

Making the **DS** SWITCH

by **Nikki Johnson**

Making the decision to have weight loss surgery is only the first step on the road to surgical weight loss. Once you decide surgery is for you, there are other choices to be made—like which surgical procedure is right for you and which surgeon you will trust to do the job. A few procedures, such as Roux-en-Y gastric bypass (RNY) and laparoscopic adjustable gastric banding (LAGB), tend to get more attention because they are more widely performed and more closely studied, but some people opt instead for the surgical road less traveled—and make the DS switch.



Eating “normally” is one thing some people facing the prospect of surgery fear losing. Who wants to miss out on the joys of the occasional slice of their child’s birthday cake, or a small portion of steak at the neighborhood summer barbecue? Nobody does. Eating is a part of our everyday lives, from social interactions to special occasions. Sacrificing participation in daily life for the sake of health and lower weight sometimes seems to be just too much to ask. Each surgical method has its own advantages—whether it is the reversibility and minimally-invasive nature of laparoscopic gastric banding or the malabsorptive feature of the RNY—but one advantage to the DS is that it does not require the same type and degree of social sacrifice.

According to John Husted, MD, the DS operation is restrictive, meaning that the amount of food the stomach can accommodate is reduced, but not like a gastric bypass or LAGB. He says that DS patients are “able to make different culinary choices. They’re able to adapt to a different food culture, which can still be healthy.” This is because the DS operation allows patients to lose weight while eating a wider variety of foods, and in somewhat larger amounts than patients with gastric bypass or LAGB. Dr. Husted explains that the stomach pouch left after duodenal switch is really more of a “gastric tube” which preserves the natural inlet and outlet of the stomach, allowing for a more normal diet after surgery.

“Once the operation has healed,” he says, “most people will settle into eating about a half to two-thirds the amount of food that they were eating beforehand. So the amount of restriction is not so severe. Patients can eat a broader variety of more healthy-type foods—raw foods, fresh veggies, dense animal proteins—those things that are more recognized as being healthier foods for us, and more suited for the natural human ecology anyway, so that they don’t have as much sense of denial.” He explains that the DS operation allows the body to incorporate food more like a lean individual’s body would, and that trouble foods for some bariatric patients, like meat and bread, are usually well-tolerated by DS patients.

Dr. Husted has performed about 700 DS operations, but his own interest in DS surgery and his understanding of its mechanisms took time to develop. “My first exposure to even the concept of a duodenal switch was in 1998,” he says. “I

Why did you **choose DS**?

DS was the right choice for me due to the normal operating stomach, needed for further usage of arthritis meds, and the greatest chance of excess weight loss in the long run: 85 percent compared to Roux-en-Y of 65 percent.

Jeanne—Post-op patient of Dr. Fernando Bonanni.

As a physician and a pediatric endocrinologist, I thought it made the most physiological sense for the treatment of a metabolic disorder. Obesity is a medical disease, and thus I wanted the best medical treatment for it, one that would offer success both at a restrictive and a malabsorptive level. However, for me, the intact pyloric valve was crucial, as I have a lifelong need for anti-inflammatories NSAIDs and was not willing to have a surgery that compromised my ability to take and absorb them properly. Lastly, I wanted the surgery that by scientific study results had the greatest long-term success rate. The duodenal switch, at the time I had my surgery, had the most superior five-year results over both RNY and Lap-band in the worldwide medical literature.

Amanda—Post-op patient of Dr. William S. Peters, pictured on the facing page.

I’ve gained and lost enormous amounts of weight many times in my life, only to gain it back with interest. The DS will give me permanent results with the least chance of regain. I like the fact that I will have a fully functioning stomach with pyloric valve intact, and no blind stomach that can form ulcers or worse with no way to scope it. I like that I will be able to eat normal amounts of food. I’m grateful that I will be able to take NSAID drugs when necessary. I like that I will be able to eat a variety of foods without experiencing dumping syndrome as with the RNY.

Anna—Pre-op patient of Dr. Dennis C. Smith, Jr.

understood the restrictive model of bariatric surgery, but the steps they were talking about with duodenal switch didn't click right away." But the more Dr. Husted learned about the operation, the more he realized what made it unique and powerful: "This is not just an operation that restricts how much food you can eat, but the relative preservation of your metabolic rate in response to dieting, and this actually takes things one step further. It's a very metabolically-active operation."

Some of the value of the DS, for Dr. Husted, lies in the way it has helped him to understand obesity and its resolution. "The more we understand about duodenal switch," he says, "the more we understand how weight loss operations work, or how they don't work, and the more we understand about obesity in general. It also broadens our understanding as to why there are some people that are naturally lean, and why some people, no matter how much they try with diet or exercise or compliance with a restrictive operation, are just always going to have a tough time when it comes to losing weight, because of their disrupted and dysfunctional metabolism."

Dr. Husted says, "In my opinion, there's no operation for obesity that uses as many mechanisms of action as a duodenal switch. The duodenal switch is definitely the granddaddy of them all." These factors make DS the operation of choice for a growing minority of bariatric patients.

According to Dr. Husted, even with all of its advantages, DS is not one-size-fits-all. Furthermore, even for those for whom DS is a good fit, the "rules of the tool" still apply. You still need supplements and must follow certain dietary and fitness guidelines, but the guidelines may just be a little bit easier to comply with after DS. Dr. Husted explains: "Not everybody with a duodenal switch is successful. There's a failure rate of duodenal switch as well. There's a saying that I tell my patients in seminars: 'No operation is an excuse for bad behavior.' I say that because many patients who rejected gastric bypass and who then want to have a duodenal switch somehow now have this mistaken idea that 'I'm going to have a duodenal switch so I can eat whatever I want.' Well, you know, people who are lean and healthy don't just sit and eat whatever they want."

Why not choose DS? For some people, the technical skill required of the surgeon and the invasiveness of the DS operation are deterrents

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when compared to the simpler, reversible LAGB or the widely-performed RNY. However, according to Dr. Husted, DS risks are ultimately comparable to those of gastric bypass. He says, "Generally speaking, the more invasive operations have better long-term durable weight loss results than the least invasive operations. There seems to be this parallel between risk and benefit in weight loss surgery. Undeniably, people are going to want something that's less invasive. People are going to want something that's going to offer fewer complications... especially when patients are paying out-of-pocket."

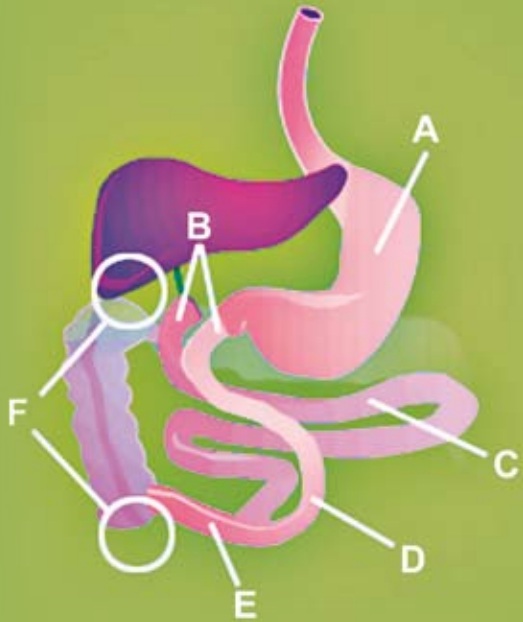
After weighing the risks and benefits, some people select DS, even as the popularity of other methods grows. Asked about the future of DS, Dr. Husted replies that the availability of the surgery will be patient-driven: "Certainly [the patients are] going to be limited by what the surgeon that they choose can provide, and by what their insurance company can pay for, too. So I think the patients that want a duodenal switch certainly will still be able to get duodenal switch surgery, but it is going to be patient-driven."

For surgeons like Dr. Husted, there is reason to keep doing DS operations. He says, "Those of us who perform and understand the duodenal switch are in the minority. I think it's easy to look at it as being something very, very special. For our patients... it is."

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Duodenal Switch

as performed by Dr. Husted



(A) The stomach is trimmed to a 3- to 4-ounce volume, preserving its natural inlet and outlet (the pylorus). Trimming the stomach results in a temporary restrictive effect on eating for several months, which then reverts to normal, and decreases the incidence of ulcer formation as well.

(B) The small intestine that the stomach normally empties into (the duodenum) is “switched” to the downstream portion of the small intestine (the digestive limb-D). The outflow from the duodenum, carrying the digestive juices and enzymes (but no food), becomes the bilio-pancreatic limb (C), utilizing approximately 60% of the small intestines length.

(D) The digestive limb takes up approximately 40% of the small bowel length, and most of this length is upstream from where the bilio-pancreatic limb deposits its juices to allow for the absorption of fats, starches and complex carbohydrates.

(E) The common limb, being the portion of intestine where both food and bilio-pancreatic outflow meet, is made up of the most downstream 100 cm of small intestine and is the only portion where absorption of dietary starches, fats and complex carbohydrates occurs. The capacity for absorption reaches a maximum within several months after surgery and cannot be overeaten, resulting in long-term sustained weight loss.

(F) The gallbladder and appendix are removed.

*Description and graphic are used courtesy of
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