Fully ambulatory Single Anastomosis Duodeno-Ileal bypass (SADIs) after Sleeve Gastrectomy (SG): 66 consecutive patients in a single tertiary Canadian bariatric center

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Introduction: The safety of SADIs as an outpatient procedure following SG has not been assessed, amid increasing limitations to traditional hospitalization.

Objectives: In light of our strong experience in ambulatory SG, we established a day-surgery SADIs program (<12h) and described its early outcomes.

Methods: Since April 2021, we retrospectively analyzed data from 66 patients who underwent ambulatory SADIs, using a prospectively maintained database following ERABS guidelines. Inclusion criteria: age <55YO, BMI ≤50kg/m^2, ASA score I or II, moderate to severe obstructive sleep apnea if well-controlled with C-PAP, Obesity Surgery Mortality Risk score grade A or B. If not met, patients were excluded. The duodenum was transected 2cm distal to the pylorus, and the duodeno-ileostomy was handsewn, 250cm from the ileo-caecal valve.

Results: Sixty-six patients (60F/6M, mean age 41.4yo, mean pre-operative BMI= 41.3 kg/m^2), underwent laparoscopic ambulatory SADIs, with robot assistance in 88% of cases. A leak test was performed at the end, and abdominal drains were inserted in one-fourth of the cases. Associated comorbidities were present in 14 (21.2%) patients. There was no mortality and 3 patients were hospitalized overnight. Among the remaining 63 patients, the rate of major complications within 30 days was 3.1% (1 intrabdominal abscess POday20 (percutaneous drainage and antibiotics) and 1 peritonitis due to duodenal fistula POday1 (surgically treated)). Minor complications occurred in 6.4% of cases (3 pain, 1 parietal cellulitis) within 30 days.

Conclusion: In highly selected patients of high-volume centers, SADIs can be performed safely as an ambulatory procedure with a postoperative safety net.

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