

# MIDBAND™

*A simple weight loss solution*



CE 0459  
ISO 13485

[www.midband.fr](http://www.midband.fr)

# MIDBAND™ - OPERATING TECHNIQUE USING LAPAROSCOPY



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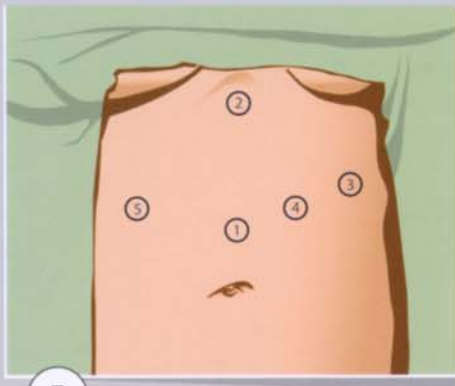
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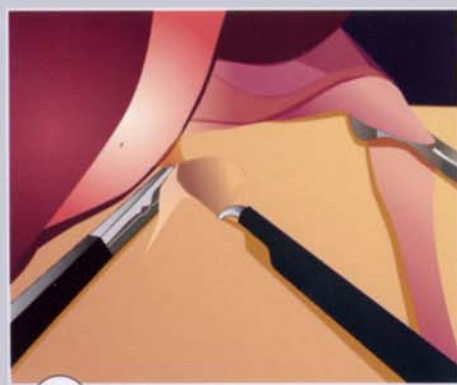
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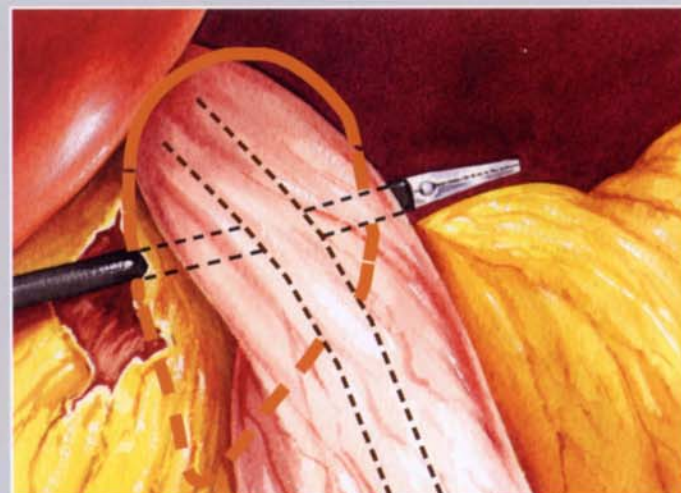
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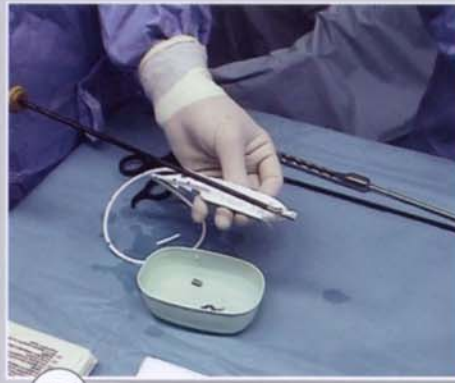
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Captions :  
Tube -----  
Pier - - - - -



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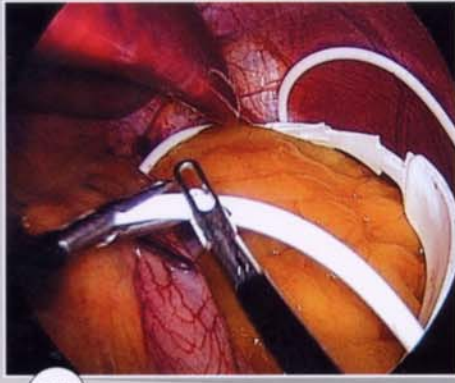
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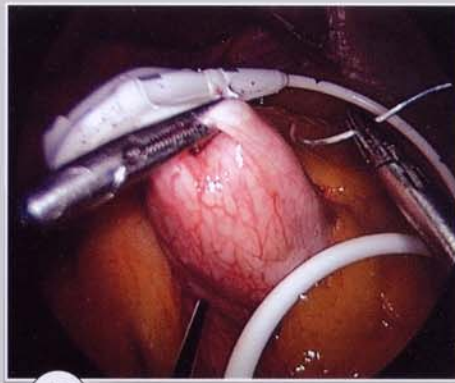
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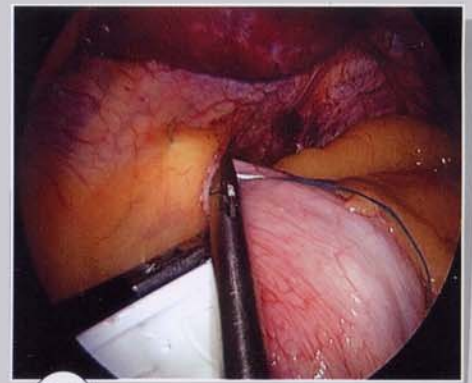
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## Captions

- 1 Place the patient in supine position, known as the "French" position, with the feet in the stirrups to obtain a 30° angle.
- 2 Equipment required
  - 5 trocars (two 5 mm trocars, one 12 mm trocar, two 10 mm trocars)
  - One 30° optical unit
- 3
  - 1 pair of laparoscopy scissors
  - 1 knot pusher
  - 2 gripping forceps including 1 large one
  - 1 dissecting hook
  - 1 retractor with atraumatic plate
  - 1 endo-Babcock forceps
  - 1 orthostatic Martin arm
- 4 The Martin arm is placed alongside the left side above the left hypochondrium. Insufflation is carried out using a Palmer needle. After securement, insufflate to 15 mm of mercury at a rate of 7 litres/minute.
- 5 Optical trocar (1) (10 mm) : this is the first trocar inserted. It is placed one palm width below the xiphoid appendix.
- 6 Liver retractor (2) (5 mm) : below the xiphoid appendix. It can be moved to the left if the liver is particularly fatty with hypertrophy of the left lobe.
- 7 Babcock (3) (10 mm) : below the patient's left costal edge, to one side as compared with the medio-clavicular line. This is the point of insertion of the Veres needle.
- 8 Trocar (4) (12 mm) for the instruments used by the right hand : halfway between the optical trocar and the trocar for the Babcock forceps.  
  
Trocar (5) (5 mm) for the instruments used by the left hand : placed symmetrically to the previous one as compared with the oblique line.
- 9 Minimum dissection of the Hiss angle along the left pier with a coagulating hook.
- 10 After dissection of the *pars flaccida*, find the base of the right pier. The dissecting line is in front of the right pier and behind the stomach. The retrogastric line is short and straight. No resistance must be felt. The stomach is lifted and moved forward using the Babcock forceps during this manoeuvre.
- 11 Left-hand forceps open, the right-hand forceps holds the end of the catheter ready for grasping with the left-hand forceps. Note that the white part of the catheter is facing the surgeon.
- 12 It is important to soak the MIDBAND™ thoroughly in a bath of physiological solution to make it slippery.
- 13 Using an atraumatic forceps, pick up the MIDBAND™ by the end opposite the catheter, with the inflatable part towards the inside of the fold.
- 14 Put it through the 12 mm trocar. Grasp the end of the catheter with the atraumatic forceps, and with the white part of the point turned towards the surgeon.
- 15 Unroll the catheter. Before placing the MIDBAND™ behind the stomach, check that it is indeed placed with the inflatable part towards the surgeon.
- 16 Tie the MIDBAND™.
- 17 We can see in the diagram the importance of using an atraumatic forceps to avoid damaging the inflatable section.
- 18 Only one stitch is required. Grasp the greater curvature at a distance from the strip.
- 19 Lift the greater curvature up against the front of the left pier. Leave the overlap loose to limit friction and avoid erosion. Avoid the gastro-gastric points.
- 20 Cut off the catheter straight.  
Never inject anything into the strip on the day of the operation.
- 21 See the insertion manual for connection of the catheter. The implantable chamber is placed in a subcutaneous pocket made with a finger. It is preferable to avoid fixing the chamber.

## ADVANTAGES OF THE **MIDBAND™**

The **MIDBAND™** is inserted by laparoscopy via 12 mm trocar.

Flexible, supple and smooth for all surfaces.

Gentle to the stomach when closed.

No bulky external locking system.

No rough edges.

Double closure device with safety in mind.

Made in one piece from band to junction with port - so leak less likely.

Most patients are able to go home one day after the operation and resume their professional activities very soon afterwards.

The **MIDBAND™** can be adjusted subsequently to the operation depending on the patient's dietary intake and weight loss.

The rate of long-term complications is very low.

The results in terms of weight loss enable a reduction in excess weight of around 80%.

## POST-OPERATIVE CARE

### **INITIAL ADJUSTMENT**

60 days after the operation.  
Maximum filling volume : 7 cc.

### **RECOVERY ROOM**

The nasogastric tube can be removed at the end of the operation.  
The patient stays in the recovery room until all his or her functions have been recovered.

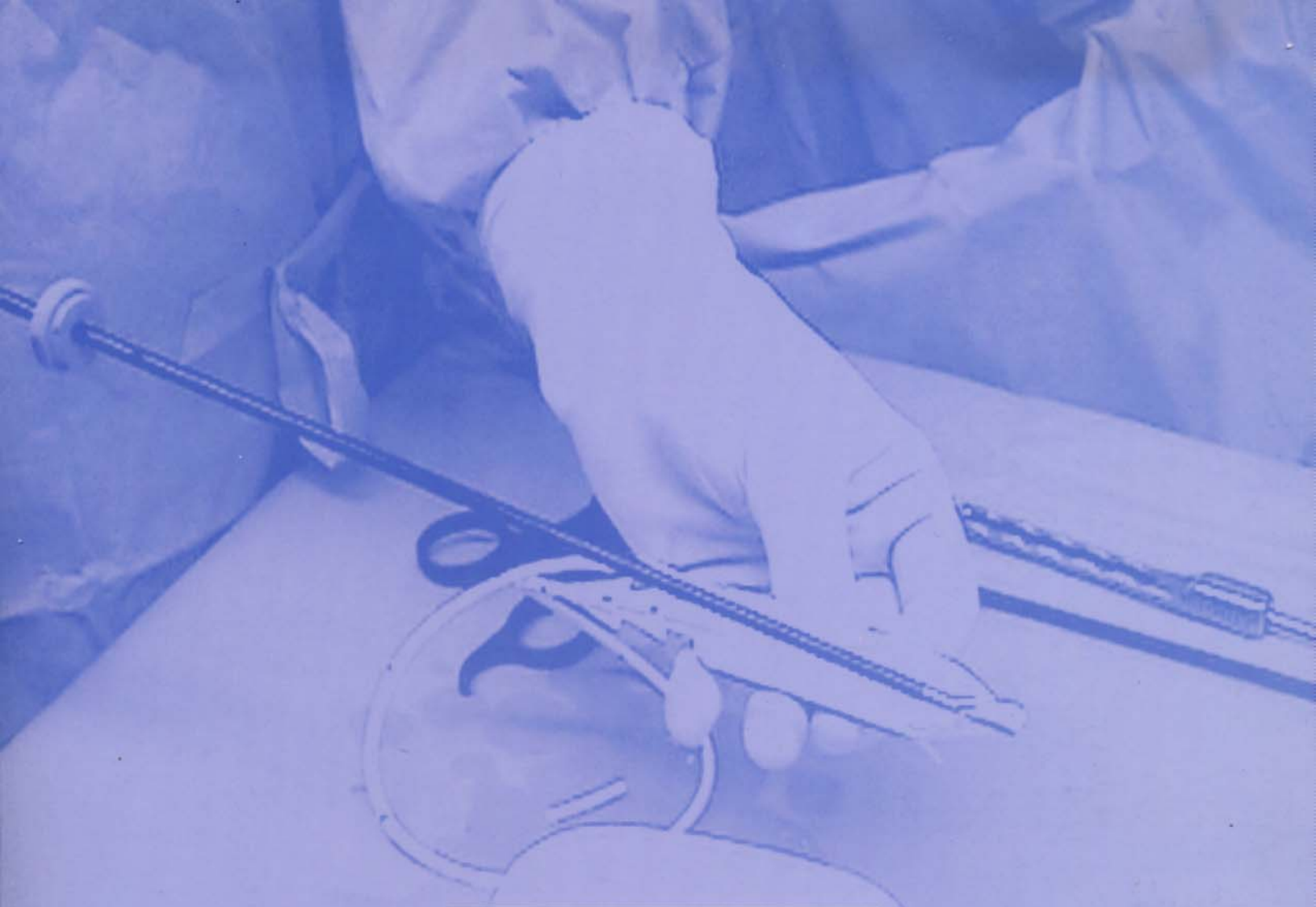
### **PATIENT MOBILIZATION**

The patient can get up in the evening after the operation. He or she can drink liquids, and perfusion can be stopped.

### **POST-OPERATIVE DIET**

For three days after the operation, the patient is on a liquid and then a soft diet.

As from the fourth day after the operation, a normal diet can be resumed, with a careful explanation as to the imperative necessity of thorough mastication. If the operation has been modified to include laparotomy, the hospital stay will be longer, so it is recommended that the patient be perfused for 24 hours.



# MID

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