

What if you could achieve

optimal surgical anatomy

in every sleeve gastrectomy
you perform?



YOU CAN.

**STANDARD
BARIATRICS**

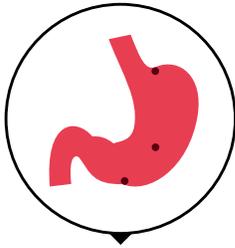
Even if you've performed thousands of sleeve gastrectomy surgeries, the **Standard Sleeve™** approach using the **Standard Clamp®** enables you to perform the procedure with better control and visualization, and achieve a more optimal sleeve pouch anatomy every time.

Make the **Standard Sleeve™** your standard...

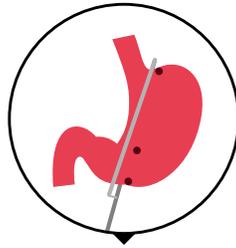
...and begin to minimize sleeve inconsistencies. Now there is a more consistent way to perform laparoscopic sleeve gastrectomy (LSG)*. We call it the **Standard Sleeve™**. It's an anatomy-based approach using the purpose-built **Standard Clamp®**, FDA-indicated for sleeve gastrectomy.** It is an elegant, proven technique that enables the achievement of a more perfect surgical sleeve anatomy every time, setting patients up for the best possible clinical outcomes.

The Standard Sleeve™

A HIGHER STANDARD



Ink the intended cut line at the three anatomical landmarks to map out the ideal output 1cm from the GE junction, 3cm from the incisura angularis and 6cm from the pylorus.



Manipulate the gastric tissue into the Standard Clamp® to align the three landmark points. Plan from top to bottom.
Visualize the full cut line in a single plane.



After the clamp is positioned, staple along the entire length of the intended cut line. The **ideal tubular surgical sleeve anatomy** is a consistent shape that is free of kinks, twists or spirals.

THE STANDARD CLAMP®

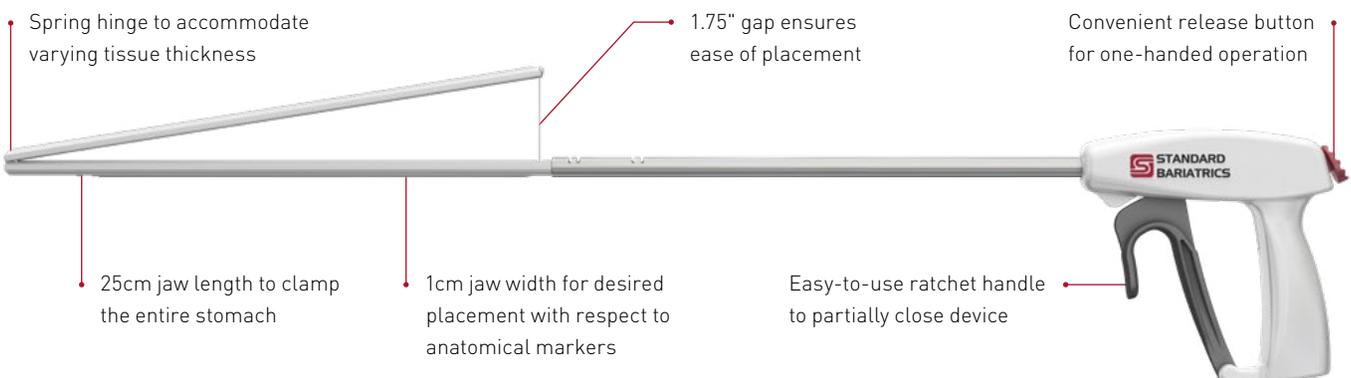
AT THE HEART OF THE STANDARD SLEEVE™

FDA-indicated for use in sleeve gastrectomy,** its procedure-specific design delivers a more consistent sleeve pouch anatomy every time.

The 25cm jaw length allows fixation of the full cut line across the entire stomach, resulting in clear visualization and smooth surgical anatomy, with no zig-zags in the staple line.

Because the cut is straight, the indicated Standard Clamp® approach requires fewer staple firings — 4.3 on average,* compared to an expected 5–7 with other freehand sleeve techniques.

The Standard Clamp® is atraumatic, with springs at either end to limit compression force. The distal hinge allows for early sequential clamping from the fundus to the antrum.



OPTIMAL ANATOMY = OPTIMAL OUTCOMES¹

There are hundreds of ways to perform LSG.² Unfortunately, freehand sleeve gastrectomy techniques yield inconsistent surgical anatomy. These approaches are highly variable, and visualization can be difficult. Tissue management is a challenge and the devices employed are not purpose-built for the procedure, potentially resulting in zig-zag staple lines, twists, and spirals of the sleeve pouch anatomy.

Because of these challenges, bariatric surgeons are able to achieve the ideal tubular sleeve anatomy less than 40% of the time. What we now know is that a symmetrical sleeve pouch anatomy is far more critical to positive outcomes than previously thought, directly affecting weight loss efficiency and GERD.^{1,3} The Standard Sleeve™ approach using the Standard Clamp® is demonstrating positive early clinical outcomes in key procedural endpoints like GERD.^{***}

		6 MONTHS			12 MONTHS		
		bougie	Standard Clamp®	p-value	bougie	Standard Clamp®	p-value
GERD	# of cases	490	301		253	56	
	Pre-op GERD	34%	34%	0.94	32%	45%	0.09
	GERD at time interval (6/12 mo.)	40%	21%	< 0.01	39%	20%	< 0.01
	Resolved GERD	29%	54%	< 0.01	35%	72%	< 0.01
	Induced GERD	24%	8%	< 0.01	27%	13%	0.12
WEIGHT LOSS	# of cases	618	336		432	84	
	% total body weight loss (mean/sd)	21.4 (7.7)	21.2 (6.7)	0.64	27.3 (9.8)	26.3 (8.7)	0.41

The Standard Sleeve™ approach using the FDA-indicated for sleeve gastrectomy** Standard Clamp® enables surgeons to plan and deliver a more consistent sleeve pouch anatomy every time.

Learn how today at StandardBariatrics.com or call 513.620.7751.

*Data on file

**The Standard Clamp, Disposable is indicated for use in laparoscopic procedures to grasp, clamp, and manipulate soft tissues. The Clamp is indicated for use in bariatric procedures such as sleeve gastrectomy as a guide, to clamp and manipulate flat tissue and organs, such as the stomach.

***Preliminary data from SET Data Collaborative

¹ Lee, Almaliki (2018). Gastro Esophageal Reflux Disease after Sleeve Gastrectomy: A Real Issue and Future Perspectives. *American Journal of General and GI Surgery*. Jun, 2018 | Volume 1 | Article 1001

² Dhar, KD, et al. (2017). What matters after sleeve gastrectomy: patient characteristics or surgical technique? *Surgery*. Jan, 2018; 571-577.

³ Toro, JP, et al. (2014). Association of radiographic morphology with early gastroesophageal reflux disease and satiety control after sleeve gastrectomy. *Journal of American College of Surgeons*. Sep; 219(3):430-8.

