

**Results:** 586 procedures were performed between 1998 and 2005. In contrast to the female preponderance of other published bariatric surgery, the VA's population was 74% male. The 30-day mortality was 1.4% with an overall complication rate of 19.7%. Most of the complications had minimal clinical impact such that only 8.7% of the patients had unexpectedly long LOS.  $95\% \pm$  Preoperative risk factors for complications were superobesity (Odds ratio, CI) OR=2.0 (1.3, 3.0) and smoking OR=1.8 (1.1, 2.9). A greater than 20-pack year history of smoking predicted difficulty in weaning from the ventilator postoperatively OR=5.16 (1.92-13.84).

**Conclusion:** NSQIP analysis for VA bariatric surgery revealed two important modifiable preoperative risk factors for complications: Smoking and superobesity. Smoking cessation with pulmonary rehabilitation may prove important as a risk reduction strategy for patients undergoing bariatric procedures. Similarly, preoperative weight loss for the superobese with a program like the VA's MOVE (<http://www.nchpdp.med.va.gov/BariatricSurgery.asp>) may reduce postoperative complications.

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## 19.

### **OBESITY SURGERY 30-DAY OPERATIVE MORTALITY.**

*Edward E. Mason, MD, PhD, Yu-Hui Huang, MS, Kathleen E. Renquist BS, Neal Kohatsu, MD, MPH, University of Iowa, Iowa City, IA.*

**Background:** With reported obesity surgery 30-day mortality rates of 0.1, 0.3 and 2.0%, there may still be room for improvement. Bypass segment obstruction, a rapidly lethal complication causing dilatation, necrosis and perforation of the stomach, has been reported years after gastric bypass but the risk begins at operation.

**Methods:** Data was contributed from 1986-2004 to the International Bariatric Surgery Registry by 86 sites, representing 117 surgeons. Multiple logistic regression analysis was used to compare restrictive and bypass procedure 30-day mortality, with covariates gender, operation year, age and BMI ( $\text{kg}/\text{m}^2$ ) at operation.

**Results:** Operative 30-day mortality for all patients was 0.24% (93/38,501). Males were 2.9 times as likely to die within 30 days of operation ( $p < 0.0001$ ), as well as older and heavier patients (age  $p < 0.0001$ , operative BMI  $p < 0.0001$ ). Forty-two of the 93 deaths occurred following discharge. The most common cause of death was pulmonary embolism (29%, 27/93); bypass 29% (23/80) and restrictive 31% (4/13). GI leak, causing 15% of deaths, was equally frequent after restriction and bypass operations. Nine patients died following small bowel obstruction and were exclusively after bypass. The odds of having a death within 30 days of a bypass procedure were 2.1 times that following a simple restrictive procedure ( $p = 0.03$ ; OR: 2.1; 95% CI: 1.1, 4.1).

**Conclusion:** Risk of operative death is low, but twice as likely after bypass (0.27% vs. 0.14%). Early discharge places high importance upon informed care, vital signs and access to emergent readmission.

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## 20.

### **LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING VERSUS LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASS: 5 YEARS RESULTS OF A PROSPECTIVE RANDOMIZED TRIAL.**

*Luigi Angrisani, MD, Michele Lorenzo, PhD, Vincenzo Borrelli, MD, Monica Giuffra, BSc, Francesco Persico, MD, Carmine Fonderico, MD, Giuseppe Capece, MD, Carlo PDe Angelis, MD, Monica Ciannella, MD, S. Giovanni Bosco Hospital, Naples, Italy.*

**Background:** Prospective randomized comparison of Laparoscopic Adjustable Gastric Banding (LAGB) versus Laparoscopic Roux-en-Y Gastric Bypass (LRYGBP) is lacking.

**Methods:** Lap-Band® via pars-flaccida and standard LRYGBP were performed. From January 2000 to November 2000, 51 patients (aged  $>19 < 50$ ) were randomly allocated into: Group A (LB;  $n = 27$ ; 5M/22F; mean age: 33.3, range: 21-52; mean weight: 120, range: 92-150 Kg; mean BMI: 43.4, range: 40.1-49.2; %EW: 83.8, range: 36.9-128.8), Group B (LGBP;  $n = 24$ ; 4M/20F; mean age: 34.7, range 20-50; mean weight: 120, range: 95-147 Kg; mean BMI: 43.8, range 40-48.9; %EW: 83.3, range: 34.6-126.53). Operative time, re-operation with hospital stay, Kg, BMI, and %EWL, were collected. Failure was considered BMI  $> 35$ . Data were analyzed by Student t-test ( $p < 0.05$  is considered significant).

**Results:** Mean operative time was 60 (Group A) and 220 (Group B) minutes ( $p < 0.001$ ). Mortality was absent. 1 patient was lost. Re-operation rate ( $p = \text{ns}$ ) was 4/26 (15.3%) and 3/24 (12.5%), with hospital stay ranging 2-3 days and 1 week-6 months in group A and B respectively. After 5 years mean weight was: 97.9 (range: 67-128) and 80 (range: 57-104) Kg, BMI was 34.9 (range 26.2-44.3) and 29.8 (range 24.7-40.5), mean %EWL was 47.5 and 66.6, with failure rate 10/26 (38.4%) and 1/24 (4.2%) in Group A and B respectively ( $p < 0.001$ ). Patients with BMI  $< 30$  were 3/26 (11.5%) and 15/24 (62.5%) in the same groups ( $p < 0.001$ ).

**Conclusion:** LRYGBP compared to LAGB produces better weight loss and reduced number of failures, despite significantly longer operative time and life threatening complications. Predictive criteria of success for Lap-Band® need to be investigated.

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## 21.

### **COMPARATIVE STUDY BETWEEN LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING AND LAPAROSCOPIC GASTRIC BYPASS. SINGLE-INSTITUTION FIVE YEAR EXPERIENCE IN BARIATRIC SURGERY.**

*Sergio J. Bardaro, MD, Dennis Hong, MD, Jay Jan, MD, Laura Jul, MD, Emma Patterson, MD, Legacy Health System, Portland, OR.*

**Background:** Laparoscopic Roux-en-Y gastric bypass (LRYGBP) and laparoscopic adjustable gastric banding (LAGB) are common surgical procedures for morbid obesity, but few studies have compared LRYGBP and LAGB.

**Methods:** All patients who underwent LRYGBP and LAGB in our practice were identified from a prospectively maintained database. Patients were allowed to choose between LRYGBP and LAGB.