

**LAP-BAND MINIMALLY INVASIVE WEIGHT-LOSS SURGERY
SENTARA CAREPLEX HOSPITAL
HAMPTON, VIRGINIA
October 11, 2007**

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NARRATOR: Welcome to Sentara CarePlex Hospital in Hampton, Virginia. Over the next hour you'll see lap-band minimally invasive weight loss surgery. In just moments you'll learn how this innovative surgical intervention works for people who have been unsuccessful in losing weight with more conservative weight reduction alternatives.

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The prescreening process, as well as patient follow-up will also be detailed. In addition, you'll hear about the surgery's impact on a patient's health. Plus, how an adjustment process helps determine the rate of weight loss for each patient.

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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.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Good afternoon. I'm Stephen Wohlgemuth, one of the bariatric surgeons at Sentara Norfolk General Hospital and thank you for joining us. We're here to look at a laparoscopic gastric banding procedure which will be done by two of my colleagues, Dr. Terracina and Dr. Clark. And we'll go to them in a second. But before we do, I'd like to tell you a bit about Sentara Health Care.

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As you can see from the slide, we are a fully integrated healthcare organization and we are a not for profit healthcare system dedicated to improving health every day. As you can see from this slide, we serve the Southeastern Virginia area and Northeastern North Carolina. And at this point, I'd like to take us into the operating room live where we'll see Dr. Thomas Clark and he'll introduce Dr. Terracina and the rest of the team.

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THOMAS W. CLARK, MS, MD, FACS: Hello. I'm Dr. Tom Clark. I'm in here in the operating room at Sentara CarePlex Hospital. And I'm in here with Dr. Anthony Terracina. We'll be doing the adjustable laparoscopic banding procedures. And, Dr. Terracina is going to tell us a little bit about what's going on with this patient, as well as introduce the operating room staff. And then very shortly we'll go ahead and get started.

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ANTHONY D. TERRACINA, MD, FACS: Welcome everyone. I want to introduce the OR staff first. We've got [Marnie Lichtey?]. He's our surgical assistant in the room. Dewey Steel, who's our physician's assistant. We've got Christie [Pham?], who's our nurse circulator in the room. Janice Wyatt, also a nurse circulator in the room. And Tanya Muller, who's the OR manager. Also Jeremy Hershey in the...in the corner there, who is our service line director.

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A little bit about what we're doing today. We're forming a laparoscopic adjustable gastric ban. of course, as Dr. Wohlgemuth and Dr. Clark mentioned. Out patient today is a thirty-

two year old female who has had about a ten-plus year history of obesity. She's done, as most of our patients have done, which is tried conservative weight loss measures over time and had no success. And she approached us about...about performing surgery for weight loss. And, of course, she's chose the laparoscopic band as a procedure.

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She's got a couple of health issues. She has hypertension, which is her main health issue. Also in her preoperative evaluation we've uncovered the fact that she has some early signs of glucose intolerance, which might lead to diabetes if she did not pursue weight loss surgery ultimately. So we're going to go ahead and get started and I'm going to turn back to Dr. Clark while we...while we do that.

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THOMAS W. CLARK, MS, MD, FACS: All right. Well, as they're getting started we can talk a little bit about obesity and the problems with obesity. We'll also talk a little bit about the adjustable band procedure. We can show you some of the bands and we'll talk about what's really needed to have good success with an adjustable gastric band. And, as we talk about...a little bit about obesity, why don't we go out to Steve here. I think we have some slides that we can go over and talk a little bit obesity and the comorbidities.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Great. Thanks, Tom. As you can see from the slide on the screen, BMI is really just a measure of weight and height. And it's a simple formula, and as you go across the screen you see the various categories. Important to realize that obesity, which is a BMI of greater than thirty, is about thirty-five pounds overweight for a person who is five foot four.

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When we talk about morbid obesity, it's a special term at which point you start to see serious medical problems because of your obesity. And we can define that very simply as twice your ideal body weight, or greater than a hundred pounds over your ideal body weight, or if your BMI is greater than forty.

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Now why is obesity a problem? Clearly, we know that there's a number of things that contribute to it. And, as you can see here, it's not just simply eating too much or being not active enough. There's a lot of genetic components, psychological components and a whole bunch of neurologic and biochemical components that contribute to obesity. So it's not simply a weakness, but it is truly a disease.

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It is a big problem. We know that about one-quarter of the industrialized world is obese. We know that one out of every two Americans are overweight. A quarter of our children are overweight and overweight kids do become overweight adults. We spend two hundred and forty billion dollars every year taking care of obesity. And if you need one reason, I can give you four hundred thousand reasons why people...why obesity is a problem. We have four hundred thousand deaths every year. Now the impact of obesity from a medical standpoint is quite significant. As this slide shows, every body part, every system is affected adversely by obesity and all this leads to premature death.

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And at this point, I'd like to turn it back over to Dr. Clark and Dr. Terracina so they can tell us what's happening in the operating room.

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THOMAS W. CLARK, MS, MD, FACS: All right. Well, we're just getting started in here and what we've done is we've obtained access into the abdomen. And, it...if we could, I could actually just show you a couple of the...the instruments that we use to obtain access into the operating room. And we refer to them as trocars. I've got one of them in my hand right now. And, by using a trocar, we can access the abdomen and subsequently we can

use instruments, some long instruments, that then we can put down the central portion of the...this trocar and work inside.

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I've got a couple of different sizes right here. This one happens to be fifteen millimeters, and this is the one that we actually place the band through, since the band itself has some size. But then we also have some smaller ones too. And, this is a five millimeter trocar here. And we use that to use some of the long instruments to work through.

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All of this is to place this adjustable band. And this adjustable band sits right around the top of the stomach, which we can show you more pictures of here in a bit. And, actually, I do have a model here that I would like to share with you. This is what we're going to do. And I'm going to kind of hold it up against my body and you can almost see about where we're going to be looking. And this is a replica of the stomach, and we're going to place this band right at the very top of the stomach.

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And what it does, is makes you a tiny little stomach that sits on top of the normal stomach and then food will all go through normally. But, it will make a tiny little stomach here, so just eating a small amount of food you'll feel full.

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The other beautiful thing about this procedure is that it's adjustable. And by being adjustable, meaning we can tighten it down. And what I'll do is I'll show you here exactly what...what that does by tightening it down. This is actually one of the band and I've connected a syringe to this and. And so, by tightening it down, we can actually fill that...that band up. Maybe if I can show you that a little bit better. There we go. And see, now I'm going to loosen it back up, now I'm going to tighten it up. And by tightening it, then we can control how quickly your little stomach will empty.

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If we can control how quickly that little stomach empties, or how slowly that little stomach empties, then we can control hunger much better. So, you'll eat only a small amount of food, and we're able to control hunger by adjusting it to the right...I'm going to say the right size, the right narrowness, so that we can control hunger better for you and we can individualize that. So a very important aspect of this is its adjustability. And in a...in a bit here, or towards the end, we may show you kind of what happens with an adjustment, because that's a very important part of how this works is that the band has to be adjusted over time for it to work well.

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Let's kind of see where...see where we are here in the stomach. Anthony, how are we doing here?

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ANTHONY D. TERRACINA, MD, FACS: Doing good. I thought I'd just point out one thing is just got in the abdomen. We're placing our liver retractor. And one thing to note about this liver is her liver is slightly enlarged. And, of course, as I've mentioned, she's got evidence it's...there's some early diabetic tendencies, high sugar in the middle of the day, and that can...can basically cause fat deposition within the liver and...and make the operations very difficult.

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As Dr. Clark probably will mention, we like to have patients undergo some what of a preoperative weight loss program. Potentially if there is some concern about this, I think it's always a good idea to have a patient try to lose some weight preoperatively. It helps out with their postoperative management and it will help control some of the liver enlargements that we see preoperatively and perioperatively.

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THOMAS W. CLARK, MS, MD, FACS: Yeah, one thing to notice on this picture that we're looking at is you see that...that kind of S-shaped retractor they're using to lift the liver up out of the way. And that's a nice little instrument that's very narrow, small, that we can lift the liver up out of the way. The liver is one of the...the organs that actually kind of sits in our way, so to speak, when we're trying to do this procedure. And, weight loss ahead of time subsequently will help shrink that liver down, because a lot of the weight...initial weight loss with people will be around the liver. And if we can shrink that liver down, it will allow us to, one, pull it out of the way a little bit easier, but also then it...it decreases the risk of either having problems with the surgery or in the...the worst case scenario is that we wouldn't be able to do the surgery.

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ANTHONY D. TERRACINA, MD, FACS: There is another point to note here, if we back up the camera. She has fairly normal gastric anatomy, stomach anatomy. The stomach is fairly normal. Diabetics can...If you have a bad...diabetic, the liver can be two to three times larger than this, which really creates significant problems. And also the stomach really takes...has a problem with...with controlling its ability to function like it should. So, that's all things to note about diabetic patients. Can we get a suction? Our bovie needs to be hooked up.

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THOMAS W. CLARK, MS, MD, FACS: All right, they're...they're just getting started here. And so what we're looking at is the stomach, as Dr. Terracina mentioned. And, so what we may want to talk about while they're just getting started is kind of who's a surgical candidate. And, Steve, I think...do we have some slides for that?

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STEPHEN D. WOHLGEMUTH, MD, FACS: We sure do, Tom. Thanks. It's an excellent point. As you can see from the slide here, we are very serious about picking the right people for these operations. Clearly, this is an elective operation and we like to make sure the patients are well...well educated. And most of us that do this have a fairly standard checklist of...of criteria. Number one, they need to meet the...what we call the NIH, or National Institute...National Institutes of Health criteria which, again, is a BMI of at least forty. If your BMI is not forty, but thirty-five, but you've got comorbidity such as diabetes, hypertension or sleep apnea, with snoring, then you're a candidate.

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There are very few what we call endocrine causes of obesity, which we don't operate on. The patients needs to be an acceptable operative risk so that they can undergo surgery safely, obviously. They need to understand the surgery and they're well very educated as to what to expect. We certainly don't want any active alcohol or drug problems, and certainly smoking is something we...we don't like to have patients to be doing at all. We do psychological evaluations to make sure patients are able to understand and don't have any factors that are going to get in the way of them having a successful operation.

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We have a team, and the team is very involved in deciding who gets surgery. And then the patients need to be dedicated and very dedicated to a significant follow-up and a severe lifestyle change. And it looks like Dr. Terracina is at a great place to get back to the operating room.

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ANTHONY D. TERRACINA, MD, FACS: All right. So the first thing we're doing here is basically we're freeing up one side of the gastric wall. This is the stomach. And we're trying to make a path, essentially, for the band to take. So we go on the left side of the stomach and we clear that area off. And she's got nice anatomy here. The stomach's really free of any significant amount of fat. And this can be a real problem in patients who are super obese, or male patients you see a lot of intra-abdominal fat in this location and you have to clear the stomach wall of that fat.

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We're going to go to the other side of the stomach now. This is an area of the...of the what we call the lesser curvature of the stomach. We're going to open up the lesser omentum. And, basically, it's just a very thin veil of tissue. And you can see right underneath the...underneath this thin veil you see the liver, another portion of the liver. It's called caudate lobe of the liver. And, the first thing you see coming into view here is a muscle called the [cuera?], the right side...right [cuera?]. And it's a...it's basically a passageway of where the esophagus passes through this muscular passage and...and meets the stomach in the abdomen.

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So, what we're going to do at this point is we're going to choose an area, usually about two-thirds the way down the right [cuera?]. And we're going to create a little dissection plain. We'll try to get something started and see if we can do it pretty easily here.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Dr. Terracina, can you show the people where the vena cava is, the inferior vena cava?

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ANTHONY D. TERRACINA, MD, FACS: Sure can. Let me...let me get just a little start on this here. Then we'll lift up the liver and show you where that is. There's...there is...This is a very safe operation when done...you know, done in experienced hands or appropriately. But there are some structures that are somewhat concerning. This is the vena cava. All the blood from the abdomen goes to the heart via the structure here. And....so, you know, it's...it's one of the things we work...you know, we look at and we...we make sure we're not close to.

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This is basically the path that we're going to take. We're going to go behind the upper stomach. We'll pan out a little bit and show you the upper stomach here. We will go to the other side. And, basically, what we're doing now is we're going to...to the opposite side of the stomach. And this is what we call the blind maneuver that is the other point and a potential risk of the operation, because you can't see the back wall of the stomach. So with that maneuver there we've now created a path for the band to sit in. And, so we're going to go ahead and prepare our band. I'll go ahead and turn it back to you all while we're doing that.

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THOMAS W. CLARK, MS, MD, FACS: All right. They'll be preparing the band. That may take a...a minute or two. You know, the education process that people go through concern...or, prior to surgery is very important. And, I think that most...most places around the country that are a center of excellence, which is a national designation that hospitals and surgical groups obtain, generally have a whole program that you can go through that will be an education program. Because education with weight loss surgery is extremely important.

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And, Steve, I know you guys have a very....a extensive program as well. And, why don't we just...We can talk a little bit about that, as far as kind of what...what you do. We can talk about what we do too, and it's...it's pretty much along the same lines.

STEPHEN D. WOHLGEMUTH, MD, FACS: Sure.

THOMAS W. CLARK, MS, MD, FACS: But all of it's very important.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Yeah. And I think...One thing I like to point out that the center of excellence concept is relatively new to surgical fields, and certainly very important. And I think that the bariatric surgeons and community are...are sort of ahead of the curve on this. To be a center of excellence, it is a very rigorous site visit. You have to do a certain number of cases a year with certain outcomes. Have the facilities and the equipment to take care of the patients who are a hundred and fifty, two hundred pounds

overweight sometimes. So, if your hospital has that, that's kind of like a Good Housekeeping Seal of Approval.

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Before I get to the program, Tom, I'd like to...we'd like to point out that there are other surgery... surgeries that can be done for obesity and I've got some questions already from the Internet about the differences. So I'm going to show a quick slide that looks at the band, which you can see, and then on the...on the right side is a gastric bypass. And they are both achieving similar results, but they're a little different in terms of the operation. The gastric bypass creates a very small gastric pouch and there is some bypass part of the stomach. Whereas, the band is really just a restrictive operation. And, Tom, I'm going to ask this question to you.

THOMAS W. CLARK, MS, MD, FACS: Sure.

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STEPHEN D. WOHLGEMUTH, MD, FACS: I've got a question from a Internet viewer who wanted to know, what's your medical opinion on the lap-band versus a gastric bypass?

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THOMAS W. CLARK, MS, MD, FACS: Okay. Well, they're...they're obviously two different operations. And, there's...I don't think that there's something good versus something bad. Now, before I get into that question too much, and we'll come right back to it, Dr. Terracina is just starting to put the band into the abdomen. So we're just starting to see...That's the band right there we're looking at. He's just putting it in. And while...we don't forget that question. We'll... we'll come right back to it, but Anthony, why don't you just kind of tell us we got...we go the band in now and we'll start putting it in place.

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ANTHONY D. TERRACINA, MD, FACS: Correct. Yes, and first...what we did we pick an appropriate sized band. There now are two major band sizes. This is the standard band size. It holds about ten cc's of fluid. If you look at the balloon on the band, this is what talk about, the adjustable balloon. We've...we've flushed it. We've put about five cc's of saline solution where we leave that in there. We've capped it off. And, at the end of the procedure we actually will allow the patient's body to dictate how much of the fluid stays in.

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So we put the tubing in the band within the grasper. This grasper is behind the stomach. You'll see that...now as we...as we pan out, we'll bring the tubing around the upper stomach. So the tubing has come in that path that we created before. Once again, one of the very rare things that can happen is you can make a hole in the stomach during the process. But, the tube...basically, the tubing slides nice and easy. The way these new bands are...are engineered is that they slide easily through that same tunnel. The tunnel was very small, but the tapering of the band is such that it really slides nicely through that little track.

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And what we'll do now is this is the collar of the band. We will address that in a second. We're going to get back to the end of the tubing here, if we can keep the tubing out of our...the way of the camera. So we've grasped the end of it and there's the collar here. And the collar, basically, is a self...has a self-locking mechanism. I tell patients it's like...it's almost like just a twist tie on a...on a garbage bag. It's going to...you're going to pull it through. It's going to have its own self-locking mechanism and we'll see that come into view here.

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So we grasp the collar and we grasp the tubing. And, actually, it's fairly...fairly hard to lock it. And that...and patients ask me, is that something that's ever going to come undone. And, if you look and see how hard it is to lock this, you'll understand that it's never going to come undone on its own. Boy, we grasp it firmly, we pull, and that little black mark tells us that we are...we are engaged.

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So, that basically is the first stage of the operation. It's putting the band in, finding an appropriate space to put the band. And now, at this point, we're going to perform the second part of the intra-abdominal procedure, which is what we call the plication. As you can see, the band is...is a donut. Essentially it's circular. And what you don't want to occur down the road is you don't want this portion of the stomach, which is the fundus, which is very redundant, you don't want it sliding through the band to the upper part of the stomach, because that can cause a...an obstruction. So, the second part of the operation is going to entail taking part of that fundus, securing it over the band such that we don't allow it to do that.

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THOMAS W. CLARK, MS, MD, FACS: Dr. Terracina, could you comment about the presence of hiatal hernias and whether or not that's a problem. Do you look for them, do you have to fix them if they have that at the time of surgery?

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ANTHONY D. TERRACINA, MD, FACS: Absolutely. And the first thing I did when I...we came into the...into the abdomen, I looked for a hiatal hernia. A hiatal hernia would be up where my instrument is. Just...just basically in this area right there. She does not have a hiatal hernia. It is a...it is ultimately important to repair a hiatal hernia with a lap-band, because this...the mechanism of hiatal hernias is that the stomach, or a portion of a the stomach is sliding in and out of the chest. If you don't repair them as part of the band operation, then you're going to have that constant pulling of the stomach in and out of the chest and you can develop an...a pouch dilation problem, which you really want to take care of now and not later at a second operation.

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So we're taking a part of the fundus, that redundant part that we talked about. And we're going to take a little stitch here. We take a...a bite below the band. And we take a bite above the band. So you...Once again, her stomach is really devoid of any significant vessels here, and that's nice. So we just take a nice...nice bite of the gastric wall. And what we'll end up with, and at the end you'll see, is a series of suture...sutures that plicate the...that part of the stomach over the band. And you'll see that here in a second.

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The important point also about hiatal hernias is that, in my estimation when you have someone who has...has a hiatal hernia, they have a higher chance of having reflux disease. That reflux disease can make it very problematic in...in performing lap-band adjustments, so you're trying to tighten this band such it should create a restriction to calories. And if you're doing those band adjustments and you've got someone who's refluxing activity, it really makes that...that a very difficult process.

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So we're trying to get our suture to straighten out here. And we'll...we'll tie this suture over. And the first stitch is always the most difficult. This is a new generation of bands. This has a three hundred sixty degree balloon. So you see that the balloon on one end of the band meets the balloon on the other end. It's a great concept. They've made the band larger. The only problem is the bands are a little bit harder to work around. But, the feeling is that this broader band, this three hundred sixty degree balloon, prevents complications in the future; such as band...band slips and really allows that band to work more effectively in a circumferential fashion. So you get even compression of the stomach. Because, really, it's all about creating a new pouch. And we'll show you where your new stomach is once we get this completed.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Dr. Terracina, are there different bands that are available from different companies in America now?

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ANTHONY D. TERRACINA, MD, FACS:

Well, there will be very soon. This Lap...this band is made by a company called Allergan. This has been around for a long time. One of the...This was the original band in the U.S. There will be other competing bands. There are other competing bands worldwide, so soon we're...we will have more than one band in the U.S. Probably will be at that level for quite some time. I'm not...I'm not aware of any other companies working on a band in the U.S. market. Are you Steve, at all?

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STEPHEN D. WOHLGEMUTH, MD, FACS: No. Just the one from Ethicon right now.

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ANTHONY D. TERRACINA, MD, FACS: So what we'd like to do is we like to really try to create a nice...at least I feel a snug fit over the band. And, we'll just take a series of sutures. We end up with anywhere from three to five sutures on average. The other day we put seven sutures in this plication, so it's a little unusual but what you want to do is you want to gather as much of this fundus up as possible so that you don't have this hanging out below the band and having the potential to slide under the band.

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And, I always tell patients it's like putting a hotdog in a bun, because the...the band being the hotdog and the bun being the stomach around it. So you end up with this...this kind of tube-like affect here. And, Steve, in your experience have you noticed any...any differences when you place three sutures versus four or five sutures? You haven't...you don't really feel like there's any significance to the number of sutures you put in; whatever is right for the patient, in other words.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Exactly. I think we sort of take it on a case by case basis. If it looks right, it is right.

ANTHONY D. TERRACINA, MD, FACS: Right.

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STEPHEN D. WOHLGEMUTH, MD, FACS: And we've not seen any significant differences between three or four sutures. One thing I would like to comment on, watching Dr. Terracina tie the knots in there, if the people out there that aren't surgeons tried to imagine tying your shoes together...tying a knot in your shoes with a pair of chopsticks, it's kind of what it's like. It's a very...very difficult task and it's very labor intensive. And Dr. Terracina makes it look relatively easy because he's very skilled at it. But this is not an easy task and...and his skill is private impressive.

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ANTHONY D. TERRACINA, MD, FACS: I always tell...tell patients and other physicians, you know, our generation of kids who play video kids is probably...they're going to be excellent laparoscopic surgeons because they've got that high hand/eye coordination that...that we didn't have growing up. And I think it's actually...you know, I think it's really what you'd...you develop over time.

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But, we're working on our third stitch now. It looks like that we'll probably end up with the standard number of four. I'd say that's right in the middle of what we see, as far as our average number of sutures. The stomach's gathered over the band. There's only a certain number of sutures you can put in this wrap, because you're going to abut the collar here. You want to stay away from the collar, leaving about a centimeter or so distance.

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You don't want the stom...the gastric wall to constantly rub up against, you know, a fixed...a fixed point. Because that fixed point comes out at a different angle. It's...it's at a...it's at a right angle to the band. And some of the early problems with bands are...the bands can erode, but it's a very small number of patients. Were probably related to surgeons being a little overzealous with...you know, getting too close to that collar. Also, I think it would be agreed by most physicians that when you're doing a second time operation, because we do

have to occasionally come back in and reposition a band if someone has developed a hiatal hernia, or someone has developed a pouch dilation.

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When we're repositioning the band, that's a slightly higher risk operation, because you're... you've got a re-operative field and...and I think that everyone would agree that the erosion rate is slightly higher in that circumstance.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Anthony, I've got actually an intra-operative question from one of our Internet viewers. They want to know what kind of suture are you using and will it degrade over time?

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ANTHONY D. TERRACINA, MD, FACS: That's a great question. It's surgeon's preference, of course, as to what suture you use. I think that most surgeons would agree that some type of braided suture. So if you look closely at this suture...We'll come on in on that suture. You know, it's...it's got some...like a hair braid almost. It's got...it's got different strands that have been woven together, so we call that a braided suture. I...You can use different types of braided sutures; silk is one type. This is called Ethibond. It's got a slight coating to it and that makes it slide a little bit easier, and that's...that's my preference. I like the ease at which it slides through the tissue. And...but I think it's really surgeon's preference. Most...most surgeons would use a braided suture, would you agree, Steve?

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STEPHEN D. WOHLGEMUTH, MD, FACS: Absolutely.

ANTHONY D. TERRACINA, MD, FACS: Yeah.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Now I know this would never happen, but what would happen if you were to have that needle stick one of those balloons right now?

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ANTHONY D. TERRACINA, MD, FACS: Yeah, that's a good question. Now----

STEPHEN D. WOHLGEMUTH, MD, FACS: And you're not going to do it, so don't worry about it.

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ANTHONY D. TERRACINA, MD, FACS: Exactly. Well, you know, patients ask me, is that balloon ever going to pop? Is the...is the band itself every going to degrade? And this is...this is always the situation, we've got a vessel right here to decide which side to go. We'll go on the medial aspect of that vessel. But, yeah, you don't...I mean, that's a surgical misadventure. You don't want that to happen. That balloon is not going to self-seal itself, so you've got to be real careful with the tip of your...your needle.

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Now that balloon, amazingly enough, it...it doesn't look thick, but that is a very thick balloon. And if you ever have...if you've ever...if you ever see one transected, it probably would take a little bit of a rubbing up against, as far as with the needle. But it's...it's going to...I think it would probably have to take a pretty significant stick to...to rupture the balloon. We've not...not had that happen. I'm sure it's well described though.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Sure.

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ANTHONY D. TERRACINA, MD, FACS: But...so we're getting near the end of our wrap here and we'll kind of show you. What we've done with the band is we've...we've placed it, we've created this wrap...and that's one of the things you look at. You want to get your needle out of the...away from the balloon. But, at this point we're going to start to assess is our wrap...is our wrap adequate, are we happy with the way the band sits. And, generally speaking, if you start in the right position on that medial side or the right [cuera?] that we

talked about. And you end up in the right spot on this side, our band should be appropriately positioned.

00:29:24

And, also, I always have to remember that what we see intra-operatively, when the patient wakes up they regain their diaphragmatic function, so the diaphragm tightens up and the band tends to rotate in that perfect position. Even though it might not look ideal when you're intra-op, when you get the postoperative x-ray, and this patient will undergo post...an x-ray, an upper GI today, we'll see that band rotated in a nice position. This band should be rotated not flat; it should have a little angulation up to the diaphragm here.

00:29:58

So, pretty much, we're going to consider...This is always the toughest thing for me to decide. We've got...we're close enough to the collar. I don't think we're going to benefit...I always look to see if there's any additional redundancy. You know, any laxity here. It looks good. I think we're going to probably stop with our four sutures here and clean the camera. And then we'll show you the...a little bit about the anatomy now, how it looks.

00:30:23

STEPHEN D. WOHLGEMUTH, MD, FACS: Anthony, that looks perfect. When you get back in, could you show people where the spleen is?

ANTHONY D. TERRACINA, MD, FACS: Sure will.

00:30:27

STEPHEN D. WOHLGEMUTH, MD, FACS: And why that's a consideration when you're doing this operation.

00:30:30

ANTHONY D. TERRACINA, MD, FACS: Absolutely. We're battling with our tube a little bit. So, once again, let's just go through the anatomy, what the band creates. Dr. Clark showed you the model. This is basically on...on the stomach. So we've got...This is a live situation. We've got our pouch up here. It's about the size...It varies. It's about the size of a medium little [R-jeg?]. We tell patients twenty-five to thirty cc's. This is the stomach. Food is going to travel down into the body of the stomach. We'll clean that camera in a second.

00:30:59

And then food passes through this normal...through this normal tract essentially. So we're not altering a person's anatomy. All we're doing is creating an obstruction point such that this is their stomach now instead of all of this being their stomach. So let's clean real quick and...and then we'll show you the spleen and some other anatomic...There we go. Okay.

00:31:19

So...Let me get another grasper in here. So to me, this is how the band sits. The band always kind of rotates like this. It's going to sit in this position. The tubing usually loops around the left upper quadrant like this. If we look over here, we'll see our spleen. Now she's got...actually a little finding in her spleen. This is probably a little bit of endometriosis on her spleen. You see this in women, a little endometriosis. You would think of that in the pelvis, you know, as far as being on your uterus. But, actually, she's got a little bit on her spleen. That's probably the second most common area that we see it. Our liver's been a little bit pesky here. A little bit of oozing from the liver, but nothing major.

00:32:02

So, anyway, that's...that's really about it for this intra-abdominal portion of the operation. We'll back...we'll pan out a little bit and give you a better idea of things. I'll get the tubing out of the way. And...this tubing is going to be important, as soon as we can get it...It's...it's long and takes an arduous path. But, we'll get it...get it out of the way here so that you can see. So this is the end of the tubing. And...and we tell patients, this is a hollow...this is a hollow tube. The tubing is capped here.

00:32:33

You can fill this tubing and what it does it translates fluid up to the band. And if you...if you look here, you might be able to see a...a bubble. You know, this...basically, this has got fluid

in it already. This is a pretty tight band at this point. When we connect this tubing to our port, our access port, we'll then allow some of this fluid to back out. But we're going to let the patient's anatomy dictate how much fluid backs out. So when we...when we do the extra abdominal portion of the...or, the operation, which is to attach the port to the...to the muscle tissue...muscle layer, we'll let the patient's anatomy dictate how much fluid comes back out. And usually there's about two cc's, or so, fluid.

00:33:16

So we're going to go ahead and do that. We're going to move our liver tractor at this point. Any other comments or anything else you'd like to see? There's the gallbladder on that side of the abdomen. We leave the gallbladder alone. With this operation, gallbladder has a tendency to have some bacteria in it, so even if a person has gallstones, we try to leave the gallbladder alone. If a person was really symptomatic or having problems with their gallbladder, my suggestion has been in the past to them, have your gallbladder out, recover from that and we can go back in and perform your lap-band operation at a later date. It's hard to get many surgeons to tell you that it would be an okay thing to do both operations at the same time.

00:33:55

STEPHEN D. WOHLGEMUTH, MD, FACS: Yes, that sounds...I agree with that a hundred percent. I actually have a patient I just did that on a couple of weeks ago. I took her gallbladder out as a first stage. and now she's going through the rest of the program and we'll get her band done in probably about, you know, three or four months. Do you do anything postoperatively to prevent gallstones from forming during that rapid weight loss period?

00:34:10

ANTHONY D. TERRACINA, MD, FACS: You know, that's...that's a great question. With the gastric bypass, as...as you've discussed...you and Dr. Clark have discussed a little bit of...and we'll take a look at that liver in a second. The...the gastric bypass patients lose weight so fast that I do feel like you have to prevent gallstones from forming. I do treat them with a pill called Actigall. That Actigall acts as a...as a nice agent to prevent gallstone formation.

00:34:32

It's a rare lap-band patient that's going to lose weight that fast. And so I...I have not gotten in the habit of doing that with lap-band patients. How do you feel about that, Steve?

00:34:43

STEPHEN D. WOHLGEMUTH, MD, FACS: I agree a hundred percent. We do it on all of our...all of our bypass patients and none...none of the band patients.

00:34:48 ANTHONY D. TERRACINA, MD, FACS: Yeah. Tom, you too? It's pretty much the same?

00:34:50

THOMAS W. CLARK, MS, MD, FACS: Right. I agree. It's the same thing. The weight loss is not nearly as fast but, you know, they typically will lose weight longer. But without the really fast weight loss, usually they're not going to get gallstones.

00:35:01

ANTHONY D. TERRACINA, MD, FACS: Yeah. So that's a nice view of how the band sits in the abdomen. We're getting...getting ready to just...just back out of the procedure and do the second...the...Actually, I guess I would say the third part of the operation, which is attaching the port to the tubing.

00:35:14

So what we do now is we'll pan out a little bit. We take the end of the tubing and...and this tubing is going to come out through one of the trocar sites. The trocars that Dr. Clark pointed out to you. We'll grasp the end of the tubing. And Dewey will show you what that looks like. So we take the tubing right out of the abdomen. So now the...the tip of the tubing is now outside of the abdomen and...and we're going to utilize that tubing and hook it

to our port. So we're pretty much done with the intra-abdominal component of the operation. Any other questions about anything?

00:35:51

STEPHEN D. WOHLGEMUTH, MD, FACS: Anthony, what happens to all the gas that you've put into the belly when you're done with this.

00:35:55

ANTHONY D. TERRACINA, MD, FACS: Yeah, we try to evacuate as much as possible. We use CO2 gas to create what we call the neumoperitoneum. That's what gives you this kind of balloon effect. Normally, everything you see, that Dewey is showing you, this muscle of the abdominal wall, is going to be sitting flat up against all the intra-abdominal contents here. So, we're creating a space to operate in. We...we need to try to get as much of that gas out as possible. It does cause a little bit of postoperative discomfort and I think it's really important in our patients...patient population to do that.

00:36:22

So we're going to go ahead and back that trocar out. What's left is the tubing, which exits the trocar site. We'll remove our other trocars and we'll swing around and take out Dewey's trocar here.

00:36:34

THOMAS W. CLARK, MS, MD, FACS: Anthony, as you're starting to get ready to...to put the port in, maybe we'll go back to Tom for a second and...

ANTHONY D. TERRACINA, MD, FACS: Yeah.

00:36:38

STEPHEN D. WOHLGEMUTH, MD, FACS: ...and, Tom, comment about the gastric bypass and the band. And I think there should be a slide up now that shows a little bit of the different weight loss results and what to expect with each operation and who should get what.

00:36:49

THOMAS W. CLARK, MS, MD, FACS: Right. Certainly there...there is some differences between the two procedures. Obviously, with the band we're not dividing any intestine at all. We're not dividing the stomach. We're just putting a band around the top. So, the concept there is fairly simple. With a gastric bypass, well, it's...it's a little more of a procedure where we do have to reroute intestinal tract. Where we make a small stomach still, but then in...we attach the small intestine to it so that we bypass the rest of the stomach.

00:37:19

So typically completely different operations meant to do a similar thing, to lose weight. Now, I think he had a very nice...And there's actually a nice picture, a diagram of each of those. On the left hand side there is the adjustable band and on the right side is a diagram of the gastric bypass. Weight loss, in the long run...I think we had a slide up there, and there it is. Weight loss in the long run potentially can be fairly similar. The weight loss with an adjustable band typically is slower. Now slow or fast doesn't necessarily mean good or bad. It's just different.

00:37:54

With a gastric bypass you typically will lose weight faster, and then it may stabilize then a little bit sooner too. With most procedures, there will be some slight regain of weight. With the adjustable band, typically you're going to have a little slower weight loss. But then if you notice on the graph there when we get out to somewhere around four years, or so, the two lines start coming closer together

00:38:21

And so, long term there may not be a tremendous difference between the two procedures, as far as just weight loss goes. And, I think time will tell us whether that really plays out the...the way this is drawn out, but that is what we're seeing. So the...the two procedures, they're fairly different and it doesn't...again, doesn't make one good, one bad; they are different. And...but the weight loss, potentially, could be fairly similar.

00:38:49

And one thing to note on the...all of these graphs or when we talk about average weight loss, is that's what they are, they're averages. And any individual can do much better or potentially may not do as well. And a lot of it has to do with the concept that the surgery, no matter what it is, is going to be a tool to help you lose weight and it's not necessarily the answer to weight loss. It's just to help you do the things that you need to do to help lose weight.

00:39:17

STEPHEN D. WOHLGEMUTH, MD, FACS: I guess for both Tom and Anthony, do you decide which patient gets which procedure or do you have the patient decide, or how does that work?

00:39:26

THOMAS W. CLARK, MS, MD, FACS: Typically, when we have discussions with the patient it...I'm a firm believer that the patient really needs to come up with what's best for them. WE can help them make that decision. Again, I don't think there's a right and a wrong. I personally do have a few biases, in that if someone is a...a young woman, so to speak, is thinking of getting pregnant in the next few years, my inclination is to lean more to an adjustable band because if she does get pregnant we can just take the fluid out of the band. And so it's a little bit easier to, you know, get adequate nutrition for the baby and the...and the patient at the same time.

00:40:07

And then with...if someone had a tremendous amount of weight to lose, say two hundred, three hundred, four hundred pounds to lose, it's just harder to lose that much weight with an adjustable band. Not that it can't be done. It certainly can be done. But with an adjustable band it's a little bit harder to lose that much weight. I don't know, what are...what are your thoughts on that, Steve?

00:40:29

STEPHEN D. WOHLGEMUTH, MD, FACS: I agree a hundred percent. I think it's...You have to look at the patient individually, find out what their eating habits are, what their expectations are. I certainly don't...don't make the decision for the patients, but it's a joint decision between the physician and the surgeon.

00:40:43

ANTHONY D. TERRACINA, MD, FACS: Yeah. I...I would agree. I would say that in our talks we talk about sweet eaters and as...as other operations in the past that were purely restrictive operations have been defeated by sweets. I present that data to the patient that if they... if they really feel like they are a significant sweet eater and they cannot control that and they don't think they can control that habit postoperatively, they may want to consider a different operation. But, you know, you never...you can never tell. I mean, I think even there's been a study that looked at sweet eaters versus non-sweet eaters and it's kind of mixed reviews on the study as far as the success of...in those situations.

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So, I do...I think...I think you're right, just let the patient decide and ultimately you try to guide them somewhat in the right direction if you feel strongly that the person needs to consider one operation versus the other. But ultimately is a...it is really up to the patient to decide.

00:41:36

STEPHEN D. WOHLGEMUTH, MD, FACS: Great, We're getting a lot of wonderful questions off the Internet. And I would just tell the viewers that if we don't answer your question, it's not that it wasn't a good question. We just have a lot more than we have time to answer. Anthony, why don't you tell us what you're doing now. It looks like you've got a lot of things going on up there.

00:41:50

ANTHONY D. TERRACINA, MD, FACS: Yeah. Actually, what we've done now is...if you can see, we've...we've taken one of the trocar sites and we've lengthened it just a little bit; maybe a couple of millimeters. We need to get down to the strength layer of the abdomen, the muscular fascia. So if you think of your rectus muscles, everybody knows the two big bands of muscle that run straight down the abdomen. It has an overlying fascia, which is the...which is the strength layer over the muscle.

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What...and our intention is, is to get to that layer such that we can put some nice hefty sutures in that layer. The port itself...and we will show it to you in a second. The port itself has some little holes in it and, you know, I always tell patients the port looks like a little flying saucer. Let's see that port, Marnie. So it looks like a little flying saucer. And in the...in the port, you see that there's little holes. And we're going to put sutures in the muscular fascia and then we're going to tie those sutures through these. And it especially secures it so that port stays in a nice constant location and, hopefully, for ever and ever and doesn't move.

00:42:55

So we're going to go ahead and place those sutures now. This can be, amazingly enough, a difficult part of the operation, depending upon how deep your...your abdominal wall is. In other words, the soft...the fatty tissue in your abdominal wall. Right here we're dealing with just kind of an average thickness. It's not too bad. We can see the muscle fascia. But you can imagine if...particularly if you're dealing with someone who is two hundred or more pounds overweight, the thickness of the abdominal wall can be a monumental task to get these sutures down to the right level.

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There can be some port issues. And, you know, the main port issues are port inversion. In other words, the port pulling away from the abdominal wall. We've seen a couple of those and. Of course, the...the band and the port are foreign bodies, so just like if you have your hip replaced or knee replaced, or any other foreign body put in, you can infect...you know, you can create an infected environment.

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We tell all of our band patients, and probably you do the same, if you're having any...any other invasive procedures...So say this patient here today is having a...you know, a D&C, or some type of gynecological procedure, or...you know, I think my tendency always is to tell the patient, you know, if you're...if there's ever any question, you need a dose of antibiotics before an invasive procedure that might stir up some bacteria in the body. Just...And you'd do the same thing if someone had a knee replacement or someone had a heart valve. You're going to try to protect that...that band, which is a foreign body and you can get infected from any number of things.

00:44:33

STEPHEN D. WOHLGEMUTH, MD, FACS: Anthony, I just got a question about the...the white tubing that people are seeing. And they want to know if that's stays outside the body. And they also, as sort of a subsequent question, does the lap-band stay permanently and can you remove it, or should you remove it?

00:44:46

ANTHONY D. TERRACINA, MD, FACS: That's a good question. SO we're looking at the tubing right now. If you look, the tubing has been capped. Marnie capped it earlier after she flushed it, so it's got five cc's of fluid from this point all the way to the...to the band. We're going to cut the tubing off. And you'll see, we let the fluid drip on out. So how much of that fluid comes out is going to be patient dependent. You know, in my estimation it ends up being about two and a half to three cc's. And we let the...we let it equilibrate, so it...Basically, it is deciding its level of tightness it needs to be at right now. And that's pretty much stopped there.

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So now, we're going to take the...the tubing and we're going to connect it to the port. And there's a little collar mechanism. I think these collars are probably getting better over the years, because I can remember in the late nineties taking out a...or, working on a couple of band patients that had this collar come...come loose and I...we haven't seen any at all. So, I think it's manufactured better, or for whatever reason we're not seeing the complication.
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We're starting to feed the tubing back in the abdomen. So in answer to your question, none of the tubing stays out. We're at the point where we're going to...we're going to put these sutures through the port, and we'll do that now. So we thread them just like a...just like a needle through there. And we've got four sutures, four holes. And...and right at the very end, we then allow that port to drop back in the abdomen. The second part of that question, Steve, was about the band staying in, correct?
00:46:18

STEPHEN D. WOHLGEMUTH, MD, FACS:

Correct. Is it something that's a permanent operation or do people...should they expect to lose seventy-five, eight a hundred pounds and then take the band out?
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ANTHONY D. TERRACINA, MD, FACS: Yeah, you know, that's interesting. And I think the original...Well, I guess we have to point out in all this discussion that the...in the U.S. we've had the band a shorter period of time than elsewhere in the world. You know, worldwide it's been around since 1993. Here in the U.S. we've really had it essentially since 2002, or late 2001 or 2002. I think the FDA's original statement on it was, well, the band is approved for...for...I think the wording exactly was temporary use. But it's really...it's a permanent device, so...
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And the intention should be that, because I think that...you know, if a patient did perfectly...And I saw one of my best patients ever yesterday. She's about a hundred and thirty pounds and...and it's interesting, she had one of the rare problems. She had the only band slip that we've seen, and we went back in and repositioned her band. And I gave her the option at surgery of just taking the band out, because she weighed a hundred and thirty pounds when she had her complication. So she had lost a hundred pounds, gotten down to ideal body weight and I said, you know, do you want me to just take the band out? And her response to me was, absolutely not. I want the band put back in because I know that the band works.
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And...and the...and the idea of, I think in my mind, is that patients might revert back to their bad eating habits or...or, you know, they might lose that assistance that they need with the band. And she felt the same way. So I think we universally see that that's the case. Patients...patients really don't ever ask to have the band out. And it really should be considered a permanent device.
00:47:55

THOMAS W. CLARK, MS, MD, FACS: I agree. I agree. I think it needs to be thought of as a permanent device. It would be...it would be kind of like taking weight loss medication, which typically are only given for a short period of time. And what's the standard thing that tends to happen when you get off the weight loss medications is, well, you regain your weight. Well, I think this is along those same lines that it would...very likely the patient would regain their weight. This is meant to be kind of a permanent tool and it certainly can be removed, but I don't think that I would really recommend it being removed, unless the patient was insisting on it.
00:48:29

STEPHEN D. WOHLGEMUTH, MD, FACS: Sure.
00:48:30

ANTHONY D. TERRACINA, MD, FACS: So we let the port slide down in the incision. This port is firmly against the abdominal wall. I've got two more sutures to tie here. And this essentially is the end of the operation. We're going to irrigate out our incisions and close them with a dissolvable suture. And, the postoperative recovery is fast. This patient will go home today. And, send her home with some oral pain medications. She, prior to going home, will have an upper GI study performed.

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I tell patients, you know, I'm not necessarily doing that to...to see if I've made a hole in the stomach, although that originally was really why we started doing them. It's more for...it's a baseline study for me. I get to see how the band looks. I can compare that x-ray to future x-rays that I will obtain to do her band adjustments. And I think it's very useful, in my mind. I think... I think we've come along way since the first bands we put in, in 2004, as far as how we manage the band postoperatively.

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STEPHEN D. WOHLGEMUTH, MD, FACS: Now I have...You've made that look very, very easy and I would caution our viewers at home to not try that because this is a...a highly skilled professional doing it. But in a serious manner, how would you compare this operation that you've just done in about a half hour – and I know you've taken a little bit more time because you've been talking and showing us other stuff – to a gastric bypass in terms of...of the operative time and the postoperative course?

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ANTHONY D. TERRACINA, MD, FACS: Yeah. I think that's a good point to note. You know, this is a simple operation. If you want to equate it to a similar operation wouldn't you just compare it to like a colon...gallbladder operation. You'd see...It's that little stress on the body. And then when you compare it to the gastric bypass, where you're having to create a pouch... create a connection with the pouch using small intestine, the body physiologically perceives that as a big operation, and it indeed is. And I think patients require somewhat of a hospital stay. You know, one day, a day and a half, two days, whatever.

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But it's a longer recovery and I think that they will...they will feel it more physically. Physiologically the drain for the...with the weight loss in the first month is greater. So, wouldn't you agree, Tom? I mean, they just....

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THOMAS W. CLARK, MS, MD, FACS: Absolutely.

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ANTHONY D. TERRACINA, MD, FACS: It's a different...it's a different operation. It's got a little bit higher risk, but the benefit of the operation is that you get the weight loss fast and...But it...They're both good operations, but they're quite different.

00:50:49

STEPHEN D. WOHLGEMUTH, MD, FACS: Before we get to talk about fills and sort of postoperative care, are there any patients that you can think of that would not be a candidate for gastric banding? I just got a question about a patient who's had a prior nisin fudoplication and they want to know if they could still get a lap-band.

00:51:04

ANTHONY D. TERRACINA, MD, FACS: Well, I...you know, I guess...So I have had two similar patients...you cannot really get a consensus. So I think the consensus out there is there's so little data on it that what you...The operation being the nisin, which is heartburn surgery, it's created a wrap around the stomach. You have to take that wrap down. You have to place a band. Is it doable? It's certainly doable. But, the problem is it adds significant risk to the operation. And...and the most recent two patients that I looked at, you know the con...from other experts in the field, the consensus was not to do it in that situation. And how do you feel about that, Tom?

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THOMAS W. CLARK, MS, MD, FACS: Well, I tend to agree. And mainly because the...the risk gets...goes way up. It's certainly a doable thing. I would agree, you'd have to take the wrap completely down, which in itself increases risk significantly. And then putting a foreign body back into that scarred in tissue, I'd be reluctant to recommend that. Again, it could be doable, but...

00:52:08

STEPHEN D. WOHLGEMUTH, MD, FACS: While we're talking about difficult surgical problems, how about the patient who's had a prior gastric bypass done maybe years ago and now has got a big pouch. They're not losing weight, or they're gaining weight back and they come to you and say they want to have a lap-band placed on top of their bypass? Have you done any of those and what would your recommendations be?

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ANTHONY D. TERRACINA, MD, FACS: I have not personally done any and I don't...I don't think, Tom, you have...haven't.

THOMAS W. CLARK, MS, MD, FACS: No.

00:52:30

ANTHONY D. TERRACINA, MD, FACS: So, you know, I think the data is so early on that that...what they call the band over bypass procedure. The only doctors that have done that have been in big university settings. They've done it and they've had just marginal results. And I guess the idea in my mind is the patient failed for a reason. And...and it's typically eating behavior and they're probably not going to do well with a secondary operation.,

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Now., the circumstances you mentioned, Steve, with the large pouch. You know, someone who actually has truly a dilated pouch from a gastric bypass, I think a better operation would be to just go back in and revise her gastric bypass with a new...a new connection between the pouch and the small bowel. That would be my preference. But...but they probably are going to have the average results. You know, secondary...secondary surgeries are always not as good as...as first time operations.

00:53:19

STEPHEN D. WOHLGEMUTH, MD, FACS: Sure. And, Anthony, just for the...for the viewers at home, what are you doing right now? What's the...how are you finishing up?

00:53:25

ANTHONY D. TERRACINA, MD, FACS: Well, we just closed the skin. This is dissolvable stitch. It's...it's kind of colorless. It looks like fishing line almost. And this stitch...suture dissolves in about fourteen to...fourteen to twenty-one days. And, we just like to give a nice cosmetic, you know, a cosmetic appearance. And, you know, they've had a ...they've had a nice laparoscopic operation. We want to give them the cosmesis...uh, cosmetic result that they...that they want with laparoscopic surgery, so we try to be...you know, very careful with our closures and...and they...and it's a...

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Like I said, it's a...I think that patients do amazingly well from this operation. She'll be up walking around this afternoon. Maybe take a walk outside tonight. We'll have her drink some clear liquids today and then start her protein shakes tomorrow. So she'll be up and going.

00:54:09

STEPHEN D. WOHLGEMUTH, MD, FACS: I have a question about postoperative fluid intake. And someone wanted to know that you're supposed to drink x number of glasses of water a day. Is it hard to do with a band or with a bypass?

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ANTHONY D. TERRACINA, MD, FACS: What do you say to that, Tom? What do you tell them generally?

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THOMAS W. CLARK, MS, MD, FACS: Well...right. I think....Certainly any diet plan, they're going to recommend you drink at least eight glasses of water. You know, no matter what surgery we're doing for weight loss, typically it's going to be hard to drink eight glasses of water a day. With the lap-band, they're going to have some...Even though the band is empty, they're going to have some swelling right there where the band is. And so typically during the first few days, especially, it's going to feel really tight and they're going to have to go slow.

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My instructions to patients when they go home is that their job is to slowly sip on liquids all day. That's what their job is. And that...I tell that, really, to both the bypass and the ...the lap-band patients. But it is difficult. But it is certainly idea. You want them to get that...stay hydrated to help with healing, but also then work on getting your protein in.

00:55:07

STEPHEN D. WOHLGEMUTH, MD, FACS: It looks like we're sort of getting towards the end of the hour. There's a slide that I put up that just talks about...because I've had a number of questions about how...how patients do after surgery and what happens to their hypertension, their diabetes, their sleep apnea. And what this slide shows is the percentage of the medial conditions that are resolved after surgery. And...and it's important to understand that that word resolve doesn't say getting better, maybe getting better, thinking about getting better, but resolved.

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And you can see across the board, all the diseases, or many of the diseases that the obese and morbidly obese suffer from are completely resolved after surgery. Particularly eighty-six percent of diabetes, vast majority of hypertension, reflux and so it really does have phenomenal... phenomenal results.

00:55:50

THOMAS W. CLARK, MS, MD, FACS: That...that is correct. I think we have just a couple of minutes left and I think it would be appropriate to talk about long term with an adjustable band, because the...the wonderful thing about the bands are it's adjustable. I also tell people that the...it won't work well if you don't get it adjusted. So, we talked a little bit about adjustments and I think we actually have a little film clip that we can show about an adjustment which we can walk through and then talk about it a little bit.

00:56:17

This is a...a patient that's come over to our fill clinic. We typically do our fills, or adjustments, under x-ray guidance. And that's what that big C-shaped machine is. It's called C-Arm. And, what we do then is we actually....You can see, that's where we put the port. The port is what...the last thing that Dr. Terracina placed on the abdomen there. And that's a look on the x-ray of the port there. And what I'm doing is just lining it up so that we then can access that port with a needle. And it feels like getting blood drawn. And we access that port with a needle and then we can put some saline in there.

00:56:57

We'll have the person drink a little bit of barium so we can watch it go through, and that 's what we're seeing there. She drank a little bit of barium. And we can watch that go through. And you couldn't see well there, we could actually see the band very nicely. And, the barium goes through easily and...but it...we've slowed it down.

00:57:17

And typically, most people are going to need a good kind of three to six adjustments during the first year. After that, they may need one, maybe two adjustments during the following years, but it is something we do have to watch forever. The band is a mechanical device. And because of that, we do need to keep an eye on it. And, obviously, there could potentially be problems with a mechanical device. But when we check that under x-ray guidance, we feel we get a good look at the band. We get a look at the little stomach

pouch. We get a good idea whether there's been anything that's moved at all. And then, obviously, we can tighten at the same time.

00:57:59

And in the long run, we'll...we'll probably want to do that around once a year. So it's not something that takes a tremendous amount of time or effort on your part, as far as the adjustments, but it is something that needs to be done forever.

00:58:14

STEPHEN D. WOHLGEMUTH, MD, FACS: Tom, I think that that's a great point. I think that the viewers at home certainly need to understand that...that this is something that you've got to follow-up with. If you do not follow-up, you will not lose weight, you will not be successful. Dr. Clark mentioned that this is a tool. It is a very, very powerful tool, but a tool that you have to use successfully.

00:58:30

At this point, I would like to thank everyone who's been here. I think we're pretty much running out of time.

00:58:36

ANTHONY D. TERRACINA, MD, FACS: Yeah, I want to say thank you. I forgot one person in the operating room, [Val Wong?]. I didn't want him to roll over my house tonight, so I wanted to mention his name. He's the nurse anesthetist. He did a good job for us, and it's a team approach and we don't want to leave anybody out.

00:58:49

STEPHEN D. WOHLGEMUTH, MD, FACS: Yeah, I think that that's a key point. It really is a team approach. And Dr. Terracina, it was beautifully done operation. I think you're to be commended. And, Dr. Clark, thank you for your insightful comments. And I'd like to thank, particularly the Sentara System for being very supportive of bariatric surgery within the system and making sure that...that if this operation is done at our hospitals, it's done at a center of excellence hospital, which is where both CarePlex and Norfolk General are. And, I think we're pretty much out of time. And I do thank you for being here and thank you for your attention.

00:59:16

ANTHONY D. TERRACINA, MD, FACS: Thank you.

00:59:17

NARRATOR: Thank you for watching this lap-band minimally invasive weight loss surgery from Sentara CarePlex Hospital in Hampton, Virginia.

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00:59:41

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