach,

Then, using your bougie as a guide, you are now firing the staples and portioning the stomach. It's the one motorized instrument we get to play with in general surgery.

Okay, and you can see the staple line, there. Absolutely amazing. So you've basically started to partition the stomach, it's sealed on both ends and cut it at the same time. And, you're going to keep marching up the stomach and, basically, partition off that piece just like we saw in the video.

Right along the bougie.

Okay. Cynthia asks, this is my sister, and I want to know what the doctor is doing at this moment. She's doing great, right?

Oh, the patient. The patient is doing great.

Okay, and then Joy asks is the yellow stuff fat.

That is absolutely correct.

Even I, as a radiologist can tell you that is fat. I recognize that stuff.

Even though it looks gray on your films.

We only have gray on my films. Everything is gray. Alright. Can we come back to me, and I want to show you guys the stapler that Dr. Sebastien actually is using. This is it, the same exact piece of equipment that he is using. I don't how to work this because I am a radiologist, not a surgeon, but fortunately, I am sitting next to Dr. Black who is a surgeon, so nobody is going to get hurt in this process. But, basically, this goes through that little trocar.

Which we have.

Which we have right here, okay. This is the trocar. It goes right through the trocar, and you can actually move this. If you pull on this right here, you can bend this, and it will spin around anyway that you want it to spin around, and you can put it right on the piece of tissue that you want to staple, and we are going to demonstrate that right now. I'm going hand it over to an expert here. The reason Dr. Black gets to fire the gun is he refused to touch the sausage, so I have to hold the sausage here.

Did not want to touch the sausage.

So, basically, what we are going to do -- this is a sausage, it's actually a turkey sausage, if you want to know details, and it has a naturally pork rind. It's intestine, if you see natural pork rind it is made out of intestine just like Dr. Sebastien is dealing with right there. And, the stuff on the inside will kind of mimic stool, and it's probably just as healthy for you.

Hopefully, the stomach has no stool in it.

Right, yes, right. But, you can use this on bowel, too, right?
You can, absolutely.
Okay, so I am putting it in. We are going to close it down on the sausage. There we go. Now, listen, you are going to see, this is an automatic thing, it puts the staples in and cuts at the same time.
You ready?
Go. So, it’s deploying the staples. It’s firing, that’s it, comes back. This better work, Emily. Oh my gosh, goodness gracious.
And there it is.
There it is, okay. So, you see how it went into, cut the sausage in half. You can see there’s still a connection, and that’s on purpose. There’s still a connection right here, and the reason there is still a connection is because the staples go beyond the cut line, and it’s designed that way so as Dr. Sebastien goes up the stomach, he doesn’t completely sever the two pieces, and he can make that cut himself or he makes the next cut right there.
Right. You make the next cut until the very end, and then you can cut that manually.
So, as you can see, when Haley asked about the risk of infection, because of that staple mechanism, even if you have to staple bowel, it kept the contents of the sausage inside the casing itself. Okay, so, great, great device. As we said before, you couldn’t do this type of procedure without this particular device. From Ethicon, we are going to give them a plug, J&J, the own everything now.
Johnson and Johnson. 
Johnson and Johnson. Buy stock. It worked. Emily, it didn’t spill out, so your job is safe for now. Okay, and so what are we doing? We’ve deployed two sets of staples now?
We’ve fired twice, yes, and we’re just continuing to march up the stomach. Again, along that bougie. We try not to go too close to the bougie to make it too tight. I want to make sure the bougie can move. Kim, pull it back slowly for me, push it in, make sure it moves easily. We fire a staple, which we like to wait 12 to 15 seconds for our good compression, and then we fire all the way. That was about right.
Sounds beautiful. Sounds good from here.
Alright.
Looks good, too, Joel. Alright, so now, just like in the animation, you are going to partition the stomach, and you are actually going to remove that outer band? Correct? On the outer - - the partition portion.
Right. This is all going to come out of the body.
Alright, fantastic. Have you already freed all that up, or is that going to be freed up - -
Yes.
So, that’s going be ready to go as soon as you’re all the way through.
Right. Looks like we’ll be about two, two or three more firings, we should be all the way through.
Okay. Alright. While you continue to partition that stomach, we are going to bring in one of your former patients, Mr. Steve Robinson, who has been gracious enough to join us for the show tonight. And, I got to tell you, I am looking at Steve, I know you guys are looking at the surgery right now, but Mr. Robinson looks fantastic.
Thank you, Scott.
He really does, and I know we are still looking at the surgery, but I am going to sit here and admire Mr. Robinson for a while until we come back on camera. You’re looking good sir.
We’re back.
We’re back, alright, so I don’t have to admire him by myself anymore. Everyone can join me in admiring Mr. Robinson. Steve, now, tell me before, you had your procedure done how long ago.
Almost a year and a month.
A year and a month, okay. And you weighted how much before the procedure.
Before I entered into the program, in August of 2010, I was about 326 pounds.
My goodness, 320, and now you weigh.
I was 178 pounds this morning.
Wow, we’ve got a picture of you up on the screen right now. You are a shell of your former self.
I don’t recognize that guy (laughing).
You are not even going to acknowledge that guy. You really do look great, and obviously, you are working out , you know where you’re supposed to be right now. How many times did you try to lose weight before the surgery.
It’s been a lifelong struggle for me. I hear it all the time, people say all of the different diets that they’ve tried. I did the same thing from Weight Watchers, South Beach, all types of products and gimmicks just to trying to lose weight. So, it’s been a lifelong struggle for me.
Now we talked to Dr. Black a little bit earlier about the process. You had a lot of counseling before the surgery, of course. They told you how to eat. And, now that you learned from that experience, I assume you maintained that health lifestyle and eating habits.

That was the most effective part of this program, for me. It wasn’t just bring the person in, give them surgery and send them on their way. The team was concerned about my nutritional wellbeing, my physical wellbeing, my emotional wellbeing, and that was most important thing for me about this program.

How long after the surgery were you able to go back to eating solid foods? I assume there was a natural progression, and they started you off with a slurry or minimal amount of intake.

Yes. They started off in stages. The first stage was a liquid stage, and then, the second stage was what they call a mushy stage. So, I would say within about 90 days I was eating pretty solid, not very solid, but pretty consistent food.

And right now, any diet restrictions? Can you eat meat if you wanted to.

Sure. I can eat meat. Obviously, the portion is controlled by the procedure, but I can eat meat, so I can eat steak, I can eat chicken, whatever I want.

I know, right now, when I go out with my wife is we always split an entrée. And, I think that’s the hardest part. If you’ve never been at a normal weight, as like I said before, it’s hard to know how to eat and what you require. We are told over and over again that you should eat three meals a day. You don’t necessarily have to have three meals a day, right? Especially as you get older, you require less, and so, I kind of feel I know where you are coming from to a point because I have had to cut way back. When I was 20, I could eat anything I wanted. Now, not so much.

Well, I could never eat anything I wanted without gaining weight (laughter).

I think it’s absolutely fantastic. You look fabulous. I would assume you would recommend this to just about anyone who has been fighting with their weight for years.

Absolutely. Absolutely. Because of the hands-on and the team approach that Dr. Sebastien and his team takes towards the weight loss goal that we seek when we come here.

Mr. Robinson, thank you so much for joining us. We really appreciate you testament of what can be done if you put your mind to it, with a little help from Dr. Sebastien.

Absolutely. Right, and the most important thing is this is only a tool. A lot of hard work you have got to do after the procedure is over with.

Well said, well spoken. I know we are getting to a point in the procedure where Dr. Sebastien is deploying his last set of staples, so I think we will be able to see that partitioned stomach in just a moment, correct?

Yes.

And that’s it.

That was the last firing, it looks like - -

You would think we planned it. Alright, so, Joel kind of tell us what we are seeing right now.

So now, just separating. Making sure that I completely went across the stomach, and it looks like I did.

We’ll separate the seam guard, and now this is the excess stomach. This is all coming out of her body.

And this, to the left, is a new stomach. Essentially, like I said, about 20% of what was there. What we are going to do now is I will take the bougie out. We are going to evaluate the staple lines by placing NG tube in and putting some dye in to make sure there is no extravasations of contrast there. Looking at the staple line, it looks pretty good and pretty dry. Looks like a nice sleeve.

That does look like a nice sleeve. Now, what kind of dye are you putting in. When I hear dye, of course, I think of the x-ray stuff.

It’s methylene blue.

Methylene blue.

Okay.

So you can see if there’s any leakage, you would see a blue staining along the staple line.

While she’s getting that in, I am just going to over sew the points where the staple line cross just as a added security because that’s generally the weakest point on the staple line.

What do mean where they cross? Where you made two staple passes, is that correct?

Right.

Where one ended and the other began.

Where one ended and the other began. Okay, so you are going to do that however many times that you made staples lines. I got you. So, it doesn’t have to be the whole edge eight there. Look at this, and this all done through the laparoscope. Right now you are just looking at your surgical instruments. You’ve got a camera in there, you’ve distended everything up and everything is done with those long instruments.
Correct.

How long does it take you to adapt to those endoscopic techniques. Is that something that you learned in residency and training, or - ?

Nowadays, just about every general surgery residency have laparoscopic procedures associated with them, and then, you have more of specialized training. You could go for a fellowship to do more.

How often would you have to convert this to an open procedure? Is that ever an issue?

Rarely have an issue. Really, the only reason, I haven’t had to but I could see myself doing it for, is for something like uncontrolled bleeding or something like that.

Okay, which we did not see any of that, today.

No, there’s very little blood loss, as you can see, with this. That’s not a manufactured picture, as far as blood loss. What you see is what you get there.

That's is just absolutely fabulous stuff. Joel, I want to talk about some of the other bypass procedures, alright? While you’re sewing up there, if you have got anything interesting you want to inject then just kind of let us know, we’ll come back to you.

Let's cue up that next video, if we could, and I want to talk about the classic gastric bypass. And, here is our corpulent model again. We’ve made the incisions, we are going to put the trocars in, just like we did before. Our surgical instruments are going to pass through these trocars and facilitate the procedure. So, still an endoscopic-type procedure. Now, this is going to be a little different than what we just saw. You’ve got the same anatomy. The foodstuff passes through the esophagus, right into the stomach, into the small bowel. Now, what we are going to do, again, using that staple, is you make a small pouch right under the GE junction, the gastroesophageal junction. You also transect a portion of the small bowel, and you staple across that just like we did with the sausage. So, you got to hook all this up. Portion of jejunum comes up, ties into that small little patch, and you can see how small that actually is. You have to do something with the drainage from the stomach. Okay, now you’ve got the blind pouch, so you’re going to take that piece of bowel that comes out of the stomach and actually tie that right into the bowel just in that location, right there.

So, now what we see is the tiny, tiny stomach, which is going to distend very, very rapidly, and then, you’re going to have the gastric juices, the pancreatic juices, the bile come into the bowel distally, correct?

That's right. The rest of the digestive juices take their normal pathway through the small interesting, and then, the stomach contents that you just ate meet up farther downstream than normal. The other thing is that pouch, it really only holds about 20 to 30 mls, or less than an ounce, of liquid. Yes. That's what it is, it is an ounce. That's it, huh? You really can’t eat anything.

The ideal pouch is less than 30 ml, more like 20 ml, 25 ml.

So, these people, they become full almost immediately.

Well, if you figure that it holds less than an ounce, and somebody eats, say, a third of a sandwich, or less than that, they can become nauseated because they ate too much.

That's exactly right. Now, this was an example of both a restrictive and a malabsorptive procedure. So, as opposed to Mr. Robinson on the other end of the table there, we have a dietary concern with the patient we just saw. Mr. Robinson can pretty much each whatever he wants to eat, I would assume, within reason, and not have to worry about malnutrition.

Well, essentially, everyone will be able to eat normally.

That's what I am certain you guys can speak more about that.

Yes. That was a question to the surgeons, here, but, yes, that's exactly right. From a dietary standpoint, he can do - - he doesn’t have to be on the supplements, is that correct?

That’s correct.

Well, he needs to be on vitamins because he will be consuming less. Actually, with all the procedures, patients have to be on supplements. But, with this one, you are right, we are concerned a little more because of the malabsorption, but, once the patient’s take their vitamins, they shouldn’t see any ill effects of bypass in the first portion of the intestines. I forgot the other part of your questions.

That’s alright. Joel, when these patients go through this rapid weight loss, I know sometimes they encounter issues like gallstone development, is that correct? Harry, either one of you can answer that. Correct.

Yes, they do.

And that is caused is by what? Is that a malnutrition thing, or is just because of the rapid weight loss?

What causes the gallstones?
It's the rapid weight loss. Anytime you lose weight rapidly affects the bowel absorption and can lead to stone formation.

The gallbladder is not stimulated to empty as much when you are in a rapid weight loss program of any kind. There’s a report several years ago of Jenny Craig or Nutrisystem being associated with gallstone formation because low fat diets don’t stimulate the gallbladder to empty it, and it sits there and forms stones.

So, it's just anything that causes you to lose weight rapidly, or if you are not contracting, that gallbladder just sits there, becomes stagnant and just forms all kinds of fun stuff.

Right.

Okay, the other thing is, with the gastric bypass, the picture you just showed, one of the things you can't eat, which we had not mentioned before, is you can't eat a large carbohydrate load because you have dumping syndrome. Cramping and nausea and diarrhea.

Great. Great point, just describe the dumping syndrome.

Well, that's pretty much it. Say you eat a Krispy Kreme donut. High sugar content, high carbohydrate content. It can cause the dumping syndrome, which is a malabsorption-type problem where you get a lot of cramping and sometimes nausea and vomiting and almost immediate diarrhea.

Is that because the sugars stay in the bowel, get metabolized by the bacteria and you produce a whole bunch of acid - -?

It's actually quicker than that. I mean, it's not so much the bacterial absorption as it is just the high carbohydrate content. (Multiple Speakers)

It just pulls it in there. And what do you do with the patients who develop some sort of dumping syndrome? They just alter their diet?

We tell them not to eat Krispy Kreme donuts.

Well, that's pretty much it. Say you eat a Krispy Kreme donut. High sugar content, high carbohydrate content. It can cause the dumping syndrome, which is a malabsorption-type problem where you get a lot of cramping and sometimes nausea and vomiting and almost immediate diarrhea.

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We tell them not to eat Krispy Kreme donuts.

We tell the watch what they eat, and if they eat those things, they wouldn't have that problem. And it's the sweet stuff, the processed simple sugar. You have a rush of fluid into the intestines, you get the abdominal cramping. You get diaphoretic. You get your heart racing. The cramping, the diarrhea, all those type of things.

I get that from a Krispy Kreme donut without having any surgery.

Most people don't like that feeling, so once they experience it a couple of times they tend not to - - They know to stop, right?

Yes.

Alright, Joel, I got a couple of good questions here. How will you remove the excess stomach, Jessica wants to know, and actually, I want to know, too.

We are going to put it in a bag, and make one of these incisions a little bigger and pull it out.

You're going to show us all that, right?

Yes.

And it's amazing how the incision doesn't have to be a whole lot larger to do that.

You don't have to macerate that thing down or cut it up or anything, it just goes into a bag and pulls straight out.

Yes.

We also have a question, what do you with all the fat after the surgery? I don't know what fat you took out, but - -

We don't take out any fat. The fat, that's a process of the weight loss.

Okay, you're not removing fat, you're facilitating the process of the body removing it over time.

Right.

Bill asks, and I'll ask Dr. Black, does insurance cover any type of this surgery, any of these types of surgery?

The insurances are different for each of them, and it really depends on the companies. Some insurances will cover the gastric bypass and not the sleeve or the band. Some will insure the bypass and the band. Some are starting to recognize the sleeve.

So, if you look here, we just placed the methylene blue through that tube, and you see the stomach is distended now. And we'll just look at our staple line to make sure theirs is no blue leaking out of it. And, it looks pretty good.

And, it's nice to see that because you can see the stomach distend with it, and that is blue fluid in the stomach, and you can see it up close, magnified five to 10 times.
So, if there’s a small leak, you’re going to see it.
That’s right.
This is the bag that we retrieve the stomach through. So, we essentially bag it, we go fishing.
Good catch, good catch Dr. Sebastien.
We can actually put a gallbladder in there, a colon, a spleen, any number of organs that we can do laparoscopic removal of.
This is like a shopping cart inside the body. I’ll take a spleen. I’ll take a gallbladder. Now, you are going to check out. So, now you are pulling the bag back in, correct?

This was a great invention also.
Jessica asked a very good question, I like this.
Does the bag ever get stuck.
No. No.
We can always make the hole bigger.
With enough force - - (laughing). It’s going to come out one way to the other, right?
Let’s see, I want to see that stomach.
Dilate the hole up a little bit.
I see how you guys get it out, so it’s definitely coming out one way or the other.
This is the part that patients feel the most pain at, for this reason. We have to dilate it up.
Your patient is asleep thought, right?
Oh yes. I mean post-operatively when they are awake.
Oh okay. I didn’t’ hear any screaming or anything, so I figured we were under general anesthesia
No, we like them sedated.
Joel, I am on the edge of my seat here. It’s like delivering a baby here, I can’t wait to see it crown.
This is actually one of the hardest parts of the procedure sometime.
You’ve got to catch it in the right position.
Yes. Do you want us to cut to a video and just show us the final comment.
Yes (laughing).
I don’t want to put you on the spot, of course, this is going to be the hardest one you ever pulled out because we are sitting here watching over your shoulder. I see something there.
He’s got it, he’s got it.
Yes, it’s going to come out in a few minutes. When I get the right end up, I will have you come back.
Okay, let us know. I want to go ahead and cue up one more video. Actually we have two more, it’s the same procedure - - there’s a portion of the stomach right there, I see it coming out. It’s crowning now. But, let’s go out and cue up that video - -
You can stay with us.
Stay with you, now? Alright. It’s looking good. Here it comes. And so the bag is basically preventing you from dropping any pieces back into the peritoneal cavity.
Transcontaminating the [rumal].
Yes, and there’s no contamination of the wound because it’s being protected there.
Unless it breaks.
So, you are going to leave the bag into the hole then.
For now, temporarily, until you get the stomach out.
And you just kind of play with it this way and that way, and promptly comes out. There it is.
Wow. Good job, man, that’s great.
This is the stomach.
Let’s take a look at that thing, there. So that’s 80% of the stomach, is that - - you’ve left about 20% behind?
Yes. Correct.
Fantastic. That’s great.
We’ll just go back and look around now and make sure everything is dry, so essentially that the sleeve gastrectomy.
And you can see the trocar going back in with the blunt on the end there. That’s supposed to prevent you from actually going into an organ right.
That’s right, and that’s 12 mm, that larger one.
Boy, everything looks so much bigger in that scope.
Yes, it’s greatly magnified.
Okay, now, let’s go ahead and cue up that last set of videos. We are going to talk about the gastric band procedure. Some of the audience was curious about that particular procedure. Starts off the same way, with the trocars in the abdomen, and we remove the inner stylets, we put our instruments in through the trocars, and we are going to see what we do at this point. Same anatomy, esophagus, stomach, so on and so forth, but what were going to do is a little different than what we’ve seen previously. Purely a restrictive, purely restrictive.

Restrictive.

We are not going to bypass anything at this point. That is the band, called the realized band, another product of J&J and Ethicon, correct? Same people who make the staple.

That’s right. It’s like a belt being cinched around the upper stomach, there. Almost the same sized pouch as you have in the roux-en-y gastric bypass.

Okay, alright, so that’s what we have with that particular portion of the procedure. Now, this is not just a static device. You can actually do something to this after the procedure is over.

Yes, you can fill it up saline and get it to tighten up, or you can take some of the saline out and loosen it up. Just like cinching a belt and letting it out.

And you adjust that based on what?
On the patients symptoms, if they are having trouble swallowing, at times, or they are being filled up too early then you can let some of the saline out. If they are not losing as much weight as they want to, or they should be, and they are keeping track of their diet, then you can put more saline in. So, that’s why it’s an adjustable band.

So, it’s adjustable, and you do that through that port, and we have a video that actually shows that if we can cue the up. I don’t know if we are ready for the video or not, but it basically shows what’s connected to the backside of that little tube coming off of the band. And, you can see the patient, again, and an incision is made. You actually run this little port right under the skin surface, and I assume you pick a spot that’s going to be, again, rather firm, hopefully, so you can push into that port.

Right. Usually the upper abdomen or sometimes the lower rib cage. And this is a neat little instrument there that attaches it and actually fixes it in the abdominal wall. You can see the injection port there, you can feel it through the skin and actually put the needle through the skin and into the port.

What you are seeing right there.

Right. It’s just like an infusaport for chemotherapy.

Exactly, and the amount of fluid that you put in there is not much, right?
No. It’s usually less than 2 ccs that it will hold, and you can see where the stomach is still in continuity, just like with the gastric sleeve, except you have a very restrictive procedure in the upper part of the stomach.

Okay. Now, is there ever a chance that you could cause ischemia in the segment of the stomach with this device?

It could - - ischemia, decreased blood supply by cinching it too tight. Yes, it’s a possibility. It’s not likely if it’s done correctly. The other thing that could happen is the band can actually erode into the stomach over a period of time. So, that’s one of the things that we have to watch for.

I know they used to do this on [anglecheck] procedure, or something, that fell out of favor because that’s exactly what it did.

That’s right. This happens less because the materials are different.

Okay.

There’s complications with any of these procedures, obviously.

Sure.

But fortunately, they are all very, very rare, especially in the hands of somebody like Dr. Sebastien. His complication rate is well below the national average, which we are all very proud of.

Exactly, absolutely. Absolutely. Now, I’ve got a couple of questions. One for Mr. Robinson, who’s still gracious enough to stick with us, and it says what advice would you give to someone looking to have surgery?

If the individual is local to the area, I would tell them to into the information session that they have routinely here at the hospital.

Thursday, 6 p.m., in the France Tower.

Every Thursday?

Every Thursday.
Okay, and there’s a number they can call, too. Is that correct? Your coordinator, is that Tammy? Tammy, yes.
Tammy’s the coordinator, now how would people get ahold of Tammy if they wanted to?
One of the numbers is 238-3295. That’s area code 386-238-3295, and there’s a phone cue for East Coast Bariatrics in that.
And Jakes asks how much weight is the patient expected to lose post-operation and how fast can you lose that. Dr. Black or Dr. Sebastian.
Well, with the sleeve gastrectomy, on average, patients lose about two to three pounds a week. The weight loss with this operation occurs over usually about six months to a year. They lose anywhere from 50% to 60% of the excess body weight, and this is average. So that means if a patient is 100 pounds overweight, they will lose about 60 pounds, on average. So some people do better, and some people do worse, for that reason. With the laparoscopic adjustable gastric band, or lap band, you lose about a pound to two pounds a week, on average about 50% of your excess body weight, and with the roux-en-y gastric bypass, you lose about three to five pounds a week, an average of about 70 percent of your excess body weight.
Now, Joel, does that lap band stay in forever. If a patient gets to their ideal weight, they feel like they can handle their diet, they can do everything they need to do, do you ever remove that band, or does that just stay in place?
It’s essentially a permanent structure. Some patients actually feel that you could take it out once they get to the health or the weight loss goal, but 95% of patients regain weight when the band is removed. Okay.
Although, it’s removable, it’s not generally done unless there is some need to.
Alright. Dr. Black, Dr. Sebastien any advice for everyone looking in. Any final words about weight loss and bariatric surgery, words of wisdom?
Get in a program. If you are going to think about the surgery, then, Mr. Robinson said earlier, it’s the program that makes the difference. It’s not just the surgeon. It’s everybody else on the team who’s helping to make a difference.
Absolutely, well that is fantastic. I want to thank everyone involved tonight. First of all, Dr. Black and Dr. Sebastien, our expert panel. Glad to have you guys with us. Mr. Robinson, thank you for joining us. We also want to thank the entire OR Live team who puts this together. Halifax Health is willing to support us each and every month, or every other month. I also want to thank Emily [Sauk] who is from Ethicon, J&J, who brought not only those wonderful videos but also these great pieces of equipment. I love using and holding these things. As a matter of fact - -
You want to take that home with you don’t you?
I am taking this home - - well, you know, I’ve got a 9-year-old little girl and I’ve got a 11-year-old son, and actually, I’ve got a 44-year-old wife, too, and I think they call use a little pinch on the hiney, and I think I could probably use this thing to do that. Except I don’t how to raise that.
You might not want to go home if your wife is watching.
Yes, so, if you guys are watching, you might want to run because I am coming home in about a half an hour, 45 minutes.
Great, great stuff, but most of all, I really want to thank each and every one of you guys for tuning in each and every month. We couldn’t do this without you. Great questions that your guys asked. On behalf of myself, Dr. Black, Dr. Sebastien and all of us here at Halifax Health, as always, stay happy, stay healthy, we’ll see you on the next OR webcast.
Thank you.