Obesity Surgery (2022) 32:3182
https://doi.org/10.1007/s11695-022-06170-1

LETTER TO THE EDITOR

# One Anastomosis Gastric Bypass: Weight Loss Results Are Not a Function of the Biliary Limb Length!

**Arnaud Liagre**[1] · **Francesco Martini**[1]

Received: 22 May 2022 / Revised: 22 May 2022 / Accepted: 24 May 2022 / Published online: 21 June 2022


I read with interest the article by Eskandaros "Outcomes and Effects of 250-cm Biliopancreatic Limb One Anastomosis Gastric Bypass in Patients with BMI > 50 kg/m$^2$ with Total Bowel Length > 6 m: a 2-Year Follow-Up" and congratulate the author who confirms good results on weight control with one anastomosis gastric bypass (OAGB) [1].

Nevertheless, I remain critical of the "à la carte" management of the length of the biliary loop in OAGB. It is simplistic to believe that weight loss depends solely on the length of the derived bile loop. I do not believe that the adaption of this length to the body mass index (BMI) is the main factor responsible for the weight loss.

Our experience of OAGB with a constant biliary loop of 150 cm in patients with BMI > 50 showed results comparable to those published by Eskandaros [2]. It has been demonstrated that the increase of the biliary loop dangerously increases the risk of malnutrition by decreasing the total alimentary limb length (TALL) [3, 4]. Our experience with 106 patients who underwent single anastomosis duodeno-ileal bypass (SADI) showed, on the one hand, the systematic manipulation of the whole intestine starting from the cecum can be responsible for iatrogenic perforation and, on the other hand, despite a short common intestinal loop, the results on weight loss can be disappointing [5]. A non-standard OAGB with variable biliary limb length and/or an OAGB with a biliary limb > 200 cm does not facilitate re-operations for reflux resistant to medical treatment, nor does it facilitate re-operations for malnutrition or those in an emergency by a surgeon, sometimes from another center, who must adapt the intervention after a calculation of the biliary limb length with risk of injury to the gastro-jejunal anastomosis or to carry out a complex operation. The OAGB in our opinion must accomplish two objectives: (1) be an intervention that is as simple, rapid, and reproducible as the sleeve gastrectomy, with weight loss results comparable to those of Roux-en-Y gastric bypass (RYGB) and (2) the conversions of OAGB, even if not frequent, should be technically simple. An OAGB with a standard biliary loop of 150 cm responds to these objectives.

## References

1. Eskandaros MS. Outcomes and effects of 250-cm biliopancreatic limb one anastomosis gastric bypass in patients with BMI > 50 kg/m$^2$ with total bowel length > 6 m: a 2-year follow-up. Obes Surg. 2022. https://doi.org/10.1007/s11695-022-06078-w.
2. Liagre A, Martini F, Kassir R, et al. Is one anastomosis gastric bypass with a biliopancreatic limb of 150 cm effective in the treatment of people with severe obesity with BMI > 50? Obes Surg. 2021;31:3966–74.
3. Jedamzik J, Eilenberg M, Felsenreich DM, et al. Impact of limb length on nutritional status in one-anastomosis gastric bypass: 3-year results. Surg Obes Relat Dis. 2020;16:476–84.
4. Wang A, Poliakin L, Sundaresan N, et al. The role of total alimentary limb length in Roux-en-Y gastric bypass: a systematic review. Surg Obes Relat Dis. 2022;18:555–63.
5. Liagre A, Martini F, Anduze Y, et al. Efficacy and drawbacks of single-anastomosis duodeno-ileal bypass after sleeve gastrectomy in a tertiary referral bariatric center. Obes Surg. 2021;31:2691–700.



✉ Arnaud Liagre
arnaud.liagre@orange.fr

Francesco Martini
framartini77@hotmail.com

[1] Bariatric Surgery Unit, Ramsay Générale de Santé, Clinique des Cedres, Rte de Mondonville, 31700 Cornebarrieu, France