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Endocrinol Diabetes Res 2017, 3:3
DOI: 10.4172/2470-7570-C1-003

19TH Asia Pacific Diabetes Conference

July 20-22, 2017 Melbourne, Australia

Pylorus preserving total duodenal exclusion for non-obese type 2 diabetes mellitus

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We have experience of laparoscopic single anastomosis gastric bypass for non-obese type 2 diabetic subject since 2009. There had been minor problems which led to patients having to undergo annoying discomfort frustrates its clinical application. To improve postoperative QoL, we modified our established procedure since December 2015. Most symptoms or complaints are linked to the absence of pyloric sphincter function. To recover this function, the entire stomach including sphincter should be preserved. While preserving the pyloric sphincter, we completely removed the duodenal tissue from the distal end of the stomach. We carry out our procedure based on three principles strictly:

1. Preservation of the pyloric ring
2. Total duodenal exclusion
3. The biliopancreatic limb should be more than 200 cm

Most importantly, duodenal mucosa should be removed. Remained duodenal mucosa is possible cause of recurrent hyperglycemia 6 months after surgery. Compensatory hypertrophy and unique pattern of epithelial regeneration of short cut end of jejunum is answer of enigma. More than 200cm of biliopancreatic limb is mandatory. Alimentary limb is not necessary in metabolic surgery, Mere existence of nutrients enough to stimulate enteroendocrine cell. In metabolic surgery, alimentary limb is functional segment. Single anastomosis between pyloric ring and small bowel does not make any problem. Postoperative sphincter function was excellent. From December 2015 to date, a total 40 patients have undergone this procedure. Postoperative GIQOL is highly satisfactory, with no significant discomfort in most subjects, and some patients have equal quality with their preoperative GIQOL. Nine patients who were followed up for more than 12 months after surgery showed no evidence of recurrence. The clinical course of glycemic control was equal to or better than that of previous surgery