Effect of Roux-en-Y Gastric Bypass Surgery: Converting 2 Alcoholic Drinks to 4

Roux-en-Y gastric bypass (RYGB) is the most common bariatric surgical procedure performed in the world. Although RYGB surgery causes a marked reduction in food intake and induces remission of food addiction, it is associated with an increased risk of developing alcohol use disorders. It is likely that RYGB-related changes in gastrointestinal anatomy alter the pharmacokinetics and subjective effects of ingested alcohol, which contributes to the increased risk of alcohol use disorders. However, results from previous studies are limited because (1) blood alcohol concentrations (BACs) were measured in venous blood samples, which underestimate the peak BAC delivered to the brain in patients who have had RYGB surgery, and (2) the subjective effects of alcohol have not been assessed using validated questionnaires. The purpose of the present study was to evaluate the effect of RYGB on the pharmacokinetics and subjective effects of ingested alcohol, using arterialized blood samples and a validated questionnaire.

Methods | Eight women who had RYGB surgery (hereafter referred to as the RYGB+ group) within the last 1 to 5 years (mean [SD], 2.2 [1.2] years) and 9 women scheduled to have RYGB surgery at Barnes-Jewish Hospital in St Louis, Missouri (hereafter referred to as the RYGB− group), provided written informed consent and participated in our study (Table), which

### Table. Characteristics of Study Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (SD)</th>
<th>RYGB+ Group (n = 9)</th>
<th>RYGB− Group (n = 8)</th>
<th>Longitudinal Study (n = 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td></td>
<td></td>
<td></td>
<td>Before RYGB After RYGB</td>
</tr>
<tr>
<td>Weight, kg</td>
<td></td>
<td></td>
<td></td>
<td>44.7 (4.6) 45.5 (4.7)</td>
</tr>
<tr>
<td>BMI</td>
<td></td>
<td></td>
<td></td>
<td>42.5 (8.0) 42.5 (7.8)</td>
</tr>
<tr>
<td>FFM, kg</td>
<td></td>
<td></td>
<td></td>
<td>120.2 (18.7) 80.8 (14.1)</td>
</tr>
<tr>
<td>Alcohol-related variables</td>
<td></td>
<td></td>
<td></td>
<td>109.3 (15.0) 79.1 (19.1)</td>
</tr>
<tr>
<td>Age, y</td>
<td></td>
<td>17.9 (3.0)</td>
<td>20.2 (2.8)</td>
<td>17.4 (2.3)</td>
</tr>
<tr>
<td>Regular drinking</td>
<td></td>
<td>20.0 (3.7)</td>
<td>25.4 (10.6)</td>
<td>20.0 (3.7)</td>
</tr>
<tr>
<td>No. of drinking days per month (in last 6 mo)</td>
<td>4.3 (4.7)</td>
<td>6.4 (5.7)</td>
<td>1.3 (0.4)</td>
<td>0.8 (0.8)</td>
</tr>
<tr>
<td>No. of drinks per drinking day (in last 6 mo)</td>
<td>2.8 (1.5)</td>
<td>1.9 (1.7)</td>
<td>2.8 (1.6)</td>
<td>1.9 (2.4)</td>
</tr>
<tr>
<td>No. of standard drinks given on alcohol challenge test</td>
<td>1.9 (0.2)</td>
<td>1.8 (0.2)</td>
<td>1.8 (0.2)</td>
<td>1.7 (0.2)</td>
</tr>
<tr>
<td>Peak BAC, g/L</td>
<td>0.60 (0.14)</td>
<td>1.10 (0.17)</td>
<td>0.58 (0.09)</td>
<td>1.23 (0.2)</td>
</tr>
<tr>
<td>Time to reach peak BAC, min</td>
<td>35.6 (12.3)</td>
<td>15.0 (0.0)</td>
<td>36.1 (15.8)</td>
<td>15.0 (0.0)</td>
</tr>
<tr>
<td>Area under the BAC time curve, g/L/min</td>
<td>99.4 (6.8)</td>
<td>151.2 (7.2)</td>
<td>99.3 (6.7)</td>
<td>173.5 (30.5)</td>
</tr>
</tbody>
</table>

Abbreviations: BAC, blood alcohol concentration; BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); FFM, fat-free mass; RYGB+, women who had a Roux-en-Y gastric bypass; RYGB−, women who did not have a Roux-en-Y gastric bypass.

*P values indicate that the values given are significantly different from the corresponding “RYGB−” or “Before RYGB” value.

*P < .001

**P = .002.

The present study is underpowered to detect clinically meaningful differences in history and pattern of alcohol use.

One standard drink contains about 14 g of pure alcohol (approximately 17.7 mL of alcohol).

P = .004.

From the time of the first sip of alcoholic beverage, which was consumed over 10 minutes.

P = .04.

P = .006.
was approved by the institutional review board of the Washington University School of Medicine. Our study was conducted in the Clinical Research Unit at the Washington University School of Medicine. Fat-free mass was determined by dual energy x-ray absorptiometry. All participants completed 2 sessions about 1 week apart in which their response to alcohol or a nonalcoholic beverage was evaluated in a randomized crossover fashion. For each session, participants were admitted to the Clinical Research Unit after an overnight fast. An intravenous catheter was inserted into a hand vein, which was heated to 50°C by using a thermostatically controlled box, to obtain arterialized venous blood. The participants then consumed either a 0.5-g/kg fat-free mass of alcohol (equivalent to approximately 2 standard alcoholic beverages). For each time point, scores on feelings of drunkenness on the alcohol day were subtracted from scores on the placebo day. Eight women were in the RYGB+ group, and 9 women were in the RYGB− group. C and D, Five women in the RYGB+ group were retested at a mean (SD) 9.7 (1.6) months after RYGB surgery and 28% (10%) weight loss. The BAC limit for driving in the United States is also the BAC threshold for binge drinking defined by the National Institute on Alcohol Abuse and Alcoholism. The point estimates are mean values. Error bars indicate +SEM.

Results | Blood alcohol concentrations increased faster, the peak BAC was approximately 2-fold higher, the total BAC area under the curve was approximately 1.5 times larger, and feelings of drunkenness were greater in the RYGB+ group than in the RYGB− group (Figure; Table). The same effects were observed in the 5 participants who were studied before and after RYGB surgery (Figure).

Discussion | The results from our study demonstrate that RYGB increases the rate of delivery of ingested alcohol into the systemic circulation, resulting in both earlier and higher BAC peaks and a greater feeling of drunkenness. The alteration in alcohol pharmacokinetics means that the peak in BAC observed after consuming approximately 2 drinks in women who have had RYGB surgery resembles that observed after consuming approximately 4 drinks in women who have not had surgery. These findings have important public safety and clinical implications. The BACs in the RYGB+ group exceeded the legal driving limit for 30 minutes after alcohol ingestion, but the BACs in the RYGB− group never even reached the legal driving limit. The peak BAC in the RYGB+ group also met the National Institute on Alcohol Abuse and Alcoholism criteria used to define an episode of binge drinking, which is a risk factor for developing alcohol use disorders. These data underscore the need to make

| A and B, Participants who had Roux-en-Y gastric bypass (RYGB) surgery (hereafter referred to as the RYGB+ group) and participants who were scheduled to have, but have not yet had, RYGB surgery (hereafter referred to as the RYGB− group) consumed a 0.5-g/kg fat-free mass of alcohol (equivalent to approximately 2 standard alcoholic beverages). For each time point, scores on feelings of drunkenness on the alcohol day were subtracted from scores on the placebo day. Eight women were in the RYGB+ group, and 9 women were in the RYGB− group. C and D, Five women in the RYGB+ group were retested at a mean (SD) 9.7 (1.6) months after RYGB surgery and 28% (10%) weight loss. The BAC limit for driving in the United States is also the BAC threshold for binge drinking defined by the National Institute on Alcohol Abuse and Alcoholism. The point estimates are mean values. Error bars indicate +SEM.

| a Value significantly different from “RYGB−” or “before RYGB” value, P < .05.
| b Value significantly different from baseline value, P < .05.

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patients aware of the alterations in alcohol metabolism that occur after RYGB surgery, to help reduce the risk of potential serious consequences of moderate alcohol consumption.

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COMMENT & RESPONSE

Effect of Gastric Bypass vs Duodenal Switch on High-Density Lipoprotein Cholesterol Level

To the Editor A recent study by Risstad and colleagues1 assessed the long-term outcomes of Roux-en-Y gastric bypass (RYGB) and biliopancreatic diversion with duodenal switch (BPD-DS) among superobese patients. Sixty patients with a body mass index (calculated as weight in kilograms divided by height in meters squared) of 50 to 60 were enrolled in a well-designed randomized clinical trial (RCT). Five years after surgery, the mean reductions in body mass index were 13.6 and 22.1 after RYGB and BPD-DS, respectively (P < .001). Reductions in the levels of total cholesterol, low-density lipoprotein cholesterol, triglyceride, and fasting glucose were significantly greater after BPD-DS than after RYGB. Conversely, concentrations of high-density lipoprotein cholesterol (HDL-C) increased after both procedures, with larger increases after RYGB (P = .002).

The protective effect of an elevated HDL-C level on cardiovascular risk is supported by studies that report the relationship between high levels of HDL-C and longevity and the relative absence of coronary heart disease.2 Because bariatric surgery and metabolic surgery are the most effective and durable treatments for obesity and most obesity-related comorbidities, the study that each type of bariatric procedure has on the lipid profile, and specifically HDL-C level, is important for patient selection.3

In addition to the RCT of Risstad and colleagues,1 2 other RCTs4,5 are available on cardiometabolic outcomes after BPD and after RYGB. Mingrone et al4 showed that, after 2 years, BPD was associated with significantly better outcomes than RYGB in terms of control of diabetes mellitus and changes in total cholesterol, low-density lipoprotein cholesterol, and triglyceride levels but RYGB had a greater impact than BPD on raising HDL-C levels.4 The RCT by Skroubis and colleagues5 demonstrated that BPD resulted in better control of weight and most comorbidities than RYGB. However, HDL-C levels were significantly higher following RYGB at 2 years of follow-up.5

A general efficacy gradient exists for the improvement of cardiometabolic risk factors after bariatric surgery (ie, BPD > RYGB > sleeve gastrectomy > gastric banding). However, growing evidence derived from the RCTs already mentioned and from observational studies shows that a unique efficacy gradient exists for the improvement of HDL-C concentration after bariatric surgery (ie, RYGB = sleeve gastrectomy > BPD, gastric banding) that is not fully attributable to the extent of postsurgical weight loss. Losing weight effectively reverses multiple steps in HDL-C metabolism that have been altered with obesity. On the other hand, research has shown that enterocytes contribute significantly to the plasma HDL-C level through synthesis of apolipoproteins A-I and A-I and the expression of adenosine triphosphate–binding cassette transporter A1. Procedures such as RYGB and sleeve gastrectomy that preserve the small intestine (particularly the je-