**Publications’ list of the « Severe Obesity Outcome Network » (SOON) cohort**

**1. Obes Surg. 2016 Aug;26(8):1994-5. doi: 10.1007/s11695-016-2257-2.**

**Totally Robotic Reversal of Omega-Loop Gastric Bypass to Normal Anatomy.**

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BACKGROUND: Gastric bypass procedures can potentially lead to middle and long-term complications (Podnos et al. Arch Surg 138(9):957-61, 2003). For several years, Roux-en-Y gastric bypass reversal procedures performed by laparotomy or laparoscopic way have been described in literature (Moon et al. Surg Obes Relat Dis 11(4):821-6, 2015). Major complications are anastomotic ulcers, anastomotic complications or functional disorder such as dumping syndrome, hypocalcemia, severe hypoglycemia, and malnutrition (Moon et al. Surg Obes Relat Dis 11(4):821-6, 2015; Campos et al. Surg Obes Relat Dis 10(1):36-43, 2014). One-anastomosis gastric bypass (OAGB) also called omega-loop gastric bypass (OLGB) or mini-gastric bypass (MGB) is a technique that has demonstrated similar results to traditional Roux-en-Y procedures in terms of weight loss and postoperative quality of life (Lee et al. Ann Surg 242(1):20-8, 2005). However, in a recent description of 1000 patients, the percentage of malnutrition was 0.2 % (two patients) with an indication to revert omega-loop gastric bypass back into normal anatomy (Chevallier et al. Obes Surg 25(6):951-8, 2015), but technical details have not been exposed yet. The first robotic gastric bypass was published by Horgan and Vanuno in 2001 (Horgan and Vanuno J Laparoendosc Adv Surg Tech A 11(6):415-9, 2001). The present work describes for the first time a robotic procedure to reverse OLGB into normal anatomy.

METHODS: We present the video report of a 69-year-old woman suffering of severe malnutrition (weight of 42 kg, body mass index of 15.8 kg/m(2), albumin 21 g/l) who had undergone laparoscopic omega-loop gastric bypass 2 years ago (initial weight of 104 kg and initial body mass index of 39.6 kg/m(2)). She was referred to our Bariatric Surgery Unit, and after a period of parenteral nutrition support to improve nutritional status (albumin 32 g/l), we decided in a multidisciplinary staff to perform a reversal omega-loop gastric bypass back into normal anatomy using the DaVinci Si™ system by Intuitive Surgical Inc ®, Sunnyvale, CA.

RESULTS: In this high definition video, we present step-by-step robotic reversal of the omega-loop gastric bypass. The procedure began with a careful adhesiolysis of the left lobe of the liver, small gastric pouch, and omega-loop. Then, the gastro-jejunostomy was transected with a 45-mm Endo GIA endocutter with purple staples. The key-point was the creation of a gastro-gastric anastomosis between the small gastric pouch and the excluded stomach. Omega-loop jejunum was resected and the anastomosis was performed in order to avoid intestinal stenosis. The operative time was 232 min. Postoperative course was uneventful and the patient was discharged in postoperative day 8. One month after the procedure, she has gained 10 kg (albumin 34 g/l) and stabilized her nutritional status without further nutritional support.

CONCLUSIONS: This is the first case described in the literature of a reversal omega-loop gastric bypass into normal anatomy and the first description of the use of a robotic approach. This intervention is challenging, but a feasible procedure. This technology may increase the number of surgeons who are able to provide the benefits of minimal invasive surgery to their patients without the increased risks of complications associated with initial learning curves. The three-dimensional robotic vision, a stable camera, and the multiples degrees of freedom of the robotic instruments are the features that seem to provide greater surgical precision for these complex laparoscopic operations.

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**Treatment Discontinuation Following Bariatric Surgery in Obstructive Sleep Apnea: a Controlled Cohort Study.**

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BACKGROUND: Uncontrolled studies looking at the discontinuation of obstructive sleep apnea (OSA) treatment after bariatric surgery (BS) have suggested that surgery improves OSA. However, this discontinuation of OSA treatment by BS patients has never been compared to a matched population without BS. The objectives of this study are to evaluate whether BS increases OSA treatment discontinuation compared to that in matched patients without BS and to identify predictive factors of OSA treatment discontinuation in BS patients. The study took place in an ambulatory, tertiary hospital.

METHODS: We included 61 OSA patients who underwent BS in a retrospective controlled cohort study. The computerized matching procedure included age, sex, body mass index, year of starting OSA treatment, treatment type, and duration selected 59 controls matched to 28 patients with BS. The main outcome was OSA treatment discontinuation within 2 years after BS.

RESULTS: Patients with BS stopped OSA treatment more often than controls, usually between 6 months and 1 year after BS: hazards ratio (HR (95 %, CI)) 15.93 (3.29, 77.00). Before 6 months or beyond 1 year after BS, treatment discontinuation was not different between BS patients and controls. In univariate analyses, female gender, absence of co-morbidities, greater weight loss, and lower baseline OSA severity were associated with stopping OSA treatment after BS. No factor remained independently associated in multivariate analysis.

CONCLUSIONS: Apneic patients having BS stop OSA treatment more than matched controls. Treatment discontinuation may be attributed to recovery or to abandonment. The effect of BS on OSA may have been overestimated in uncontrolled BS studies that ignored basal OSA treatment discontinuation in routine clinical practice.

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