

LAPAROSCOPIC SLEEVE RESECTION OF THE STOMACH – HOW TO CHOOSE A BALANCE BETWEEN THE RESULT AND COMPLICATIONS

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The present study is devoted to a comparative analysis of two tactical and technical approaches to laparoscopic sleeve resection of the stomach in patients with morbid obesity: the classical technique (Classic) and a modified version with enhanced restriction (Hard). The study included 785 patients operated on from 2019 to 2022, with follow-up for at least 36 months. Early and late surgical and metabolic complications, body weight dynamics, and the frequency of repeated weight gain were evaluated.

The results of the study, which included 785 patients with morbid obesity, revealed the convincing superiority of the Hard LSG technique over the classical method in a number of key parameters. The enhanced technique, based on the formation of a narrower gastric tube (32 Fr), a high resection line and extended mobilization of the Gis angle, made it possible to achieve faster and more pronounced weight loss in the early stages after surgery. After 3 months, the average body weight in the Hard group decreased to 98.7 ± 24.6 kg, while in the Classic group it was 108.7 ± 26.1 kg ($p < 0.0001$). At the 12th month after surgery, the average BMI in the Hard group was 22.4 ± 3.8 kg/m² versus 24.6 ± 3.9 kg/m² in the Classic group ($p < 0.0001$). Especially important is the fact that the proportion of patients who reached a normal body mass index after one year was 70.7% in the Hard group and only 42.2% in the Classic group. Moreover, it was the Hard technique that showed significantly greater stability of the result in the long term.: At the age of 12 to 36 months, the normal body mass index was maintained in 59.3% of patients, whereas in the Classic group — only in 20.4%. Repeated weight gain was recorded in 24.7% of patients after Hard LSG, compared with 62.4% in the Classic group ($p < 0.001$). Thus, increased restriction provides both deep weight reduction and a high probability of long-term weight control.

However, these advantages are achieved at the cost of increased complications. The incidence of early metabolic disorders in the Hard group was 64.3% versus 25.7% in the Classic group ($p < 0.001$), including hypovolemia, hypercoagulation, and metabolic acidosis. The incidence of late surgical complications in the Hard group reached 10.4%, including gastroesophageal reflux disease (9.2%), gastric tube stenosis,

dumping syndrome, and even isolated cases of gastro-colic fistulas. Late metabolic disorders such as micronutritionality, vitamin B12, iron and calcium deficiency were observed in 6.8% of cases, which is 5 times higher than in the Classic group. In addition, a significantly higher proportion of psychological disorders was registered - 21.5% versus 15.0%, including anxiety and depression, eating disorders and social maladjustment.

Thus, the answer to the dilemma cannot be unambiguous. If the priority in a particular clinical situation is a rapid and profound reduction in body weight in a patient with high metabolic risk, the choice in favor of the Hard technique may be justified. However, in cases where safety, metabolic stability and a reduced risk of complications are more important, the Classic method remains preferred.