

# The Obituary of Routine Roux-en-Y Reconstruction in Bariatric Surgery

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## Abbreviations

GORD Gastro-oesophageal reflux disease  
DS Duodenal switch  
RYGB Roux-en-Y gastric bypass  
OAGB One anastomosis gastric bypass

Dear Editor,

Bariatric surgery has come a long way over the past couple of decades and at the heart of our progress lies our desire to simplify our procedures and reduce risks for our patients. We are recognising that when the competition is against therapy that struggles to deliver a sustainable weight loss of even a few kilograms [1], we will never score poorly on effectiveness. All we need to do is continue to improve our short- and long-term morbidity and mortality.

Over the last century, the Roux-en-Y configuration as developed by the Swiss surgeon César Roux became very popular in gastrointestinal surgery [2]. Diverting biliopancreatic juices away from the site of reconstruction improved the efficacy of the drainage irrespective of the organ it was carried out for. As opposed to the loop reconstruction, where the efferent limb would always have something in it coming from the afferent channel, the Roux limb in a Roux-en-Y reconstruction is virtually empty as it would be difficult for biliopancreatic secretions to travel 50–60 cm against the peristalsis of the Roux limb. This makes Roux limb ideal for drainage purposes. Used on the stomach, it improves acid clearance and therefore reduces gastro-oesophageal reflux. Since a large proportion of obese subjects suffer from gastro-oesophageal reflux disease (GORD) [3], it was only natural that Roux-en-Y reconstruction became the default choice for bariatric surgery procedures like gastric bypass [4] or duodenal switch (DS) [5].

But a default Roux-en-Y reconstruction for all patients undergoing a gastric bypass or duodenal switch is not without its

own problems. The second anastomosis, more internal spaces, and long Roux limb can lead to an increased morbidity and mortality mainly due to an increase in the incidence of chronic unexplained abdominal pain and bowel obstruction [6, 7]. Given that Roux-en-Y gastric bypass (RYGB) is one of the commonest procedures worldwide [8], one has to question if the increased morbidity due to Roux-en-Y configuration is justified especially because one anastomosis gastric bypass (OAGB) can deliver the same clinical benefits without the need for a jejunojejunostomy and is now also regarded as a mainstream bariatric procedure by the bariatric community [9]. Similarly, the benefits of a DS can be achieved through a single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) [10].

One accepts that a proportion of patients undergoing OAGB may need conversion to Roux-en-Y configuration for persistent GORD symptoms, unresponsive to medical management. But the number appears to be < 5.0% [11] and is probably no more than 1.0–2.0% if attention is paid to technical details [12]. This means that majority (> 95.0%) of these patients can still avoid the second anastomosis and the additional short-term and long-term morbidity associated with it.

## Compliance with Ethical Standards

**Conflict of Interest Statement** The authors declare that they have no conflict of interest.

**Statement on Human and Animal Rights** This article does not contain any studies with human participants or animals performed by any of the authors.

**Informed Consent** Not applicable

**Ethical Approval** Not applicable

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