A case of severe anorexia, excessive weight loss and high peptide YY levels after sleeve gastrectomy

Andrea Pucci1,2, Wui Hang Cheung1,2, Jenny Jones1, Sean Manning1,2,3, Helen Kingett2, Marco Adamo2, Mohamed Elkalaawy2,4, Andrew Jenkinson2, Nicholas Finer1,2, Jacqueline Doyle2, Majid Hashemi2 and Rachel L Batterham1,2,3

1Department of Medicine, Rayne Institute, Centre for Obesity Research, University College London, 5 University Street, London WC1E 6JJ, UK
2UCLH Centre for Weight Loss, Metabolic and Endocrine Surgery, University College London Hospitals, Ground Floor West Wing, 250 Euston Road, London NW1 2PG, UK
3National Institute of Health Research, Biomedical Research Centre, University College London Hospitals, London W1T 7DN, UK
4Clinical and Experimental Surgery Department, Medical Research Institute, University of Alexandria, Hadara, Alexandria 21561, Egypt

Summary

Sleeve gastrectomy (SG) is the second most commonly performed bariatric procedure worldwide. Altered circulating gut hormones have been suggested to contribute post-operatively to appetite suppression, decreased caloric intake and weight reduction. In the present study, we report a 22-year-old woman who underwent laparoscopic SG for obesity (BMI 46 kg/m²). Post-operatively, she reported marked appetite reduction, which resulted in excessive weight loss (1-year post-SG: BMI 22 kg/m², weight loss 52%, >99th centile of 1-year percentage of weight loss from 453 SG patients). Gastrointestinal (GI) imaging, GI physiology/motility studies and endoscopy revealed no anatomical cause for her symptoms, and psychological assessments excluded an eating disorder. Despite nutritional supplements and anti-emetics, her weight loss continued (BMI 19 kg/m²), and she required nasogastric feeding. A random gut hormone assessment revealed high plasma peptide YY (PYY) levels. She underwent a 3 h meal study following an overnight fast to assess her subjective appetite and circulating gut hormone levels. Her fasted nausea scores were high, with low hunger, and these worsened with nutrient ingestion. Compared to ten other post-SG female patients, her fasted circulating PYY and nutrient-stimulated PYY and active glucagon-like peptide 1 (GLP1) levels were markedly elevated. Octreotide treatment was associated with suppressed circulating PYY and GLP1 levels, increased appetite, increased caloric intake and weight gain (BMI 22 kg/m² after 6 months). The present case highlights the value of measuring gut hormones in patients following bariatric surgery who present with anorexia and excessive weight loss and suggests that octreotide treatment can produce symptomatic relief and weight regain in this setting.
Learning points:

- Roux-en-Y gastric bypass and SG produce marked sustained weight reduction. However, there is a marked individual variability in this reduction, and post-operative weight loss follows a normal distribution with extremes of ‘good’ and ‘poor’ response.
- Profound anorexia and excessive weight loss post-SG may be associated with markedly elevated circulating fasted PYY and post-meal PYY and GLP1 levels.
- Octreotide treatment can produce symptomatic relief and weight regain for post-SG patients that have an extreme anorectic and weight loss response.
- The present case highlights the value of measuring circulating gut hormone levels in patients with post-operative anorexia and extreme weight loss.

Background

Bariatric surgery is the most effective treatment for severe obesity; it produces marked sustained weight loss, reduced obesity-associated co-morbidities (1) and decreased mortality (2). Roux-en-Y gastric bypass (RYGB) and sleeve gastrectomy (SG), the most common procedures that are undertaken globally (3), are known to reduce appetite and decrease caloric intake. The mechanisms that mediate these changes remain to be clarified (4). However, post-operative changes in circulating gut hormones, in particular, the anorectic hormones peptide YY (PYY) and glucagon-like peptide 1 (GLP1) and the orexigenic hormone ghrelin, have been suggested to play causal roles (5). Weight loss after RYGB and SG follows a normal distribution (6), with ‘good responders’ and ‘poor responders’ exhibiting differential appetite and gut hormone profiles (7) (8).

Case presentation

A 22-year-old woman underwent an uneventful laparoscopic SG for severe obesity (weight 135 kg, BMI 46 kg/m²). Her initial post-operative course was unremarkable, except she reported marked loss of appetite. One-year post-SG, she reported continued anorexia, her weight had decreased to 64.6 kg, and her BMI had decreased to 22 kg/m²; this represented a 52% body weight loss, which is at the extreme end of the normal distribution of 1-year post-operative percentage of weight loss for SG patients (n = 453) in our bariatric unit (Fig. 1). She did not suffer from flushing or diarrhoea. She was commenced on anti-emetics and received increased dietic support, including advice on high-energy oral supplements. However, her weight loss continued, and she developed continuous profound nausea with occasional vomiting.

Investigation

The patient underwent computed tomography (CT) imaging of her abdomen and pelvis, barium swallow and follow-through, oesophageal–gastro-duodenoscopy, oesophageal motility analysis and pH studies, all of which were normal. Psychological assessments excluded an eating disorder. Her symptoms worsened, her weight decreased to 55.8 kg, her BMI decreased to 19.5 kg/m² and she required in-patient management with nasogastric feeding. A random gut hormone assessment revealed high circulating PYY levels (1200 pg/ml). Her fasted plasma
octreotide treatment, her hunger increased and her nausea
resolved (Fig. 2A and B). Her circulating fasted and
nutrient-stimulated PYY (Fig. 2C), active GLP1 (Fig. 2D)
and insulin levels were suppressed (15 min post-meal
3.2 pmol/l). Her plasma acyl-ghrelin and total ghrelin
levels remained undetectable.

Discussion
SG, which involves removing 90% of the gastric fundus
while leaving the rest of the gastrointestinal tract intact,
has recently been advocated as a ‘stand-alone’ bariatric
procedure. However, it has become apparent, at least in
the short- to medium-term, that the weight loss and
metabolic benefits post-SG are comparable to RYGB (11).
Consequently, the number of patients that underwent SG
globally per annum increased from ~25 000 in 2008 to
95 000 in 2011 (3). Furthermore, research efforts have
identified that mechanisms other than restriction and/or

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malabsorption underlie the sustained weight-loss effects and weight-loss-independent glycaemic improvements of these two procedures (5). Decreased energy intake, as a consequence of reduced hunger, altered food preferences and changes in food reward, is a key driver of the sustained weight loss that follows SG and RYGB. Post-operatively, nutrient-stimulated circulating levels of the anorectic gut hormones PYY and GLP1 are markedly increased, whereas plasma levels of the orexigenic hormone ghrelin are reduced post-SG and are lower than those seen after RYGB (12). These post-operative circulating gut hormone changes have been suggested to contribute to the altered feeding behaviour (5). We and others have reported that weight loss following SG and RYGB is variable and follows a normal distribution (6) (13). Interestingly, ‘poor’ and ‘good’ weight loss responders exhibit differential appetite and gut hormone changes post-surgery (7) (8).

We report the first case of a patient post-SG with profound anorexia and excessive weight loss coupled with high fasted PYY levels and elevated nutrient-stimulated GLP1 and PYY levels. Unlike in our control post-SG patients, we were unable to detect either acyl-ghrelin or total ghrelin in our patient at baseline. Previously, we have shown that exogenous PYY administration suppresses circulating ghrelin levels (14) (15), and a similar mechanism may be at work in the present case, with high endogenous PYY levels suppressing ghrelin. Our patient reported disabling nausea with occasional vomiting, symptoms that are entirely consistent with elevated PYY and GLP1 levels (16) (17). Studies that were undertaken in ‘poor’ as compared to ‘good’ weight loss responders have suggested that variability in post-operative gut hormone responses may contribute to variable weight loss outcomes (7) (8). The present case further supports this hypothesis. However, the biological mechanisms that underlie post-operative gut hormone variability remain to be elucidated. High nutrient-stimulated GLP1 levels have been suggested by some but not all researchers to contribute to post-RYGB hyperinsulinaemic hypoglycaemia (18), a complication that affects ~0.1% of patients post-RYGB (19). Octreotide administration produces symptomatic relief in some of these patients (20), and in others RYGB reversal has been beneficial (21). However, surgical reversal is not possible following SG. Interestingly, there have been reports of resolution of post-RYGB hyperinsulinaemic hypoglycaemia that have allowed medical therapy to be discontinued (21). Possible future outcomes for our patient are that her gut hormone profile could ‘normalise’, which would allow the withdrawal of octreotide therapy or that an increased understanding of enteroendocrine cell biology may enable the selective targeting of her GLP1- and PYY-producing enteroendocrine L-cells. There are some limitations to the present study. We compared the case patient’s nutrient-stimulated gut hormone levels to those measured in a relatively small number of control patients who were 3 months post-SG. Thus, the case patient had a lower BMI and greater weight loss as compared to the control post-SG group. These differences in weight loss and interval post-SG could have impacted the circulating gut hormone levels (22). In addition, the case patient could only tolerate 100 ml (200 kcal) of the liquid test meal as compared to the 250 ml (500 kcal) consumed by the control post-SG group, which makes a direct comparison difficult. However, given that nutrient-stimulated plasma GLP1 and PYY levels are proportionate to the calorie load consumed, it is likely that the matching of the caloric loads would have further increased the difference between the case patient and the control group.

**Conclusion**

The present case highlights the value of measuring gut hormones in patients following SG who present with anorexia and excessive weight loss and suggests that octreotide treatment can produce symptomatic relief and weight regain for patients in this challenging clinical setting.

**Declaration of interest**

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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**Patient consent**

Full informed consent was obtained from the patient before drafting the case report.

**Author contribution statement**

A Pucci, W H Cheung, S Manning, H Kingett, M Adamo, M Elkalaawy, A Jenkinson, N Finer, J Doyle, M Hashemi and R L Batterham were directly involved in the management of the patients. A Pucci, W H Cheung and S Manning undertook the meal studies. J Jones and R L Batterham undertook and analysed the hormone assays. A Pucci and R L Batterham drafted the case report. All of the authors contributed to and approved and the final draft of the report.
References


