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Chapter 1 : Mechanism of Postgastrectomy Hypoglycemia | JAMA Internal Medicine | JAMA Network

The current generation of general surgeons is being trained to regard gastrectomy as a rare surgical procedure. It is both intriguing and humbling to reflect on the changes that occur from time to time in what was thought to be an ideal surgical practice.

Diagnosis Your doctor may use some of the following methods to determine if you have dumping syndrome. Medical history and evaluation. Because low blood sugar is sometimes associated with dumping syndrome, your doctor may order a test oral glucose tolerance to measure your blood sugar level at the peak time of your symptoms to help confirm the diagnosis. A radioactive material is added to food to measure how quickly food moves through your stomach. Treatment Early dumping syndrome is likely to resolve on its own within three months. If not, your doctor may recommend medications or surgery. Medications For people with severe signs and symptoms unrelieved by dietary changes, doctors sometimes prescribe octreotide Sandostatin. This anti-diarrheal drug, administered by injection under your skin subcutaneously , can slow the emptying of food into the intestine. Possible side effects include nausea, vomiting and stomach upset. Talk with your doctor about the proper way to self-administer the drug. Request an Appointment at Mayo Clinic Alternative medicine Some people use supplements such as pectin, guar gum, black psyllium and blond psyllium to thicken the digestive contents and slow its progress through the intestines. Lifestyle and home remedies Here are some dietary strategies that can help maintain good nutrition and minimize your symptoms. Try eating five or six small meals a day rather than three larger ones. Avoid fluids with meals. Drink liquids only between meals. Avoid liquids for a half-hour before eating and a half-hour after eating. Eat more protein â€” meat, poultry, creamy peanut butter and fish â€” and complex carbohydrates â€” oatmeal and other whole-grain foods high in fiber. Limit high-sugar foods, such as candy, table sugar, syrup, sodas and juices. The natural sugar in dairy products lactose might worsen your symptoms. You might want to see a registered dietitian for more advice about what to eat. Psyllium, guar gum and pectin in food or supplements can delay the absorption of carbohydrates in the small intestine. Check with your doctor about drinking alcohol. You may then be referred to a doctor who specializes in treating digestive system disorders gastroenterologist. What you can do Be aware of pre-appointment restrictions. Write down your symptoms, including any that may seem unrelated to the reason for which you scheduled the appointment. Write down key personal information, including major stresses or recent life changes. List all medications, vitamins or supplements you take. Take a family member or friend along to help you remember everything. Bring your medical records about past treatment, especially stomach surgery. Write down questions to ask your doctor. Questions to ask your doctor For dumping syndrome, some basic questions to ask your doctor include: What is likely causing my symptoms? What are other possible causes? What tests do I need? What is the best course of action? Should I see a dietitian? I have other health conditions. How can I best manage them together? Should I see a specialist? Are there brochures or other printed material that I can take? What websites do you recommend? What to expect from your doctor Your doctor is likely to ask you questions, including: Have you had stomach surgery, and if so, what kind? When did your symptoms begin? Have your symptoms been continuous or occasional? How long after eating do your symptoms begin? Do certain foods make your symptoms worse? How severe are your symptoms? What, if anything, seems to improve your symptoms? What, if anything, appears to worsen your symptoms?

Chapter 2 : Postgastrectomy Syndromes: 2nd ed : Frederick L. Bushkin :

This work offers a practical guide to the diagnosis and treatment of the known complications of surgery for peptic ulcer disease and the treatment of patients with suspected postgastrectomy syndrome.

Clearly defining the syndrome that is present in a given patient is critical to developing a rational treatment plan World J Surg ; Most are treated nonoperatively and resolve with time. Prolonged iron, folate, vitamin B12, calcium, and vitamin D deficiencies can result in anemia, neuropathy, dementia, and osteomalacia. These can be prevented with supplementation. Dumping syndrome Dumping syndrome is thought to result from the rapid emptying of a high-osmolar carbohydrate load into the small intestine. Gastric resection leads to the loss of reservoir capacity and the loss of pylorus function. Dumping syndrome is most common after Billroth II reconstruction. Early dumping occurs within 30 minutes of eating and is characterized by nausea, epigastric distress, explosive diarrhea, and vasomotor symptoms dizziness, palpitations, flushing, diaphoresis. It is presumably caused by rapid fluid shifts P. Symptoms are relieved by recumbence or saline infusion. Late dumping symptoms are primarily vasomotor and occur 1 to 4 hours after eating. The hormonal response to high simple carbohydrate loads results in hyperinsulinemia and reactive hypoglycemia. Symptoms are relieved by carbohydrate ingestion. Treatment is primarily nonsurgical and results in improvement in nearly all patients over time. Meals should be smaller in volume but increased in frequency, liquids should be ingested 30 minutes after eating solids, and simple carbohydrates should be avoided. If reoperation is necessary, conversion to Roux-en-Y gastrojejunostomy is usually successful. Alkaline reflux gastritis Alkaline reflux gastritis is most commonly associated with Billroth II gastrojejunostomy and requires operative treatment more often than other postgastrectomy syndromes. It is characterized by the triad of constant not postprandial epigastric pain, nausea, and bilious emesis. Vomiting does not relieve the pain and is not associated with meals. Endoscopy reveals inflamed, beefy-red, friable gastric mucosa and can rule out recurrent ulcer as a cause of symptoms. Bile reflux into the stomach is occasionally seen. Enterogastric reflux can be confirmed by hydroxy iminodiacetic acid HIDA scan. Mechanical obstruction is absent, distinguishing alkaline reflux gastritis from loop syndromes. Nonoperative therapy consists of frequent meals, antacids, and cholestyramine to bind bile salts but is usually ineffective. Surgery to divert bile flow from the gastric mucosa is the only proven treatment. The creation of a long-limb cm Roux-en-Y gastrojejunostomy effectively eliminates alkaline reflux and is the preferred option for most patients Gastroenterol Clin North Am ; It is characterized by chronic abdominal pain, nausea, and vomiting that is aggravated with eating. It results from functional obstruction due to disruption of the normal propagation of pacesetter potentials in the Roux limb from the proximal duodenum, as well as altered motility in the gastric remnant. Near-total gastrectomy to remove the atonic stomach can improve gastric emptying and is occasionally useful in patients with refractory Roux stasis. Loop syndromes Loop syndromes result from mechanical obstruction of either the afferent or efferent limbs of the Billroth II gastrojejunostomy. The location and etiology of the obstruction are investigated by plain abdominal x-rays, CT scan, upper GI contrast studies, and endoscopy. Relief of the obstruction may require adhesiolysis, revision of the anastomosis, occasionally bowel resection, or conversion of Billroth II to Roux-en-Y gastrojejunostomy. Afferent loop syndrome can be caused acutely by bowel kink, volvulus, or internal herniation, resulting in severe abdominal pain and nonbilious emesis within the first few weeks after surgery. Lack of bilious staining of nasogastric drainage in the immediate postoperative period suggests this complication. Examination may reveal a fluid-filled abdominal mass, and laboratory findings may include elevated bilirubin or amylase. Duodenal stump blowout results from progressive afferent limb dilation, leading to peritonitis, abscess, or fistula formation. In the urgent setting, jejunojejunostomy can effectively decompress the afferent limb. A more chronic form of afferent loop syndrome results from partial mechanical obstruction of the afferent limb. Patients present with postprandial right upper quadrant pain relieved by bilious emesis that is not mixed with recently ingested food. Stasis can lead to bacterial overgrowth and subsequent bile salt deconjugation in the obstructed loop, causing blind loop syndrome steatorrhea and vitamin B12, folate, and iron deficiency by interfering with fat and vitamin B12 absorption. Efferent loop

syndrome results from intermittent obstruction of the efferent limb of the gastrojejunostomy. Patients complain of abdominal pain and bilious emesis months to years after surgery, similar to the situation with regard to a proximal small bowel obstruction. The diarrhea is typically watery and episodic. Treatment includes antidiarrheal medications loperamide, diphenoxylate with atropine, cholestyramine and decreasing excessive intake of fluids or foods that contain lactose. Symptoms usually improve with time, and surgery is rarely indicated. Please follow and like us:

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Weakness Rapid heart rate Some people have both early and late signs and symptoms. And dumping syndrome can develop years after surgery. When to see a doctor Contact your doctor if any of the following apply to you. Your symptoms are not controlled by dietary changes. You are losing large amounts of weight due to dumping syndrome. Your doctor may refer you to a registered dietitian to help you create an eating plan. Causes Stomach and pyloric valve Stomach and pyloric valve Your stomach is a muscular sac about the size of a small melon that expands when you eat or drink to hold as much as a gallon of food or liquid. Once your stomach pulverizes the food, strong muscular contractions peristaltic waves push the food toward the pyloric valve, which leads to the upper portion of your small intestine duodenum. In dumping syndrome, food and gastric juices from your stomach move to your small intestine in an uncontrolled, abnormally fast manner. This is most often related to changes in your stomach associated with surgery. Dumping syndrome can occur after any stomach surgery or major esophageal surgery, such as removal of the esophagus esophagectomy. Risk factors Gastric bypass surgery Gastric bypass surgery Before gastric bypass, food see arrows enters your stomach and passes into the small intestine. After surgery, the amount of food you can eat is reduced due to the smaller stomach pouch. Food is also redirected so that it bypasses most of your stomach and the first section of your small intestine duodenum. Food flows directly into the middle section of your small intestine jejunum , limiting the absorption of calories. Surgery that alters your stomach can increase your risk of dumping syndrome. These surgeries are most commonly performed to treat obesity, but are also part of treatment for stomach cancer, esophageal cancer and other conditions. Gastrectomy, in which a portion or all of your stomach is removed. Gastric bypass surgery Roux-en-Y operation , which is performed to treat morbid obesity. It connects the small intestine to this pouch in the form of a gastrojejunostomy. Esophagectomy, in which all or part of the tube between the mouth and the stomach is removed.

Chapter 4 : Dumping syndrome - Symptoms and causes - Mayo Clinic

Postgastrectomy Syndromes! s! e! s! Gastroparesis! s! e! a. Metabolic/Nutritional Alterations! Anemia DB, Woodward ER. Alterations in Gastrointestinal Emptying of.

Chapter 5 : Postgastrectomy Syndromes Best Doctor, Best Hospital, Best Treatment, Best,Surgeon

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Chapter 6 : Formats and Editions of Woodward's postgastrectomy syndromes. [blog.quintoapp.com]

Postgastrectomy syndromes requiring further operation are fortunately uncommon, as the symptoms are disabling and the results of corrective surgery are, at times, disappointing.

Chapter 7 : Postgastrectomy syndromes.

The disturbance is great enough to result in a postgastrectomy syndrome in about 20% of operated patients. Clear definition of which motor abnormalities are present through the use of endoscopy, contrast radiography, and scintigraphy is critical for the development of a rational treatment plan for the syndromes.

Chapter 8 : The Long-Term Fate of Patients With Dumping Syndrome | JAMA Surgery | JAMA Network

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Chapter 9 : Dumping syndrome - Diagnosis and treatment - Mayo Clinic

Woodward ER: The Postgastrectomy Syndromes. The mechanism of the postgastrectomy "dumping" syndrome. Mechanism of Postgastrectomy Hypoglycemia.