PRESS RELEASE

Gastroplasty with Partial Stomach Plication

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Dr Jean-Yves LE GOFF,
WORLD PIONEER in GASTROINTESTINAL
LAPAROSCOPIC SURGERY and
INTERNATIONALLY RENOWNED SPECIALIST
in BARIATRIC SURGERY

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Dr Jean-Yves Le Goff OVER 23 YEARS

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A new reversible, adjustable and non-invasive method for the surgical treatment of morbid obesity, the “GPSP Technique”, or “Band Gastroplasty with Partial Stomach Plication” developed by the surgeon Jean-Yves Le Goff, has demonstrated remarkable efficacy over a 23-year period, with significant weight loss and, above all, no cases of operative or postoperative mortality, unlike other methods that are currently most commonly used (Sleeve, Bypass). It continues to produce lasting results over time in a large case series of patients*, with respect to short-, medium-, and long-term weight loss, quality of life, a low rate of complications and no deficits.

*more than 1214 patients with severe or morbid obesity aged between 16 and 69, with a body mass index (BMI) of between 35 and 59, evaluated between March 1996 and February 2019. 9.5% men per 100 patients.

The GPSP technique consists in gastroplasty with band fixation and partial gastric plication, combined with significant pre- and postintervention psychological management. It has allowed morbidly obese individuals to lose an average of 67.1% of excess weight at 18 months, 65.8% at five years, and 61.1% at 10 years. This weight loss ranges from 70 to 100% over this 1- to 23-year period.

“This method gives more lasting results than simple placement of the band without fixation, with zero mortality and a morbidity rate that is much lower than the sleeve and bypass”, states Dr Jean-Yves Le Goff of the Trocadero Clinic (Paris) and Seine-Saint-Denis Private Hospital (Le Blanc Mesnil).

The results of this study conducted by Dr Jean-Yves Le Goff in 1,214 patients evaluated between March 1996 and February 2019 were communicated at the Annual Congress of the Société Francaise et Francophone de Chirurgie de l’Obésité et des Maladies Métaboliques (French and Francophone Society for Obesity Surgery and Metabolic Diseases) (SOFFCO.MM) in Lille in May 2019. They were previously published at the SOFFCO.MM Congresses in Angers in 2013, Versailles in 2014, Lyon in 2015, Nice in 2016, and finally Marseille in 2017, and finally Nancy 2018 and in the journal Obésité. They had initially been published at the Congrès Mondial Annuel de la Chirurgie de l’Obésité (Annual World Congress of Obesity Surgery, IFSO) in Montreal in August 2014, in Dubai in September 2018 and in the journal Obesity.

The study aimed to compare the results of gastroplasty with plication with those of the sleeve and bypass in terms of weight loss, morbidity, mortality and quality of life.
MORTALITY, COMPLICATIONS AND WEIGHT REGAIN

The number of obesity operations in France multiplied more than threefold between 2006 and 2017, with almost 450,000 individuals undergoing operations, a number that continues to rise. As studies indicate, in the case of severe obesity, surgery is still the method which gives the most convincing results, under certain conditions, i.e. management by a multidisciplinary team that includes a psychiatrist and nutritionist alongside the surgeon beforehand and continuous postoperative follow-up afterwards.

It is evident that over the medium and long term, operations prove either ineffective (30% to 50% of patients regain weight), or cause a number of postoperative deaths in the first 30 days and subsequently within a year (113 deaths in France in 2011) but also very high rates of complications and reinterventions.

Three techniques are principally used in bariatric surgery for the treatment of morbid obesity: gastroplasty with placement of a band, the sleeve and the gastric bypass (the Roux-en-Y and Omega-loop bypass, more commonly called the mini bypass).

While the first method has low postoperative mortality (4 deaths in the first 30 days after the operation and within a year, PMSI data, 2011) (medicalised information system program), it most often fails because of defective or unstable fixation of the band. Very widely used 10 years ago, it is peripheral today.

The other two methods generate significant mortality: 55 deaths observed postoperatively and within a year for the sleeve and 54 deaths for the bypass (PMSI data, 2011) and significant morbidity (complications) and a very high number of successive reinterventions (up to 8 or 9 times), either for complications, or for significant weight regain. These methods also generate a very high number of patients that are “lost to follow-up”.

Dr Jean-Yves Le Goff
Surgeon

Dr Vasseur
Nutritionist

Dr Pons
Psychiatrist-Psychoanalyst

The attending physician

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THE GPSP TECHNIQUE: CLEAR ADVANTAGES, ZERO MORTALITY

The “GPSP Technique” developed by Dr Le Goff 23 years ago consists in a band Gastroplasty with Partial Stomach Plication. In other words, band placement is coupled with the folding over of the top part of the stomach (gastric fundus) which is erased, ineffective, virtually removed (as in the sleeve) in order to cover the band itself. The band is fixed by 6 to 7 stitches to the gastric serosa and to oesophageal muscle which reduces the size of the underlying stomach cavity. Gastric evacuation is slowed, by sectioning the branches of the left vagus nerve. This anterior valve stimulates the IGLE satiety centers in the wall of the abdominal oesophagus, which considerably reduces appetite and this (very substantial) reduction in appetite is potentiated and increased by other technical aspects. In fact, the common denominator of patients who have undergone GPSP surgery is that they experience very little, indeed no hunger at all which helps them considerably in managing their addictive impulses for food and therefore to lose weight regularly and physiologically.

This team is associated with multi-disciplinary, medical-surgical, nutritional, and psychiatric-psychoanalytic management, two to four appointments in the year preparing for the intervention, placing the emphasis strongly on the psychological factors at the root of 80% to 90% of severe obesity cases (psychotherapeutic support often indicated) and on the resumption of sporting activity. Once the factors in the personal history that caused the patient’s obesity are diagnosed and begin to be treated (several months) it is then possible to envisage operating under the correct conditions. Dr Jean-Yves Le Goff points out that the psychological aspect is crucial in metabolic surgery, emphasising the fact that a holistic approach to the patient is vital in this preoperative phase of in-depth diagnosis.
“In 1994-1995, my Belgian friend Guy-Bernard Cadière (like me a worldwide pioneer in laparoscopic surgery and bariatric surgery), inventor of the laparoscopic band, which he miniaturised, told me that the main problem was that the band most often slipped (downwards) during collaborative work in the operating theatre in Brussels at the time. It was therefore necessary to find a solution to fix it firmly. As digestion is a dynamic, mobile process, I therefore had the idea of folding the superior part of the stomach (the gastric fundus, which is very dilated in obese individuals) over the band so as to be able to have 6 to 7 stable fixation stitches (and not 2 unstable stitches in fat as with the classic bands), and so reduce the size of the stomach cavity. The problems of expansion due to slippage are considerably diminished. The patients generally feel very full, with intake of small quantities of food” explains Dr Jean-Yves Le Goff.

“The GPSP technique is a reversible, adjustable, non-invasive, conservative method with no mutilation. It has fully proved its worth over 23 years. Which encourages me today to spread the word about it. It is an alternative to offer without the morbidity and mortality of the other types of intervention” he adds, also emphasising that one of his method’s keys to success lies in the fact that it generates much fewer “lost to follow-up” patients than the other methods, as the vast majority of patients on whom he has operated are the subject of regular follow-up, extending beyond the postoperative support period, and for up to 23 years in some cases. One of the reasons for the failure of other bariatric surgery techniques is the absence of long-term follow-up of patients, with a very large number being “lost to follow-up” beyond two years (50% not seen again at 2 years). The patients were relying on the surgery alone (Sleeve, Bypass) to lose weight.
THE IMPORTANCE OF PSYCHOLOGICAL MANAGEMENT

This surgical method takes places within a multidisciplinary management context, with, in particular, consultations with a psychiatrist-psychoanalyst and a nutritionist doctor, as well as exploratory cardiology, respiratory medicine, endocrinology, radiology examinations for a complete diagnosis of the patient’s state of health and the causes of their obesity.

“These presurgical consultations encourage the patient to commit to the gastroplasty project. They allow the psychological causes at the root of the morbid obesity, present in 80 to 90% of cases, to be clarified, and help patients to understand that this support is essential to prepare for the intervention, to lose weight successfully, and to accept the change in their body image in order to regain lasting physical and mental health”, explains the psychiatrist Didier Pons.

THIS METHOD PRESENTS A NUMBER OF ADVANTAGES IN COMPARISON WITH CURRENT METHODS:

• Zero mortality and extremely low postoperative morbidity
• Reversible, adjustable, mini invasive method, without mutilation
• Very clear reduction in complications and in dilatation problems caused by slippage of the band
• Significant weight loss in the medium and long term with a high level of satiety
• No nutritional deficits and a very high quality of life
• Enhanced regular follow-up, potentiated by the method (inflation envisaged for 85% of patients who have undergone the GPSP operation, 15% of GPSP patients lose weight without any inflation at all, highlighting the GPSP assembly’s fundamental effects on hunger) and substantial patient supervision over time.
• If there is an associated gastroesophageal reflux, which is relatively common, (sleeve contra-indicated as well as the Omega-loop bypass for many): it is possible to treat this reflux at the same time, by tightening the diaphragmatic crura, lengthening the abdominal oesophagus, and GPSP. All this enables the gastroesophageal reflux to be totally cured and to disappear.
• Very low reintervention rate.
Dr Jean-Yves Le Goff is a gastrointestinal laparoscopic surgeon, worldwide pioneer in laparoscopic and bariatric surgery. He specialises in obesity surgery, and has been practicing at the Trocadero Clinic (16th arrondissement, Paris) since 1997 and at the private hospital in Le Blanc-Mesnil, a town in Seine-Saint-Denis, since 2009.

Former Chef de Clinique - Assistant and former Resident with Paris Hospitals, he is the founder and former Director of the Bichat Hospital Laparoscopic Surgery Unit (1988-97). He is also a founding member of the Société Française de la Chirurgie Endoscopique (French Society for Endoscopic Surgery - SFCE), the European Association for Endoscopic Surgery (EAES) and the Fondation pour le Développement de la Chirurgie Laparoscopique (Foundation for the Development of Laparoscopic Surgery-FDCL) born of the association of 40 French and Belgian worldwide pioneers (including Guy-Bernard Cadière) of gastrointestinal laparoscopy with Philippe Mouret, who carried out the first laparoscopic cholecystectomy in the world in 1987.

He is also a member of the Société Française de la Chirurgie de l’Obésité (French Society for Obesity Surgery).

PLACES OF PRACTICE

Currently and since 1997, Trocadero Clinic (16th arrondissement, Paris); Seine-Saint-Denis Private Hospital (Le Blanc-Mesnil, since 2009).

1997 1991
Turin Clinic (8th arrondissement, Paris)

1997 1987
Former Chef de Clinique - Assistant des Hôpitaux (Clinical Lecturer): Bichat Hospital (18th arrondissement, Paris)

1992 1988
Instigator of liver and pancreatic transplantation, Bichat Hospital
Former Director and Founder of Bichat Hospital Laparoscopic Surgery Unit. In the same year he took part in a liver transplantation internship with Professor Starzl, worldwide pioneer in the field of liver transplantation, Presbyterian Hospital, Pittsburgh (USA, Pennsylvania)

Chef de Clinique - Assistant des Hôpitaux, Broussais Hospital

Assistant at Porte de Choisy Mutualist Clinic (funded by mutual insurance scheme) (13th arrondissement)

Former Resident with Paris Hospitals

Head of Department, Surgeon on Flores Island (Portugal) (military service)

**LEARNED SOCIETIES**

Member of the Société française de la Chirurgie de l’Obésité

Founding Member of the Société française de Chirurgie Endoscopique (SFCE)

Founding Member of the European Association for Endoscopic Surgery and other Interventional Techniques (EAES)

Founding Member of the Fondation pour le Développement de la Chirurgie Laparoscopique (FDCL): 40 French and Belgian pioneers who spearheaded the development of gastrointestinal laparoscopic surgery

**MANDATES/OTHER REPRESENTATIVE AND ORGANISATIONAL ACTIVITIES**

Deputy Secretary General of the Collège des Chirurgiens Français, Syndicat des Chirurgiens Français (French College of Surgeons, French Union of Surgeons)

President of the Syndicat des Chefs de Clinique Assistants des Hôpitaux de Paris (Union of Chefs of Clinic - Assistants des Hôpitaux of Paris), National Secretary General of the Chefs de Clinique des Villes de Faculté Assistants des Hôpitaux (Chefs de Clinique - Assistants des Hôpitaux of University Towns)

This method is reversible, non-invasive, adjustable: it consists of a band Gastroplasty with Partial Stomach Plication.

A band is placed using the retrogastric approach in all cases (only 1 pars flaccida approach), associated with release of the dilated gastric fundus as far as the first vessel of the left gastroepiploic artery: the spleen grips are sectioned but the first vessel of the left gastroepiploic artery is rarely sectioned.

The band is fixed to the gastric serosa and oesophageal muscle using an anterior approach by 6 to 7 stitches, consequently reducing the size of the gastric cavity underlying the band.
The anterior aspect of the lower oesophagus is totally stripped of fat, blood vessels and the branches of the left vagus nerve.

All the branches of the left vagus nerve that supply the lower oesophagus and stomach are sectioned de facto, gastric evacuation is slowed. What is more, this anterior valve stimulates the basal state of the satiety centres (IGLE) in the wall of the abdominal oesophagus, which decreases appetite considerably.

This assembly is associated with multidisciplinary, medical-surgical, nutritional, psychiatric-psychoanalytical management, before and after the intervention with long-term follow-up, placing the emphasis strongly on psychological factors (psychotherapeutic support often indicated) and on resumption of sporting activity.

Moreover, the inflations and deflations are performed by the surgeon himself using radiology. He can thus make a judgement regarding the functioning of the band, the decrease in weight relative to band tightening, the adaptation and acceptance of the band by the patient and therefore band functioning, which mirrors mental functioning.
PHASE 1

A band is placed using the retrogastric approach in all cases (only 1 “pars flaccida” approach), associated with release of the gastric fundus as far as the first vessel of the left gastroepiploic artery: the spleen grips are released but the first vessel of the left gastroepiploic artery is rarely sectioned.

PHASE 2

All the branches of the left vagus nerve that supply the lower oesophagus and stomach are sectioned de facto, gastric evacuation is slowed.
IN THE EVENT OF ASSOCIATED GASTRO-OESOPHAGEAL REFLUX
(COMMON)

2 to 3 stitches to tighten the diaphragmatic crura

band completely covered by the gastric fundus with 6 to 7 fixation stitches

The band is stitched to the gastric serosa and oesophageal muscle, which reduces the size of the underlying stomach cavity, creating an anterior anti-reflux gastroesophageal valve. What is more, this anterior valve stimulates the satiety centres (IGLE) in the wall of the abdominal oesophagus, which decreases appetite considerably.
The gastric fundus (virtually removed, non-functional) covers the band completely, fixing it firmly and forms a valve which stimulates the satiety centers. As a result, it considerably reduces the part of the stomach under the band.

1. The bottom of the oesophagus is stripped of the branches of the left vagus nerve.

2. The band surrounding the bottom of the oesophagus which is stripped of the branches of the left vagus nerve.

3. The gastric fundus begins to cover and fix the band with separate stitches.

4. The gastric fundus (virtually removed, non-functional) covers the band completely, fixing it firmly and forms a valve which stimulates the satiety centers. As a result, it considerably reduces the part of the stomach under the band.
SCIENTIFIC PUBLICATIONS & COMMUNICATIONS

2019

IFSO 3-7 September 2019, Madrid. Dr Le Goff Jean-Yves.
Abstract: Gastroplasty with partial stomach Plication associated with significant psychological support: a 23-yearlong experience on 1,214 cases. Should we after all, in 2019, keep on using Sleeves and Bypass techniques? (Accepted communication).

SOFFCOM 23-25 May 2019, Lille. Dr Le Goff Jean-Yves.
Gastroplasty with Partial Stomach Plication (GPSP) and signficant psychological support. (Experience with 1,214 cases over 23 years). Should we, despite everything, continue to perform Sleeve and Bypass surgery in 2019? (Presented communication).

Two Referenced Abstracts:
- Gastroplasty With Partial Stomach Plication : A 22- yearlong experience on 1,102 Cases. Should we, after all, in 2019, keep on using Sleeves and Bypasses ? (id 83579). Sat 02 Feb 2019, Oral presentation (8 minutes duration). (Presented communication).

2018

IFSO 2018 26-29th September, Dubai (World Congress). Dr Le Goff Jean-Yves.
Abstract: Gastroplasty with Partial Stomach Plication (GPSP) and psychological support 22-Yearlong 1102 cases. Do we in 2018 keep on using Sleeve and Bypass? (Presented communication).

EAES (European Association of Endoscopic Surgery) 30 May - 1 June 2018, London. Dr Le Goff Jean-Yves,
Abstract: Gastroplasty with Partial Stomach Plication (GPSP) and psychological support 22-Yearlong 1102 cases. Do we in 2018 keep on using Sleeve and Bypass? (Presented communication).
Gaps 2017 June 24-25, Bordeaux. Dr Le Goff Jean-Yves.
What have the repercussions and impact of the situation been for the reconstructive surgery after the 3 different techniques of bariatric surgery: sleeve gastrectomy, gastric bypass and partial plication gastroplasty?

Annual Congress of the Société Française et Francophone de Chirurgie de l’Obésité et des Maladies Métaboliques (SOFFCO.MM), 25 to 27 May 2017, Marseille, France. Dr Le Goff Jean-Yves.
Abstract reference 0-65: “Gastroplastie avec Plicature Partielle de l’Estomac et suivi important psychologique: (Gastroplasty with Partial Stomach Plication and significant psychological support): Expérience de 1102 cas sur 22 ans. (Experience with 1,102 cases over 22 years). Faut-il en 2018 persister à pratiquer malgré tout encore des Sleeves et bypass? (Should we, despite everything, continue to perform Sleeve and Bypass surgery in 2018?)” (Presented communication).

“Impact of reconstructive surgery after the 3 different techniques of bariatric surgery: sleeve gastrectomy, gastric bypass and partial plication gastroplasty” has been included as a video paper on Thursday 1st Feb. “Gastroplasty with Partial Stomach Plication associated with significant psychological support” has been included as a poster.

2016

Abstract title: Gastroplastie avec Plicature Partielle de l’Estomac et suivi important psychologique (Gastroplasty with Partial Stomach Plication and significant psychological support): Expérience de 897 cas sur 20 ans, faut-il en 2016 pratiquer encore des Sleeves et By-pass? (Experience with 897 cases over 20 years, should we, despite everything, continue to perform Sleeve and Bypass surgery in 2016?) (Oral communication).

**Topic:** Techniques chirurgicales: indications et résultats / Techniques innovantes et mini-invasives (Surgical techniques: indications and results/Innovative, mini-invasive techniques (Oral communication).

**Abstract title:** Gastroplastie avec Plicature Partielle de l’Estomac associée à une prise en charge importante psychologique: une Expérience de 794 cas sur 19 ans, Méthodes et Résultats: faut-il en 2015 pratiquer encore des Sleeves et bypass? (Gastroplasty with Partial Stomach Plication associated with significant psychological management: experience with 794 cases over 19 years, Methods and Results: should we, despite everything, continue to perform Sleeve and Bypass surgery in 2015?)

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Congrès mondial de Chirurgie de l’Obésité (IFSO), August 26th-30th 2014, Montréal.
Dr Le Goff Jean-Yves - Trocadero Clinic, Paris and Seine Saint Denis Private Hospital.

**Abstract:** Gastroplasty with Stomach Plication of the Stomach associated with significant psychological support: a real alternative to the Sleeve and Gastric Bypass.

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SOFFCO.MM 2014, 22 May-24 May 2014, Versailles.
Dr Le Goff Jean-Yves - Trocadero Clinic, Paris and Seine-Saint-Denis Private Hospital.

**Abstract title:** Anneau Gastrique, une méthode pluridisciplinaire originale de traitement de l’obésité morbide: (Gastric Band, an original multidisciplinary method for treating morbid obesity:) Gastroplastie avec Plicature de l’Estomac associée à une prise en charge importante psychologique. (Gastroplasty with Stomach Plication associated with significant psychological management). Une expérience de 684 cas sur 18 ans (Experience with 684 cases over 18 years)

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SOFFCO.MM 2013, 6 June – 8 June 2013, Angers.
Dr Le Goff Jean-Yves - Trocadero Clinic, Paris and Seine-Saint-Denis Private Hospital.

**Abstract title:** Anneau Gastrique, une méthode pluridisciplinaire originale de traitement de l’obésité morbide: (Gastric Band, an original multidisciplinary method for treating morbid obesity:) Gastroplastie avec Plicature de l’Estomac associée à une prise en charge importante psychologique. (Gastroplasty with Stomach Plication associated with significant psychological management.) Une expérience de 634 cas. (Experience with 634 cases).
OTHER OBESITY SURGERY TECHNIQUES

1 - THE ADJUSTABLE GASTRIC BAND

Technique performed for the first time using laparoscopy in the middle of the 1990s.

Also called a band, it is a restrictive technique that reduces the volume of the stomach and slows down the passage of food (acts solely by activating and deactivating band inflation). However, it does not disrupt the digestion of food.

This band is placed (fixed by 2 stitches to fat, which is very unstable) around the upper part of the stomach, demarcating the gastric pouch. Just a small amount of food fills this pouch and the feeling of satiety appears rapidly (when the band is inflated). The food travels very slowly according to the hourglass principle.

It is the only adjustable technique (apart from GPSP). A small tube connects the band to a control unit placed under the skin. This band can be tightened or loosened by injecting liquid into the unit, through the skin.

In the event of complications, ineffectiveness or at the request of the patient, the band can be removed in a subsequent surgical intervention.

The duration of the intervention is estimated at 1 hour and the duration of hospitalisation at 1 to 2 days, sometimes as an outpatient.

The weight loss expected is around 40 to 60% of excess weight (much less in reality and not lasting), which represents a loss of around 20 to 30 kg (HAS figures, for a person of average height (1.70 m) with a BMI of 40 kg/m²).

Numerous mechanical complications may arise after the intervention, even after several years. We note problems associated with the control unit, such as infections, displacement of the unit, pain experienced at the site of the unit or splitting of the silicone tube connected to the unit. Moreover, slippage of the band and the dilatation of the pouch (very common complications) can cause vomiting, indeed it may be impossible to eat. But also, oesophageal disorders (reflux, oesophagitis, motor disorders, etc.) and stomach lesions caused by the band (erosion of the stomach, migration of the band, because of the very frequent vomiting caused most often by dilatation) are not to be overlooked.

Although this method displays a low mortality rate (0.1%), it most often fails because of the very unstable band fixation (2 stitches in fat, which hold very poorly), as digestion is a dynamic and mobile process and also because of possible vomiting which occurs frequently with the simple band because of the associated dilatation that frequently occurs.

_Mortality associated with the intervention: 0.1%
(Source: French National Authority for Health, HAS)_
2 - THE SLEEVE (currently the most frequently performed surgery)

This intervention, referred to also as “Manchon”, has been performed for around fifteen years in France in patients presenting with severe obesity with a BMI of over 35 with at least one comorbidity factor (high blood pressure, diabetes, sleep apnoea, significant arthrosis, metabolic problems, etc.) or a BMI of over 40.

It is a restrictive, irreversible technique, which consists in removing 4/5 of the stomach, notably the part containing the cells that secrete the appetite-stimulating hormone (Ghrelin). The stomach is reduced to a vertical tube and foods pass rapidly into the intestines. In addition, appetite is diminished. However, the technique does not disrupt digestion of food.

The operation is irreversible, lasts around 1 to 2 hours and requires a hospitalisation period of 2 to 4 days.

The weight loss expected is between 45 to 65% of excess weight after two years, which corresponds to a loss of around 25 to 35 kg for a BMI of 40 kg/m².

The principal complication risks are ulcers, fistulae (leaks), narrowing of the stomach as well as postoperative haemorrhages, nutritional deficits (vitamins B1, B6, B12, etc.), disabling oesophageal reflux (70% reflux at 5 years), inflammation of the oesophagus (Barrett’s ulcer, 16% at 10 years, severe dysplasia including in situ cancer cases, and invasive cancer of the bottom of the oesophagus published in 2018, SOFFCO.MM Nancy) or dilatation of the stomach.

This is why pioneers of the sleeve, including Professor David Nocca (Montpellier, 34), and Belgian teams began to modify the sleeve in 2014 by making a large posterior anti-reflux valve, therefore resulting in much smaller gastric exeresis (N-sleeve).

The addition of a band (to this N-sleeve), makes this technique very similar to the option that I selected 23 years ago to develop my GPSP operative technique, except that there is very little perspective and my technique is reversible and non-mutilating, without exeresis, and with efficacy proven by 23 years of experience.

The estimated mortality rate is 0.5%.

This technique generates significant mortality: 55 deaths postoperatively and within a year according to CNAM (PMSI 2011) and the SOFFCO.MM (2012, Montpellier), numerous complications and a high reintervention rate (up to 8 to 9 times).

(Source: French National Authority for Health; CNAM/PMSI; SOFFCO.MM)
3 - THE BYPASS

The bypass is the surgical technique which until recently seemed to give the best results over the long term. It has been performed laparoscopically for more than 16 years on individuals with a BMI of over 35 with at least one comorbidity factor (high blood pressure, diabetes, sleep apnoea, significant arthritis, metabolic problems) or a BMI of over 40.

It is a restrictive and malabsorptive technique which reduces both the quantity of food ingested (the size of the stomach is reduced to a small pouch) and the absorption of these foods by the organism, by means of a short-circuit of one part of the stomach and the intestines (no organs are removed).

The duration of the intervention is estimated at between 1.5 to 3 hours and the duration of hospitalisation between 4 to 8 days.

The weight loss expected is in the order of 70 to 75% of excess weight, which corresponds to a loss of around 35 to 40 kg for a BMI of 40.1

The main complications encountered are of a surgical nature with the formation of ulcers, the appearance of leaks, fistulae, haemorrhages or narrowing of the junction between the stomach and intestines. But also functional complications with bouts of hypoglycaemia (sometimes very severe and resulting in a coma) after meals, dumping syndrome, occlusion, constipation, uncontrollable diarrhoea and nutritional deficits of vitamins A, B1, B6, B12, C, D, iron, calcium, zinc, selenium, amino acids, proteins, different essential ions, etc. Very severe lifelong deficits that cannot be corrected by oral intake, but also disabling anaemia, osteoporosis, primary or secondary sterility.

This is why many pioneers of the bypass, including Professor Jean-Pierre Marmuse (Bichat Hospital, 18th arrondissement, Paris), are currently abandoning this technique (SOFFCO.MM, Marseille 2017).

The mortality rate is estimated at 0.5%.

54 postoperative deaths for the bypass in 2011 (PMSI data), significant morbidity (complications) and a very high number of successive reinterventions (up to 8 or 9 times), either for complications, or for significant weight regain.

For proponents of the Roux-en-Y bypass, the physiological consequences of the Omega-loop bypass (mini bypass) are very controversial, in particular in combination with biliary reflux in the Omega-loop bypass, suspected of being carcinogenic in the long term.

For the mortality associated with the sleeve and bypass in France: 214 deaths were reported in 2014 and this figure is put forward by insurance company experts (214 deaths, a figure that therefore falls short of reality, as not all families refer the matter to insurance companies). Moreover, the JAMA Surgery 2016 study demonstrated an increase in self-destructive behaviour following bariatric surgery (mainly sleeve and bypass): 50% additional risk of suicide after the intervention, excessive consumption of alcohol, drugs. 20% of patients who underwent the operation suffer from serious alcohol problems (Soard 2017).

All this further emphasises the absolute necessity to take account of psychological problems (bereavements, divorce, diverse desertions, sexual problems and abuse, psychological difficulties, etc.) at the root of the severe obesity, and of their treatment for bariatric surgery: Primum, non nocere - first, do no harm.

1 For a person of average height (1 m 70) with a BMI of 40 kg/m² (Source: French National Authority for Health, HAS).
“After having spent the best years of my life on diets of all kinds (diuretic treatments, diets from women’s magazines, getting weighed at meetings, cold techniques, hot techniques, etc.), I seriously damaged my health. Despite succeeding in losing weight, I never managed to stabilise myself.

Until the day that I met Dr Le Goff. I cancelled my first operation as I was paralysed by the idea of having surgery – it was no longer a simple diet. But his patients reassured me considerably and explained to me that it is not just a simple placement of the band. I therefore rescheduled a second operation and everything went well.

Today, I have gone from a size 58 to a 36 and I have gained confidence in myself. I have re-learned how to eat by listening to my body and my band. I feel beautiful and am proud of having done it for my daughter and myself. My only regret: not having met Dr Le Goff sooner.”

“Now everything is easier, I am more open to others.”

**Ambre, 44 years**

“I learned of the GPSP technique while accompanying my wife to an appointment with Dr Le Goff. She also had weight problems. The doctor then warned me about my condition and suggested placing a band in me as well. Six months later, I had an operation, which I have never regretted.

The band has transformed me physically and mentally. I feel younger. I no longer have high blood pressure, no longer have problems with fatigue and sleep. From a family point of view, our new dietary habits are an example for our youngest son who is in good health, while our elder son is obese and has always seen us eat copious amounts of food at home.

This has also had an impact at a professional level. My change in behaviour makes me go to work on a bike, which delights my children and gives me lots of energy! Taking up sport again makes me feel very alive!”

“I feel 20 years younger, I have regained my health, I really feel alive.”

**Mickael, 56 years**

“I had an operation in October 2011 and I lost 54 kg. Following advice from friends treated by Dr Le Goff, I wanted to meet him. Before, I had tried different diets. I limited sweets, I had acupuncture, lymphatic drainage. I lost weight but I regained twice as much.

I was very impatient to have an operation. The operation went very well. I stayed in hospital for three days. I was not hungry, or thirsty. I said to myself but how will I have to feed myself?

At the beginning, it was liquid and semiliquid food. And then, gradually, I began to introduce normal foods. I feel much better mentally and physically but I do not see myself as I really am. I have more confidence in myself, more assurance. It is a new life, a renaissance for me.”

“I feel much better mentally and physically.”

**Fatima, 35 years**
“Before the operation, the trajectory of my eating behaviour was rather chaotic, I began to gain a lot of weight at the age of 14, when my parents divorced. Then, after several diets which only resulted in a yo-yo effect, I began to take appetite suppressants, putting my health in danger. I then gained 30 kg during my first pregnancy. But it was during my second pregnancy, when I regained 35 kg, that I really wondered how I could win this battle.

At the time, I was working in a wedding dress shop and a customer came back regularly to have her dress all altered because she was losing weight in a spectacular manner (the wedding dress she chose initially no longer needed to be altered after a few months). She then gave me the contact details of Dr Le Goff who had operated on her.

Since my operation, I have remained fond of good food and continue to eat what I like. I have a social life, I go to restaurants, except that I eat small quantities without feeling at all frustrated. For me, it is a real deliverance, I am completely transformed both physically and mentally.”

“I am a happy woman, this technique has really been life-saving for me”

Cynthia, 42YEARS

-43 kg
2007 — 2019

www.legofftechnique.com
OBESITY IN FRANCE

Obesity has been recognised by the World Health Organisation (WHO) since 1997 as a chronic disease and is a major public health issue in France. A complex disease, obesity is not solely imputable to individual nutritional behaviour, several factors come into play: genetic, epigenetic, lack of sleep, metabolic disorders...

DEFINITION OF OBESITY:

According to the WHO, obesity is defined as an abnormal or excessive accumulation of body fat that can damage health.

For adults between 18 and 74 years old, obesity is measured according to body mass index (BMI) that is obtained by dividing weight by height in metres squared. A BMI of more than 25 kg/m² is overweight. One in eight adults in France is obese.

A BMI in excess of 30 kg/m² is obese. A BMI of between 35 and 40 is severely obese, a BMI of more than 40 kg/m² is morbidly obese, and a BMI of more than 50 is super-obese. For children, a corpulence curve that appears in the Child Health Record is used. One in five children in France is obese.

The health authorities consider however that this indicator is not sufficient and can lead to an underestimation of the risks of cardiovascular or metabolic disorders.

A new indicator is taken into account: abdominal obesity, characterised by a waist circumference of at least 94 cm in men and 80 cm in women. The circumference around the hips is also taken into account.

KEY OBESITY FIGURES (2015 AND 2016)

- **32.3 %** of French adults are overweight (25 ≤ BMI < 30 kg/m²), that is close to 15 million people.
- **17.2 %** of adults are obese without distinguishing between men and women (BMI ≥ 30 kg/m²). Only 8% of adults were obese in 1997.
- **3.1 %** of French people have a BMI of between 35 and 40, that is 1,390,000 individuals.
- **550,000** French people have a BMI of over 40 kg/m², and are morbidly obese.
- The over-60s display the highest rates of obesity (20.8% for men and 18.8% for women), while these rates are lowest for those in the 30-39 age bracket, 10.4% for men and 11.4% for women).
- Obesity is more marked in the North and East of France: 25.6% of adults in the Hauts-de-France region, 22.9% in Meurthe-et-Moselle are obese, compared with 10.7% in Paris.
• Although all socio-professional categories are affected, there is a proportionally inverse relationship between income level and the frequency of obesity, the lowest income categories are the most affected.
• Disease of the poor in rich countries and of the rich in poor countries.
• Abdominal obesity affects 41.6% of adult men and 48.5% of adult women.

(Source: IRDES (INSTITUTE FOR RESEARCH AND INFORMATION IN HEALTH ECONOMICS), CNAM, SANTE PUBLIQUE France (PUBLIC HEALTH France), COHORTES CONSTANCE ET ESTEBAN (CONSTANCES AND ESTEBAN COHORTS))

THE IMPACT OF OBESITY ON HEALTH

• In 40-year-old individuals, life expectancy is reduced by 7.1 years in women and by 5.8 years in men
• The risk of developing high blood pressure is multiplied by 4
• The risk of developing diabetes is multiplied by 8
• There are significant respiratory complications (respiratory failure, referred to as restrictive) as well as an increased risk of developing sleep apnoea syndrome (SAS)
• So, 70% of patients with sleep apnoea are obese
• Excess weight and obesity are responsible for 3.6% of new cancer cases in adults
• The risk of suffering from arthrosis is multiplied by 5
• The risk of developing depression is multiplied by 1.8

Bariatric surgery in France: 60,000 interventions in 2016 (35,000 sleeves, 15,000 bypasses, 2,500 bands (including GPSP), 7,500 others.

Obesity surgery is increasingly practiced in France. Although France is in 25th position among the OECD countries in terms of the percentage of the population who are obese, it is 1st for the number of operations performed. Women have surgery much more than men representing 90% of patients who undergo operations.

These treatments are initiated at an average age of 39 and must meet precise indications:

When everything has failed to combat severe obesity (as diets fail most of the time), bariatric surgery (sleeve gastrectomy, bypass, gastric band, GPSP) intervenes as the only last-chance solution that will allow:

• Lasting loss of excess weight
• A decrease in comorbidities which may even disappear, true metabolic surgery
• Increased life expectancy
• BMI > 40 kg/m² or > BMI between 35 and 40 kg/m² associated with a comorbidity
AN IMPROVEMENT IN PHYSICAL AND SOCIAL QUALITY OF LIFE:

- A 40% reduction in overall mortality
- A 92% reduction in the occurrence of diabetes
- A 56% reduction in cardiovascular risk
- A 95% reduction in the development of SAS

In this respect, bariatric surgery is life-saving, non-cosmetic surgery, that impacts prognosis. True metabolic surgery through its effectiveness on high blood pressure, diabetes, sleep apnoea, lipids; cholesterol, free fatty acids, oestrogens, progesterone, cycle regulation (ovulatory cycles), through its action on leptin, Ghrelin and their receptors. Moreover in 2007, the first major reference study (SOS Study) demonstrated that 7 years after gastric surgery, the following were observed:
LE GOFF GASTROPLASTY:
THE PERSPECTIVE OF THE PSYCHIATRIST-Psychoanalyst

By Dr Didier Pons, psychiatrist, psychoanalyst, child psychiatrist, former Resident with Paris-Ile-de-France Psychiatric Hospitals.

The medical and psychological approach to the patient for the GPSP gastroplasty surgical intervention is a multidisciplinary approach involving several specialists, in both somatic and mental disciplines (surgeon, cardiologist, pneumologist, nutritionist, endocrinologist, radiologist, anaesthetist, psychiatrist, etc.).

The appointment with the psychiatrist is medically and legally obligatory, lasts between one and one-and-a-half hours, and can be repeated, if needed, depending on whether or not the patient commits to the treatment project. This interview allows the patient to discuss milestone events in their personal life and especially to make links to the occurrence of obesity in line with their life experiences and to perceive its development.

These presurgical consultations promote the patient’s commitment to the gastroplasty project, a project which perhaps was already being silently contemplated several months or several years previously. They very often highlight the importance of the psychological factors at the root of the morbid obesity, present in 80 to 90% of cases, and help patients to understand that this monitoring is essential and crucial for successful weight loss, in order to restore physical and mental health.

The interview with the psychiatrist, before the intervention, will be followed by two or four appointments in the post-surgery phase to appraise patient compliance with to the gastroplasty plan, to assess any psychological difficulty in tolerating this treatment and to judge whether the treatment process is proceeding correctly. Likewise, a minimum of two monitoring appointments are suggested during the second year after the surgical procedure for the same reasons.

So formulated, patients therefore enter into a contract with themselves which values the gastroplasty surgical procedure as the starting point for a new approach to their person. They then become the main actor in the project, in the center of their request to lose weight and not a mere spectator who “would pass from one person to another”.

It is therefore important to see all the consultants in the multidisciplinary team, in the same way as the surgeon, who holds their patient’s contract.

Indeed, avoidance behaviour, with respect to one of these specialists, in particular the psychiatrist, would be highly significant of the resistance (fear, apprehension, anxiety, etc.) of the patient herself to her own change. Which can appear normal and may require psychological support.

Successful slimming therefore goes together with the restoration of good mental health, maintenance of their vital momentum and their participation in the project.
Information is crucial, in offering the addresses of psychological, psychotherapeutic, psychiatric colleagues close to their place of residence and/or work to encourage the patient in their undertaking and to let them know that they can access psychological support at any time.

Moreover, the inflation (or deflation) sessions performed by the surgeon become a time for appraising the patient's mental and physical condition and an opportunity to check that the gastric band is functioning correctly. This therapeutic presence allows for the evaluation of the necessity or not for repeat appointments with the referent psychiatrist of the multidisciplinary team.

The excess weight may represent the site of expression of a psycho-emotional refuge in a way of eating, even an addictive behaviour, in which food (become a full-blown expression of the symptom) translates an excessive attachment, an alienation of the patients towards themselves, impeding all other possibilities of expressing their desire.

It is therefore essential to evaluate the person's psychological profile, their weaknesses, their life events and the unconscious links that they have created with this body to reach this situation of excess weight and morbid dependency. It should be noted that a higher ratio of women than men is found in surgery for morbid obesity, (in nine out of ten cases).

Thus different forms of psychotherapy will be offered: individual, group (talk, motivational, etc.), behavioural and/or cognitive therapy, involving mind-body mediation or an analytic approach. The patient will be directed to specific information forums on the surgical approach to obesity.

It is also recommended that meetings between patients be encouraged (whether or not they have undergone an operation), either within associations, or more simply as can be seen in the surgeon’s waiting room which then becomes a place for discussion, questions, sharing of experiences.

For this purpose, the surgeon recommends a list of patients who have already had surgery who may be called.

The overweight individual who consults the multidisciplinary team therefore comes to objectify their realisation (at first uncertain) of the danger they are in, both physical, physiological, locomotor and mental. This realisation thus obliges them to re-evaluate themselves in their own eyes, in the eyes of those close to them, and encourages them to undertake treatment, as much on the vital plane as for their own well-being.
FAQ - FREQUENTLY ASKED QUESTIONS

Why don’t other surgeons use the GPSP technique?

Generally, each specialised obesity center has their own history built around a technique developed by a team. For some it is the band which, although its use is declining, continues to persist in some centers as almost the main operative technique. For others it is the sleeve or the bypass. Patients consult by word of mouth or via their own research on the internet and social networks to choose the technique which seems to best meet their needs and to seek advice.

Patients recommend the surgeon who operated on them by word of mouth. The perspective available now allows the short, medium and long-term effects of the GPSP technique to be appraised in a meaningful way, the technique which I have developed and presented at the congresses of learned societies such as SOFFCO.MM for many years (since the appearance of communications on sleeves and bypasses and through personal communications in 2012, 2013, 2014, 2015, 2016, 2017, 2018, IFSO Montreal 2014 as well as IMCAS 2018 and GAPS 2015, 2016, 2017). Some of my colleagues in France and abroad are interested in this technique and are beginning to offer it by talking about GPSP and performing it. And this more and more, specially because patients are more and more refusing sleeve and bypass.

The heterogeneity of practices and the need to better organise treatments now requires that the emergence of alternative practices such as GPSP be encouraged, validated by its safety, its sustainable, lasting weight loss, its quality of life, zero mortality and a very low rate of postoperative complications with a perspective of 23 years. All factors which are arousing the growing interest of my colleagues and sparking their requests for information and training, specially for answering patients’ choice for GPSP.

“First, do no harm”

Bariatric surgery is a young surgical technique for which the first challenge, as with all surgery, should still be “Primum, non nocere!”

With regard to the heterogeneity of bariatric surgery practices, while the question of certified obesity centers is now urgent, let us evaluate all techniques from the benefit/risk perspective. In this respect, the GPSP technique that I developed 23 years ago, is indisputably a safe and reliable alternative for obese patients in the present and the future.

Is the GPSP operative technique applicable to those in the 13-18 age bracket and should it be more applied more easily?

Yes, it is. Here again, it is the technique of choice, the most reversible and non-invasive, conservative, adjustable, allowing for psychological management that is always necessary and paramount, without mutilations.
Are there too many operations or are operations conducted badly?
No, we do not perform too many operations if we operate using a good technique, as the benefits of obesity surgery are verified by the French National Authority for Health (HAS), as only surgery gives convincing results in respect of severe obesity. But it requires good follow-up as technique and follow-up are the two essential elements of the same process to move towards weight loss, a return to health and a more normal quality of life.

Should the bypass and the sleeve be banned?
No, but all the risks, the results, the irreversible nature, the postoperative and one-year mortality rate, the resulting complications, the sometimes-dramatic deficits, the need for lifelong compensatory treatment, the weight loss failure rates (in the order of 30 to 50%) should be shown clearly without restriction.

Is there a minimum limit for the number of bariatric surgery interventions to be performed per year?
The minimum limit for a center should be 100 interventions from the point of view of the surgical experience of the teams and patient follow-up.

Should postoperative follow-up from 2 years onwards be provided as part of the care pathway of the general practitioner who referred the patient?
No. It should be provided by the team, principally the surgeon, and the nutritionists, psychiatrist and attending physician who should be trained in the technique and its complications. Which implies their agreement and that they will free up time for complete training, but also to monitor the patient in consultations in a thorough manner, which is not always compatible with the activity of a general practitioner, or the duration of appointments (their remuneration) does not allow it. The GPSP technique through its low rates of complications, through its quality of life, and the absence of deficits makes postoperative follow-up easier.

Two-thirds of operations take place in private clinics, well obesity impacts the lower income social classes more extensively, is there a “bariatric divide”?
No, as regards fees surgeons must adjust to patient heterogeneity, but it is essential that patients make a personal commitment (however in accordance with their means) to invest in the method and be players in their return to health.

Should we go further in the description of the different forms of obesity to improve patient treatment?
No, but the comorbidities for BMIs of between 30 and 35 should be highlighted: the surgery is scientifically validated, but not reimbursed in France.
How can the GPSP technique be more widely accessible to the largest possible number of patients eligible for surgery for severe or morbid obesity?

To meet the demand from numerous patients and colleagues, a center project on the GPSP technique that I developed is currently being developed. It is important that the GPSP method, an alternative safe and reliable method, with lasting results over time can be presented to patients in the group of operative techniques available in order that they can make an informed choice from all existing operative techniques according to their benefits/risks.

The GPSP center, a multidisciplinary surgical center will make possible the training in France and in Europe of surgeons and operating teams capable of offering patients this safe, reversible, adjustable and non-invasive technique with zero mortality and a very low rate of postoperative complications.

In view of feedback from patients who have undergone the procedure, the GPSP center is giving itself the mission of increasing preoperative and postoperative monitoring of patients eligible for a bariatric surgery operation, in order to forestall the number of “lost to follow-up” patients, as the GPSP technique; through band inflation at regular intervals, allows maintenance of this link and the prevention of nutritional deficits which are however exceptional, while correcting and adjusting the psychological and behavioural trajectories if applicable (low rate of lost to follow-up patients compared to other techniques).

The GPSP center will also have the mission of conducting research (already outlined with a large University Hospital) on the hormonal phenomena associated with this operative technique (GPSP patients experience very little indeed practically no hunger, which helps greatly in controlling their urges, and therefore in this way to subjugate them, and to greatly facilitate weight loss) which in terms of patient experience displays a positive impact on leptin levels (probably high) and Ghrelin levels (also low), appetite-regulating hormones.

Finally, the GPSP center will also have the mission of continuously improving this operative technique and of informing all of the medical community about this complex phenomenon of obesity, a major public health issue.
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