

Versatility of Duodenal Transit Bipartition: Duodenoileal Anastomosis at the Third Portion of the Duodenum

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Abstract

Context: Duodenal transit bipartition is a metabolic and bariatric surgical concept proposed by De Melo, representing an adaptation of the classic concept of intestinal transit bipartition proposed by Santoro [1]. The architecture of the procedure is versatile and, owing to the postpyloric positioning of the duodenoileal anastomosis, allows its performance at different anatomical portions of the duodenum. Recently, we published an article demonstrating the versatility of this technique. The classic procedure is performed at the first portion of the duodenum. At the first postoperative outpatient evaluation, 30 days after the procedure, the patient presented a weight loss of approximately 11 kg, corresponding to approximately 10% of her initial body weight, with excellent clinical tolerance. **Case Presentation:** Female patient, 30 years old, with a 15-year history of progressive class III obesity, presenting an initial body weight of 112.2 kg, height of 1.62 m, and baseline body mass index (BMI)



of 42.8 kg/m². The patient had a documented history of repeated failures of clinical and pharmacological strategies for weight management. Previous interventions included lifestyle modifications, hypocaloric nutritional regimens, and the use of semaglutide, a glucagon-like peptide-1 (GLP-1) receptor agonist, which resulted in an initial weight loss of 12 kg but had to be discontinued due to fatigue symptoms. Subsequently, a therapeutic attempt with tirzepatide was carried out for two months, without measurable weight reduction. Her surgical history included a previous cholecystectomy. The patient had no diagnosis of type 2 diabetes mellitus, systemic arterial hypertension, or active symptoms of gastroesophageal reflux disease, and denied tobacco and alcohol use. Preoperative evaluation by upper digestive endoscopy revealed moderate antral gastritis, with a negative rapid urease test. Abdominal ultrasonography identified grade 2 hepatic steatosis. Laparoscopic sleeve gastrectomy combined with duodenal transit bipartition was indicated and performed. During the surgical procedure, an anatomically unfavorable duodenal configuration was identified, characterized by a short and plunging first portion of the duodenum, precluding its safe mobilization for the performance of the duodenoileal anastomosis. Consequently, the surgical strategy was adjusted to establish the duodenoileal anastomosis at the horizontal third portion of the duodenum, via an inframesocolic approach. After careful retroperitoneal dissection, a 4.5 cm stapled side-to-side duodenoileal anastomosis was performed, without complications. The sleeve gastrectomy had been performed prior to the construction of the anastomosis. The methylene blue test demonstrated adequate flow through the gastric tube and the duodenoileal anastomosis, without evidence of leaks. The postoperative period was uneventful, with hospital discharge 24 hours after surgery. **Conclusion:** This clinical case reinforces the versatility of the duodenal transit bipartition proposed by De Melo. This feature is related to the postpyloric location of the duodenoileal anastomosis, allowing its performance at different anatomical portions of the duodenum. In addition, the gastric component can be adapted to the needs and profile of each patient, including gastric preservation, laparoscopic sleeve gastrectomy, endoscopic sleeve gastropasty, or proportional sleeve gastrectomy. The performance of the anastomosis at the third portion of the duodenum proved technically feasible in this case, representing an alternative in the face of unfavorable anatomical conditions at the first portion of the duodenum. The medium- and long-term metabolic outcomes and the clinical evolution of the patient will be documented subsequently.

Keywords

Case Report, Obesity, Bariatric Surgery, Sleeve Gastrectomy, Duodenal Transit Bipartition

1. Introduction

Bariatric and metabolic surgery remains one of the most established and durable

therapeutic modalities for the treatment of severe obesity and its associated metabolic comorbidities [2].

Among modern bariatric and metabolic operations, duodenal transit bipartition constitutes an alternative with a physiological approach.

Duodenal transit bipartition, proposed by De Melo, represents an adaptation of the concept of intestinal transit bipartition developed by Santoro [3]-[5].

The main difference between the procedures lies in the anatomical positioning of the anastomosis. While the classic intestinal transit bipartition establishes an anastomosis at the level of the gastric antrum, duodenal transit bipartition performs this communication in the duodenum, in a postpyloric position, preserving the sphincteric function of the pylorus [1] [4] [6] [7].

The first duodenal transit bipartition was performed approximately 20 years ago, and its long-term results were published recently [3].

One of the main features of duodenal transit bipartition is its anatomical versatility. This versatility is related to the postpyloric positioning of the duodenoileal anastomosis, allowing its performance at different anatomical portions of the duodenum, associated with different gastric configurations [4].

The aim of this manuscript is to reinforce the concept of the versatility of duodenal transit bipartition through the presentation of a case in which the patient presented a short and plunging first portion of the duodenum, precluding a safe approach for the performance of the duodenoileal anastomosis.

Faced with this anatomical limitation, we used the versatility of the procedure and performed the anastomosis at the third portion of the duodenum, without complications.

2. Case Presentation

2.1. Patient Information

A female patient, 30 years old, presented to the outpatient clinic of bariatric and metabolic surgery seeking surgical treatment for chronic obesity, refractory to clinical treatment, with an evolution of more than 15 years.

The patient presented no clinical manifestations or upper gastrointestinal symptoms, specifically denying pyrosis, chronic acid regurgitation, postprandial retrosternal burning, or persistent dyspepsia.

Her surgical history included a previous cholecystectomy, performed without complications.

She had no diagnosis of type 2 diabetes mellitus, systemic arterial hypertension, dyslipidemia, obstructive sleep apnea, or cardiovascular diseases.

She denied tobacco use, alcohol consumption, and regular use of non-steroidal anti-inflammatory drugs.

Ethical approval was not required for this report, as it describes a single clinical case in which the surgical strategy was modified due to an anatomical/technical difficulty encountered during the operation. The procedure was performed as clinical care, in accordance with the principles of the Declaration of Helsinki.

Written informed consent was obtained from the patient for both the surgical procedure and the publication of this case report. Patient-identifying information has been omitted from the manuscript.

2.2. Previous Treatments

Over the previous 15 years, the patient had undergone different clinical treatments, including dietary modifications, physical activity, and pharmacological treatment.

Among the pharmacological interventions, she used GLP-1 analogs.

Initially, she was treated with semaglutide (Ozempic), a GLP-1 receptor agonist, achieving a documented weight loss of 12 kg.

However, the treatment was discontinued due to the development of intense and persistent fatigue, which compromised her daily activities.

After a period without medication and subsequent weight regain, treatment with tirzepatide (Mounjaro), a co-agonist of the GIP and GLP-1 receptors, was initiated.

The patient used the medication for two consecutive months, with dose escalation.

Despite adherence to the treatment, she presented no measurable weight loss, motivating her referral for surgical evaluation.

2.3. Clinical Findings

On physical examination, the patient was alert, oriented, and in good general condition, without peripheral edema or respiratory distress.

The cardiopulmonary evaluation showed no abnormalities.

The abdominal examination revealed a flaccid, painless, and non-distended abdomen, with well-consolidated surgical scars resulting from the previous cholecystectomy.

No palpable ventral hernias, visceromegalies, or localized pain were identified.

The initial anthropometric measurements demonstrated a body weight of 112.2 kg and a height of 1.62 m, corresponding to a BMI of 42.8 kg/m², compatible with class III obesity.

2.4. Diagnostic Assessment

The patient underwent multidisciplinary preoperative clinical evaluation.

Upper digestive endoscopy demonstrated normal esophageal mucosa, without evidence of erosive esophagitis, hiatal hernia, or Barrett's metaplasia.

The gastric mucosa presented changes compatible with moderate antral gastritis, with a negative rapid urease test for *Helicobacter pylori*.

Abdominal ultrasonography identified grade 2 hepatic steatosis, as well as absence of the gallbladder, compatible with the previous cholecystectomy.

The cardiopulmonary evaluation and preoperative laboratory tests showed no abnormalities that contraindicated the surgical procedure.

Given the condition of class III obesity, associated with hepatic steatosis and the failure of clinical treatment strategies, laparoscopic sleeve gastrectomy combined with duodenal transit bipartition was indicated.

2.5. Therapeutic Intervention

The patient was positioned in the modified lithotomy position, under general anesthesia, and the pneumoperitoneum was established with a Veress needle.

The initial inspection of the abdominal cavity identified mild omental adhesions related to the previous cholecystectomy, which were carefully released.

The greater gastric curvature was mobilized starting approximately 4 to 5 cm proximally to the pylorus, progressing towards the left crus of the diaphragm.

During this step, the short gastric vessels were divided, and complete mobilization of the gastric fundus was performed.

The sleeve gastrectomy was performed before the construction of the duodenoileal anastomosis, using a 32-Fr Fouchet bougie for calibration of the gastric tube, with sequential firings of a linear stapler up to the angle of His.

After completion of the sleeve gastrectomy, attention was directed to the exposure and mobilization of the postpyloric duodenum.

During the duodenal approach, a short and plunging duodenal bulb was identified, with a posterior and inferior course towards the retroperitoneum.

This anatomical configuration precluded safe mobilization of the first portion of the duodenum for the performance of the duodenoileal anastomosis.

Faced with this limitation, we chose to use the versatility of duodenal transit bipartition, transferring the site of the anastomosis to the third portion of the duodenum.

An inframesocolic approach was initiated, by elevating the transverse colon and cephalad displacement of the greater omentum.

The retroperitoneum covering the horizontal third portion of the duodenum was carefully exposed and dissected, respecting the adjacent vascular structures.

The dissection allowed adequate identification and exposure of the third portion of the duodenum, preserving the regional mesenteric vascular bundles.

Subsequently, the ileocecal valve was identified. The entire small intestine was measured, totaling 650 cm. After the total bowel measurement, a second count was started from the ileocecal valve, and the distal ileum was measured retrogradely. An ileal loop was selected at a distance of 260 cm from the ileocecal valve, representing the segment destined for the anastomosis. This 260-cm measurement corresponds to 40% of the total intestinal length, which is the percentage we generally use to create the common channel in duodenal transit bipartition procedures, particularly in patients with a body mass index of 40 or higher. This percentage provides the assurance that the anastomosis is performed in ileal territory.

The selected ileal loop was then brought towards the previously exposed third portion of the duodenum, verifying the absence of tension and mesenteric torsion.

An enterotomy in the selected ileal segment and a corresponding duodenotomy were performed.

Through these openings, a stapled side-to-side duodenoileal anastomosis was constructed, with a length of 4.5 cm, using an endoscopic linear cutting stapler.

The common opening of the anastomosis was closed with continuous intracor-

poreal suturing, using absorbable synthetic material.

After completion of the anastomosis, a systematic review of hemostasis was performed, both at the gastric stapling line and at the duodenoileal anastomosis.

The intraoperative methylene blue test, performed through the orogastric tube at the end of the procedure, demonstrated adequate flow through the gastric tube and the duodenoileal anastomosis, without signs of extravasation or leaks.

No intraoperative complications or mesenteric torsion were identified.

2.6. Follow-Up and Outcomes

The patient was transferred to the post-anesthesia recovery room in stable clinical condition, presenting satisfactory recovery.

Early ambulation was initiated approximately four hours after surgery.

Clear liquids by mouth were introduced on the first postoperative morning, with good tolerance and without episodes of nausea, vomiting, significant abdominal pain, or respiratory discomfort.

Serial clinical evaluations demonstrated hemodynamic stability and satisfactory postoperative evolution.

The patient was discharged from the hospital 24 hours after the procedure, without complications.

Clinical and nutritional follow-up remains ongoing. During the first 30 postoperative days, the patient maintained a progressive liquid and pureed diet under nutritional guidance, without complications. She did not present clinical signs of leak, intestinal obstruction, nutritional deficiencies, or other postoperative complications. The patient tolerated the diet well, with no nausea or vomiting, normal bowel function, no complaints of diarrhea, good tolerance of vitamin and protein supplementation, and no episodes of fever. In the first month after surgery, a weight loss corresponding to approximately 10% of the initial body weight was documented.

The clinical evolution and weight loss parameters in the medium and long term will be monitored and may be presented in a subsequent publication.

3. Discussion

The main objective of this article is to highlight the versatility of the concept proposed by De Melo. Duodenal transit bipartition (DTB) represents an evolution of the anatomical concept of transit bipartition described by Santoro [2] [4].

In duodenal transit bipartition, the anatomical concept of transit bipartition is applied to the duodenum; therefore, both procedures share the same principle: creating a second drainage pathway for gastric contents towards the distal ileum, without completely excluding the food transit through the duodenum and proximal jejunum [1] [4] [6]-[8].

Unlike classic malabsorptive techniques, DTB maintains the continuity of food transit through the proximal intestine, preserving the possibility of nutrient contact with these segments and endoscopic access to the digestive tract, including

the duodenal papilla [3] [5] [6] [9] [10].

The main difference of DTB is the postpyloric positioning of the anastomosis.

This feature preserves the sphincterian function of the pylorus, responsible for the regulation of gastric emptying, and may contribute to reducing the occurrence of dumping syndrome, marginal ulcer, and biliary reflux into the remnant stomach [8] [11].

The present case illustrates one of the main features of DTB: its anatomical versatility. In the classic configuration, the duodenoileal anastomosis is performed at the first portion of the duodenum. However, certain anatomical variations may hinder or preclude a safe approach to this region.

A short duodenal bulb, with a posterior and inferior course towards the retroperitoneum, limits the segment available for the anastomosis and hinders its mobilization.

Under these conditions, insisting on dissection may increase the risk of injury to adjacent structures, including the head of the pancreas, the gastroduodenal artery, and the biliary tract.

In addition, inadequate mobilization may result in an anastomosis under tension, increasing the risk of complications, including leaks.

Since in the concept of duodenal transit bipartition the anastomosis is postpyloric, the surgeon is not restricted to a single anatomical site.

It is possible to shift the anastomosis along the duodenum (D1, D2, D3), respecting its anatomical and vascular particularities, enabling variations without characterizing a departure from the concept of the procedure proposed by De Melo [6] (**Figure 1**). In fact, duodenal transit bipartition with the anastomosis at the second portion of the duodenum (D2) has been described and published [10].

In the present case, the choice of the third portion of the duodenum, via an inframesocolic approach, allowed the performance of a 4.5 cm side-to-side anastomosis, without tension and without intraoperative complications.

The patient presented a satisfactory postoperative evolution, being discharged from the hospital 24 hours after surgery.

The performance of the anastomosis at the third portion of the duodenum presents anatomical and physiological particularities that deserve consideration.

From a technical standpoint, the third portion of the duodenum is relatively fixed and retroperitoneal, crossing anteriorly to the aorta and the inferior vena cava and posteriorly to the superior mesenteric vessels.

Its exposure requires careful retroperitoneal dissection and detailed knowledge of the adjacent vascular structures.

The inframesocolic approach allows access to the horizontal portion of the duodenum and enables the performance of the anastomosis with the selected ileal segment, provided that the principles of absence of tension, adequate vascularization, and correct orientation of the intestinal loop are respected.

From a physiological standpoint, an important difference is that the anastomosis performed at the third portion of the duodenum lies distal to the major

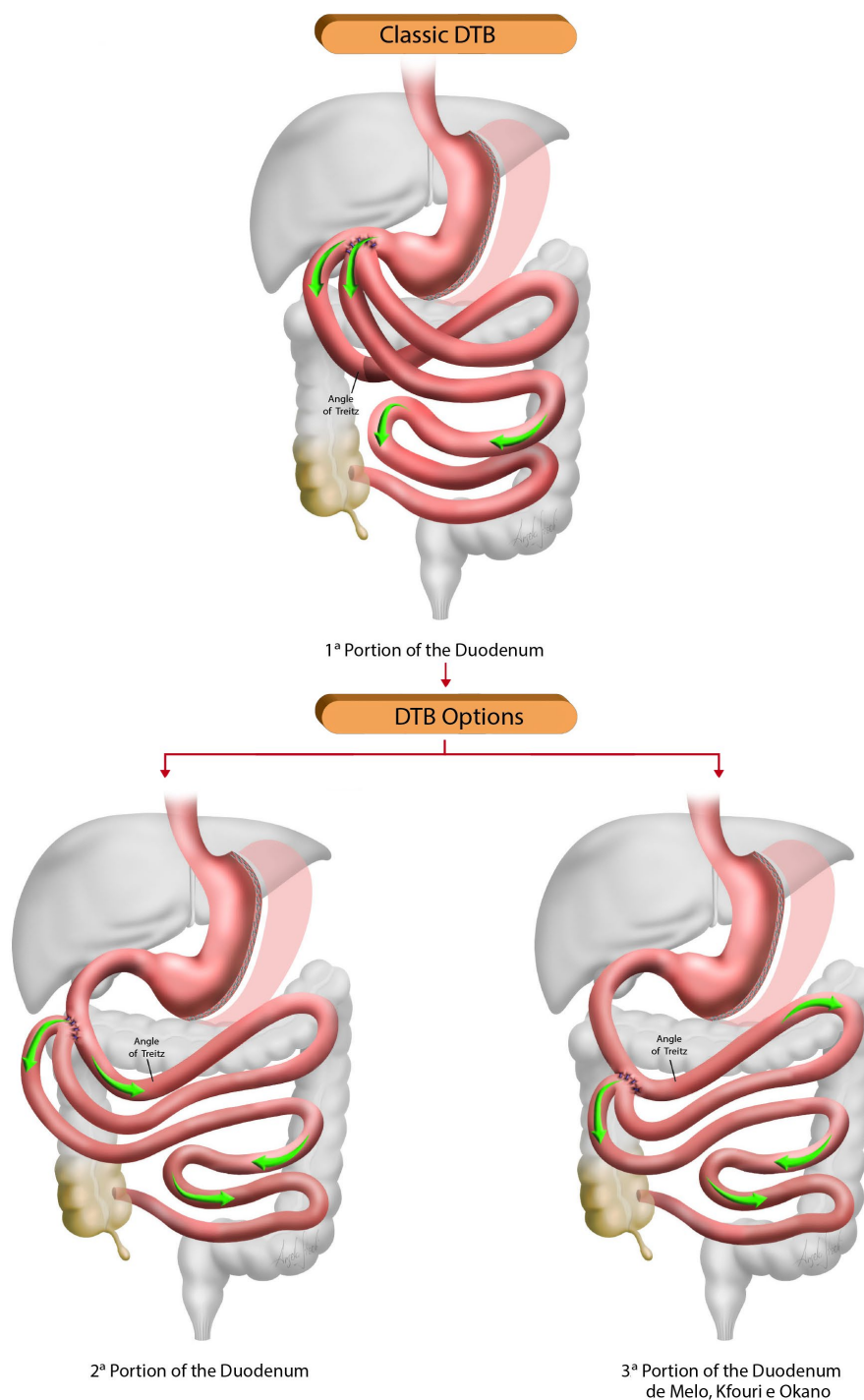


Figure 1. Classical duodenal bipartition and its variants.

duodenal papilla [6].

In classic DTB and in the configuration presented in this report, chyme may reach the anastomosis already mixed with the biliopancreatic secretions [6].

However, the location of the anastomosis in relation to the papilla may modify the timing and extent of the contact of food with these secretions.

Theoretically, these differences may influence the digestion and absorption of

nutrients, especially fats and fat-soluble vitamins.

Duodenal transit bipartitions may also modify the arrival of bile acids to the distal ileum, where they act as signaling molecules through the FXR and TGR5 receptors, with possible repercussions on glucose metabolism and energy expenditure.

At the same time, the maintenance of food contact with the first duodenal portions may influence the metabolic signaling of the proximal intestine.

This component is related to the foregut hypothesis [6] [7].

The early arrival of nutrients to the distal ileum, in turn, stimulates the intestinal L cells and the secretion of GLP-1 and peptide YY, mechanisms related to the hindgut hypothesis and to the effects on satiety and glycemic control [6] [7].

However, it has not yet been established whether the different anatomical positions of the duodenoileal anastomosis produce clinically relevant differences in metabolic, weight, and nutritional outcomes.

Comparative studies will be necessary to clarify these questions.

The approach presented here also fits into the broader context of bariatric procedures that use postpyloric duodenoileal anastomoses, such as the SADI-S (single anastomosis duodeno-ileal bypass with sleeve gastrectomy). SADI-S is a well-established surgical procedure with significant results in the treatment of obesity and its comorbidities [12].

However, there are technical differences between the procedures.

Unlike SADI-S, DTB does not involve complete transection of the duodenum, preserving the anatomical continuity of the proximal intestinal transit [6] [12].

Consequently, there is no formation of a duodenal stump, specifically eliminating the possibility of a fistula of this stump.

The maintenance of two pathways of food transit constitutes a fundamental feature of the technique.

Another relevant aspect is the possibility of adapting the gastric component to the clinical and anatomical characteristics of each patient.

Duodenal transit bipartition can be associated with gastric preservation, laparoscopic sleeve gastrectomy, endoscopic sleeve gastroplasty, or proportional sleeve gastrectomy [6].

In the patient presented, the choice of sleeve gastrectomy calibrated with a 32-Fr Fouchet bougie was based on the presence of class III obesity, the previous failure of different clinical and pharmacological strategies, and the absence of symptoms of gastroesophageal reflux disease.

The absence of a satisfactory response to pharmacological treatment also deserves emphasis.

Semaglutide provided initial weight loss but had to be discontinued due to clinical intolerance.

Subsequently, tirzepatide produced no measurable weight reduction during the treatment period.

These findings illustrate that, despite the advances in pharmacotherapy for obe-

sity, some patients present insufficient response or intolerance to the available medications.

In these situations, bariatric and metabolic surgery remains an important therapeutic alternative.

The loss of approximately 10% of the initial body weight in the first 30 days represents a favorable early postoperative outcome.

However, this follow-up period is still insufficient to evaluate weight and metabolic efficacy in the medium and long term.

Some technical and safety considerations should be highlighted.

Dissection of the third portion of the duodenum is more complex and requires familiarity with the retroperitoneal anatomy and special attention to the relationships with the superior mesenteric vessels and the uncinate process of the pancreas.

The selection and ascent of the ileal loop must respect its vascularization, anatomical orientation, and absence of tension.

In addition, the possibility of the formation of mesenteric spaces should be evaluated during the procedure, considering preventive measures to reduce the risk of internal hernias.

The measurement of the small intestine and the choice of the ileal segment destined for the anastomosis must also follow standardized technical criteria.

In the present case, after the identification of the ileocecal valve, the entire small intestine was measured, and the ileal segment destined for the anastomosis was selected at 260 cm from the ileocecal valve, corresponding to 40% of the total intestinal length, the percentage generally used to define the common channel in duodenal transit bipartition, particularly in patients with a body mass index of 40 or higher.

This segment was brought to the third portion of the duodenum and used for the construction of the anastomosis.

The present report presents limitations inherent to the description of a single clinical case and to the short follow-up period.

The case demonstrates the technical feasibility of a surgical alternative of classic duodenal transit bipartition in the face of a rare and unfavorable anatomical configuration of the first portion of the duodenum.

The possibility of performing the anastomosis at the third portion of the duodenum allowed maintaining the original concept of DTB, avoiding a potentially unsafe dissection of the duodenal bulb.

4. Conclusions

This case report reinforces the concept of the versatility of duodenal transit bipartition proposed by De Melo, showing the applicability of the concept at the third portion of the duodenum (D3).

The performance of the duodenoileal anastomosis at the third portion of the duodenum proved technically feasible in this case, allowing the continuity of the

procedure in the face of an unfavorable anatomical configuration of the first portion of the duodenum.

This versatility is related to the postpyloric positioning of the anastomosis, which enables its performance at different anatomical portions of the duodenum, respecting the technical and vascular particularities of each region.

In addition, the possibility of associating duodenal transit bipartition with different gastric configurations expands its capacity for adaptation to the individual needs and characteristics of patients.

The patient presented a satisfactory postoperative evolution, without complications, with hospital discharge at 24 hours and initial weight loss of approximately 10% at 30 days.

However, the follow-up is still limited, and it is not possible to establish definitive conclusions on the metabolic, weight, and nutritional outcomes in the medium and long term.

Studies with a larger number of patients and prolonged follow-up will be necessary to evaluate the safety, the efficacy, and the possible clinical differences related to the anatomical location of the duodenoileal anastomosis.

Author Contributions

Conceptualization, P.R.R.E.M.; writing—original draft preparation, D.S.K. and P.R.R.E.M.; writing—review and editing, C.A.S.M., V.R.M.D., L.A.V.A., R.J.S.R., H.O.J., R.O.F., M.R.R.J., and A.T. All authors have read and agreed to the published version of the manuscript.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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