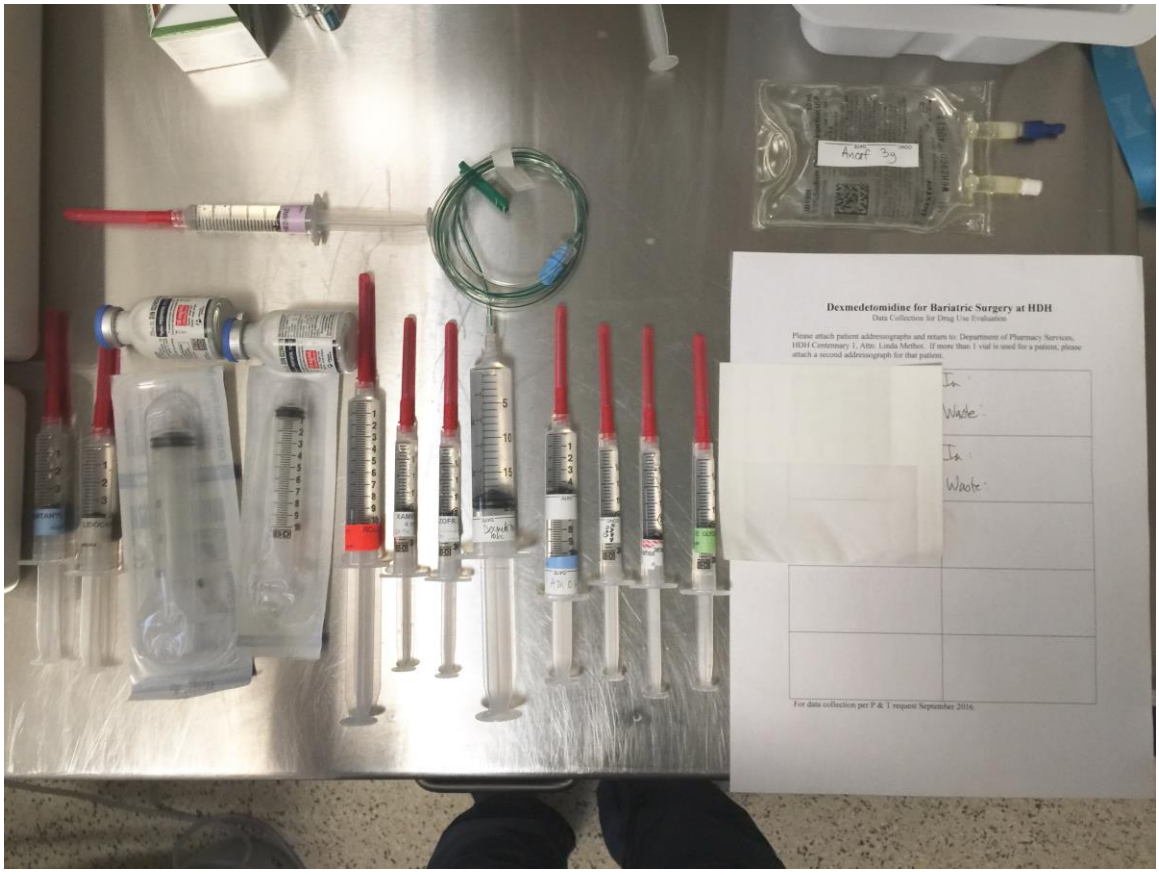
# S120	Gastric bypass with Roux-en-Y anastomosis, for morbid obesity	7	1350.00	10
# S115	Reversal of previous vertical banded gastroplasty	7	820.00	10
# S114	Sleeve gastrectomy	7	820.00	10

Set Up

Regular IV (no warmer) – minimal fluids required (500-800cc) for most patients
Troop (removed after induction)
BIS
Alaris pump
Bed slide max head
Upper body Bair

Drugs:
Fentanyl (~300mcg), Propofol (~400mg), Rocuronium (~70mg), Lidocaine (80-100mg), Dexmedetomidine (200mcg in 20cc (10 mcg/cc) – manual set up A3U/kg/h for 0.2 mcg/kg/hr; can be found in anesthetic room in the core in plastic boxes with the other drugs), Zofran 4mg, Dexamethasone 8mg, Maxeran 10mg, antibiotics (Ancef 2 g<120kg or 3g>120kg)

Pt. stickers for dexmedetomidine must be put on the proper paperwork (one vial per patient)

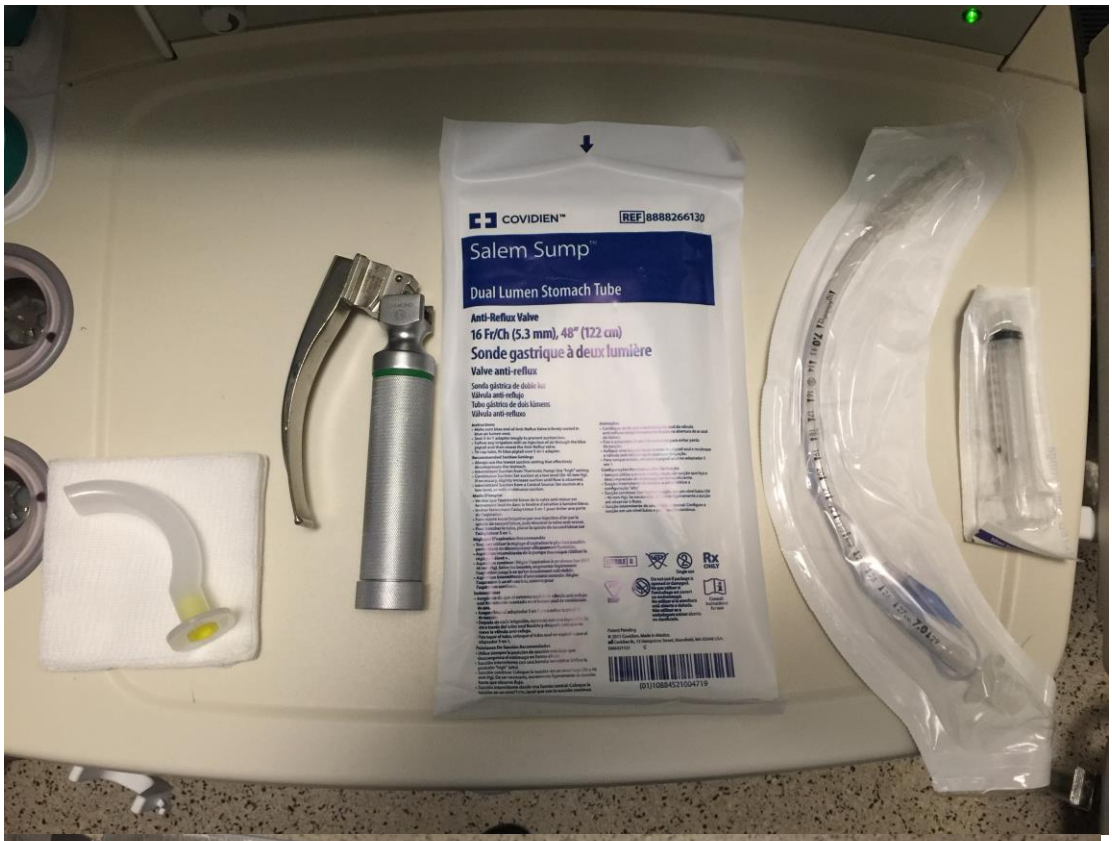


Pt in OR and time out
On Troop pillow – ensure head all the way to the end
Turn on dexmedetomidine infusion at 0.2mcg/kg/hr actual body weight – consider a small bolus (10-20 mcg) with induction if patient's HR and BP permit; if patient already bradycardic, start infusion at the start of insufflation
Induction and intubation; give ondansetron and dexamethasone at the start of the case
OG tube insertion (low wall suction); I insert the OG first, then I intubate – this may not be practical in difficult airways
Troop pillow out and patient moved down the bed; towels around arms to keep on armboards during reverse Trendel.
Slide bed down so monitor fits in between arm board and anesthetic machine
BIS – I titrate my volatile to this; I'm more comfortable with 35-40 in this age group and with no dexmedetomidine 'load'

Parts:

1) Start of laparoscopy – sometimes requires a small bolus of demedetomidine, I usually give 0.5-1mg hydromorphone around this time
2) J-J anastomosis – patient is supine
3) Creation new stomach – steep reverse Trendelenburg which can cause hypotension; may need ephedrine or decrease dexmedetomidine
4) Orvil passage – this can be a challenge – have someone help you the first time (I take patient out of steep reverse Trend. for this)
5) Endoscopy to check anastomosis – help the surgeon with scope insertion by doing a jaw thrust; turn dexmedetomidine off at start of endoscopy
6) End of case – give reversal after endoscopy, given Maxeran 10 mg after endoscopy; patients will start breathing at this point so I put the on PSV and titrate in small boluses of fentanyl to respiratory rate
7) Wake up – typically very cooperative; the bed should come in the room with oxygen tank turned on and a mask attached for transport to PACU with oxygen

General Points:
Keep patient paralyzed - this typically means 60-70 mg of roc up front at induction followed by another 10mg mid-case
Cases are about 2-2.5 hours including anesthesia time
Laparoscopic sleeve gastrectomies are only about one hour – I do not think the use of dexmedetomidine is justified for these short cases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