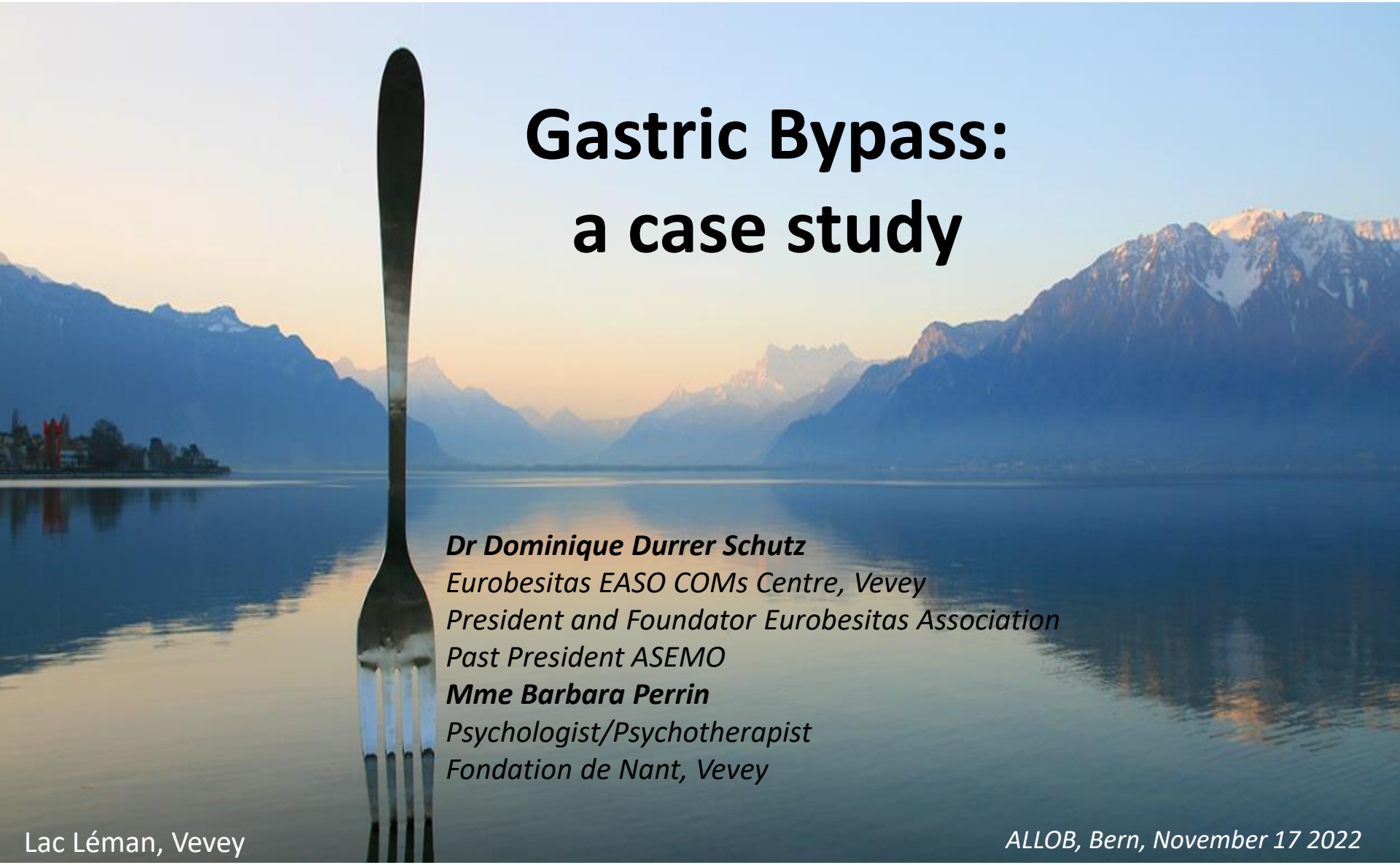

Gastric Bypass: a case study

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ALLOB, Bern, November 17 2022

Case History

- Male Patient of Portuguese origin, 27 years old, in Switzerland since the age of 14.
- Occupation: nursing assistant and community health worker
- Separated, 1 daughter 8 years old
- In 2015, BMI 38 kg/m2, Gastric bypass
- Patient lost to follow-up
- January 2022: Hospitalisation with confusional state, oculomotor disorders (ophthalmoplegia and nystagmus), cerebellar ataxia and amnesic syndrome with frontal signs.

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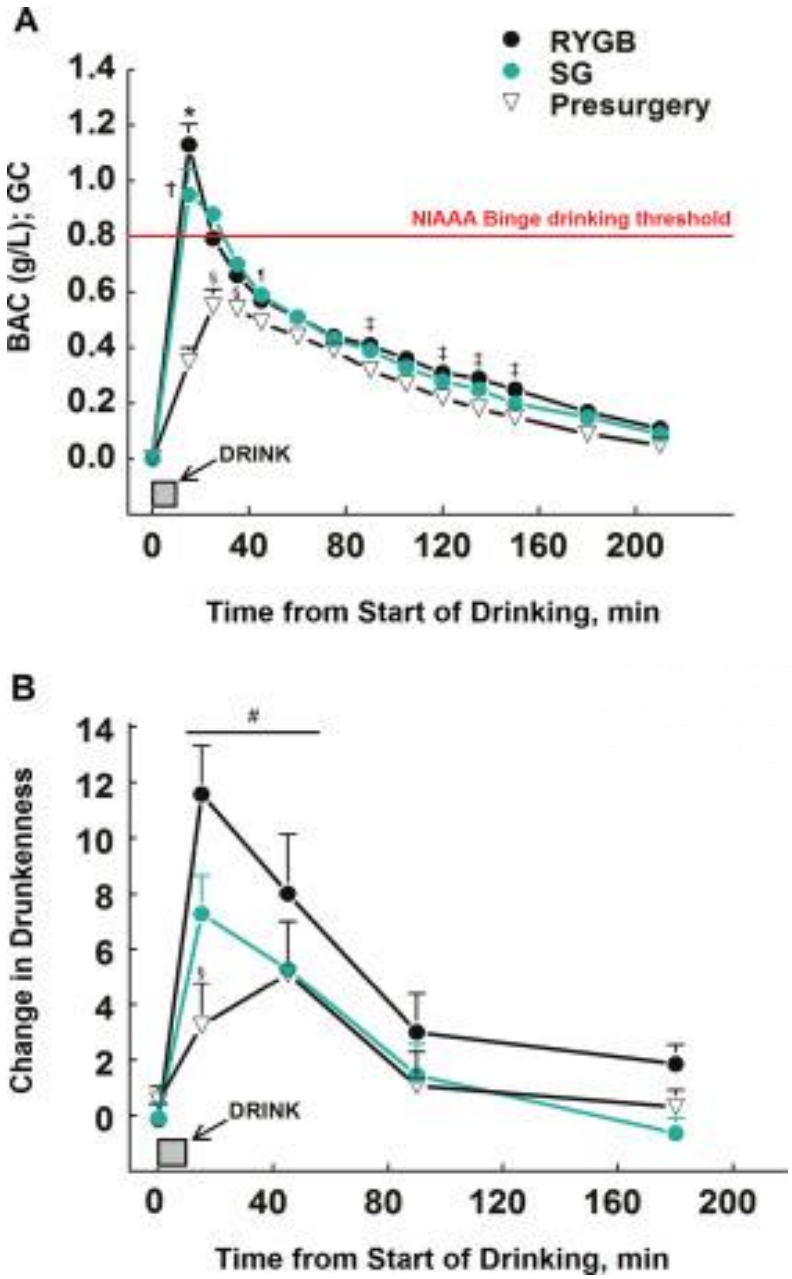
Syndrome Gayet-Wernicke/Korsakoff

- Neurodegenerative disease thiamine deficiency, generally secondary to **chronic alcoholism**
- Clinical triad: confusional state, oculomotor disorders (ophthalmoplegia and nystagmus) and cerebellar ataxia
- *Korsakoff's syndrome* (chronic form) is an amnesic syndrome with frontal signs.

- **Current situation of the patient:**

- Irreversible situation
- Severe visual and balance disorders
- Massive memory impairment
- Anosognosic patient
- Today the patient can no longer live on his own and will be permanently interned in a medical-social institution



RYGB and Alcohol

- RYGB accelerates the passage of the food bolus from the gastric neo-pocket to the jejunum where 80% of the alcohol is absorbed.
- Decreased gastric volume drastically reduces the amount of gastric alcohol dehydrogenase available, influencing the first passage of alcohol metabolism.
- Earlier and drastically higher peak plasma alcohol concentration compared to patients without bariatric surgery

Sleeve gastrectomy surgery: when 2 alcoholic drinks are converted to 4, M.B.Acevedo et Al, surgery for obesity and related disease, volume 14,issue 3, P277-283, 2018

Overview of studies on alcohol use after bariatric surgery

Authors	N	Type of Operation		% ETOH Misuse, abuse or addiction
Mitchell et al. 2001	78	RYGB	13–15 ans	7,8 %
Buffington et al. 2007	318	Variable	Variable	28,4 %
Ertelt et al. 2008	70	RYGB	6–10 ans	10,0 %
Welch et al. 2011	75	RYGB	2–3 ans	1,3 %
Suzuki et al. 2012	23/28	RYGB/LAGB	31–59 mois	21,4 %/0,0 %
Svenson et al. 2013	164/135	RYGB/Bandes	10/15 ans	% non indiqué
Conson et al. 2013	100/55	RYGB/Bandes	24mois	% non indiqué
Wee et al. 2014	328	RYGB/LAGB/SG	2 années	13 % combinés
Alfonson et al. 2014	129	RYGB	1 an	2,3 %
Ivezaj et al. 2014	143	RYGB	Moyenne 2,7 ans	19,6 %
Burgos et al. 2015	277	RYGB/LAGB	2 années	9,4 % combinés
Roi et al. 2017	752/250	RYGB/LAGB	7 ans	16,4%/---
Spadola et al. 2017	69	RYGB/LAGB/SG	5 à 55 mois	14,5 % combinés
Coluzzi et al. 2018	142	LAGB	1 an	2,1 %
Ibrahim et al. 2019	5724	RYGB/SG	2 ans	11,9 %/14,4 %

Changes in Alcohol Use after Metabolic and Bariatric Surgery: Predictors and Mechanisms, Valentina Ivezaj et Al, Current Psychiatric report, 21, article 85, 2019

Gastric Bypass and alcohol

- Food and alcohol stimulate the secretion of dopamine from the nucleus accumbens.
- Dopamine has been defined as a "pleasure neurotransmitter".
- The predisposition to addictions is secondary to down-regulation of dopamine receptors due to its repeated stimulation. As a result, **more food or alcohol** is needed to stimulate the reward and pleasure circuits.

Bypass ... and psychic mechanisms

- The symptom is the attempt to resolve an unconscious conflict. (*Freud's construction of delusions*)
- The suppression of the symptom does not imply the suppression of the underlying unconscious conflict (*Patients do not know why they swallow, whether in the mode of nibbling or gulping*).
- They do not eat: they do not do the action of eating.
- The unconscious conflict and unhappiness persists ... the means of evacuating the conflict in the body is removed.
- The symptom moves to another addiction → alcohol…..methadone

BYPASS DENIAL

- Patients arriving in a psychiatric outpatient department that deals with addiction. Patients with severe co-morbidities who are followed in an outpatient setting (schizophrenics, bipolar, PD, ...)
- They arrive from the somatic hospital with a series of dypsomaniacal alcoholizations or a diagnosis of chronic alcoholism

BUT NO NOTION of BYPASS! No somatic history, they are presented as chronic alcoholics.

- **The patients themselves do not indicate that they have had a bypass** and do not make the connection between the alcohol consumption and the food addiction. They do not realize that they have substituted one behavior for another.
- "I eat beer".
- Patients are referred by the family also because of problematic behavior, temperamental patient on alcohol, massive alcoholizations.
- Families do not make the connection with Bypass.

Intra-psychic difficulties/Exit from denial

The patient become aware

- link to **gastric bypass**
- that the problem **is not over**
- that they have **no longer** their old solution
- that alcohol consumption and metabolism are **influenced by the bypass**

Risk → depression, suicidality

Patient **Need** → drug help, hospitalization for withdrawal

What are the solutions?: Framework and co-construction

- The solution is multifocal management.
- Need to train addictologists in this new alcohol problem.
- Need to introduce psychological and psychotherapeutic treatments: use psychotherapy to open a way to elaboration, and work on trauma.
- But also acceptance of the surgery and a psycho-educational approach with the aim of making people responsible for the follow-up.
- For many, it is necessary to introduce medicinal treatments.
- Need to co-construct with General Practitioners.
- Need for lifelong treatment.
- Importance of management, regular blood tests, regular controls…
- Importance of working with families.

Conclusions

- The phenomenon of onset of alcoholism in a patient who did not abuse or drink alcohol before bypass is certainly underestimated
- The patient should be made aware of this specific risk before surgery
- This is also highly important for driving!
- Regular follow up on this topic is also required as well as thiamine control among others
- Need for follow-up with an psychologist addictologist in the case of alcoholism and to work on bypass denial as well

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THANK YOU For YOUR ATTENTION

Lake of Geneva, Montreux