Bariatric surgery in duodenal switch procedure: weight changes and associated nutritional deficiencies

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Abstract

Introduction: Bariatric surgery using the duodenal switch procedure is considered to be one of the most effective treatments for achieving weight loss and decreasing comorbidity in patients with morbid obesity. However, this procedure may be associated with various nutritional deficiencies that should be known and adequately managed.

Objectives: To assess weight loss and the occurrence of nutritional deficiencies in morbidly obese patients undergoing bariatric surgery using a duodenal switch procedure.

Patients and methods: One hundred and twenty-eight morbidly obese patients underwent a duodenal switch procedure at Hospital General Universitario in Albacete. Weight changes and the most important nutritional deficiencies occurring after surgery were recorded.

Results: Median follow-up time was 30 months (interquartile range, 18 months). Body weight markedly decreased, with mean body mass index (BMI) decreasing from a preoperative value of 52.9 ± 7.7 kg/m² to 30.8 ± 5.2 kg/m² 18 months after surgery. Percent excess weight loss (%EWL) was 81.4 ± 16.4% in this period. Weight loss slowed down subsequently, reaching its lowest value 30 months after surgery (%EWL 82.1% ± 16.8, BMI 30.2 ± 4.3 kg/m²) and tended to stabilize in patients with longer follow-up times. The most significant nutritional deficiencies requiring replacement therapy were found in some micronutrients such as iron (42.9%), zinc (38.3%), vitamin A (55.5%), and vitamin D (57.8%), amongst others.

Conclusions: Duodenal switch is a very effective surgical procedure for treating morbidly obese patients because it allows them to achieve a significant and sustained weight loss. Close lifetime monitoring is required in these patients because of the high prevalence of nutritional deficiencies during follow-up.

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Keywords: Bariatric surgery; Duodenal switch; Weight loss; Nutritional deficiencies; Morbid obesity
Cirugía bariátrica mediante la técnica del cruce duodenal: evolución ponderal y deficiencias nutricionales asociadas

Resumen
Introducción: La cirugía bariátrica mediante la técnica del cruce duodenal está considerada como uno de los tratamientos más efectivos para conseguir la pérdida de peso y la disminución de comorbilidades en pacientes obesos mórbidos. Derivada de su práctica se pueden producir deficiencias nutricionales que debemos conocer y tratar.

Objetivos: Valoración de la pérdida de peso y del desarrollo de síndromes carenciales en pacientes obesos mórbidos sometidos a cirugía bariátrica mediante la técnica del cruce duodenal.

Material y métodos: Se ha estudiado la evolución de 128 pacientes obesos mórbidos sometidos a cirugía bariátrica mediante la técnica del cruce duodenal en el Hospital General Universitario de Albacete. Se realizaron controles ponderales y de las deficiencias nutricionales más relevantes surgidas tras la intervención.

Resultados: El peso corporal desciende de manera acusada desde un índice de masa corporal (IMC) promedio de 52,9 ± 7,7 kg/m² (40,7-78,5) hasta un IMC de 30,8 ± 5,2 kg/m², con un porcentaje de exceso de peso perdido (%EPP) de 81,4 ± 16,4% a los 18 meses tras la intervención. La pérdida de peso se ralentiza en el seguimiento posterior, llegando a su valor más bajo a los 30 meses postintervención (%EPP del 82,1 ± 16,8; IMC de 30,2 ± 4,3 kg/m²) y tiende a estabilizarse en los pacientes con seguimiento más prolongado. Las deficiencias nutricionales más significativas que requirieron tratamiento sustitutivo se detectaron en algunos micronutrientes como el hierro (42,9%), zinc (38,3%) y vitaminas liposolubles A (55,5%) y D (57,8%), entre otros.

Conclusiones: El tratamiento de la obesidad mórbida mediante cruce duodenal es una técnica muy efectiva para conseguir una importante pérdida de peso de forma mantenida. La elevada presencia de déficits nutricionales durante el seguimiento obliga a realizar revisiones periódicas de forma indefinida.

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Mean patient body weight before surgery was 139.3 ± 22.3 kg (99-202), and mean preoperative BMI was 52.9 ± 7.7 kg/m² (40.7-78.5).

The most prevalent associated comorbidities included high blood pressure in 60 patients (46.9%); liver steatosis in 52 (40.6%); obstructive sleep apnea syndrome in 46 (35.9%); diabetes mellitus in 26 (20.3%); dyslipidemia in 26 (20.3%); and bone and joint pathology in 26 (20.3%).

Weight changes over time

Patients lost weight rapidly in the first 18 months after surgery, with a %EWL of 81.4 ± 16.4% and a BMI decrease to 30.8 ± 5.2 kg/m² (n = 104). Weight loss slowed down subsequently and reached a nadir at 30 months, with a %EWL of 82.1 ± 16.8 (n = 70) and a BMI of 30.2 ± 4.7 kg/m². BMI slightly increased then to 32.2 ± 3.9 kg/m² at 48 months (n = 30) and tended to stabilize in patients with the longest follow-up (Table 1). Figure 1 plots weight changes over time.

Nutritional deficiencies occurring after surgery

Deficiencies were found in vitamin A (71 patients, 55.5%), vitamin D (74 patients, 57.8%), iron (55 patients, 42.9%), and zinc (49 patients, 38-3%). Deficiencies in B vitamins and magnesium were less common (Table 2).

Table 3 summarizes the nutritional supplements added to correct the above deficiencies.

Discussion

Duodenal switch is an alternative to the biliopancreatic diversion (BPD) of Scopinaro et al12 in which distal gastrectomy is replaced by tubular gastrectomy, thus preserving gastric function. Some authors consider duodenal switch the procedure of choice in the subgroup of patients with higher BMI, who show a greater rate of associated comorbidities and/or metabolic syndrome. At reference centers, a long-term overweight reduction of up to 70% has been achieved with good patient quality of life and the disappearance of or a marked improvement in comorbidities. This represents results which are better and more stable over time as compared to other surgical procedures with no strict dietary limitations and a low mortality13-16.

Short-term results reported in a sample of 118 patients undergoing DS showed a mean weight loss of 25 kg in the first three months17. In a small series from a single center, a mean EWL of 84% was seen in 61 patients at 16 months of

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**Table 1** Changes in weight parameters during postoperative follow-up

<table>
<thead>
<tr>
<th>Time (months)</th>
<th>Weight (kg)</th>
<th>BMI (kg/m²)</th>
<th>Weight loss (kg)</th>
<th>%EWL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-surgery (n = 128)</td>
<td>139.3 ± 22.3</td>
<td>52.9 ± 7.7</td>
<td>13.4 ± 5</td>
<td>18.8 ± 6.8</td>
</tr>
<tr>
<td>1 (n = 127)</td>
<td>125.9 ± 20.5</td>
<td>47.8 ± 7.2</td>
<td>13.4 ± 5</td>
<td>18.8 ± 6.8</td>
</tr>
<tr>
<td>3 (n = 125)</td>
<td>114.3 ± 18.9</td>
<td>43.5 ± 7</td>
<td>25.8 ± 11.5</td>
<td>36.5 ± 17.4</td>
</tr>
<tr>
<td>6 (n = 118)</td>
<td>98.9 ± 17.2</td>
<td>37.7 ± 7.9</td>
<td>42.8 ± 17.3</td>
<td>59.3 ± 21.4</td>
</tr>
<tr>
<td>12 (n = 113)</td>
<td>86.1 ± 15.3</td>
<td>32.7 ± 5.2</td>
<td>54.7 ± 13.1</td>
<td>76.1 ± 18.6</td>
</tr>
<tr>
<td>18 (n = 104)</td>
<td>81.6 ± 15.9</td>
<td>30.8 ± 5.2</td>
<td>58.9 ± 15.1</td>
<td>81.4 ± 16.4</td>
</tr>
<tr>
<td>24 (n = 92)</td>
<td>80.1 ± 15.4</td>
<td>30.2 ± 4.7</td>
<td>60.3 ± 16</td>
<td>82.1 ± 17.7</td>
</tr>
<tr>
<td>30 (n = 70)</td>
<td>79.2 ± 14.7</td>
<td>30.2 ± 4.3</td>
<td>60.8 ± 15.8</td>
<td>82.1 ± 16.8</td>
</tr>
<tr>
<td>36 (n = 51)</td>
<td>82 ± 15.9</td>
<td>31.1 ± 4.3</td>
<td>58.9 ± 15.9</td>
<td>79.4 ± 13.3</td>
</tr>
<tr>
<td>48 (n = 30)</td>
<td>85.5 ± 16.4</td>
<td>32.2 ± 3.9</td>
<td>57.8 ± 17</td>
<td>75.4 ± 11.3</td>
</tr>
<tr>
<td>60 (n = 9)</td>
<td>81.4 ± 24.4</td>
<td>32.4 ± 10.9</td>
<td>52.3 ± 17.1</td>
<td>74.3 ± 8.3</td>
</tr>
<tr>
<td>72 (n = 4)</td>
<td>78.5 ± 34.4</td>
<td>32.3 ± 3.7</td>
<td>58 ± 25.3</td>
<td>75.1 ± 8.5</td>
</tr>
</tbody>
</table>

%EWL: percent excess weight lost; BMI: body mass index.

**Figure 1** Change in body mass index (kg/m²) after surgery.
Bariatric surgery in duodenal switch procedure: weight changes and associated nutritional deficiencies

In larger studies including 701 patients with a mean initial BMI of 52.8 kg/m², a mean BMI of 31 kg/m² was achieved at 36 months, with a slight increase in the patient group with the longest follow-up. These results are similar to those achieved in the 104 patients in our series for which follow-up was available following similar surgery.

BS induces anatomic and functional gastrointestinal changes resulting in food intake reduction and/or nutrient malabsorption which may compromise the nutritional status of patients, leading to protein-energy malnutrition and/or selective deficiency of some micronutrients. Such nutritional changes may be present in some cases before surgery. In order to minimize these complications, BS should be performed by a multidisciplinary team that includes experienced surgeons and applies strict rules for patient selection and long-term clinical follow-up.

The DS procedure may compromise the absorption of fat and liposoluble vitamins (A, D, E, K), iron and calcium, among other nutrients, and may also affect protein absorption and induce calorie-protein malnutrition in up to 3%-5% of patients. Vitamin A, K, and D and zinc deficiencies have been reported in more than 50% of patients at 12 months of surgery. These rates gradually increase, suggesting that intestinal adaptation allowing for the maintenance of a balance in the absorption of certain micronutrients still has not occurred four years after duodenal switch surgery.

In a study comparing BPD and DS, Dolan et al found hypoalbuminemia in 18% of patients, anemia in 32%, iron deficiency in 23%, calcium malabsorption in 25%, and a mean deficit of almost 50% in vitamins A, D, E, and K. They also reported zinc, selenium, and magnesium deficiencies in 10.8%, 14.5%, and 4.8% of patients, with no significant differences between both procedures. In our series, hypoalbuminemia and anemia were less common, which could be attributed to the surgical procedure (greater length of the common limb) and/or to a close postoperative follow-up by the clinical nutrition unit.

BS using the DS procedure achieves good weight loss results in the middle term. However, the gradual occurrence of nutritional deficiencies in more than half of the patients mandates indefinite follow-up at the clinical nutrition clinic to reinforce new feeding habits, promote physical activity, prevent and treat nutritional deficiencies, diagnose late postoperative complications, and assess the need for correcting cosmetic sequelae after massive weight loss as an essential component in the recovery of patient quality of life and satisfaction.

**Conflict of interest**

The authors state that they have no conflict of interest.

**References**

