John M. Rabkin, MD, FACS

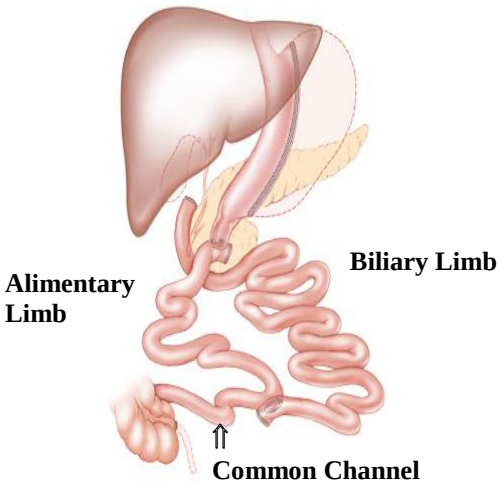
Welcome to Pacific Laparoscopy

This introduces our surgical program for morbid obesity. We have been offering bariatric surgery since 1979. We began with Gastroplasty, a purely restrictive procedure. In the 1980's, we began offering the Roux-en-Y Gastric Bypass, where there is significant food restriction and mild malabsorption.

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 feel the DS is by far the best weight loss procedure available today.

Duodenal Switch (DS)

Our San Francisco program was established in 1998. We developed the laparoscopic approach and first performed the laparoscopic DS (Lap DS) in 1999. Ours is one of the few programs worldwide offering this technique. All of our primary DS procedures are now performed laparoscopically and includes more than 1500 procedures.



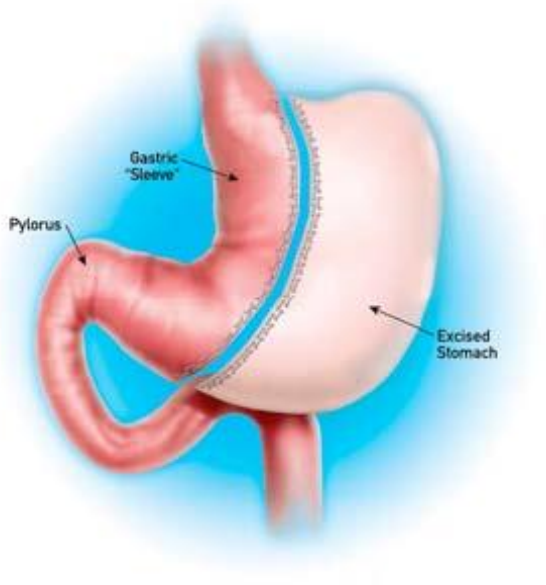
Laparoscopic technique offers the advantages of reduced post-operative pain, fewer wound problems, a shorter hospital stay and a smaller scar. The internal anatomy and intestinal construction is identical whether the DS is done laparoscopically or via a conventional open midline incision.

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**: 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 3 to 4 hours. Hospital stays range from 3 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. CPAP masks for sleep apnea are no longer needed. By 18 months after surgery, continuing through at least 5 years after surgery, our average Lap DS patient maintains a loss of 90% of his or her excess weight.

Vertical "Sleeve" Gastrectomy (VG)

The Vertical Gastrectomy (VG), which is the restrictive component of the DS, provides excellent short-term weight loss. For the higher risk patient or those with less severe obesity, this procedure may be a good alternative. The VG 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 over time. For the first four to six weeks following surgery, patients may experience nausea and occasional vomiting as a result of having a smaller stomach, but there is usually no diarrhea. If patients start to regain weight due to the expansion of the stomach over time, discussion of conversion to the DS should then be entertained.



Conversion to the DS (DSC)

We also take a special interest in patients where older bariatric procedures have failed, resulting in inadequate weight loss, weight regain or other complications. We have converted many patients to the DS with overall excellent results. Surgeries for patients being converted from older failed bariatric procedures (excluding the adjustable gastric band patients) are routinely performed open as opposed to primary procedures which are performed laparoscopically.

Reconstructive Surgery

We offer reconstructive procedures to remove excess skin from weight loss surgery patients after weight loss. Many patients find that, after losing 100, 200 or more pounds through weight loss surgery, their skin does not shrink to fit their new body. Excess, sagging skin and residual fat can create more than just cosmetic problems, and may prevent some patients from fully enjoying their smaller size. The best time to do reconstructive surgery is when weight loss has stabilized, typically 15-18 months post operatively, or later. If a hernia is present, the repair is optimally done at the same time as the abdominoplasty/panniculectomy ("tummy tuck").

Monthly Meetings and Follow-Up

We support monthly group meetings for pre-and post-operative patients and their supportive persons in many locations. We strongly encourage attendance at two (2) support group meetings prior to surgery and regular attendance at monthly support groups. We have found that group meeting attendance and participation can be directly linked to the success of the surgery. We follow our patients on a long-term basis, and offer full-time telephone availability. Patients receive a handbook to assist them during the post-operative period. 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.