

Outcomes Following Gastric Bypass Reversal for Refractory Complications: A UK Tertiary Centre Retrospective Case Series

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Abstract

Background

Gastric bypass is an effective and safe metabolic bariatric surgery, yet patients develop refractory long-term complications that exhaust conservative options, prompting consideration of reversal. Outcomes following reversal remain poorly characterised.

Methods

Performed a retrospective analysis of patients undergoing, or referred after, gastric bypass reversal at a UK tertiary bariatric centre (2019–2026). Eight cases were identified. Data included demographics, pre-reversal complications, nutritional status, operative approach, and post-reversal symptomatic and nutritional outcomes, with follow-up to 24 months.

Results

The cohort was predominantly female (n=5) with a median age of 41 years (IQR 38–46.5). Index procedures included Roux-en-Y (n=5), one-anastomosis (n=2), and jejunoileal bypass (n=1). Reversals were laparoscopic (n=5) or open (n=2), with one patient referred post-reversal. Median time to reversal was 4.5 years (IQR 2.5–6.5), during which patients underwent a mean of two further interventions. Indications included gastrojejunal stenosis/ulceration, recurrent internal hernias, malabsorption, and dumping syndrome, often with severe weight loss. Median pre-reversal BMI and albumin were 21 kg/m² (IQR 17.3–27) and 30 g/L (IQR 30–39). Post-reversal complications included anastomotic leak, ulcers, and hernia. Symptom resolution was inconsistent; patients reported persistent abdominal pain (6 of 7), reflux (4 of 5), dysphagia (4 of 7), poor intake (3 of 7), and vomiting (3 of 8). Post reversal albumin increased to 38 g/L (IQR 32–41) and BMI to 29 kg/m² (IQR 23.1–33).

Conclusion

Gastric bypass reversal improved nutritional status but yielded inconsistent symptom relief. Repeated pre-reversal interventions suggest possible delays in definitive decision-making. Prospective multicentre studies are needed to define optimal timing and selection criteria.

Key points

- Reversal was used as salvage for refractory post-bypass complications.
- Reversal improved BMI and albumin but symptoms often persisted.
- Patients frequently had multiple failed interventions before reversal.
- Reversal carried significant morbidity, requiring supporting specialist-centre care.

Introduction

Whilst gastric bypass is an effective and safe procedure for management of obesity and in some cases for gastroesophageal reflux disease (GERD), a small but clinically significant subgroup develops refractory complications that cannot be managed with medical, endoscopic, or standard revisional measures. These late problems include marginal ulcers, gastrojejunal stricture, dumping syndrome, often leading to malnutrition due to severe nausea and vomiting, all of which are recognised causes of reversal consideration after Roux-en-Y gastric bypass (RYGB) (1, 2, 8). Similar indications have also been reported after one-anastomosis gastric bypass (OAGB), where protein-energy malnutrition, diarrhoea, hepatic steatosis, and bile reflux are among the main reasons for reversal to normal anatomy (3). Historical jejunoileal bypass can also require reversal because of severe metabolic complications and liver fibrosis. (4)

Gastric bypass reversal is a technically demanding procedure; the available literature suggests that the operation is usually as a salvage procedure reserved for patients experiencing severe chronic complications refractory to multidisciplinary team (MDT) management (8). In RYGB reversal, operative morbidity has included leaks, gastrostomy-related complications, abdominal pain, de novo gastro-oesophageal reflux after reversal, Intensive Care Unit (ICU) admission postoperatively and re-operation post reversal (5, 6). Reversal of OAGB is rare and not without risk, with complications including bleeding, leak, delayed refeeding syndrome and mild gastroparesis reported in the literature (3, 7). These data underline that reversal should be viewed as salvage surgery rather than a routine revisional option.

Despite an increasing number of RYGB and OAGB surgeries performed over the last decade and therefore an increase in reversals of bypass to normal anatomy procedures performed, the evidence base remains limited to small retrospective series, isolated case reports, and narrative reviews, with most published data focused on RYGB rather than OAGB or JIB-related anatomy. There is therefore little consensus on patient selection, optimal timing, operative approach, or the balance between expected nutritional recovery, the likelihood of persistent symptoms and complications after reversal. There are currently no available guidelines to standardise practice when it comes to reversal of gastric bypass surgery. This is particularly relevant in tertiary referral practice, where patients often present after multiple failed interventions and prolonged nutritional deterioration.

The aim of this study was to describe the indications, operative approaches, complications, and short- to medium-term outcomes of gastric bypass reversal in a UK tertiary bariatric centre, with particular emphasis on symptomatic response and nutritional recovery.

Methods

Study design and setting

This was a single-centre retrospective case series of patients managed at a UK tertiary bariatric referral centre. We identified patients who had undergone reversal of any type of gastric bypass to normal

anatomy either at our institution or elsewhere and who were subsequently followed up by our bariatric service. The study period covered January 2019 to January 2026.

Inclusion and exclusion criteria

Eligible patients were adults aged 18 years or older who had previously undergone gastric bypass surgery and later underwent surgical reversal. Patients were included if they had at least 1 month of postoperative follow-up under our bariatric team.

Case identification and data extraction

Cases were identified through review of all bariatric operations recorded in the hospital electronic theatre management system and by screening referrals to the bariatric team. Clinical data were extracted from electronic patient records and entered into a secure anonymised database. No patient-identifiable information was stored.

Variables collected

We recorded age at reversal, sex, smoking history, and alcohol intake. For the index gastric bypass, we extracted the date, original indication, and procedure type. For the interval between index gastric bypass and reversal, we documented symptoms, complications, and all endoscopic or surgical interventions. The multidisciplinary team outcome on the indication for each reversal was documented. Reversal details included date of surgery and approach. Post-reversal data included symptoms, complications, nutritional support requirements, body mass index (BMI), and serum albumin measured during a follow-up period extending up to 24 months.

Data analysis

Data were analysed descriptively. Continuous variables are presented as medians with interquartile ranges (IQR), and categorical variables as counts and proportions. No formal hypothesis testing was performed because of the small sample size. Analyses were conducted using Microsoft Excel (Microsoft Corporation, Redmond, WA, USA) on anonymised data.

Ethical consideration

This anonymised retrospective evaluative study was registered with the institutional governance office. All data were handled in accordance with institutional confidentiality and data protection standards and the principles of the Declaration of Helsinki. As this was a retrospective review of routinely collected anonymised data, formal individual informed consent was not required.

Results

Cohort characteristics

Eight patients met the inclusion criteria. The cohort was predominantly female (5 of 8), and the median age at reversal was 41 years (IQR 38–46.5). Four patients were ex-smokers, three had never smoked, and one was a current smoker. Five patients did not consume alcohol, two reported occasional alcohol intake and one reported excess alcohol intake.

Index bariatric procedures

Five patients had undergone laparoscopic RYGB, two had undergone OAGB outside the UK, and one patient had a complex historical bypass pathway involving JIB followed by a Scopinaro procedure before eventual reversal to normal anatomy. Seven of the eight index operations had been performed for the management of obesity, and one had been performed for reflux. Pre-bypass BMI was available in seven patients, with a median of 45.8 kg/m² (IQR 38–55.8).

Post-bypass complications and interim procedures

All patients underwent investigations prior to reversal to identify the cause of their symptoms. Six patients had had at least one or more computed tomography (CT) imaging of the abdomen and pelvis, endoscopies and barium swallows. Two patients had one or more barium swallows and endoscopies and no CTs.

Six patients developed complications related to the gastrojejunal anastomosis, three developed recurrent internal hernias, one experienced dumping syndrome and one malabsorption. Among those with gastrojejunal complications, five had marginal ulcers and two of these had perforation; all six had some degree of anastomotic stenosis. The most common symptoms before reversal were dysphagia, vomiting, and abdominal pain, each present in all patients. Reflux symptoms were reported by five patients, and one reported persistent diarrhoea. Excessive weight loss occurred in all patients, and four required supplemental nutrition via nasojejunal feeding. The lowest recorded post-bypass BMI had a median of 21 kg/m² (IQR 17.3–27), excluding one patient for whom data were unavailable. Median serum albumin measured within the 4-month period before reversal was 30 g/L (IQR 30–39). It must be of note that patients were nutritionally optimised prior to reversal.

Patients underwent a mean of two interventions per patient before reversal. These included endoscopic balloon dilatation, laparoscopic revision of the bypass, laparoscopic or open internal hernia repair, and laparotomy for perforated ulcer repair.

Two RYGB patients underwent balloon dilatation of the gastrojejunal anastomosis before reversal, one having one dilatation and the other three. Two patients required repairs of perforated gastrojejunal ulcers before reversal; one patient required two repairs after OAGB and the other required one repair after RYGB.

Three patients required surgery for internal hernia repair, including two OAGB patients and one RYGB patient. One OAGB patient underwent laparotomy for internal hernia repair 1 year after bypass. The second OAGB patient had emergency laparoscopic internal hernia repair 4 years after bypass, followed by further laparoscopic reduction and defect closure 3 years later, and then an emergency laparotomy with reduction of internal hernia and gastrostomy insertion 2 years later. The RYGB patient had two diagnostic laparoscopies with closure of mesenteric defects for internal hernia before reversal.

One OAGB patient underwent a laparoscopic revision procedure, with shortening of the afferent limb from 4.2m to 1.5m with the aim to resolve diarrhoea and malabsorption.

The patient with a jejunoileal bypass underwent laparoscopic conversion procedure to a Scopinaro bypass before eventual reversal to normal anatomy.

One RYGB patient underwent only one diagnostic laparoscopy before reversal.

Indications and timing of reversal

The decision to proceed with a gastric bypass reversal for all patients resulted following extensive multidisciplinary team discussion. The indication for reversal was gastrojejunal anastomotic complications, including stenosis and ulceration with dysphagia, weight loss, and malnutrition, in six patients. The indication for one patient was dumping syndrome following Scopinaro bypass and the remaining patient had a reversal due to malabsorption and intermittent internal herniation, causing recurrent diarrhoea, abdominal pain, vomiting and weight loss.

In four patients, the desire to undergo reversal was explicitly documented; one patient with reflux reported that they preferred reflux to persistent dysphagia and vomiting. The median interval between index bypass and reversal was 4.75 years.

Technique of reversal

Roux-en-y gastric bypass reversals

All five reversals were performed laparoscopically by experienced, high volume bariatric consultants. Four patients had a single laparoscopic operation, whilst one patient had a two-stage reversal consisting of two operations, two years apart.

In all procedures, the gastric pouch and remnant stomach were exposed by adhesiolysis and mobilised. Reversal was achieved by constructing a side-to-side gastro-gastric anastomosis between the pouch and remnant using a linear stapler, followed by closure with absorbable sutures. The Roux limb was resected and continuity restored with a side-to-side jejunojejunostomy with the gastrostomy defect being closed with absorbable sutures.

Anastomotic integrity was assessed in all cases using intra-operative leak testing with methylene blue, with or without air insufflation, via a nasogastric or nasojejunal tube; all tests were negative. A

gastrostomy tube was placed in one high-risk patient to allow postoperative gastric decompression and enteral access. Drains were selectively used and placed adjacent to the gastro-gastric anastomosis in two cases; in the remaining procedures no drains were left in situ.

One-anastomosis gastric bypass reversals

Two reversals of one-anastomosis gastric bypass were performed, by the same bariatric surgeon, as open procedures through a midline laparotomy. After adhesiolysis, the existing gastrojejunostomy was divided with a linear stapler. Gastric continuity was restored in both cases by a side-to-side stapled gastro-gastric anastomosis between the pouch and remnant and the gastrostomy defect being closed with absorbable sutures.

Jejunioleal gastric bypass reversal

One patient had a jejunioleal bypass which was converted to a modified Scopinaro bypass, the latter then reversed.

Post-reversal outcomes: nutritional recovery and symptom resolution

Follow-up was available for up to 24 months, except for one patient who did not attend postoperative appointments and later died from unrelated causes. Median latest postoperative BMI was 29 kg/m² (IQR 23.1–33), excluding one patient without dietetic follow-up. Median postoperative albumin during follow-up was 38 g/L (IQR 32–41), excluding one patient with no follow-up laboratory data. Albumin improved after reversal in all but one patient, whose value fell from 30 g/L preoperatively to 17 g/L at 20 months because of persistent complex nutritional difficulties.

Five of the seven patients with postoperative nutritional follow-up required some form of supplemental nutrition at some stage after reversal. Three required nasojejunal feeding, and one of these remains dependent on nutritional support, including total parenteral nutrition. Two patients required gastrostomy feeding for five and two months, respectively, and one patient also required total parenteral nutrition. Once nutritionally stabilised, these two patients no longer required ongoing artificial feeding. The remaining two patients did not require supplemental nutritional support after reversal, although persistent nausea and vomiting were still documented in one case.

Symptom resolution was incomplete. Of seven patients with pre-reversal dysphagia, four had persistent symptoms at the latest follow-up. Of eight patients with vomiting before reversal, five still reported vomiting at first postoperative follow-up; one of these was lost to follow-up after 1 month, one resolved by second follow-up, and three had persistent vomiting. Of seven patients with abdominal pain before reversal, six reported ongoing pain at latest follow-up. Of five patients with reflux before reversal, four had persistent reflux, while one patient who did not have reflux before reversal developed transient reflux

at 1 month, which resolved by 3 months. Of the two patients with diarrhoea before reversal, one was lost to follow-up and one had diarrhoea for 1 month that subsequently resolved; a further patient developed diarrhoea after the first stage of a staged reversal, which resolved after completion of the second stage. The patient with dumping syndrome before reversal continued to experience symptoms after surgery. One patient developed constipation and bloating 1 year after reversal, which had resolved by 19 months.

Table 1 Number of patients experiencing symptoms pre- and post-reversal of gastric bypass to normal anatomy.

Symptom (n)	Pre reversal	Post Reversal	Reduction
Dysphagia	7	4	3
Vomiting	8	3	5
Abdominal pain	7	6	1
Reflux	5	4	1
Diarrhoea	2	0	2
Dumping syndrome	1	1	0

n = number of patients

Postoperative morbidity and mortality

Postoperative complications included chronic ulceration at the gastro-gastric anastomosis with secondary candida colonisation and candidaemia requiring intravenous antifungal treatment, viral hospital-acquired pneumonia requiring intensive care support, incisional hernias in two patients, and a gastro-gastric anastomosis leak leading to a mesenteric haematoma and peritonism. The latter required emergency laparotomy seven days after reversal for omental patch repair of the leak, with subsequent critical care admission. This patient developed sepsis due to an infected PICC line and another patient developed a PICC line thrombus. One patient was diagnosed with delayed gastric emptying secondary to gastric nerve damage from previous surgeries. One patient died ten months after reversal from causes unrelated to the operation. In total, five patients had significant morbidity postoperatively.

Discussion

In this single-centre case series, we describe outcomes following reversal of gastric bypass in eight patients referred to a UK tertiary bariatric service with refractory complications after RYGB, OAGB, or JIB. The dominant indications were severe gastrojejunal anastomotic complications, dumping syndrome, recurrent internal herniation and malabsorption, all with significant symptom burden on patients. Our findings add to the limited evidence base by providing a detailed description of contemporary decision-making, operative strategy, and early to mid-term outcomes in a small but complex cohort managed in a high-volume UK centre.

A key observation from this series is the contrast between relatively consistent nutritional rescue and the limited resolution of gastrointestinal symptoms after reversal. Median BMI and albumin improved following restoration of continuity, and most patients could ultimately be supported without long-term artificial nutrition, mirroring reports that reversal is effective for malnutrition and excessive weight loss in selected patients (3, 6, 9, 11, 14). Half of the patients experienced an improvement in their symptoms, oral intake and have reported an improvement in quality of life after the reversal, whilst three patients who continue to experience daily vomiting and reduced oral intake. However, of those who have achieved a satisfactory recovery, symptom resolution despite improvement is not complete, reporting abdominal pain, reflux and or occasional vomiting frequently persist. Additionally, the majority of the patients who achieved appropriate symptom control, once had post reversal complications, some of them such as incisional hernias which require future intervention. This pattern aligns with systematic and multicentre data demonstrating that while reversal can normalise nutritional parameters and halt further deterioration, symptom relief—particularly for pain and functional complaints—is often incomplete, and reversal surgery increases the probability of further surgical complications (2, 10). These findings support counselling patients that reversal is best conceptualised as a nutritional salvage procedure rather than a guaranteed cure for complex symptom clusters. Nevertheless, gastric bypass reversal remains the salvage procedure for symptom resolution in these patients, as in most cases other medical and surgical interventions have been trialled.

Our series also highlights that patients typically travelled a long and intensive pathway before reversal was considered. The median time from index bypass to reversal was just under five years, during which patients underwent multiple endoscopic dilatations, reoperations for perforated ulcers, internal hernia repairs, and revisional procedures aimed at alleviating complications. Similar patterns of repeated interventions before reversal have been described in previous series and multicentre cohorts, reflecting both the desire to exhaust less invasive options and the perceived risk of reversal surgery itself (6). In this context, our data raise an important question: whether prolonged cycles of failed interventions and progressive nutritional decline might delay timely referral to tertiary MDTs and consideration of definitive reversal in selected patients. Prospective data will be needed to determine whether earlier escalation could improve overall morbidity or quality of life.

Operative strategies in our cohort were tailored to anatomy and risk. All RYGB reversals were performed laparoscopically with construction of a stapled side-to-side gastro-gastric anastomosis and variable management of the Roux limb, while OAGB reversals were conducted via open midline laparotomy. The

Scopinaro reversal case illustrates the additional complexity of such procedures, where operative details are often incompletely documented and anatomy may be heavily distorted. These technical choices are consistent with published experience, where both laparoscopic and open approaches have been reported, and where management of the Roux limb and jejunojejunostomy remains heterogeneous (2). As in other series, our patients experienced non-trivial morbidity, including anastomotic leak, incisional hernias, line-related sepsis, and critical-care admissions (6, 13). Together, these observations support current guidance that reversal should be undertaken in centres with appropriate specialist expertise, multidisciplinary support, and access to advanced nutritional and critical care.

Compared with the broader literature, the indications in our cohort are weighted more heavily towards anastomotic ulceration and stenosis with secondary malnutrition, and less towards hypoglycaemia or isolated dumping syndrome (1). The literature describes marginal ulcer formation after RYGB and OAGB due to the jejunal mucosa being chronically exposed to gastric acid without the protective mechanisms of the duodenum such as bicarbonate secreting glands to neutralise the acid (12, 15). Additionally, studies have reported circular stapled anastomosis and the use of non-absorbable sutures can result in higher rates of marginal ulcers (12). Known factors such as NSAID use, *Helicobacter pylori* infection, smoking and alcohol also increase the risk of marginal ulcers (12, 18); one of the patients in our cohort with an anastomotic ulcer had a history of alcohol excess and smoking. Systematic reviews quote the incidence of marginal ulcer following RYGB is approximately 4.6%, and 2.5% for OAGB (12, 19); despite low, our study and others quote anastomotic ulceration, refractory to medical management such as proton pump inhibitors and to revisional surgery, as one of the main indications for reversal.

Previous studies also describe anastomotic stenosis as one of the most frequent early complications after gastric bypass (16). The aetiology is also thought to be related to local factors of inflammation around the anastomosis and the main form of early treatment is via endoscopic dilatation (16, 17). In our cases, GJ anastomosis ulceration and stenosis were concomitant in all cases except for one, and the risk of perforation in stenosis after failed repeated dilatations is evidently high. Thus, our findings amongst the existing literature highlight the importance of early investigation of symptoms such as dysphagia, abdominal pain and vomiting to increase the chances of early identification of anastomosis related complications, and raises the question is it possible that reversal can be discussed proactively rather than as salvage procedure in complications that might be anticipated to be refractory to other management options.

Our findings have several practical implications. They emphasise the importance of early, multidisciplinary recognition of high-risk complication trajectories—particularly patients with recurrent marginal ulceration, refractory stricturing, or severe nutritional compromise. Additionally, they support detailed preoperative counselling regarding the likely trade-off between nutritional rescue and incomplete symptom resolution, as well as the risk of postoperative morbidity and potential need for ongoing nutritional support.

This study provides granular, clinically rich data from a tertiary referral centre, including detailed operative descriptions for different bypass anatomies, systematic documentation of pre-reversal interventions, and structured follow-up of both nutritional and symptomatic outcomes. It also contributes contemporary UK data to a literature still dominated by small single-centre series and heterogeneous international reports.

However, important limitations must be acknowledged. The sample size is small, reflecting the rarity of reversal and limiting the precision and generalisability of our findings. The retrospective, descriptive design is susceptible to information bias, and symptom assessment relied on clinical documentation rather than validated patient-reported outcome measures. Follow-up was incomplete in some patients, and one patient did not attend postoperative appointments, which may underestimate late complications or delayed symptom resolution. Finally, our cohort is heterogeneous in terms of index procedure, indication, and operative technique, and we did not attempt formal comparisons between subgroups. The small sample precluded sex-stratified analysis, despite known sex differences in bariatric surgery outcomes.

Conclusions

In this single-centre retrospective case series, gastric bypass reversal was used as a salvage procedure for refractory complications after RYGB, OAGB, and JIB. Reversal was associated with meaningful nutritional rescue, as evidenced by improvements in BMI and serum albumin, but symptomatic benefit was inconsistent, with frequent persistence of abdominal pain, reflux, dysphagia, and vomiting despite correction of anatomical problems. The long interval between index surgery and reversal, coupled with multiple prior interventions, suggests that definitive operative decision-making may be delayed in this complex cohort.

These findings reinforce the view that gastric bypass reversal should be reserved for carefully selected patients and undertaken in specialised centres, with clear preoperative counselling that the primary goal is nutritional stabilisation rather than guaranteed symptom cure. Future prospective multicentre studies, ideally incorporating structured quality-of-life measures and standardised definitions of indications and outcomes, are needed to refine patient selection, define optimal timing, and guide technical strategies for reversal.

Declarations

Data availability

The datasets generated and analysed during the current study are not publicly available due to institutional data protection policies but are available from the corresponding author on reasonable request and subject to local governance approval.

Informed consent

For this type of retrospective study, all data was anonymised from the initial collection point, formal individual consent was not required.

Ethical approval

This anonymised retrospective evaluative study was registered with the institutional governance office. All data were handled in accordance with institutional confidentiality and data protection standards and the principles of the Declaration of Helsinki. This was a retrospective evaluation with institutional registration rather than formal REC approval.

Conflict of Interest

The authors declare that they have no conflict of interest

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Figures

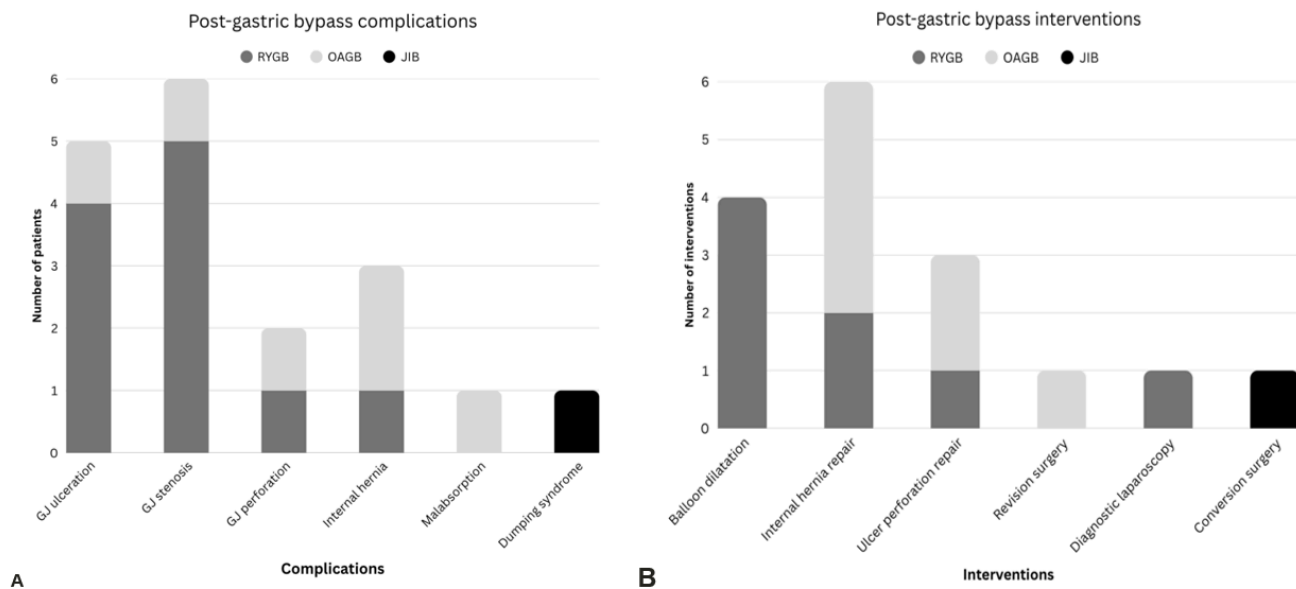


Figure 1

Distribution of the complications post-gastric bypass. Main complications included gastro-jejunal (GJ) anastomosis ulceration(n=5), perforation (n=2) and stenosis (n=6); internal hernias(n=3); malabsorption(n=1); and dumping syndrome(n=1). b) Distribution of the interventions post-gastric bypass, which included diagnostic laparoscopy (n=1), balloon dilatations (n=4), internal hernia repairs (n=6), ulcer perforation repairs (n=3), revision (n=1) and conversion procedures (n=1).

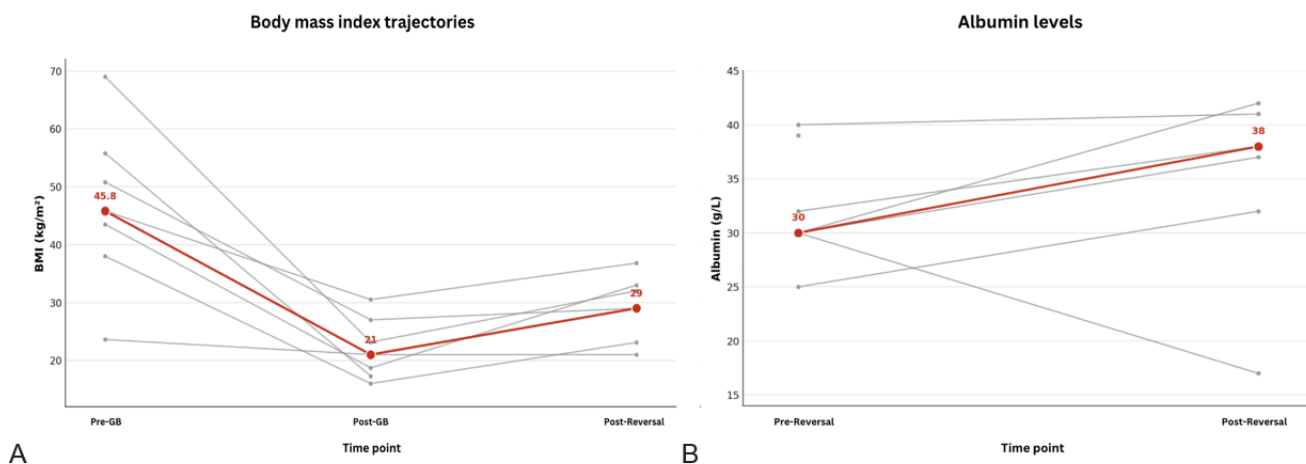


Figure 2

a) Body mass index (BMI) trajectories in patients before undergoing gastric bypass (pre-GB), after gastric bypass (post-GB) and after undergoing reversal of gastric bypass to normal anatomy (Post-Reversal). Black points show median BMI. b) Albumin levels in patients before and after undergoing reversal of gastric bypass to normal anatomy. Black points show median albumin levels.

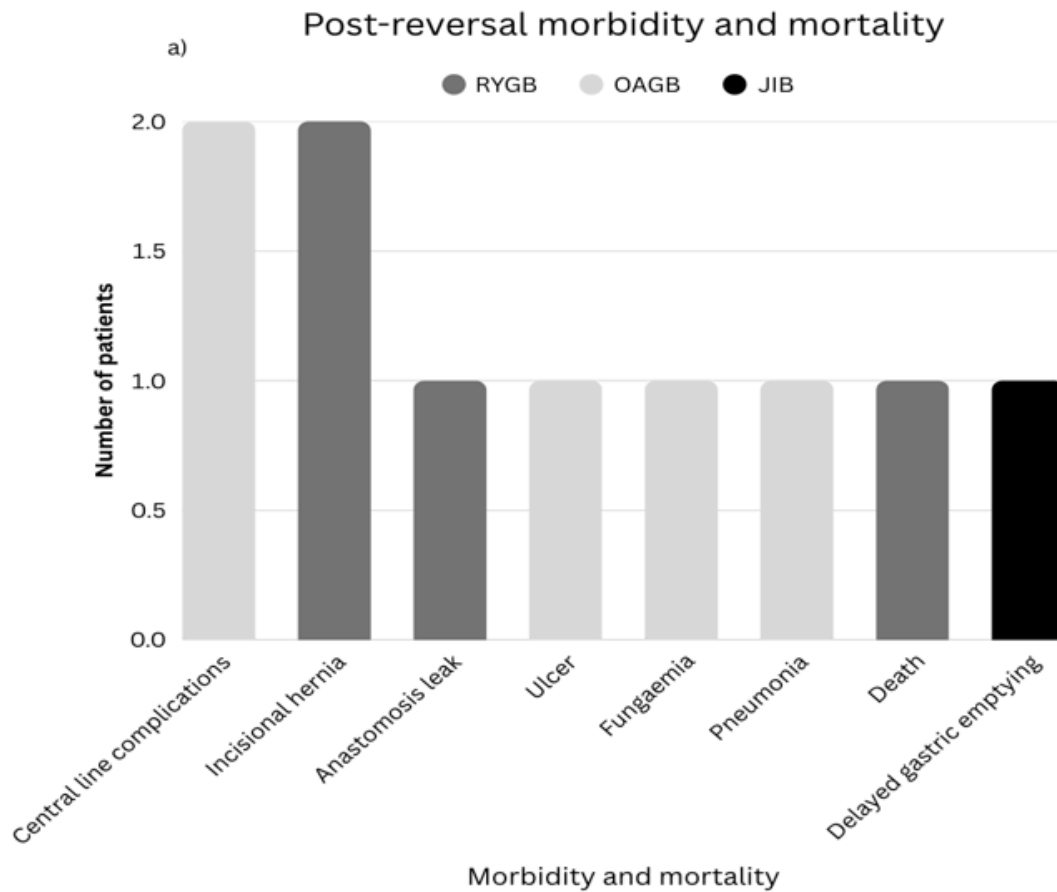


Figure 3

Distribution of morbidity and mortality in the eight patients who had a gastric bypass reversal to normal anatomy.