

Bariatric surgery

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Which patients should have it?

Obesity is one of the most important public health issues of the 21st century. The World Health Organization (WHO) estimates that being overweight or obese contributes to 44% of diabetes, 23% of ischaemic heart disease and up to 41% of some cancers.¹

Bariatric surgery, also known as weight-loss surgery or metabolic surgery, is recognised by the National Health and Medical Research Council (NHMRC) as the most effective treatment for those with a body mass index (BMI) of >40 and those with weight-related comorbidities with a BMI of 35–40.²

The most common bariatric procedures in Australia are sleeve gastrectomy, adjustable gastric banding, and Roux-en-Y gastric bypass.³ The choice of procedure takes into account factors including age, access to follow-up and monitoring, risk profile, prior interventions and commitment to follow-up, and lifestyle interventions.²

These procedures impact or change the anatomy and, in some cases, the physiology of the gastrointestinal tract, which reduces oral intake and/or absorption of nutrients and aids weight loss. This subsequently prevents or treats obesity-related comorbidities and decreases mortality.^{2,3}

GPs will often be the first point of contact for people considering bariatric surgery, which is an option if patients meet all necessary criteria (refer to table, left).^{4,5} GPs can discuss these criteria to help guide patients in making a decision about whether to pursue bariatric surgery or try another path to weight management.

It is also important for GPs to help patients understand the surgery's required ongoing commitment, as well as expected results and any potential complications.

The rate and amount of weight loss varies between bariatric procedures, as does the resolution of comorbidities. Recent data identified a cohort of patients who were predominantly female (79%), had a mean age of 44.2 and mean BMI of 43, and 14.8% of whom identified as having diabetes.³ Of the procedures performed, 60% were for the sleeve gastrectomy and 15% gastric bands. Expected weight loss at three years after surgery was 51.2%, and 38% of patients no

longer required diabetes management one year after the surgery.³

Management does not stop with surgical intervention, however. Obesity and its management are complex and there is evidence that better outcomes are achieved when a multidisciplinary team – bariatric physician, GP, dietitian, bariatric nurse, psychologist, exercise physiologist – is involved.²

Dietitian's role

People who present for bariatric surgery may actually be in a state of malnutrition. Poor diets, fad diets, lifestyle factors and side effects from some medications negatively influence the preoperative micronutrient status of people with obesity. Preoperatively, people with overweight or obesity are at risk for deficiencies in several micronutrients, including iron and vitamins D, B12, E and C.⁵ Postoperatively, lifelong multivitamins, calcium and vitamin D supplements are recommended for most procedures.⁵

Engaging a bariatric accredited practising dietitian (APD) is a vital component of the process, starting prior to hospital admission and continuing after discharge. APDs assess patients' nutritional status, identify and treat any nutritional deficiencies, design medical nutrition therapy interventions, and provide extensive education, counselling and support.

Bariatric surgery is now more commonly used as a treatment for obesity. GPs play an important role in coordinating collaborative care with an APD and other members of the healthcare team to maximise the health benefits to the patient. Referral to and regular review by a bariatric APD are essential components in treatment. 🍷

References

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4. National Institute for Health and Care Excellence. Obesity: identification, assessment and management. London: NICE, 2014.
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Criteria for bariatric surgery

| Parameter | Criteria |
|-----------------------|--|
| Age | <ul style="list-style-type: none"> • Adult • Post-pubertal adolescents with BMI ≥ 40 kg/m² (or ≥ 35 kg/m² with obesity-related complications and unsuccessful weight-loss outcomes) • Pregnancy not anticipated within 12 months of surgery |
| Body weight | <ul style="list-style-type: none"> • BMI ≥ 40 kg/m² without coexisting medical problems • BMI ≥ 35 kg/m² with associated obesity illness such as type 2 diabetes, hypertension, obstructive sleep apnoea, non-alcoholic fatty liver disease • BMI 30–34.9 kg/m² with diabetes or metabolic syndrome |
| Resistant obesity | <ul style="list-style-type: none"> • All appropriate non-surgical measures have been attempted, but have not achieved or maintained adequate, clinically beneficial weight loss |
| Psychological profile | <ul style="list-style-type: none"> • Undergone comprehensive preoperative assessment of psychological or clinical factors that may affect adherence to postoperative care requirements (such as changes to diet) before performing surgery • Ability to comply with and adhere to behavioural changes required after surgery • Capacity to understand the associated risks and commitment |