Chapter 11
Sleeve Gastrectomy

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Overview

- Divide greater omentum off stomach, ligating short gastric arteries
- Size 36–40 bougie place, and pouch created by stapling from distal to proximal
- Leak test performed

Clinical Pearls

- Early tachycardia suggests anastomotic leak – always keep your suspicion for a leak low!
- Start with liquid diet, early satiety will be expected.

Patient Preparation

Supine with arms extended.

Sequential compression stockings are placed prior to induction of anesthesia.

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A preoperative antibiotic is administered within 1 hour prior to incision.

Weight based chemical prophylaxis given in pre-op area.

Anesthesia

General anesthesia.

A Transversus Abdominis Plane (TAP) block can be used to improve perioperative pain control.

Additional Consideration

There may be some variations in the port placement as well as methods of sleeve sizing among surgeons. This chapter describes one arrangement.

The surgeon stands on the patient's right side and assistant on the patient's left.

Operative Steps

1. A Veress needle is used to enter the abdomen at the palmar point and abdomen is insufflated to 15 mmHg. Using a 0-degree camera, a 5 mm optical trocar is placed under direct vision at Palmer's point.
2. A 12 mm port is then placed 15 cm below the xiphoid and 3 cm to the left of the umbilicus.
3. The camera is switched to a 30-degree angled 10 mm scope and placed through the 12 mm port. An additional 5 mm port is placed at the right lateral flank slightly below the costal margin and a 12 mm port placed in the right mid-epigastric region a palm's width medial and inferior from the right flank port.
4. A subxiphoid Nathanson liver retractor is used to lift the liver off the anterior stomach.
5. The greater curve of the stomach is identified and an ultrasonic scalpel is used to enter the greater sac at the

mid greater curve by division of the greater omentum cranially with division of the short gastric blood vessels and caudally extending to a point of 4 cm proximal from pylorus. Any posterior gastric adhesions should be lysed.

6. A bougie (size of 36–40) is inserted through the mouth by the anesthesia team, advanced further and positioned at the lesser curve of the stomach.
7. An endoscopic linear stapler is used to staple lateral to the bougie beginning 4–6 cm from the pylorus and making sure not to narrow at the level of the incisura (Fig. 11.1).
8. Continue serial staples cranially up to the left crus of the diaphragm while staying next to the bougie.
9. The transected stomach is removed through the 12 mm port.
10. The sleeve staple line is tested for a leak with gentle insufflation while it is submerged under some irrigation fluid.
11. The 12 mm port site fascia is closed with an absorbable suture on a suture passer.
12. The skin incisions are closed with an absorbable suture and skin glue is applied.

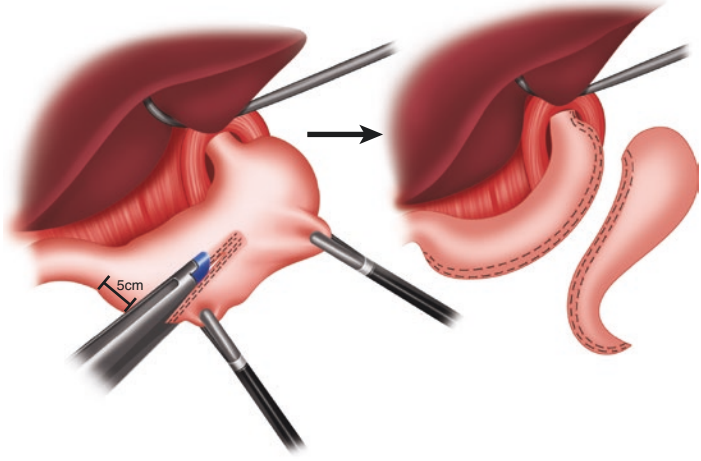

FIGURE 11.1 When performing a sleeve gastrectomy, it is really important to avoid narrowing at the level of the incisura