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A nonsurgeon's guide to bariatric surgery

The subject of bariatric surgery often receives very little attention despite the profound impact it can have on the care of patients suffering from the disease of obesity and its related comorbidities. Some of the myths about bariatric surgery need to be countered with the realities, and the surgical outcomes and current treatment options available in British Columbia need to be better understood.

When I was a medical student, the subject of bariatric surgery was not covered, nor was the larger subject of obesity management. I received a single 30-minute lecture on the subject during my entire 6-year general surgery residency. During residency, when we encountered bariatric surgery patients in the ER, they were often suffering from dreadful complications after aggressive open procedures. The sordid history of bariatric surgery from the 1970s to the 1990s was one of high complication rates and poor outcomes that left the subject shrouded in mystery and controversy.

It is no wonder that so few medical professionals are familiar with bariatric surgery for obesity and

struggle to discuss it with patients. Obesity is a complex disease and was only officially recognized as such by the Canadian Medical Association in 2015. It is ubiquitous and epidemic and, in my opinion, the mother of many other diseases.

What is bariatric surgery?

It is important to start by stating what bariatric surgery is not: it is not a cosmetic procedure, nor is it a quick fix or an easy way out. Bariatric surgery is a treatment for obesity and obesity-related diseases. It is safe and exceptionally effective when done for the right patient using a multidisciplinary approach. The two gold standard procedures, the proximal gastric bypass and the sleeve gastrectomy, are both performed laparoscopically and are fully covered by MSP in British Columbia. When the surgery is done in a high-volume centre with today's surgical techniques, patients rarely suffer from chronic diarrhea, malabsorption, or other surgical complications.¹⁻³

Why should you care?

Whether you practise in primary or subspecialty medicine, you almost definitely care for patients who suffer from the disease of obesity. And

make no mistake, this is a disease and a very complex one. Telling patients to “eat less and exercise more” is often futile and unsustainable. Restrictive diets and exercise typically produce limited results in the long term.⁴ Telling patients that this disease is “their fault” can only harm our relationships with them.

Management of this disease requires a multimodal approach: lifestyle modification counseling, diagnosis and treatment of psychological and eating disorders, teaching of coping mechanisms, medication use, and assessment for bariatric surgery.

When surgery is included in a multimodal approach, patients can lose more than 70% of their excess weight.^{5,6} Without surgery, treatment for obesity is often far less effective.^{7,8} More importantly, surgery combined with multimodal therapy can have an almost unbelievable impact on obesity-related comorbidities such as diabetes. After bariatric surgery, more than 70% of diabetic patients can cease taking medications for diabetes.^{6,9} Mortality rates are dramatically improved¹⁰⁻¹¹ and health care costs are reduced.¹²⁻¹⁴

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What is metabolic surgery?

The dramatic impact of weight-loss surgery on a whole spectrum of obesity-related diseases has become increasingly apparent. Conditions such as gastroesophageal reflux disease, polycystic ovary syndrome, dyslipidemia, degenerative joint disease, and obstructive sleep apnea have been found to improve within days and months of surgery. In the case of type 2 diabetes, high rates of complete remission have been seen^{7,15,16} and this has led to use of the term “metabolic surgery,” which more appropriately encompasses the far-reaching impact that bariatric surgery can have and helps us better understand the complex relationships between obesity and its comorbidities.

In 2016, global guidelines were developed at the 2nd Diabetes Surgery Summit (DSS-II).¹⁷ Metabolic surgery should be considered for patients with type 2 diabetes and BMI of 30.0 to 34.9 kg/m² if hyperglycemia is inadequately controlled despite optimal treatment with either oral or injectable medications. These BMI thresholds should be reduced by 2.5 kg/m² for Asian patients as this population is prone to complications of obesity at a lower BMI.

The DSS-II guidelines are supported by multiple RCTs looking at bariatric surgery to treat diabetes in patients with a BMI greater than 35.0 kg/m².¹⁶ I believe that “metabolic” will eventually replace “bariatric” when we describe weight-loss surgery and this will make it easier for patients to access surgical resources appropriately.

This theme issue tackles some of the major considerations for weight-loss surgery, whether the term “bariatric” or “metabolic” is used. These considerations include the surgical options, the clinical assessment process, and the prevention and man-

agement of surgical complications. I hope you enjoy these articles and find them useful in future discussions with your patients.

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