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FEATURES OF BILIOPANCREATIC BYPASS IN THE TREATMENT OF OBESITY

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Abstract. SADI operation, being simpler in technical execution and quite safe in terms of development of early and remote postoperative complications, can be more often used as a primary operation in the presence of MO, and also performed on patients with super obesity.

Key words: bariatrics, mini gastroshunting, gastroshunting.

Relevance. Obesity is associated with reduced economic and social opportunities, quality of life (QOL) and, most importantly, with an increased incidence of associated diseases that affect life expectancy. In young individuals with an extremely high body mass index ($>45 \text{ kg/m}^2$), life expectancy is reduced by 13 years for men and by 8 years for women (1,2,3,9). The growing prevalence of morbid obesity (MO) leads to an increased role of bariatric surgery: after both restrictive, malabsorptive and mixed surgeries, there is a decrease in the incidence of concomitant metabolic disorders, the risk of cardiovascular diseases and overall mortality. Bariatric surgeries are highly likely to promote remission of type 2 diabetes mellitus (T2DM), affect the main components of the metabolic syndrome, often regardless of the degree of body weight (BW) loss [2, 4,5,6,7,8,10], which allows us to refer to them as "metabolic surgeries" (1,11,12,13). It is well known that metabolic surgeries lead to more significant improvement of lipid profile and blood glucose control compared to traditional treatment (2,14,15,16,17,18). Currently, bariatric surgery has become the gold standard in the treatment of MO. Despite the fact that recent meta-analyses have demonstrated similar long-term results in sleeve gastropasty and gastric bypass with Roux-en-Y gastrojejunostomy (RYGB Roux-en-Y gastric bypass) [2,3], as well as mini gastric bypass (MGS) [1,19], the existing probability of repeated weight gain and relapse of obesity-associated diseases when using these techniques leaves room for the use of more effective surgical technologies (1), including biliopancreatic diversion (BPSH). Based on the experience gained with jejunioileal bypass, in 1979 N. Scopinaro proposed his version of bypass bariatric surgery - BPSH [1,20], which served as the beginning of the development of a new type (section) of bariatric surgeries in the world. Since 1988, the Hess-Marceau modified BPSH technique (BPD-DS, Hess-Marceau) [1] has

been known, consisting of longitudinal gastrectomy (LGR) in combination with bypass of most of the small intestine, in order to reduce absorption primarily of fats and complex carbohydrates (starches). At the same time, the technical complexity of the operation combined with a certain risk of developing undesirable effects limit the spread of this type of surgery (2). In 2007, A. Sanchez-Pernaute and A. Torres performed the first sleeve gastrectomy with duodenoileal bypass (SADI), simplifying the Hess-Marceau modification by imposing one duodenoileal anastomosis (DIA), excluding the interintestinal anastomosis according to Roux (2). Due to the simpler technique of intervention due to the reduction in the number of anastomoses, SADI has the potential for wide application in bariatric surgery, primarily performed by laparoscopic access (3). We did not find any data in the literature on the comparative evaluation of the remote results of SADI and BPD-DS in the Hess-Marceau modification in the long-term (more than 2 years) perspective, performed in one surgical center. Both the advantages of SADI and possible disadvantages, compared with the previous modification of BPD/DS, remain insufficiently studied.

Objective of the study. To improve the results of surgical treatment of patients with morbid obesity based on predictive analysis of the effectiveness and safety of bariatric surgeries.

Material and method. A total of 152 patients who were examined and treated in the clinic of the Tashkent Medical Academy in Tashkent from 2018 to 2024 were included in the clinical retrospective study. To achieve the goal and objectives of the study, we developed and introduced into clinical practice a database including 67 parameters (anthropometric, anamnestic data, examination and observation results, treatment options, etc.) intended for statistical processing.

Results and discussion. Against the background of the development of excess protein malabsorption (EPM), diarrhea syndrome, one patient underwent 12 months after the operation, the DEA was moved to a higher level and abdominoplasty was performed. Another patient showed a sharp decrease in BW by 20 kg after 4.5 years (during the 4th year after the operation), as a result of which he underwent DEA at a higher level using a technique similar to the Carbajo operation, which was proposed in 2015 as a reconstructive surgery after MGS [1]. In relation to SADI, a similar technique was first used by Yashkov Yu.I. in 2021 [3], noting its advantages - preserving the integrity of the pylorus and the previously applied DEA. Unlike SADI, the conversion of MGS to RYGB requires shortening the gastric stump to prevent the development of a peptic ulcer of the anastomosis and the formation of a new GEA [1,2]. With the development of adhesive disease of the abdominal cavity in 1 patient, 1 year and 3 months after the operation, an interintestinal anastomosis according to Brown was applied between the

BPP and the OP in combination with hernioplasty with the installation of a mesh implant. Another patient with acute adhesive intestinal obstruction (AAIO) underwent resection of 200 cm of the BPA, after which a decrease in BM to normal values and development of diarrhea syndrome, effectively responding to conservative therapy, were noted. The following reconstructive interventions were performed in 8 patients with recurrent weight gain after surgery. 5 patients who, along with recurrent weight gain, had clinically significant pronounced bile reflux, underwent reconstruction in BPD/DS in combination with abdominoplasty, pubic plastic surgery (n=1) and reconstruction in BPD/DS in combination with abdominoplasty, hernioplasty and installation of a mesh implant (n=3), reconstruction in BPD/DS (n=1).

Accordingly, a fundamentally important point in reconstructive surgeries is the enhancement of the malabsorptive component or, conversely, the reduction of the manifestations of the malabsorptive component in the event of the development of side effects and complications of the primary operation. Strengthening only the restrictive component for the purpose of correcting the relapse of the MT set did not give any effect.

CONCLUSION

. Biliopancreatic diversion modified by SADI with a total loop length of 250 cm (SADI-250) and BPD/DS by 5 years of observation lead to significant stable and comparable loss of excess body weight (%EWL) at the level of 78.4% and 77.7%, respectively, with an average period of body weight stabilization at 18 months after both surgeries. The dynamics of postoperative weight loss are generally identical in patients who underwent SADI and BPD/DS, regardless of the initial BMI values.

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