

**LAPAROSCOPIC SLEEVE GASTRECTOMY (LSG)
OUR LADY OF THE LAKE REGIONAL MEDICAL CENTER
BATON ROUGE, LOUISIANA
August 28, 2007**

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ANNOUNCER: Welcome to Our Lady of the Lake Regional Medical Center in Baton Rouge, Louisiana. Over the next hour, you'll see a laparoscopic sleeve gastrectomy. The surgery removes a large portion of the stomach, effectively turning a big bag into a small tube. Patients feel full with smaller food portions and their feeling of hunger is greatly reduced. Some of the advantages of this laparoscopic procedure include smaller incisions and faster recovery. Since no part of the intestines is altered, patients do not need to take nutritional supplements. OR-Live makes it easy for you to learn more. Just click on the "request information" button on your webcast screen and open the door to informed medical care. Now let's go live to the operating room.

00:01:11

MARGARET LAWHON: Good evening, and welcome to Our Lady of the Lake Regional Medical Center in Baton Rouge, Louisiana. I'm Margaret Lawhon. For thousands of people, obesity is a continuing problem, a chronic battle not only with extra unwanted pounds but also with the health risk that accompany extreme excess body fat. This evening, we're going to share with you a procedure called a vertical sleeve gastrectomy that's designed for people who have been diagnosed with morbid obesity. Joining me this evening to help moderate this webcast is Dr. Carl LeBlanc. He is a laparoscopic surgeon here at Our Lady of the Lake. He is also a member of a number of distinguished medical boards. He is a professor and a published author. And in the operating room, Dr. Mark Hausmann, also a laparoscopic surgeon, will be performing this evening's procedure. Dr. LeBlanc, before we go into the O.R., tell us a little bit about what would make a person a good candidate for this procedure. We're not talking about people who just want to lose 5, 10, 15 pounds, we're talking about the morbidly obese. What is that?

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CARL LeBLANC, MD, MBA, FACS: Well, the decisions we use to make the -- which operation to do on a patient is based all on the National Institute of Health's criteria, and roughly, this guide is based upon -- for a woman, it's about 80 pounds overweight, for a man, it's about 100. Now, the real number that we use is a ratio of the height to the weight, the BMI. So anybody is overweight if their BMI is over 25, and then it increases.

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MARGARET LAWHON: Body mass index, right, BMI?

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CARL LeBLANC, MD, MBA, FACS: Body mass index. The -- once you get past 35 to 40, there will be some morbidly obese over 40. And those are all -- 35 to 40, if they have some comorbid condition like diabetes, hypertension. Beyond 40, they're a candidate just because of their weight alone.

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MARGARET LAWHON: All right. Let's go join Dr. Hausmann now in the operating room. Dr. Houseman, thanks for letting us join you. Why don't you introduce us to your team in there and tell us where you are in this procedure.

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MARK HAUSMANN, MD: We've just started, but I'll introduce everybody first. This is Dr. Kenny Kleinpeter assisting me, he's a general surgeon who's spending a year fellowship learning advanced laparoscopy with our program. We have Clem, who's running our camera. Monica is our scrub tech, and Vicki and Kay, our circulators. And anesthesia are Dustin and Craig.

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MARGARET LAWHON: All right, we can see that you have a number of trochars inserted into the abdomen there, and that is to enable you to do this procedure, right?

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MARK HAUSMANN, MD: Yes. We've got five trochars fanned out across the upper abdomen. One in the midline for the camera, two for Dr. Kleinpeter, my assistant on the left side, and two for me on the patient's right side. And then we have this retractor here called the Nathanson that holds the left lobe of the liver up out of the way. And we got started a little bit early. This patient has had multiple previous operations, including open surgery for gall bladder disease, she's had several laparotomies, even surgeries for bowel obstruction and surgery for hernia repair. And that's one of the things that's nice about the sleeve is that you -- the previous surgeries aren't as much of an issue because you're dealing just with the upper abdomen and the stomach, you don't have to worry about going into the lower bowel and taking down all the other adhesives that are -- she still has down below. Would've made that a bigger operation, much more difficult.

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MARGARET LAWHON: All right, well, that sounds good for her. And we also right now, doctor, want to remind our viewers that we welcome your questions for Dr. Hausmann and for Dr. LeBlanc. Very simply, all you need to do is click on the MDirectAccess button on your computer screen in order to send us your questions. also, at any time during this webcast, you can click on the "request information" button on your screen in order to get more information about this procedure and also to make an appointment. And we realize that in reaching you, our online viewers across the country and around the world, we're able to share these new procedures and treatment options like this one with you to improve your health and your quality of life. Dr. LeBlanc, as we're looking at this, I know that there are other surgical procedures to help people who are in this category, the morbidly obese: gastric bypass, the lap-band procedure, each with advantages and risks. What are some of the other advantages of this sleeve procedure? Dr. Hausmann was just mentioning someone who had had prior surgeries, some adhesions, this seems to be a good option for her. What are some of the other advantages?

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CARL LeBLANC, MD, MBA, FACS: The other advantage that appeal to patients with this -- here's a nice picture of a sleeve gastrectomy -- you can see that, and we'll see tonight as this is created, that the stomach is actually made into a tube, and that's it. There's no re-routing of the intestine like you would with a bypass. And the normal opening of the stomach, which is called the pylorus, is maintained. So these patients have less of a problem with taking certain pills and that sort of thing. They don't have to modify their diet to some extent. Particularly, they don't have to take multivitamins specially made for bariatric patients that have had the gastric bypass because it goes straight into the intestine. An advantage of it over the band is that they don't have to come back for repeated fills, and that's actually what we've seen

in our practice. A lot of patients that do have these lap bands somehow miss their appointments to come back to get them adjusted.

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MARGARET LAWHON: Now, the band is -- here we have a little graphic here for us to see -- tell us a little bit about that. That is literally wrapping a band around the top of the stomach, is that right?

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CARL LeBLANC, MD, MBA, FACS: I describe it to patients as just taking a belt and wrapping on the top of the stomach. And that basically just restricts the amount of food intake. And the adjustments that are done tighten the balloon on the inside of that to limit the amount of food as it exists the stomach. And it does, it works well in a subset of patients that are amenable to that type of procedure.

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MARGARET LAWHON: How important, Dr. LeBlanc, is compliance for a patient who has any type of weight-loss surgery in terms of lifestyle changes after the procedure? Are there certain things that they're just absolutely going to need to adhere to from here on out?

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CARL LeBLANC, MD, MBA, FACS: Well, from what we tell all of these patients is when you eat, you would eat your protein first, because you can't eat a whole lot. So you want to eat that and make sure that you get that in. You want to take vitamins, particularly with the gastric bypass patients. There's certain vitamins that they won't absorb. You also need to drink a little bit of water all day long because we've now limited the amount of stuff that can be put into the stomach, and you don't want to get dehydrated.

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MARGARET LAWHON: So you really have to be conscious of these things.

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CARL LeBLANC, MD, MBA, FACS: All of them. And exercise. The patients that do the best of all are the ones that exercise on a regular basis.

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MARGARET LAWHON: Wow, and that's good advice for everybody, as we know. We discussed prior to us going on the web on this webcast some recent reports on an international study in the *New England Journal of Medicine*. Very good news for people indicating longer life, higher quality of life, healthier lives, who have had weight-loss surgeries. Not just the vertical sleeve that we're seeing here but any type of weight-loss surgery, right?

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CARL LeBLANC, MD, MBA, FACS: Right, right. There was a marked decrease, particularly with the gastric bypass, there was a marked decrease in the death of patients followed over seven to ten years. There were two very well-done studies that were published in the *New England Journal of Medicine*, and in one of those studies, the death rate of the patients that had the surgery was 40% less. And deaths from diabetes were 92% less.

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MARGARET LAWHON: That's significant.

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CARL LeBLANC, MD, MBA, FACS: Very significant. And a little bit of a surprising also finding was 60% of cancer deaths were less in the patients that had surgery.

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MARGARET LAWHON: Amazing. Let's go back into the O.R. Dr. Hausmann, tell us what you're doing right now.

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MARK HAUSMANN, MD: Okay, we'll give you a little -- let's back off a little and orient everybody. Let's see what we've got here. So we've been here a little while taking down adhesions from her prior surgeries. What we're looking at, we're looking toward the upper abdomen. Here's the left lobe of the liver that's held by a retractor. Can you vent some of that smoke? This is called -- this is the GE junction here, where the esophagus meets the stomach. This is the upper part of the stomach, and we've been taking down this paraesophageal fat pad so we can see the junction at that point. You follow around here, this is the stomach and then follow around this way, and this is called the antrum of the stomach, and we're heading toward the pylorus, which is sitting back here. She's still got some scar tissue from her prior gall bladder surgery, but we can see the pylorus right here. And so our plan is to basically resect this portion of the stomach along there, all the way -- and all this portion to the right will be gone. We'll leave a long tubular stomach along what we call the lesser curvature.

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MARGARET LAWHON: All right, and doctor, you are retracting there sort of the top of the screen, that's the liver, is that correct?

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MARK HAUSMANN, MD: This is the liver, and if you look over here for orientation as well, that's the spleen sitting over there.

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MARGARET LAWHON: Okay. And the pylorus again is the opening into the stomach, is that correct?

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MARK HAUSMANN, MD: The pylorus is the opening from the stomach to the small bowel, and so that's where we're going to start. We've actually just taken down some adhesions down what's called the angle of His to the peritoneum at the upper part of the stomach, and now we're going to go back down toward the pylorus. And we start somewhere between four to six centimeters proximal to the pylorus. Can you lift that up here? Push up?

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MARGARET LAWHON: All right. And, Dr. LeBlanc, as we're looking at this, you and I discussed prior to this webcast that you have had experiences, too, where you go in and you discover a certain amount of scar tissue that you absolutely cannot detect until you get in, is that right?

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CARL LeBLANC, MD, MBA, FACS: That's right. That's real common with all operations that we do on patients. And that's one of the benefits of laparoscopy, though, is that it diminishes those -- that much scar tissue. Prior procedures were not laparoscopic, and he's had to deal with those. We didn't see him do that, but he spent a considerable amount of time getting that down just to get to this stage. But it's just something that, like I tell patients, we open the hood and see what the engine looks like, and then we start working.

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MARGARET LAWHON: Exactly. We have a couple of questions from our online viewers. The first one is: why is this called a sleeve? Dr. LeBlanc, why would you call this a sleeve?

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CARL LeBLANC, MD, MBA, FACS: Well, it comes about just because when -- as the procedure is done, the stomach basically looks like a sleeve of a long-sleeved shirt. It's a tube, and it's just some name that was just picked up for it.

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MARGARET LAWHON: All right. What kind of recovery time is this patient going to be in for? This is another question from one of our internet viewers. Recovery time after this procedure's over.

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CARL LeBLANC, MD, MBA, FACS: These patients -- actually, to put it in perspective, the patients that have a lap-band procedure, they go home the same day. This patient will go home the day after surgery. And the bypass patients go home two days after surgery. And so the recovery for pretty much all of them is very similar. They -- it's amazing that regardless of the operation, most of them are pretty much ready to go back to work in a week or two. Now, when we first started doing this operation, we said, "oh, you've got to take a month off," and then we'd find out that our patients weren't listening to us. They would just --

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MARGARET LAWHON: They were actually going on back to work or other activities.

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CARL LeBLANC, MD, MBA, FACS: Yeah, so it's real variable. It depends on their level of activity prior to the surgery, what their comorbidities might be, and what activities they participate in their jobs, so we don't -- we do limit it to somewhat, particularly if they're, say, like a policeman. We certainly wouldn't want them to go back to work real quick for safety issues.

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MARGARET LAWHON: Sure, sure. Dr. Hausmann, tell us a little bit about the lighting in there. You and I visited about that a little bit, that you do dim the lights in order to really be able to use these tools and to see what you're doing, right?

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MARK HAUSMANN, MD: Yeah, we dim the lights in the room so we can see the monitors better, basically, when we're doing laparoscopic surgery. It helps us visualize -- see the monitors better, basically.

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CARL LeBLANC, MD, MBA, FACS: Yeah, typically, actually, we see this well-lit surface of the patient's abdomen, it's actually not usually that lit.

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MARGARET LAWHON: Oh, okay. All right. What kind of discomfort/pain is this patient going to experience in recovery after the surgery is over, Dr. Hausmann?

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MARK HAUSMANN, MD: There's really not a whole lot of discomfort. They have six little bitty incisions. There is some expected discomfort, but it's really not to a great degree, and it's well controlled with our pain medicine.

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CARL LeBLANC, MD, MBA, FACS: The one thing -- the one thing we do do prior to actually making the skin incisions, we actually infiltrate some local anesthetic, say like you would have in a dentist's office to help diminish that. That makes a significant difference, but frankly what I tell patients is if they've had a tremendous amount of pain, we couldn't send them home as quickly as we do.

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MARGARET LAWHON: Right, right. One of the things that I think people need to understand is that this is not a cosmetic remedy, although there is certainly a cosmetic aspect to all of this, but there are some very serious consequences to being morbidly obese, to being seriously overweight, such as -- as you mentioned -- diabetes, high blood pressure, even sleep problems, sleep apnea, right?

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CARL LeBLANC, MD, MBA, FACS: Sleep apnea, yes. And remember, Reggie Jackson, a football player, died of that, sleep apnea.

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MARGARET LAWHON: Right, right.

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CARL LeBLANC, MD, MBA, FACS: And this -- it's amazing how these operations we do, in a month or so, some of these are completely eliminated very quickly.

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MARGARET LAWHON: In some of the literature I read, even depression is a part of this, and you can well see, if you don't feel good about yourself, if you're not feeling well...

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CARL LeBLANC, MD, MBA, FACS: There -- I can tell you that patients come to us, and the large majority of them are on some type of Prozac or Cymbalta, something like that because they just don't feel well about themselves. And their personality change as we watch them get thinner is amazing, and it's very pleasing as a surgeon to help patients that way.

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MARGARET LAWHON: Oh, I'm sure it is. Another question from one of our internet viewers: what are the long-term effects/risks of the stomach being removed or a portion of the stomach being removed and how much of the vagus nerve is removed?

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CARL LeBLANC, MD, MBA, FACS: The -- the long-term risks are -- we get that question a lot, actually, and we're basically not seeing any of that. The stomach is just made smaller so you can't really eat much, so there's really no long-term outcome that is adverse at this time, that's known at this time.

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MARGARET LAWHON: Is the vagus nerve touched in all this?

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CARL LeBLANC, MD, MBA, FACS: The vagus nerve is touched, and when you come across the stomach at the top of it, we will divide that part of the vagus, but that's the part of the vagus that goes to the stomach. The part of the vagus on the other side of the stomach that's left, that will be left intact.

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MARGARET LAWHON: Dr. Hausmann, you're cauterizing here, you're incising?

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MARK HAUSMANN, MD: Yes. We finally found our plane here. This is the stomach we've got here, we're taking what's called the gastrocolic omentum off. You're looking behind the stomach here, but we're taking -- we're freeing the stomach from these attachments here. And that's -- that's going to go all the way up beyond the spleen, up to the GE junction, and that's going to take the first part of the operation, just clearing all these adhesions -- or not the adhesions, this portion of the omentum off the stomach.

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CARL LeBLANC, MD, MBA, FACS: Yeah, the omentum is the fat layer that's attached to the stomach that lies over the rest of the intestine, and you can see how close he is to the stomach, and that's because there's a blood vessel that runs adjacent to the stomach right there that you need to preserve because that's the blood supply to the omentum. So if you cut that, then it won't survive. Which wouldn't be a tragedy, but it's unnecessary.

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MARGARET LAWHON: Another question for you, Dr. LeBlanc or Dr. Hausmann: how long has this procedure been performed laparoscopically?

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CARL LeBLANC, MD, MBA, FACS: Actually, this -- I am not aware of this procedure being done on an open-type situation because as you and I discussed earlier, Margaret, the -- this procedure originated as part of the first stage of another operation, called the biliopancreatic diversion, and all of that was pretty much done laparoscopically. And as time progressed, the patients would get the first stage of the operation but not go on to complete the second stage because they were having such good weight loss. So it's really been done almost exclusively laparoscopically.
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MARGARET LAWHON: Of course, we want to invite everybody who is watching to send us questions. You can do that simply by clicking on the MDirectAccess button on your computer screen. We love hearing from you. We look forward to answering your questions. Another thing that I wanted to ask Dr. Hausmann: you mentioned that this patient had a prior gall bladder surgery; was this patient experiencing any of the other medical problems, symptoms that might go along with being this much overweight? Diabetes, high blood pressure, this kind of thing?
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MARK HAUSMANN, MD: This patient is pretty much a textbook patient. She had almost everything. She has high blood pressure, diabetes, gastro-acid reflux disease, urinary stress incontinence, cholest-- hypercholesterolemia. She was a pretty typical patient with a long list of medical problems associated with her obesity.
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MARGARET LAWHON: How soon can she expect to start losing weight? Will this be almost immediate after this procedure?
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MARK HAUSMANN, MD: It'll start immediately because we put them on a pretty strict regimen postoperatively. They're on pure liquids initially after the operation for a period of time, and the weight-loss is very rapid.
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MARGARET LAWHON: Dr. LeBlanc, what are some of the things that patients need to be aware of, some things that they need to do to get ready for this kind of surgery? Do they need to change their diet, do they need to be checked out psychologically maybe?
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CARL LeBLANC, MD, MBA, FACS: Yeah, the process that we follow in all of our patients, and actually most bariatric surgeons do, is that we have -- as any operation, we have them have -- undergo a specific battery of laboratory tests. Everybody expects that. We also get on all of them an upper GI so we can actually see their anatomy. Because rarely, we'll see something that we have to modify the technique for, not just for this operation but for others. I mean, I have had a patient that actually had everything reversed, and you certainly don't want to -- your trochar positions are a little bit different, you're doing -- you're kind of doing the operation backwards.
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MARGARET LAWHON: The organs were reversed? Goodness.
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CARL LeBLANC, MD, MBA, FACS: Mm-hmm. So and you can still do it, it's just you would be in the wrong place if you didn't know that. We also, if the patients have a propensity for sleep apnea, we sometimes test for that, but most of us come to us with that diagnosis. And the final thing is we do get psychological evaluations on all of these patients. And a lot of patients are a little bit resistant to that because they say, "I know I'm not crazy." Well, that's not why we're doing that. All surgery has a mental component, and you have to be committed to the operation. Now even -- that's just if you're even having your gall bladder out. If you're having a life-altering

procedure, you have to be willing to accept the consequences of the procedure and what you have to do to make it go forward and work. So that's what that psychological evaluation -- and I've had a few patients that just either didn't have the support systems in the family, and the psychiatrist said, "Please delay it a little while." Or they had severe depression that the patient didn't even know about. And those patients particularly are at risk for having problems because they just can't follow the rules and they can't handle the changes of what they have to eat and all that sort of thing.

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MARGARET LAWHON: Is there an age range that's prescribed for this surgery, or I guess a better way of asking it is do you have to be a certain age before you would be a good candidate?

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CARL LeBLANC, MD, MBA, FACS: Currently, the -- basically, typically 18, 18 years of age.

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MARGARET LAWHON: A full-grown adult.

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CARL LeBLANC, MD, MBA, FACS: Yeah. There are some centers in the world and some specific ones in the United States that are actually approaching the pediatric population, which I think it will go to some of that, and some are in these various operations.

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MARGARET LAWHON: Pediatric obesity is a problem.

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CARL LeBLANC, MD, MBA, FACS: It's a big problem, big problem.

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MARGARET LAWHON: It's a big problem. All right, is this procedure appropriate for someone who has had prior surgery removing one-third of the colon and one-third of the small intestine? This viewer says this procedure was done on him or her in 1987.

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CARL LeBLANC, MD, MBA, FACS: I think that that would probably somewhat depend on what those were removed for, that would have something to do with it, but typically that's still a plenty amount of intestine that I think that that's not out of the question that they couldn't have that surgery. I think that they're potentially a candidate.

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MARGARET LAWHON: Dr. Hausmann, tell us what we're looking at here.

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MARK HAUSMANN, MD: Well, we're trying to -- these are called the short gastric vessels. This is some of the more difficult part of this operation because it's sometimes very -- the stomach's very fused to the spleen. As you can see, we're trying to separate the stomach from the spleen, and there are a number of vessels right here we're trying to divide.

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CARL LeBLANC, MD, MBA, FACS: And this is similar, if anybody had watched Dr. Hausmann do the Nissen fundoplication we did a few months ago, he did this same part of this operation for that operation as well.

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MARGARET LAWHON: Right, I do remember that, and those who watch this may remember that, too. Dr. Hausmann, while you're working on that, we're going to take a few more questions from our viewers. Dr. LeBlanc, what are the complication rates and mortalities of this particular surgery?

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CARL LeBLANC, MD, MBA, FACS: Actually, the -- going to the mortalities, very, very rare. We -- it's hardly even discussed, it's so rare. The complication rates are very few. The most common one, frankly, is going to be maybe a pneumonia, potentially blood clots because all obese patients are at risk for that. But we, on our own series of patients, we have not actually had any complications.

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MARGARET LAWHON: Important for patients to get up and about as soon as they're able?

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CARL LeBLANC, MD, MBA, FACS: Oh, we have them up that afternoon.

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MARGARET LAWHON: Wow. Now here's another question: if you have a hernia, is it possible to repair the hernia and do this surgery at the same time with a quick recovery? Everybody wants a quick recovery, I know that.

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CARL LeBLANC, MD, MBA, FACS: Oh, yeah. The -- unfortunately, I'm not quite sure what hernia they're talking about. Now, if they have a hernia up at the hiatus like a lot of patients that have a hiatal hernia, you wouldn't -- if they're significant, we'll put a stitch or two up there, and the patient really wouldn't even know that that part was even done. If they have a hernia that's say like -- say like this patient that had an open gall bladder surgery, say she had a hernia. If -- what we approach those with all of these operations, if that turns out to be more complex, then we'll just repair the hernia. But typically you can -- it's possible to do both, and it's almost -- we try to do both if necessary. If we can at the same time. But the recovery would be a little bit prolonged because the nature of the operation that you would do to fix the hernia actually would end up causing more pain than this surgery.

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MARGARET LAWHON: Oh, wow. Dr. Hausmann, are there patients who would not be good candidates for this surgery because of some other comorbid condition, some other complication that you could think of?

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MARK HAUSMANN, MD: Well, they need to be, you know, able to tolerate anesthetic first off, just like any other surgical patient we have. And dependant on if they've had some upper abdominal surgery, that may -- that may change the complexity of the issue and make them not a candidate. Lower abdominal surgery would not, but upper abdominal surgery -- they had something done to their stomach -- it may or may not make this not a good option.

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CARL LeBLANC, MD, MBA, FACS: Yeah, if they've had -- say they've had cancer of the stomach and they've had some of it -- removed that, we'd certainly eliminate it. And also, it would make it -- except a lot of these patients could potentially have had a Nissen fundoplication, and that does not eliminate them from consideration. It would just depends on the circumstances at that time.

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MARGARET LAWHON: Dr. LeBlanc, here's a question for us: what is the advantage of this procedure over liposuction and band ligation, and who is the ideal patient for this procedure? We sort of touched on who good candidates are.

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CARL LeBLANC, MD, MBA, FACS: Yeah, liposuction is actually a plastic surgery procedure, and basically all that is is just removal of the fat underneath the skin. This is not at all what this is. This operation is designed to help the patients lose that fat with surgery. And I'm not quite sure what they mean by band ligation. If they

mean the lap band, the advantage over a lap band is that you don't have to come back for fills. And -- and that's the main one. And it seems, early on, that the weight loss that's achieved with this operation is a little bit better than the lap band in some patients.

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MARGARET LAWHON: Here's an interesting observation and a good one from one of our viewers: the O.R. team have inserted extremely long objects into the patient's stomach area; from where I sit, it seems it's possible you could injure the patient internally with those objects even though the stomach appears to be inflated. How is injury prevented? Dr. Hausmann, care to comment on that?

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MARK HAUSMANN, MD: I mean, we're careful with where we place the instruments is the simple answer to the question. That's -- you're right, we're concerned any time we're moving instruments in there that we can't see, and that's why Clem is actually so important, our camera driver, so she visualizes the areas that we're concerned about.

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MARGARET LAWHON: So technology is definitely a huge part of this, makes it possible.

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MARK HAUSMANN, MD: Yes.

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CARL LeBLANC, MD, MBA, FACS: It is, but it turns out that the space that we're working in is really larger than it seems, and injuries like that of course can occur, but it's actually really, really uncommon.

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MARGARET LAWHON: We always use medical terminology when we do these things, obviously. One question: what does "gastrectomy" mean?

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CARL LeBLANC, MD, MBA, FACS: Oh, good question. "-ectomy" of anything means it's being removed, and we're doing a gastrectomy, so we're removing part of the stomach; "gastric" is "stomach." And that -- that term is used a lot, but we're doing a sleeve, which is actually technically a partial, not a whole gastrectomy.

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MARGARET LAWHON: Okay. We talked before this broadcast, before this webcast, about how long this surgery has been around and how long you here at Our Lady of the Lake have been doing it. Talk to us about that a little bit more.

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CARL LeBLANC, MD, MBA, FACS: Yeah, the surgery has been around for some time. As a solo operation, it's probably been around for about six years or so. And it was really getting, in our journals and that sort of thing, it was getting a lot of press about how good it was. And we here didn't offer it to any patients until a year -- last year because we wanted to wait on data and to show -- I didn't want to offer it and neither did Dr. Hausmann want to offer a patient an operation that we didn't really know the results of. And we were so impressed with the results, we actually went and watched a friend of mine up in New York do a few of these, and came away thinking, "Hey, this is really a good option." So that's -- we started doing them last year.

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MARGARET LAWHON: Dr. Hausmann, the portion of the stomach that you will leave inside of her, how big is it and will it stretch over time?

00:25:54

MARK HAUSMANN, MD: Well, it's -- we put a tube down called a bougie that measures about -- probably about the size of your thumb, maybe a little bigger. So you end up with a long, narrow tube -- sleeve about the diameter of your thumb, and that's pretty much what's left of the stomach except for the most distal antrum. We leave a little pouch there, she'll probably have over 100 cc's. And over time, we do suspect it will dilate a little bit over time, but the early results -- information we're seeing is excellent, weight loss. And the question's going to be long-term, as Dr. LeBlanc said. This has been performed for five or six years now as a primary operation, and so we don't know the results 10 years, 20 years from now.

00:26:33

MARGARET LAWHON: Could you potentially convert to, let's say, the gastric bypass later if the patient -- you and the patient so chose to do that?

00:26:40

MARK HAUSMANN, MD: Yeah, that's another benefit of this procedure, and it's used that way in some fashions in a planned way. But if a patient gets to the point where they're unsatisfied with their weight loss or they get a plateau, it can be converted to either a duodenal switch or a gastric bypass.

00:26:55

CARL LeBLANC, MD, MBA, FACS: And we do use it to -- I have like a patient that her BMI was almost 80, and you do the bypass, it's actually a very technically demanding, risky operation, so we did that first, and she's doing wonderfully. I don't think she'll ever do any more than that. The other question I see that's asked here is does the stomach stretch? And yeah, all of these will result in some enlargement -- I don't care if it's the gastric bypass -- however, as you will see, the part of the stomach that's left, if you're looking at the stomach, it's on the left side, that's called the lesser curve of the stomach. That is the part of the stomach that stretches the very least, and so it -- we -- basically, the operation's accounting for that stretch.

00:27:35

MARGARET LAWHON: We apparently have some viewers who have had this experience, they've had the surgery. Someone says: I just had this surgery a week and a half ago, it's amazing to see what actually went on inside my body. Yes, it is. And that's really neat.

00:27:46

CARL LeBLANC, MD, MBA, FACS: Well, that might have been one of my patients.

00:27:48

MARGARET LAWHON: It might've been, it might've been.

00:27:49

CARL LeBLANC, MD, MBA, FACS: Yeah, like he answered, the stomach, it's anywhere from 85 to -- anywhere, it depends on the patient's size, but it's anywhere from 80 to 90% of the stomach sometimes.

00:27:58

MARGARET LAWHON: Okay. In talking about lifestyle changes after this surgery, a couple of different questions: can a patient who has this surgery ever consume alcohol again, and also do you have to drink a protein drink after surgery? Dr. Hausmann?

00:28:11

MARK HAUSMANN, MD: You can drink alcohol. We recommend it in moderation, of course. And protein's never a bad idea, but one of the benefits of this operation is you don't have malabsorption, so you're not reliant upon the protein supplements and the vitamin and mineral supplements that you would be with the bypass.

00:28:27

MARGARET LAWHON: Dr. Hausmann, tell us where we are with this process.

00:28:30

MARK HAUSMANN, MD: Okay. We're trying to -- I'm trying to measure from the pylorus, which we see right here, I'm trying to get a little closer to it. This -- the jaws of this is about three centimeters, so I'm now about six centimeters from the pylorus, which is where I want to start. And that's where we're going to start resecting the stomach. But we're going to put that bougie down first. The bougie is the little tube I was explaining to you. It's about the size of a thumb, and that's what we're about to do right now, and that's how we -- that's how we size the tube, the sleeve. As it comes down, can you push it this way?

00:29:02

CARL LeBLANC, MD, MBA, FACS: And if you notice the way he started the operation, he was going right to left, now he's kind of going left to right of the patient.

00:29:09

MARGARET LAWHON: We're hearing from someone who describes herself as a 36-year-old 5'9" female who currently weighs 236 pounds. I know that it's hard to give a thorough diagnosis or recommendation to someone on just a little bit of information, but Dr. LeBlanc, do you think this patient might qualify for this procedure?

00:29:24

CARL LeBLANC, MD, MBA, FACS: She might, just guessing. At that height and weight, she -- if she qualifies under the criteria that we described earlier, she would -- she would qualify for a weight-loss surgery, maybe. It just depends on what her -- if she has hypertension and medical problems and that sort of thing.

00:29:42

MARGARET LAWHON: Dr. LeBlanc, we are looking at a picture of the stomach right there, is that right?

00:29:44

CARL LeBLANC, MD, MBA, FACS: That's correct. That's right.

00:29:46

MARGARET LAWHON: And beyond it, sort of in that upper left portion, is that the liver we're seeing?

00:29:50

CARL LeBLANC, MD, MBA, FACS: That's the liver. What they're trying to do right now -- you see that thing that's kind of poking that Dr. Kleinpeter's poking on, pushing it, that is the bougie that's going in. And that's what we'll size. See, he's pushing it toward the pylorus, which is the opening of the stomach.

00:30:04

MARGARET LAWHON: Okay. Dr. Hausmann, a question about the length of time it takes to do this surgery. Does it really just depend on what you find when you get in there?

00:30:11

MARK HAUSMANN, MD: Yeah, well, this one actually happens to be a pretty difficult one because of all her scarring, but typically, it's about an hour procedure, sometimes a little more than that. If we're lucky, it's a little less than that. Okay, you've got to push it from here.

00:30:21

CARL LeBLANC, MD, MBA, FACS: Now, you see, look right here, Margaret, you can see that's being pushed on by that up-- that instrument on the right. That is the bougie that's being pushed in. You have to maneuver that -- you can see it's stiff, and they're trying to maneuver it into the right position.

00:30:36

MARGARET LAWHON: How much of the weight loss at least immediately after this procedure can be credited to a liquid diet? Dr. LeBlanc?

00:30:44

CARL LeBLANC, MD, MBA, FACS: Yeah, the -- well, initially, that is a fairly significant part of it, but that is only -- that's a very -- the liquid diet is very short-lived. They move on to more solid food within a month, and basically it's the amount of food that they cannot eat that is responsible for that.

00:31:02

MARGARET LAWHON: And we talked about supplements, dietary supplements and the need for them or the fact that you might not need them. Would a patient who has this sleeve gastrectomy need to take B12?

00:31:11

CARL LeBLANC, MD, MBA, FACS: No, they don't, unlike the gastric bypass. They -- because their pylorus is intact and there's no bypass, they don't have to take any supplemental vitamins, because they'll absorb it.

00:31:21

MARGARET LAWHON: Dr. Hausmann, how much of a problem is bleeding during this procedure? It doesn't seem to be excessive, and is that pretty typical?

00:31:29

MARK HAUSMANN, MD: That's pretty typical. And we're actually having more bleeding than we often do, but not to a significant degree. It's just aesthetically, it's a bit un-- displeasing. But it's not clinically significant.

00:31:40

CARL LeBLANC, MD, MBA, FACS: Yeah, Mark, why don't you tell us what you're doing right now.

00:31:42

MARK HAUSMANN, MD: Right now, this is going to be the first firing of the stapler, and we're trying to -- as you can see, I can fit -- the bougie is right here, so it's sizing -- here's the -- what's called the lesser curve of the stomach. This is the antrum, this is the remainder of the stomach. This is the antrum right there, which is about six centimeters. This is three, six, and this is the first firing to get started with the sleeve. And we got -- the key thing is having that bougie in there so we don't make it too small. That's the size we want to go with right there.

00:32:07

MARGARET LAWHON: Okay. So you're actually going to be removing part of the stomach laparoscopically through one of these trochars, right? One of the ports?

00:32:16

MARK HAUSMANN, MD: Yes, this is -- and that stomach is removed. This is a permanent operation -- give me a little slack, Kenny.

00:32:22

CARL LeBLANC, MD, MBA, FACS: Now, what -- what --

00:32:24

MARK HAUSMANN, MD: Now what we're doing here, this device is a surgical stapling device, it creates parallel rows of staples. We have what's called a seam guard on -- you see that white thing. It kind of helps reduce bleeding and helps our anastomosis. And you see, it staples and then has a blade that cuts between the --

00:32:44

CARL LeBLANC, MD, MBA, FACS: Yeah, staples and cuts at the same time.

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MARGARET LAWHON: Wow.

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CARL LeBLANC, MD, MBA, FACS: And he's just going to follow that tube up.

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MARGARET LAWHON: Okay. That's amazing. Is there a risk of injuring the portal vein?

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MARK HAUSMANN, MD: The portal vein is really not in the --

00:32:57

CARL LeBLANC, MD, MBA, FACS: Yeah, the portal vein is way, way over to the left of where he is.

00:32:59

MARGARET LAWHON: Okay, okay. And I don't know if I asked you this before, but I know we had a question earlier about whether or not you put a trochar or used as a port the navel. Did you use the navel?

00:33:08

MARK HAUSMANN, MD: We're kind of above the navel actually.

00:33:10

CARL LeBLANC, MD, MBA, FACS: Yeah, the navel actually is too far down for the -- because we're working way up in the upper abdomen.

00:33:14

MARGARET LAWHON: Okay. There's that question. All right, here's one -- a person who's writing, saying: I had a left colon resection, would I be a candidate for this procedure, and why would I choose this over gastric bypass?

00:33:26

CARL LeBLANC, MD, MBA, FACS: Well, a left -- the left colon resection would not disclude -- exclude them from being a candidate, and regardless of any operation or even not having an operation, the choice is more the patient's choice is if they don't want to take the supplements, if they -- this is associated with a little bit less risk, and so that'd be the same choice any patient would make. Now you see, he's flipped over the colo-- the stomach so he can see the bougie from behind and make sure that it's tight up against it. He can see it pushing up.

00:33:55

MARK HAUSMANN, MD: We're tight up against that bougie again. You can kind of get the idea that's how big the stomach's going to be. A long --

00:33:58

MARGARET LAWHON: Just like that, okay.

00:33:59

MARK HAUSMANN, MD: Just like that, you can kind of get an idea. That's the bougie that I can feel in place.

00:34:03

MARGARET LAWHON: So we're talking about maybe frequent smaller meals? Would that make sense? Would that be the...

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MARK HAUSMANN, MD: Well, we don't want them to be necessarily more frequent, we just want them smaller.

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MARGARET LAWHON: Just smaller.

00:34:14

CARL LeBLANC, MD, MBA, FACS: Yeah, if they -- if you're just a quote, "grazer," you can eat a little bit all day long, and then you'll just go on through and you'll actually defeat the operation if you really are trying.

00:34:24

MARGARET LAWHON: Wow. Now someone writes saying: I'm told after the surgery I will rapidly lose weight; what can I do to prevent having loose, hanging skin flaps while I'm losing weight?

00:34:35

CARL LeBLANC, MD, MBA, FACS: Well, that's a big question for everyone, and what we tell them is to make sure the things that help, by all means, exercise.

00:34:41

MARGARET LAWHON: Exercise, sure.

00:34:42

CARL LeBLANC, MD, MBA, FACS: Drinking a lot of fluid to help flush, basically if you will, the stuff that's coming out of the fat as it's being metabolized, those sort of things, but exercise and taking vitamins, and that is about all that you can do. It depends on where the skin is loose and that sort of thing, but the younger the patient, if you're not diabetic, if you're not a smoker, that we see many patients that have no issues with that.

00:35:06

MARGARET LAWHON: How does the anesthesia affect a patient who might have sleep apnea, Dr. Hausmann?

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MARK HAUSMANN, MD: The weight loss that we see after this procedure actually results in the resolution of sleep apnea in about 85% of patients.

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MARGARET LAWHON: Would the anesthesia that's given have any effect on that?

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CARL LeBLANC, MD, MBA, FACS: No, it would not. It would not. With the patients that have sleep apnea, we ask them to bring -- if they're on CPAP, we ask them to bring that with them so we can monitor --

00:35:28

MARGARET LAWHON: CPAP, you mean the machine that you wear when you sleep?

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CARL LeBLANC, MD, MBA, FACS: Right, right, or BIPAP is another type. We have them so we can monitor them closely.

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MARGARET LAWHON: All right, so Dr. Hausmann, you're continuing with that stapling and --

00:35:40

MARK HAUSMANN, MD: Yes, we're just marching up the stomach in parallel to the lesser curvature of the stomach toward where we initiated back up at the GE junction. And we've got a couple more firings to go and we'll be there.

00:35:53

CARL LeBLANC, MD, MBA, FACS: Can you -- Mark, can you maybe just take a second while she's reloading that maybe just to show us where the spleen is so we can get an appreciation of where we are?

00:36:00

MARK HAUSMANN, MD: Okay. That's why we've done three firings. We were taking the blood vessels off the spleen. There's the spleen right there. We're kind of heading up toward -- here's the GE junction right there. This is going to be the last bit of it is right along here, is where we're going to divide. We've got probably two or three more firings and the procedure will be completed.

00:36:22

MARGARET LAWHON: Dr. Hausmann, if someone has had a splenectomy in the past, would that affect or complicate this procedure?

00:36:28

MARK HAUSMANN, MD: Actually, it would probably make it easier because as one of your questioners asked about risk of complications, and injuring the spleen's one of them. If the spleen's already gone, it's really not an issue.

00:36:39

CARL LeBLANC, MD, MBA, FACS: And it would depend, though. If they had an open procedure, it might make it a little bit more time consuming because of the adhesions.

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MARGARET LAWHON: What about those staples? What happens to them over time?

00:36:48

CARL LeBLANC, MD, MBA, FACS: They're there forever.

MARGARET LAWHON: Okay.

00:36:50

CARL LeBLANC, MD, MBA, FACS: And these are staples -- these are not unique to this procedure. They're staples we use for all kind of resections.

00:36:56

MARGARET LAWHON: Okay.

MARK HAUSMANN, MD: Let's see where we are, Kenny.

00:36:59

MARGARET LAWHON: So, doctor, we see the screen over your shoulder there, and that is what you are seeing, too. You're operating off of that, right?

00:37:04

MARK HAUSMANN, MD: Correct, that's the monitor I'm looking at. Where is that bougie?

00:37:11

MARGARET LAWHON: So the camera is the one in the middle, is that correct?

00:37:14

MARK HAUSMANN, MD: The camera is the one in the middle, yes. And we're just -- we just keep checking, make sure we have our right, correct orientation here. It's a little bit more difficult as we get up higher.

00:37:27

MARGARET LAWHON: Here's a question about age. If a person is -- this person is 67 years old, five feet tall and 270 pounds. What is the cutoff age for this surgery, would I still be able to have this done?

00:37:38

CARL LeBLANC, MD, MBA, FACS: That depends on a lot of other factors, maybe the medical conditions that the patients have and age -- a lot of people don't tend to do the older patients. I hate to use -- I'm not going to define "older", but that does play a lot --

00:37:53

MARGARET LAWHON: A patient who might have age-related medical conditions. Again, we talk about terminology, and a lot of times, we use terms that we know, and maybe they're not so well-known. A bougie, explain that again if you would, doctor.

00:38:06

CARL LeBLANC, MD, MBA, FACS: A bougie actually is -- and it's spelled B-O-U-G-I-E -- a bougie is actually just a big tube, and it's just a solid tube that is passed. There's many different types but it's just a solid tube that's passed. It's made out of a flexible material so that we can manipulate it.

00:38:21

MARGARET LAWHON: Now, why might gastric bypass be recommended over the sleeve for a person with the lowest possible level of BMI?

00:38:30

CARL LeBLANC, MD, MBA, FACS: Well, frankly, I always let the patients choose what they want to have because what I will tell them in the office is the risk and benefit of the procedure is not mine to have, so I will discuss with them all the different options, and then they will discuss it. The issue that we see with many patients, though, is that from an insurance standpoint, this operation is -- how do we say it? -- not as much frequently covered. And so patients will opt for the -- for the bypass, even though they may have wanted the sleeve, but the insurance, based on that.

00:39:04

MARGARET LAWHON: This graphic really helps us to see the -- the things that people need to consider when they're considering these three options, the gastric bypass on the left, the sleeve, and the lap-band. The sleeve, the one in the middle, is obviously the one that we're watching this evening. Bypass has been around for a while, right, Dr. LeBlanc?

00:39:18

CARL LeBLANC, MD, MBA, FACS: Since the late '60s, yeah. And it's been done laparoscopically since the early '90s.

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MARGARET LAWHON: So we definitely see less of an operative risk with the sleeve.

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CARL LeBLANC, MD, MBA, FACS: That's correct.

00:39:28

MARGARET LAWHON: And also with the lap-band. And one of the things that I'm hearing you say that would sound appealing to me is no supplements. Even though a slower weight loss and less weight loss with the sleeve, but it seems like you can just live your life and not worry about so many changes.

00:39:42

CARL LeBLANC, MD, MBA, FACS: Oh, yeah, and that's one of the significant benefits of it. But there's lesser need of compliance than there is with a band, but there's a little bit more than with the bypass.

00:39:51

MARGARET LAWHON: Another question for us. This person writes saying he or she is overweight, has muscle disease, is also diabetic and has high blood pressure. Lap-band or bypass or this? Again, we're asking you to make calls on things with very little information.

00:40:08

CARL LeBLANC, MD, MBA, FACS: Yeah, there's a lot of different factors in there. And again, I usually don't choose for the patient, however I have one patient that has a lot of medical conditions, and she's actually on dialysis, and for that particular patient, because they're considering a transplant, I feel like in her particular case that because of the medications that they need to take -- she's going to need to absorb all of those -- and so I really think in her case a lap-band would be the best option for her.

00:40:35

MARGARET LAWHON: Dr. Hausmann, where are you right now?

00:40:37

MARK HAUSMANN, MD: I'm at what I think is going to be our last firing. It's just we're a little -- gets to be tight quarters up here, so we're trying to get at what I think is going to be the last firing across the stomach, but I'm not sure.

00:40:49

MARGARET LAWHON: With each firing, you're putting in approximately what length of staples?

00:40:54

MARK HAUSMANN, MD: It's six-- a staple is 60 centimeters.

MARGARET LAWHON: Okay.

00:40:56

CARL LeBLANC, MD, MBA, FACS: Which is close to three inches.

00:40:57

MARK HAUSMANN, MD: I mean, 60 millimeters, six centimeters.

00:40:59

MARGARET LAWHON: Okay. Dr. LeBlanc, here's another question for us, someone who believes that she has an umbilical hernia, just happened a few weeks ago, haven't had it looked at. Is this the type of hernia that could be done at the same time as the vertical sleeve gastrectomy?

00:41:13

CARL LeBLANC, MD, MBA, FACS: Yes, it could be, yeah.

00:41:15

MARGARET LAWHON: Okay. And again, with these questions, which are wonderful and we appreciate them and we're thrilled that people are watching and interested in getting educated, you need to check with your physician.

00:41:23

CARL LeBLANC, MD, MBA, FACS: Absolutely. Yeah, this is just a few words, but just on that surface, looks like it'd be okay.

00:41:28

MARGARET LAWHON: All right, let's see. Someone had gastric bypass and lost 100 pounds since July 19, 2006, but have gained 3-5 pounds. How do I get back to losing?

00:41:38

CARL LeBLANC, MD, MBA, FACS: Exercise. Exercise, and also they might check and see how much -- what type foods they're eating. The stomach does stretch, it's not unusual for weight to fluctuate somewhat. That's not -- actually 3-5 pounds is not unusual at all.

00:41:52

MARGARET LAWHON: Again, we just flashed on the screen a way for you to contact us. If you want more information, you can click on the "request information" button or the "make an appointment" button on your computer screen. And of course, to send us your questions, click on the MDirectAccess button on your computer screen. And we've talked, Dr. Hausmann, about your staff. You have a number of people in there. I guess it takes everybody on that team to perform this type of surgery, right?

00:42:15

MARK HAUSMANN, MD: Yes, we do need a lot of help. We've got good help.

00:42:20

MARGARET LAWHON: Dr. LeBlanc, what's the difference in how much weight you might lose with the lap-band as opposed to the bypass surgery? Is there a significant difference there?

00:42:27

CARL LeBLANC, MD, MBA, FACS: Yeah, I think there is. Basically the statistics are such that if you choose the lap-band, you'll probably lose 40-50% of your excess body weight in two to three years. With the bypass, you'll typically lose 60-80% of your excess body weight in a year. So there is a difference.

00:42:48

MARGARET LAWHON: You mentioned before when we were talking about dietary changes, you suggested eating protein first, I believe, and this person writes saying: I'm six weeks out from this surgery, the vertical sleeve gastrectomy, why can't you drink liquids when you eat? Is that something you would advise your patients against?

00:43:08

CARL LeBLANC, MD, MBA, FACS: Well, if it's liquid -- well, the reason for these operations that we ask them not to drink a lot of liquids is because you're going to fill up with something. And if you put the liquids in, you're not likely to complete enough of the protein intake. And that's the main reason why we ask them to do that and drink very limited amounts of liquids.

00:43:26

WOMAN ON INTERCOM: James Lewis, please dial extension 8850. James Lewis, 8850.

00:43:33

MARGARET LAWHON: We want to remind you that we are in a hospital and this is a real-life medical situation, so when -- when we hear the PA system, it is part of the process here at Our Lady of the Lake, of course.

00:43:41

CARL LeBLANC, MD, MBA, FACS: Happens all the time.

MARGARET LAWHON: That's right. That's right. Dr. Hausmann, have you been using a Harmonic scalpel? This is a question from one of our viewers.

00:43:50

MARK HAUSMANN, MD: I have used that in the past, actually. In this case, I'm using a device called an N Seal. The Harmonic scalpel -- the different injury sources we use to coagulate, you know, seal blood vessels and divide blood vessels, and the Harmonic scalpel is an excellent one. We just happen to be using a device called the N Seal that has a different energy source that uses electrical current rather than ultrasonic energy.

00:44:13

MARGARET LAWHON: And this person also asks what type of surgical stapling device will you use for this gastrectomy?

00:44:19

MARK HAUSMANN, MD: We happen to be using a device by Ethicon called an Echelon stapler, Echelon 60. There are a couple companies that make different staplers, and it can be done with various -- various brands. This happens to be the Echelon.

00:44:34

MARGARET LAWHON: So it looks like you're getting close to the end there.

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MARK HAUSMANN, MD: Yeah, we're waiting for just a reload on the stapler.

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MARGARET LAWHON: Dr. LeBlanc, is pregnancy safe after this procedure?

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CARL LeBLANC, MD, MBA, FACS: Yes. Pregnancy can be safe after any of these operations, but what we always recommend is that these patients wait until they're at least two years -- that we want their weight loss to be completely stopped by the time they get pregnant because you're obviously feeding two people, not one, and you can have problems with the baby if you get pregnant too soon.

00:45:04

MARGARET LAWHON: Is there a risk of acid reflux after this procedure?

00:45:08

CARL LeBLANC, MD, MBA, FACS: Actually, it can happen. One of the keys to all the weight-loss surgery is that it really helps reflux. But occasionally, we'll have some patients that will for a period of time have some difficulty with reflux, but that usually clears with time. And a lot of the reflux has to do sometimes with -- everybody has to reeducate themselves about how much they can actually put in there at one time.

00:45:28

MARGARET LAWHON: Right, right.

CARL LeBLANC, MD, MBA, FACS: If they put in too much, it'll lead to either reflux or even worse, they'll vomit. Because it can't get that much.

00:45:36

MARGARET LAWHON: We have to readjust our thinking on that.

CARL LeBLANC, MD, MBA, FACS: Yeah, mm-hmm.

00:45:38

MARGARET LAWHON: What about potential shock if part of the vagus is being cut? Part of the vagus nerve? Is that something you've --
00:45:47

CARL LeBLANC, MD, MBA, FACS: We have not encountered that, haven't even -- that's something that -- that's not even discussed, really, not with this at all.
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MARGARET LAWHON: All right. So, doctor, you are getting ready to staple again or --
00:45:58

MARK HAUSMANN, MD: Well, I've stapled, but the little peel-away string is just kind of -- we just need to get that off.

00:46:08

MARGARET LAWHON: Dr. LeBlanc, more questions from our viewers: how will this surgery affect the perineum?

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CARL LeBLANC, MD, MBA, FACS: Ah, they mean the peritoneum, I would think.

00:46:15

MARGARET LAWHON: Peritoneum.

CARL LeBLANC, MD, MBA, FACS: The surgery -- it -- well, you have to pierce the peritoneum any time you do intra-abdominal surgery, so it really won't -- that'll heal in rela-- in just a few hours or a day, so that won't really be a problem at all.

00:46:29

MARGARET LAWHON: So again, this patient will go into recovery and wake up when? What can she expect, let's just say, over the next 24 hours?

00:46:38

CARL LeBLANC, MD, MBA, FACS: Well, she'll go to recovery for roughly about an hour, and then she'll go to her room and we let them have liquids today. And tomorrow, she'll -- what we do is she gets an upper GI so we can assess -- he'll check her to make sure all these staple lines are good at the end, the completion of the operation, but we actually have a third check for safety reasons to have them have enough GI tomorrow. And then we start letting -- we typically send them home after that.

00:47:03

MARGARET LAWHON: Wow. Dr. Hausmann, tell us what we're looking at right here.

00:47:07

MARK HAUSMANN, MD: Well, we just completed, but I have to pull that little suture out I'm working on. You'll be able to see better once I get rid of that. But we completed the gastrectomy. And I'll be able to show you after I get this out and suction it -- suction it out. So let me just -- give me a second to do so.

00:47:24

MARGARET LAWHON: All right, we're going to take a couple more questions out here. Someone writes saying that they've heard that you might need gall bladder surgery after bariatric surgery. Dr. LeBlanc?

00:47:33

CARL LeBLANC, MD, MBA, FACS: Gall bladder surgery is frequent after any weight loss. If you're on Weight Watchers and you lose a significant amount of weight, that can happen. It's real common for patients that get gallstones after weight loss.

00:47:43

MARGARET LAWHON: Okay. What type of supplements or vitamins would you recommend just generally speaking to someone who's had this type of surgery?

00:47:50

CARL LeBLANC, MD, MBA, FACS: Just a regular standard multivitamin or any other -- a lot of people like to take Vitamin E or Vitamin C, all those things. They can take any -- any ones that they feel comfortable taking.

00:48:01

MARGARET LAWHON: All right, and where we are in this procedure, we can see that Dr. Hausmann was dealing with some of the sutures there, had used that stapling device and had done the sleeve, made the sleeve. You've done this surgery so many times. How many -- rather, how do you pull out the disengaged portion of the stomach? How is that removed?

00:48:17

CARL LeBLANC, MD, MBA, FACS: Well, the port that I don't think we got a good look at all the way toward Dr. Hausmann's side is actually 15 millimeters, the one that he's actually moving right this second. That one is 15 millimeters, which is a centimeter and a half, and that one is where it's removed. We simply just grab it and pull it out. Usually it's adequate to get that out, because the stomach is very compressible at that point and it's not -- sometimes we have to enlarge that, but not usually.

00:48:43

MARGARET LAWHON: Okay. We talked about sleep apnea as being one of the consequences of being morbidly obese and one of the problems that these patients experience. Here's a question: is a sleep study required of every patient before this procedure?

00:48:55

CARL LeBLANC, MD, MBA, FACS: No, it is not. We take a history from them, and if they -- it just depends. If they don't have any evidence of it, we don't really do it.

00:49:03

MARGARET LAWHON: But you would certainly want to know if they used the CPAP or a similar type of a machine.

00:49:07

CARL LeBLANC, MD, MBA, FACS: Oh, definitely. Right. We're more concerned if they have it actually when they see us.

00:49:10

MARGARET LAWHON: Okay, all right. This person says he or she will be 60 in November, has high blood pressure which is under control, otherwise in good health. Would I be a candidate for this procedure?

00:49:21

CARL LeBLANC, MD, MBA, FACS: Well, again, age -- we'd be more interested -- actually, that's the determining factor, what their weight and height is and if they have any medical conditions as a result of that. And I think they also asked if insurance covers it. The majority of insurances in Louisiana do not pay for it, which is a bit of a disappointment.

00:49:41

MARGARET LAWHON: Dr. Hausmann, tell us what you're looking at, just making sure everything's in place.

00:49:45

MARK HAUSMANN, MD: Yeah, we've finally got the stomach divided. As you can see -- would you pull back, Clem? Here's the stomach remnant that we've removed. You can see the long tubular sleeve stomach we have in place, and I can pinch on that bougie, and you can see that's the bougie in place. That's how narrow the lumen is. You can go ahead and pull that bougie out, but that's the sleeve right there.

00:50:07

CARL LeBLANC, MD, MBA, FACS: Can you go back and show us where the pylorus is?

00:50:10

MARK HAUSMANN, MD: Follow it all the way down, Clem. Goes down here, we leave a little bit of distal stomach as a remnant, and the pylorus is right here.

00:50:17

MARGARET LAWHON: Okay.

MARK HAUSMANN, MD: Which is the end of the stomach.

00:50:20

CARL LeBLANC, MD, MBA, FACS: Can you just hold up the stomach that's been divided?

00:50:23

MARK HAUSMANN, MD: Okay. Let's go back here. And here's the -- this is the -- you can see how much of the stomach we have removed or will be removing right there. This is all fully detached, and that's what's coming out, so we end up with a long tubular sleeve-like stomach right there.

00:50:38

MARGARET LAWHON: Wow. Ready to work.

00:50:41

CARL LeBLANC, MD, MBA, FACS: Yep. Oh, yeah.

MARK HAUSMANN, MD: Yep.

00:50:43

MARGARET LAWHON: That's wonderful. Do patients need to follow a special liquid diet before surgery?

00:50:49

CARL LeBLANC, MD, MBA, FACS: The only patients that we actually require that are if we suspect that they have a -- as you can see, the liver at the top of the screen there in her is not that large, but --

00:50:58

MARGARET LAWHON: That's that dark area, right, at the top of the screen?

00:51:00

CARL LeBLANC, MD, MBA, FACS: Right. And we have some patients that have a huge, huge liver, and it will actually -- because you can see, it has to be held out of the way, if it looks like there's a potential that it may be in the way, we'll put them on a liquid diet, and that has a tremendous impact of shrinking the stomach -- the liver.

00:51:15

MARGARET LAWHON: Shrinking the liver. Okay. All right, a question which is probably leading up to the next thing we're going to see, or at least in a minute or two. Dr. Hausmann, how do you test for leaks during and after the surgery?

00:51:27

MARK HAUSMANN, MD: Funny you should ask. We're just about to do that right now, and I'm trying to get a bowel clamp on the stomach beyond where the -- where we divided it. Kenny, you can go up above. And we're going to fill some saline in this part of the abdomen and then Dr. Kleinpeter is going to do what's called a gastroscope and blow air into that sleeve, and we'll -- if there -- we can check for bubbles just like you're checking a tire for leaks. And he's about to do that, so we're about to get started on that.

00:51:55

CARL LeBLANC, MD, MBA, FACS: You can see, he's flooding the abdominal cavity with saline.

00:51:57

MARGARET LAWHON: Right, okay.

00:51:58

CARL LeBLANC, MD, MBA, FACS: And this -- what I tell patients is when we walk away from the operating table, we know that this staple line is intact and there's no leak. And if there's a leak beyond that, we can't change the patient's healing processes. And if there's a leak after that, it has to do something with that.

00:52:16

MARGARET LAWHON: Okay. This person writes asking us to repeat what we talked about -- what you talked about, rather, Dr. LeBlanc -- concerning a patient with muscle disease. This person has a disease called limb girdle, no medication needed. Exercise is limited and he or she has type-2 diabetes. Well, she's a female, 5'6" and 245 pounds.

00:52:34

CARL LeBLANC, MD, MBA, FACS: We'd have to actually -- that patient, you'd kind of have to discuss it with their neurologist if they're seeing a neurologist and get opinions from the medical folks and see if she's a candidate. For BMI, she's a candidate, but we'd have to see the side effects of the surgery in terms of how they can handle themselves afterwards, because it does weaken a little bit people. But laparoscopic surgery really eliminates -- minimizes that.

00:52:57

MARGARET LAWHON: Sure. Here's a problem that many people who have tried to lose weight experience, that --

00:53:02

WOMAN ON INTERCOM: Trauma alert, emergency room. Trauma alert, emergency room. Trauma alert, emergency room.

00:53:08

MARGARET LAWHON: Again, the PA system in a hospital, and we apologize for that. But again, it's part of it. This person says she had gastric bypass, exercises almost every day for one to two hours, eats very healthy, but has been at a plateau since July. Drinks two liters of water a day, having more plateaus than weight loss. Any advice there?

00:53:28

CARL LeBLANC, MD, MBA, FACS: Well, it would've been nice to know when they actually had the surgery. Plateaus are very, very common, and it -- it's kind of hard to answer that question without knowing when they had the gastric bypass.

00:53:41

MARGARET LAWHON: When the surgery actually took place.

00:53:42

CARL LeBLANC, MD, MBA, FACS: But, I mean, overall, it's intake and how many calories you burn, bottom line for everything.

00:53:49

MARGARET LAWHON: Dr. Hausmann, you are now just checking the sleeve here.

00:53:51

MARK HAUSMANN, MD: Yeah, we're having little issues just trying to get our monitor, the gastroscope monitor up, and that's what we're waiting on right now. We're about to start testing, but...

00:54:00

MARGARET LAWHON: All right. Again, we talked about the bougie just a few minutes ago, and extracting the other part of the stomach, what happens?

00:54:07

CARL LeBLANC, MD, MBA, FACS: Well, he actually, we miss-- he did it so quickly, we actually missed it when he removed the bougie. It's already out.

00:54:12

MARGARET LAWHON: It's out.

CARL LeBLANC, MD, MBA, FACS: It's out, and the other part of the stomach -- now this is the gastrostomy.

00:54:17

MARGARET LAWHON: This is the gas-- okay.

00:54:19

CARL LeBLANC, MD, MBA, FACS: Where he's in the esophagus right now, and he's going to advance that as you can see.

00:54:25

MARGARET LAWHON: And this is typical after the procedure has been completed, right?

00:54:28

CARL LeBLANC, MD, MBA, FACS: Correct. Yeah, he's just pressure-testing. Now he's in the stomach.

00:54:30

MARK HAUSMANN, MD: --while we look outside the stomach, and he'll blow up the stomach with air. We're checking to see for bubbles on the outside. He's checking the lumen on the inside.

00:54:37

CARL LeBLANC, MD, MBA, FACS: See, that's the staple line on the left. That's the staple line. And you can see, it's just two -- from sidewall to sidewall, there's not much space there.

00:54:47

MARGARET LAWHON: How does it look to you, Dr. Hausmann?

00:54:48

MARK HAUSMANN, MD: Looks good. We have no bubbling, everything looks hemostatic. There's no bleeding on the inside, a nice tubular stomach. That's how we --

00:54:56

CARL LeBLANC, MD, MBA, FACS: And you see now again, the stomach right now is under pressure, so you can see even though it's distended, that's as big as it is.

00:55:03

MARK HAUSMANN, MD: So when we leave, we're confident we don't have a leak. So we do check the next morning, we get an x-ray again the next morning to be double sure. When we leave the operating room we're confident there's no leak.

00:55:13

MARGARET LAWHON: When will she be discharged if everything goes well?

00:55:16

MARK HAUSMANN, MD: She'll spend the night and go home tomorrow.

00:55:18

CARL LeBLANC, MD, MBA, FACS: Yeah, you can kind of see the light from the outside there on the right.

00:55:22

MARGARET LAWHON: When can she start exercising, Dr. Hausmann? I know we talked about the importance of that in losing weight and maintaining that weight loss. When can she start?

00:55:30

MARK HAUSMANN, MD: We're really pretty liberal about that. As her discomfort resolves, she can start exercise which in most of these patients ends up being vigorous walking, you know, early in the first week and then progress from there. So we don't -- there's not a whole lot of downtime. The more exercise they do, the more successful they'll be.

00:55:49

CARL LeBLANC, MD, MBA, FACS: You know, the other part of that question was what's going to happen to the stomach that we're looking at there on the right? He's going to actually extract that --

00:55:56

WOMAN ON INTERCOM: Trauma alert, emergency room. Trauma alert, emergency room. Trauma alert, emergency room.

00:56:01

MARK HAUSMANN, MD: We are pretty much all finished except removing the stomach remnant.

00:56:05

MARGARET LAWHON: Okay.

MARK HAUSMANN, MD: That's the last part of the operation is getting out that stomach.

00:56:09

MARGARET LAWHON: Dr. Hausmann, do you use any type of adhesive to reinforce that line of staples?

00:56:13

MARK HAUSMANN, MD: Well, we use a seam guard, which is not an adhesive, it's a staple line reinforcer. Some people do apply some adhesive on there. I think most people just use these staple line reinforcers rather than adhesives.

00:56:26

MARGARET LAWHON: And she won't know those staples are in, right?

00:56:28

MARK HAUSMANN, MD: She'll never know they're there.

00:56:30

CARL LeBLANC, MD, MBA, FACS: Except you can see them on an x-ray.

00:56:32

MARGARET LAWHON: Okay. Dr. LeBlanc, a question from a 30-year-old male who says his cholesterol is 290, 6'1" tall, 305 pounds. Do cholesterol and weight make that person a candidate for surgery?

00:56:44

CARL LeBLANC, MD, MBA, FACS: Yes. Yes.

MARGARET LAWHON: Yes.

00:56:46

CARL LeBLANC, MD, MBA, FACS: That's an easy one.

00:56:49

MARGARET LAWHON: So that's the portion of the stomach you're going to remove, right, Dr. Hausmann?

00:56:51

MARK HAUSMANN, MD: Yes.

00:56:52

CARL LeBLANC, MD, MBA, FACS: If you look at the color, it's darker because there's no blood supply to it any longer.

00:56:57

MARGARET LAWHON: We noticed that a few minutes ago on the liver.

00:56:59

CARL LeBLANC, MD, MBA, FACS: That's right.

00:57:00

MARGARET LAWHON: The liver became much darker.

00:57:02

CARL LeBLANC, MD, MBA, FACS: But the liver, it's just a temporary thing.

00:57:04

MARGARET LAWHON: Right. So that again would be the liver at the upper portion of the screen. We can't really see it now.

00:57:10

CARL LeBLANC, MD, MBA, FACS: Right, at 12 o'clock, maybe 10 o'clock. Now we're looking at him, he's basically holding on to the stomach. That's that larger trochar. He's enlarging the skin incision. Now, the light is rather bright. We can't really see it too well.

00:57:23

MARK HAUSMANN, MD: I'm sorry.

00:57:25

MARGARET LAWHON: No, you need the light the way you need it, doctor.

00:57:27

CARL LeBLANC, MD, MBA, FACS: Yeah, that's good there.

00:57:29

MARGARET LAWHON: Doctor, how will you close those incisions? Just with little sutures?

00:57:32

MARK HAUSMANN, MD: Yeah, we have sutures that we're going to use that -- that we put laparoscopically and close these holes.

00:57:42

CARL LeBLANC, MD, MBA, FACS: Yeah, there's some special instruments that are designed to help us close those.

00:57:50

MARGARET LAWHON: Amazing that this can be done, and all the technology that comes to bear on making this possible, the camera and...

00:57:56

CARL LeBLANC, MD, MBA, FACS: Oh, yeah.

00:57:57

MARGARET LAWHON: The retractors and everything.

00:57:59

CARL LeBLANC, MD, MBA, FACS: You know, having done this for a number of years, the cameras and instrumentation that we have nowadays -- can you move the light just a little bit, Mark?

00:58:05

MARK HAUSMANN, MD: Sure, we're okay now, we've got it started.

00:58:06

CARL LeBLANC, MD, MBA, FACS: No, no -- Oh, yeah, that's great.

00:58:08

MARK HAUSMANN, MD: Is that better? Okay.

00:58:09

CARL LeBLANC, MD, MBA, FACS: Now, that's the stomach he's pulling out.

00:58:11

MARGARET LAWHON: Okay, so we're actually above the navel, is that correct, Dr. LeBlanc?

00:58:14

MARK HAUSMANN, MD: We're above the navel.

CARL LeBLANC, MD, MBA, FACS: That's right.

00:58:15

MARGARET LAWHON: Okay.

MARK HAUSMANN, MD: Just orientation. Navel's here and the camera's here.

00:58:18

MARGARET LAWHON: All right.

MARK HAUSMANN, MD: So this is the port that I was working through and stapling through.

00:58:26

MARGARET LAWHON: And this seems like it -- even though with all those adhesions that you had to remove prior to us going up on the internet, Dr. Hausmann, this seems like a pretty typical, about an hour procedure.

00:58:35

CARL LeBLANC, MD, MBA, FACS: Yeah.

MARK HAUSMANN, MD: Yep.

00:58:37

CARL LeBLANC, MD, MBA, FACS: Now we're looking through the camera. That's the stomach on the left that's being removed.

00:58:43

MARK HAUSMANN, MD: Almost got it out.

00:58:45

MARGARET LAWHON: So it all comes out in one piece rather than having to take it out in portions.

00:58:48

CARL LeBLANC, MD, MBA, FACS: Right, take it out in pieces, yeah.

00:58:55

MARGARET LAWHON: As we mentioned before, we're hearing from people who have had this procedure, and I would be interested to get their reactions to seeing exactly what the anatomy is inside and -- and how it's all done, but it's certainly amazing.

00:59:08

CARL LeBLANC, MD, MBA, FACS: Yeah, I'm not sure how many people want to see all that. Occasionally, it's sometimes a little bit difficult right at the end.

00:59:18

MARGARET LAWHON: Again, this is one of the three options that you might offer when you're talking to a patient about weight-loss surgery, and you do the gastric bypass, this vertical sleeve gastrectomy, and of course, the lap-band, so it is -- it is standard procedure and something that is -- that is certainly available for -- sounds like for a lot of the people who have written in to us, that they might be good candidates.

00:59:39

CARL LeBLANC, MD, MBA, FACS: Yeah, and actually, not all surgeons are doing the -- this particular procedure, but it's -- it's really gaining more popularity.

00:59:47

MARGARET LAWHON: Here's a question, Dr. LeBlanc: what are the chances that a patient will develop gastric ul-- ulcers rather after this procedure?

00:59:53

CARL LeBLANC, MD, MBA, FACS: Well, it's -- it's always possible, but it's minimized because a large portion of the acid producing portion of the stomach has been removed. now you see, he's just extracted the stomach completely. He's got his hand over the hole to allow the inflation of the carbon dioxide to continue. He'll replace that with that trochar.

01:00:11

MARGARET LAWHON: Okay. and again, that's typical in any laparoscopic procedure, the use of the carbon dioxide to inflate the abdomen so you can move around in there.

01:00:19

CARL LeBLANC, MD, MBA, FACS: That's correct.

MARGARET LAWHON: Which is part of, I guess, what I was hearing with the question from one of our viewers about these long sharp objects going into the abdomen.

There are accommodations made so that you're not just hitting soft tissue right off the bat.

01:00:31

MARK HAUSMANN, MD: Just to get an idea, this is what we've removed. That's the -- can you see that?

01:00:39

MARGARET LAWHON: So that's -- that's the stomach.

01:00:40

MARK HAUSMANN, MD: That's the stomach that we've removed. It came out, and all done laparoscopically.

01:00:45

MARGARET LAWHON: And was that -- that's pretty much exactly the way you saw it happening, doctor, prior to the surgery, what you had planned on?

01:00:51

MARK HAUSMANN, MD: Yes.

01:00:54

MARGARET LAWHON: Wonderful. And how long does it take to close after this procedure?

01:00:57

MARK HAUSMANN, MD: We're just about done. We're going to -- we'll do this first, and we're going to close it. The only hole we have to close is the one that we had to dilate out to get the stomach removed. So the rest of them are small enough that really don't need -- warrant any closure.

01:01:11

MARGARET LAWHON: Okay.

MARK HAUSMANN, MD: But here we're going to -- you'll see, we'll see we'll pass a suture.

01:01:17

CARL LeBLANC, MD, MBA, FACS: Suture attached to that instrument, and then they'll grab it.

01:01:21

MARGARET LAWHON: Okay.

CARL LeBLANC, MD, MBA, FACS: See that clamp, he's going to grab that.

01:01:25

MARGARET LAWHON: So both Dr. Hausmann and Dr. Kleinpeter are part of this suturing process.

01:01:30

CARL LeBLANC, MD, MBA, FACS: Right. He's handing it, and Dr. Kleinpeter's grabbing it away. And then he's going to go on the opposite side. That's his finger we're looking at.

01:01:38

MARGARET LAWHON: Okay, right there.

CARL LeBLANC, MD, MBA, FACS: Right. And you see, there's some adhesion still left on the left side. He didn't fool with those because you don't need to fool with them. Now, see that's the suture that will close that hole up.

01:01:48

MARGARET LAWHON: Okay.

CARL LeBLANC, MD, MBA, FACS: Now, what happened just now is when he let go his finger, this carbon dioxide left.

01:01:54

MARGARET LAWHON: Yes, yes.

CARL LeBLANC, MD, MBA, FACS: But it'll allow it to inflate again so they can get that retractor over the liver out. That's basically the last step.

01:02:04

MARGARET LAWHON: Basically a pretty simple procedure once you get in and see where everything is, right?

01:02:08

CARL LeBLANC, MD, MBA, FACS: Yeah, for us it's a -- it's a very pleasant operation. It's even more pleasant when you see the patients in a year.

01:02:16

MARGARET LAWHON: Here's one more question: what drugs are needed for this patient postoperatively and why do you need stitches in addition to stapling? Dr. LeBlanc?

01:02:25

CARL LeBLANC, MD, MBA, FACS: Well, the main drugs that the patients, in addition to whatever medications they were on before the surgery, they would just typically need something for pain. They do get a dose of antibiotics, but that's -- that's only the dose they need. The stitches that he was using here was just to close the hole. We don't typically use staples -- sutures over the staple line.

01:02:47

MARGARET LAWHON: So you're just about out, right, Dr. Hausmann?

01:02:49

MARK HAUSMANN, MD: Yep, we've removed our trochars and we're out.

01:02:53

CARL LeBLANC, MD, MBA, FACS: He's completed. He's done.

01:02:54

MARGARET LAWHON: Wonderful. Dr. Hausmann, thank you so much for allowing us to be with you. Dr. Mark Hausmann, laparoscopic surgeon. Please wish your patient well. Dr. Kleinpeter, thanks to all the team in there. We appreciate your being with us. And Dr. Carl LeBlanc, thank you so much for being with us and helping to moderate this webcast. I think we all learned a lot.

01:03:10

CARL LeBLANC, MD, MBA, FACS: Well, I'm glad. I'm glad.

01:03:11

MARGARET LAWHON: And we want to thank you, our online viewers, for being with us and for participating by sending us your questions. remember, if you'd like more information on this procedure or you'd like to make an appointment, simply click on the "request information" button on your screen. An archived copy of this webcast will be available a little bit later this evening on the OR-Live website, that's or-live.com, also on the website for Our Lady of the Lake, and that is ololrnc.com. For all of us here at Our Lady of the Lake Regional Medical Center, I'm Margaret Lawhon. Good night from Baton Rouge.

01:03:49

ANNOUNCER: This has been a laparoscopic sleeve gastrectomy performed from Our Lady of the Lake Regional Medical Center in Baton Rouge, Louisiana. OR-Live makes it easy for you to learn more. Just click on the "request information" button on your webcast screen and open the door to informed medical care.

01:04:38

[end of webcast]