

Medical Societies Support Bariatric Surgery

A Review of Current Clinical Guidelines and Position Statements

In its 2011 Scientific Statement,¹ the **American Heart Association**—after summarizing the NIH consensus, which indicates surgical therapy for patients with BMI >40 kg/m² or >35 kg/m² with serious comorbidities—recommends



- Bariatric surgery for patients with severe obesity who have failed medical therapy
- Additional long-term data is needed before bariatric surgery in patients with BMI <35 kg/m² becomes standard practice

Postoperative follow-up:

- Postoperative management focuses on diet, band adjustments, lifestyle changes, and physical exercise
- Patients undergoing LAGB should be seen every 4 to 6 weeks for monitoring until appetite is controlled and early satiety is achieved. Thereafter, patients should be seen at least annually for monitoring, nutritional status, and comorbidity assessment

In 2011, the **International Diabetes Federation** issued a position statement² with the following recommendations, considering bariatric surgery appropriate in patients with



**International
Diabetes
Federation**

- BMI ≥35 and T2D who do not achieve treatment targets through medication, especially in the presence of other obesity-related comorbidities
- BMI 30-35 and complementary to T2D medical therapies, especially in the presence of severe cardiovascular comorbidities

Postoperative follow-up:

- Multidisciplinary teams should monitor glycemic control and provide long-term nutritional supplementation and support

A 2011 comprehensive care plan for patients with T2D was developed by the **American Association of Clinical Endocrinologists**.³ Among recommendations specific to bariatric surgery, the medical guidelines state that



- LAGB may be considered in patients with T2D and BMI >30 kg/m²
- RYGB may be considered in patients with T2D and BMI >35 kg/m²

Postoperative follow-up:

- All patients with T2D should have a comprehensive care plan that moves beyond a single focus on glycemic control
- RYGB patients require meticulous follow-up because of the risk of vitamin and mineral deficiencies and hypocalcemia

The 2010 **American Diabetes Association** position statement⁴ recommends bariatric surgery for



- Adults with BMI >35 kg/m² and type 2 diabetes (T2D), especially if diabetes or obesity-related comorbidities are difficult to control
- Patients with BMI 30-35 kg/m² only within a clinical trial setting

Postoperative follow-up:

- Patients need lifelong lifestyle support and medical monitoring after surgery

The 2008 **AACE/ASMBS/TOS Guidelines**⁵ state that bariatric surgery should be offered to patients with



- BMI ≥40 kg/m² who are healthy enough to sustain the procedure
- BMI ≥35 kg/m² and one or more severe obesity-related conditions

Postoperative follow-up:

- A multidisciplinary team approach is recommended for long-term follow-up care
- Postoperative lifestyle management, including nutritional and metabolic support, should be maintained



Medical Societies Support Bariatric Surgery

A Review of Prevailing Consensus Statements and Guidelines

In its 2003 *Roadmaps for Clinical Practice* series on obesity,⁶ the **American Medical Association** refers to the National Heart, Lung, and Blood Institute (NHLBI) Clinical Guidelines when stating that bariatric surgery is an option for



- “Carefully selected patients with clinically severe obesity (a BMI ≥ 40 or a BMI ≥ 35 with comorbid conditions), when patients are at high risk for obesity-associated morbidity or mortality and when less invasive methods of weight loss have failed”

Additionally, appropriate patients should

- Understand the procedure, be able and willing to adjust their diet, have the support of friends or family, be in good psychological health, and have a record of compliance with previous treatments

Postoperative follow-up:

- A multidisciplinary team with medical, nutritional, and psychological expertise is required for ongoing medical education and monitoring

The 1998 **NHLBI Clinical Guidelines**⁷ state that advancements in bariatric surgery have replaced previous malabsorptive procedures that were associated with serious side effects and therefore recommend surgery in well-informed and motivated individuals with

- BMI ≥ 40 whose quality of life is severely impacted
- BMI ≥ 35 who have obesity-related comorbidities and are healthy enough to undergo the procedure



Postoperative follow-up:

- Life-long weight loss maintenance program including diet, exercise, and behavioral support should be a priority, especially for the first 6 months following surgery
- Frequent contact between patient and practitioner over the long term is suggested

In 1991, the **National Institutes of Health** issued an original consensus statement⁸ on surgery and obesity, describing potential candidates for surgery as patients with



- BMI > 40 who can clearly acknowledge and commit to life changes after surgery
- BMI 35-40 and high-risk obesity related conditions, e.g. severe sleep apnea or severe diabetes mellitus

Postoperative follow-up:

- Long-term diet counseling and monitoring of diabetes, high blood pressure, and dyslipidemia is recommended



References: 1. Poirier P, Cornier M-A, Mazzone T, et al; on behalf of the American Heart Association Obesity Committee of the Council on Nutrition, Physical Activity, and Metabolism. Bariatric surgery and cardiovascular risk factors: a scientific statement from the American Heart Association. *Circulation*. 2011;123:1-19. 2. International Diabetes Federation (IDF). Bariatric surgical and procedural interventions in the treatment of obese patients with type 2 diabetes; a position statement from the IDF Taskforce on Epidemiology and Prevention. 2011. 3. Handelsman Y, Mechanick JI, Blonde L, et al. American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for developing a diabetes mellitus comprehensive care plan. *Endocr Pract*. 2011;17(Suppl 2):1-53. 4. American Diabetes Association. Standards of medical care in diabetes—2010: Position Statement. *Diabetes Care*. 2010;33(Suppl 1):11-61. 5. Mechanick JI, Kushner RF, Sugerman HJ, et al. American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic & Bariatric Surgery Medical Guidelines for Clinical Practice. *Endocr Pract*. 2008;14:1-83. 6. American Medical Association. Assessment and management of adult obesity: a primer for physicians—Booklet 7; Surgical Management. 2003;SEE:03-0107:4M:11/03. <http://www.ama-assn.org/resources/doc/public-health/booklet7.pdf>. Accessed March 28, 2011. 7. National Heart, Lung, and Blood Institute. Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults. NIH Publication No. 98-4083. September 1998. http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf. Accessed March 30, 2011. 8. NIH conference: gastrointestinal surgery for severe obesity: Consensus Development Conference Panel. *Ann Intern Med*. 1991;115:956-961.

www.lapbandhcp.com