Introduction

Obesity is the most common form of malnutrition and has been increasing over the past few decades, not only in western society but also globally ***(Fried et al., 2000)***.

Morbid obesity is a condition of persistent and uncontrollable weight gain that is a potential threat to life. It is defined as a body mass index >40 or >35 with secondary serious diseases ***(Flegal et al., 2002)***.

Morbid obesity has a significant impact on cardiac risk factors, incidence of diabetes, obstructive sleep apnea, debilitating arthritis of weight bearing joints, infertility, psychosocial and economic problems and various types of cancers ***(Dhabuwala et al., 2000)***.

Various treatments have been in use, with varying results. However, massive or clinically severe obesity is a major challenge ***(Stunkard, 1996)***.

Medical treatment for this disease has included dietary manipulation, behavior modification and medications. These therapies have been tried individually and in combinations, but with only limited long-term success ***(Dewald et al., 2006)***.

Surgical treatment of morbid obesity (Bariatric surgery) is a well-established method of long-term weight control for morbidly obese adults. Compared to non-surgical treatments, weight-loss surgery yields the longest period of sustained weight loss in patients who have failed other therapies ***(Brolin, 2002)***.

Bariatic surgery refers to the various surgical procedures performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and/or absorption ***(Buchwald et al., 2004)***.

There are three categories of weight-loss surgery malabsorptive, restrictive and combination. Malabsorptive shortens and re-configures the digestive tract to limit the number of calories and nutrients that can be absorbed. Options include jejuo-ileal by pass. Restrictive reduces the amount of food the stomach can hold but does not interfere with normal digestion and absorption of food and nutrients. Options include adjustable gastric banding, vertical banded gastroplasty and sleeve gastrectomy. Combination as rouex-en-y gastric by pass and duodenal switch ***(BCBSA, 2005)***.

Bariatic operation are performed using either an open or laparoscopic approach, however, the clear trend for the future is to have most procedures done laporoscopicaly ***(Nguyen et al., 2001)***.

Minimally invasive approaches have been used in bariatric surgery since 1991. the benefits of a laparoscopic approach appear to be similar to those realized with laparoscopic cholecystectomy, including but not limited to a shorter recovery with an earlier return to normal activity. In addition, wound complications such as infection, abdominal wall hernia, seroma and hematoma are significantly reduced ***(Parikh et al., 2005)***.

The patient under going bariatric surgery requires programs that address both preoperative care and long term management. Carefull preoperative evaluation and patient preparation are critical to success. Patient should have a clear understanding of expected benefits, risks, and long term Consequences of surgical treatment. Surgeon must know how to diagnose and manage complication specific to bariatic surgery.

For safe, and effective laparoscopic treatment of obesity advanced laparoscopic skills are required therefore appropriate training in advanced laparoscopic techniques is mandatory ***(Ali et al., 2005)***.

Surgical risks and complications of bariatric surgery fall into two major groups: early complications and late complications. Early complications are those that occur while you are in the hospital or shortly after you leave the hospital. Late complications can occur days to years after your surgery.

The five most common complications were dumping syndrome anastomosis complications, abdominal hernias, infections and pneumonia ***(Pietras et al., 2007)***.