Effects and side-effects of partial ileal by-pass surgery for familial hypercholesterolaemia

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SUMMARY Ten patients with familial hypercholesterolaemia were subjected to partial ileal by-pass surgery. Plasma cholesterol fell by 41 and 38% and low-density lipoprotein cholesterol by 51 and 46% after six and 18 months respectively. High-density and very low-density lipoprotein cholesterol and plasma triglycerides were unaffected. Alanine aminotransferase increased transiently in half of the patients. Diarrhoea and slight steatorrhoea troubled most of the patients for the duration of the 18 months' period of observation. Other long-term side effects were slight but significant increase in the renal excretion of oxalic acid and reduction in the intestinal absorption of calcium. The study shows that this operation has metabolic side-effects that warrant continued medical care of these patients.

Partial ileal by-pass surgery is in general more effective than drug treatment of familial hypercholesterolaemia. It is also cheaper and poses no problems of patient compliance. Whereas much is known about the side-effects of the jejunoileal by-pass operation for obesity,1 little is known about other than the most obvious side-effects of the partial ileal by-pass for hypercholesterolaemia. We have studied effects on plasma lipoproteins as well as several possible side-effects in patients operated on because of familial hypercholesterolaemia in the heterozygous form.

Methods

PATIENTS Criteria for the diagnosis were (1) raised lipoprotein cholesterol concentration, (2) similarly affected first-degree relative, and (3) normotriglyceridaemia. Details of the patients are given in the Table. In all cases, family history indicated a high risk of premature ischaemic heart disease. They had all been instructed to follow a cholesterol-lowering diet,2 but adherence was variable. They were asked to continue the diet postoperatively. Previous attempts at pharmacological cholesterol reduction had been unsatisfactory, and, at the time of operation, they were not in treatment with lipid-lowering drugs.

The operation was performed essentially as described by Buchwald et al.3 The small intestine was transected either 200 cm from the ileocaecal valve or between the proximal two-thirds and distal one-third whichever procedure by-passed the largest segment. The distal ileal segment was closed, duplicated, and fixed to the mesentery to avoid invagination. The proximal segment, the jejunum, was anastomosed end-to-side to the ascending colon 6–8 cm distal to the ileocaecal valve (for details, see reference 3).

The patients were followed closely in the outpatient clinic and studied while they were in hospital before as well as six and 18 months after the operation. Of the 20 patients operated on to date, 10 have been followed for 18 months. The present study deals with these 10 patients, except as otherwise stated.

After an overnight fast, plasma lipoproteins were separated into very low-density lipoprotein, low-density lipoprotein, and high-density lipoprotein by ultracentrifugation of plasma at d 1.006 g/ml for 108 × 106 g × min, removal of very low-density lipoprotein as the supernatant material, and precipitation of low-density lipoprotein from the infranatant material with heparin-manganese.4 Cholesterol5 and triglycerides6 were measured in

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whole plasma and in the \( d > 1.006 \) g/ml infranatant before and after heparin-manganese treatment.

During a one-week hospital admission, the patients were studied on a controlled diet providing 70 g fat, 800 mg calcium, and 200 mg oxalic acid per 24 hours.\(^7\) After an equilibration period of three days, stools and urine were collected over four 24-hour periods, and the following procedures were performed: (1) stools were weighed, homogenised, and analysed for fat;\(^8\) (2) oxalic acid in urine was measured as described by Archer et al.,\(^9\) and intestinal absorption of oxalate was estimated by measurement of \( ^{14} \)C in urine after oral administration of \( ^{14} \)C oxalate,\(^7\) (3) absorption of calcium from the gut was determined by comparison of radioactivity in the forearm after an intravenous and subsequent 20 times larger peroral dose of \( ^{47} \)Ca as described by Curtis et al.,\(^10\) and (4) bone mineral content was estimated by bone densitometry – that is, measurement of absorption of \( ^{241} \)Am emitted gamma rays by a forearm.\(^11\) Intravenous urography and cholecystography as well as routine blood analyses were performed by standard methods in the Departments of Radiology and Clinical Chemistry.

Statistical analyses were performed with Wilcoxon’s rank sum test and Spearman’s rank correlation test.

Results

Six and 18 months after the operation, the plasma cholesterol concentration had decreased significantly by 41 and 38% respectively, from a median of 11.9 to 7.1 and 7.4 mmol/l (Fig. 1). Low-density lipoprotein cholesterol decreased from a median of 10.4 to 4.9 and 5.4 mmol/l over the same time periods, or by 51 and 46% respectively. Very low-density lipoprotein and high-density lipoprotein cholesterol were unchanged, as were total very low-density lipoprotein, low-density lipoprotein, and high-density lipoprotein triglycerides (Fig. 2). In two patients, marked but unquantified regression of xanthelasmata and tendon xanthomata occurred.

Moderate diarrhoea and steatorrhoea troubled most patients. This was reflected in significant increases in stool mass (\( p < 0.01 \)) and faecal fat (\( p < 0.05 \)) (median 427 g/24 hours corresponding to 209% increase in median value and 8 g/24 hours corresponding to 167% increase respectively after six months) that persisted after 18 months (436 g/24 hours corresponding to 216% increase and 9 g/24...
hours corresponding to 200% increase) (Figs. 3 and 4). In contrast, a small but significant reduction in body weight (p < 0.001) was transitory in most patients (Fig. 5). Thus, six and 18 months after the operation the median body weight had decreased by 6 and 1% respectively. Patients KN and JV, preoperatively moderately obese, sustained a substantial but desirable 13 and 21% loss of body weight, respectively.

As shown in Fig. 6, 24 hour renal excretion of
oxalic acid increased slightly but significantly (p < 0.05) in several patients. Six and 18 months postoperatively the median urinary oxalic acid was 54 and 51 mg/24 hours corresponding to a median increase by 86 and 76% respectively. Postoperative intestinal $^{14}$C-oxalate absorption correlated with renal oxalate excretion ($r = 0.70$, p < 0.05). Eighteen months postoperatively, intravenous urography in these 10 patients revealed no instances of urolithiasis.

Discussion

The lowering effect on plasma cholesterol of the partial ileal by-pass operation exceeds substantially that obtained in a closely similiar group of patients treated with neomycin (23%) or cholestyramine (27%). This agrees well with reports from other groups. The reduction in plasma cholesterol was entirely due to a fall in low-density lipoprotein, the class of lipoproteins specifically raised in familial hypercholesterolaemia. No changes occurred in total high-density lipoprotein, but our study does not preclude changes within this heterogeneous class of lipoproteins. The triglyceride-rich lipoproteins, very low-density lipoprotein, were also unchanged.

We made no attempt to evaluate the possible beneficial effects of the reduction in lipoprotein on iron supplementation. Other routine blood variables were unchanged (haemoglobin, transferrin, albumin, prothrombin, bilirubin, sodium, potassium, magnesium, creatinine, standard bicarbonate).
the atherosclerotic process. This is the subject of a much larger, on-going, secondary prevention trial using the partial ileal by-pass operation. Our patients PB and FP died \( \frac{1}{2} \) and three years after the operation with acute myocardial infarction. Both patients had suffered from ischaemic heart disease preoperatively as evidenced by prior myocardial infarction and typical angina pectoris, respectively. Other deaths did not occur.

Weight loss, although substantial in several patients, was not a clinical problem. In our patients, however, diarrhoea and steatorrhoea were not transient as found by some but not all previous workers. The severity of the problem varies and has caused one of our patients (IC) to request restoration of intestinal continuity, which promptly relieved her symptoms. In general, the problem, if present, can be managed by careful medication with antidiarrhoeal drugs, bile acid sequestering drugs to reduce bile acid concentrations in the colon, and low intake of dietary fat.

About half of the patients developed some degree of hyperoxaluria due to increased absorption of dietary oxalate. None of the patients, however, has to date developed urolithiasis.

Similarly, none of the patients studied by cholecystography 18 months after the operation had developed cholelithiasis. This agrees with findings by Buchwald et al and is consistent with the experience with bile acid sequestering drugs, the mechanism of action of which resembles that of the ileal by-pass.

The transient rise in serum alanine aminotransferase was less pronounced and of shorter duration than that observed after jejunoileal shunt for obesity, but it obviously suggests similar, transient liver damage. To our knowledge, no study has indicated long-term liver damage. Malabsorption of vitamin \( B_{12} \) occurs after partial ileal by-pass, and we therefore administer injections of vitamin \( B_{12} \) every three months.

An important finding of the present study was reduced absorption of dietary calcium from the intestine. The reduction corresponded to that observed in obese patients subjected to jejunoileal by-pass. Results of bone densitometry 18 months postoperatively were inconclusive and at this point we have considered it unwise not to assume that, with time, these patients will develop some degree of premature halisteresis. To prevent this, if this is possible, we prescribe for our patients 1000mg calcium and 1800 units vitamin D (\( D_2 \) and \( D_3 \) daily.

Familial hypercholesterolaemia is a disease that often causes premature ischaemic heart disease and death. At present, the effective reduction of low density lipoprotein concentrations that can be obtained with the partial ileal by-pass operation seems very desirable. It is apparent from this study, however, that the procedure has metabolic side-effects the importance of which is not necessarily minor. Moreover, it imposes bothersome gastrointestinal symptoms on the patients, and it does not free them from drugs and continued medical care. We continue to recommend it to patients with familial hypercholesterolaemia only if drug treatment has been tried and found ineffective, either because of the patient's inability to comply or because of lack of response despite good compliance.

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