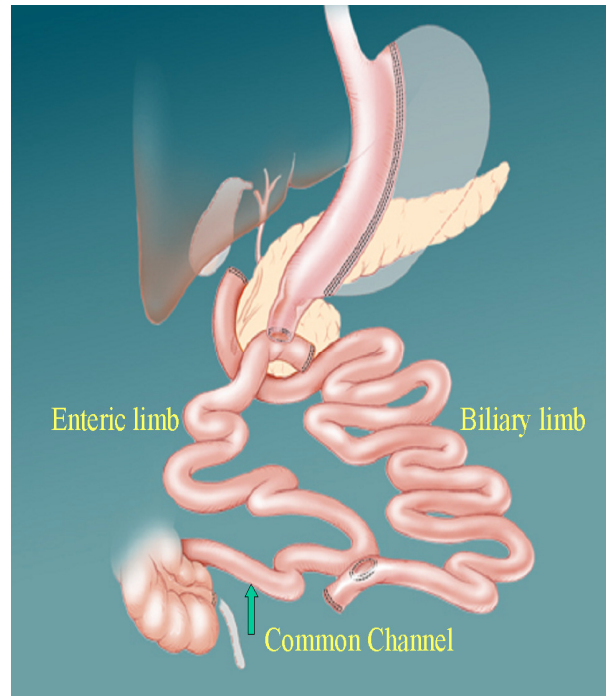


Welcome to Pacific Laparoscopy

This letter is an introduction to our current surgical program for morbid obesity. We began in 1979 with gastroplasty, a purely restrictive procedure. In 1984 we introduced a “hybrid” procedure combining moderate restriction of food with moderate malabsorption. A refinement, the Duodenal Switch (DS), has been our primary procedure since 1993. We also offer laparoscopic Roux-en-Y Gastric Bypass (LAP RGB) and vertical gastrectomy (LapVG).

We developed the **Laparoscopic Duodenal Switch** technique, one utilizing only four small surgical incisions, and first performed laparoscopic DS in 1999. Ours is one of the few programs worldwide utilizing this technique. For most of our patients, laparoscopic DS is now the preferred approach rather than the older open technique, and our series of over 1400 patients currently includes more than 950 who underwent the laparoscopic DS procedure. Laparoscopic technique offers the advantages of reduced post-operative pain, fewer wound problems, a shorter hospital stay and a smaller scar. The internal anatomy and intestinal construction is identical whether the DS is done laparoscopically or via a conventional open midline incision.



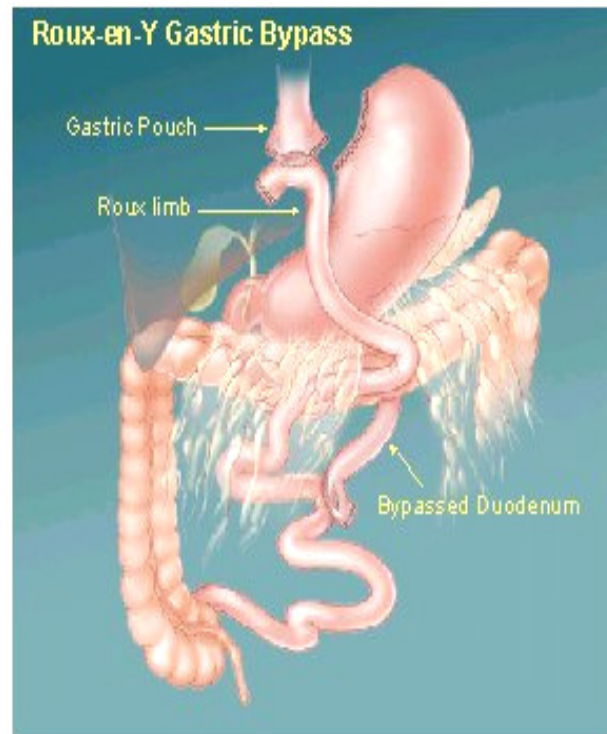
Technically, the DS is performed by dividing the duodenum between the point where it connects to the stomach and where the bile ducts enter. This prevents the food from mixing with pancreatic juice and bile. The stomach is reduced to a capacity of about 4 ounces. The small intestine is carefully measured and then divided into two segments. Note that no portion of the intestine is removed. The lower segment of small intestine is then connected to the open end of the duodenum. The upper segment of the small intestine is reattached to the lower segment approximately 40 inches from the colon. This creates the “common channel”, where most of the digestion and absorption of nutrients takes place. Because of the restricted length, the amount of fat emulsification and absorption is reduced and complex carbohydrate calories are not fully absorbed.

Time in surgery for Lap DS averages 2 to 4 hours and hospital stay ranges from 2 to 4 days. Patients average a 50% excess weight loss after 6 months. Those who are diabetic can usually discontinue their diabetes medications completely. Medication for other conditions such as hypertension often can be reduced or eliminated. At 18 months after surgery, our average Lap DS patient maintains a loss of 90% of his or her excess weight.

The **Roux-en-Y Gastric Bypass** is an operation that has gained wide acceptance in the past decade, especially as laparoscopic versions have been introduced.

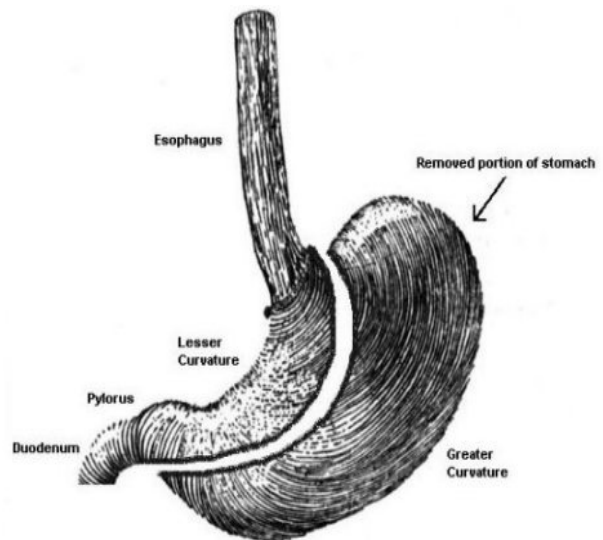
The operation has a weight loss potential in the range of 70-75% of the excess body weight, on average. Many studies commonly show some regain of weight at three to five years post-surgery. The operation makes a small pouch at the top of the stomach, and then routes the food through a "Roux" limb of small bowel before it joins the biliopancreatic secretions.

The Roux-en-Y Gastric Bypass is the most commonly done laparoscopic bariatric procedure in the U.S. It is acceptable for patients who have a moderate amount of weight to lose. It may cause dumping, which is a bloated, sweaty feeling experienced after eating sugars. This has been cited as a benefit in patients who are "sweets eaters", since it reinforces the behavior modification of avoidance of those sweets. The operation also has the potential to cause stomal ulcers, which are ulcers that form at the connection between stomach and small intestine; an area not designed to be exposed to such raw acidity. The incidence of significant dumping and stomal ulcers varies since there are so many variations of this procedure being done. Various vitamin and nutritional deficiencies are possible, but are usually manageable with supplements. With proper post-



op care and compliance, these problems should be unusual. This operation requires eating small frequent meals for best results.

The **Laparoscopic Vertical Gastrectomy** works exclusively by restricting the size of the stomach, while preserving normal stomach functioning. Purely restrictive procedures may not have good weight loss maintenance, and patients must pay strict attention to their calorie consumption. For the first four to six weeks following surgery, patients may experience nausea and vomiting as a result of having a smaller stomach, but there is usually no diarrhea. There are no long-term studies available on this procedure, since it was developed only recently. Initially it was offered as part of a planned two-stage Lap DS. But the second stage was delayed in several patients who appeared to have responded well to only the first stage. Weight regain may appear. This surgery can be considered for patients who are at the highest or lowest ends of the spectrum with respect to selection criteria.



Pyloric Valve (Pylorus): This valve, located at the exit of the stomach, regulates the release of the stomach contents into the small intestine.

Monthly Meetings:

We strongly encourage attendance at our monthly group meetings located throughout California. If possible we prefer at least 2 meetings prior to surgery. Post-operatively, we also recommend continuing to attend these group meetings, as we have found that group meeting attendance and participation can be directly linked to the success of the surgery. At the meetings you will meet patients like yourself who are learning about the DS, as well as those who recently had DS surgery and those whose surgery was further in the past. Please see the attached schedule for a group meeting in your area.

Our program maintains continued emphasis on good nutrition and exercise. We support monthly group meetings for pre- and post-operative patients and for their supporting persons. We follow our patients on a long-term basis, and offer full-time RN and PA telephone availability. Patients receive a handbook to assist them during the post-

operative period, quarterly newsletters with current events and annual calendars. Many patients participate in DS_pacificlaparoscopy@yahoogroups.com, an internet email community specific for our practice. Our research program is ongoing and is recognized by the American Society of Bariatric Surgeons (ASBS). Our non-profit organization, Pacific Institute Explorers, helps educate about obesity and promote awareness of the surgical treatment of obesity.

For additional clinical information, you may contact us directly at (888) 848-8446 or visit our website at www.paclap.com. Most insurance providers will authorize payments for these procedures if you are a qualified candidate. Many of our patients have volunteered to speak to new candidates about the improved physical and mental well being that accompanies sustained weight loss.