Obesity surgery in adults

Obesity is defined by a BMI ≥ 30 kg/m². It is a chronic disease requiring global, multidisciplinary and long-term management.

For selected patients, obesity surgery (or bariatric surgery or weight loss surgery), combined with changes in eating habits and increased physical activity, is an effective weight loss method. It can also be used to control or improve certain comorbidities, to improve quality of life and reduce obesity-related mortality.

This information document is based on the clinical practice guidelines available on the HAS website: www.has-sante.fr

Six conditions are required to benefit from bariatric surgery

- BMI ≥ 40 kg/m² or BMI ≥ 35 kg/m² with at least one comorbidity that is likely to improve following surgery (high blood pressure, obstructive sleep apnoea syndrome (OSAS), type 2 diabetes, incapacitating joint disorders, non-alcoholic steatohepatitis, etc.).
- Failure of medical, nutritional, dietetic and psychotherapeutic treatment that has been properly conducted for 6 to 12 months (weight loss is not sufficient or weight loss is not maintained).
- Well informed patients (information brochure for patients available on the HAS website).
- Multidisciplinary preoperative assessment and management for several months.
- Patients having understood and accepted the need for lifelong surgical and medical follow-up.
- Acceptable operating risk.

There are contraindications, some of which may be temporary:
- severe cognitive or mental disorders;
- severe and non-stabilised eating disorders;
- alcohol or psychoactive substances dependence;
- diseases that are life-threatening in the short and medium term;
- contraindications to general anaesthesia;
- absence of identified prior medical management of obesity and likely inability of the patient to participate in lifelong medical follow-up.

Preoperative medical, psychological and educational management for several months is necessary

- Assessment and management of comorbidities (high blood pressure, OSAS, diabetes, etc.), assessment of eating behaviour and management of any eating disorder, nutritional and vitamin assessment and correction of any deficits, upper gastrointestinal endoscopy with tests for Helicobacter pylori.
- Psychological/psychiatric assessment: for all patients who are candidates for obesity surgery.
- Therapeutic education programme: diet and physical exercise.
Deciding whether to operate

A decision is made following multidisciplinary medical and surgical discussion and consensus (physical meeting or other consensus procedure), that may involve the general practitioner.

The surgical techniques used are restrictive or malabsorptive

The techniques based exclusively on gastric restriction are used to reduce food intake by reducing gastric capacity without malabsorption:

- adjustable gastric banding;
- vertical banded gastroplasty (less and less frequently practised);
- longitudinal gastrectomy or sleeve gastrectomy.

Mixed techniques combine gastric restriction with the principle of intestinal malabsorption through the creation of a bypass or diversion:

- gastric bypass;
- biliopancreatic diversion.

Laparoscopy is the recommended approach.

It is not possible to make a classification of the different techniques based on their benefit/risk ratio.

The more effective procedures are in terms of weight loss (40 to 80 % of excess weight), the more complex and risk-prone they are: postoperative complications, risk of nutritional consequences and operative mortality (0 to 1 %). Gastric banding is the intervention presenting least risk but it also the least effective. Conversely, biliopancreatic diversion presents the greatest risk but is the most effective.
Morbidity

- Early morbidity is mainly linked to digestive perforations and leakage, occlusions, bleeding, and thromboembolic and respiratory complications (atelectasis, etc.).
- In the longer term, complications may be surgical (band slippage and/or pouch dilation, anastomotic stenosis, occlusion, migration of the band), nutritional (in particular following malabsorptive surgery) or psychological.

Patients operated on must receive lifelong follow-up

This is carried out by the multidisciplinary team which approved the indications for the intervention and by the general practitioner.

Assess weight loss and its kinetics

Detect complications from the surgical procedure: certain symptoms must result in urgent consultation with the surgeon of the multidisciplinary team

- Symptoms appearing early: tachycardia, dyspnoea, abdominal pain, confusion or hyperthermia, even in the absence of guarding or tenderness.
- Symptoms that may appear late: abdominal pain, vomiting, dysphagia, incapacitating gastro-oesophageal reflux.

Prevent and screen for vitamin and nutritional deficiencies, some of which may lead to serious neurological conditions

- Following malabsorptive surgery, supplementation is automatic (multivitamins, calcium, vitamin D, iron and vitamin B12 are most common).
- Following restrictive surgery, it may be discussed if the results of the clinical and biological assessment warrant it.

Adapt any medicines and their dosage

- Bariatric surgery can improve or control certain comorbidities, sometimes only a few weeks after the operation (diabetes in particular). These comorbidities must be reassessed early and their treatment adapted.
- Malabsorptive surgery can lead to malabsorption of various medicines (antivitamin K, thyroid hormones, antiepileptic drugs, etc.), the dosage of which must then be modified.
- Gastrotoxic medicines (aspirin, non-steroidal anti-inflammatory drugs, corticosteroids, etc.) must be avoided as far as possible.

Continue the education of the patient (diet and physical activity) started in the preoperative phase by checking in particular that they are adapting well to their new eating habits.

Assess the necessity of psychological or psychiatric follow-up

- Follow-up recommended for patients who presented eating disorders or other psychiatric pathologies before the operation.
- Follow-up proposed on a case-by-case basis for other patients.
- Weight loss can lead to psychological changes that may not be easy to manage. A period of adaptation to the change is often necessary, both for the patient and for their family, friends and colleagues.

If necessary, plan for reconstructive surgery

- This is possible 12 to 18 months after obesity surgery, once weight loss has stabilised and in the absence of malnutrition.
Contraception is recommended as soon as surgery is planned and then for 12 to 18 months after the operation

- The efficacy of oral contraception could be reduced following malabsorptive surgery. Another method of contraception must be discussed.

- If a patient intends to conceive following obesity surgery, we recommend planning nutritional follow-up by the multidisciplinary team before conception, and failing this, at the very start of the pregnancy, during the pregnancy and post-partum.

  If an adjustable gastric band has been fitted, its adjustment must be discussed.

- Obesity surgery is contraindicated for pregnant women.

Obesity surgery is reimbursed by National Health Insurance provided prior agreement has been given

However, National Health Insurance does not reimburse some vitamin supplements (multivitamins for example; cost: 9 to 25 euros a month), most protein supplements, consultations with private psychologists and dieticians, certain biological procedures (for example vitamin B1 test) and some reconstructive operations.

Some useful links for finding out more or informing your patients*

- Société française et francophone de chirurgie de l’obésité et des maladies métaboliques (French and French-speaking Society of Obesity Surgery and Metabolic Diseases): 29, rue Antoine-Péricaud 69008 Lyon, telephone: 33 4 78 00 45 87, website: <www.soffco.fr>, e-mail: <soffco@orange.fr>.

- Patient associations
  - Collectif national des associations d’obèses: 38, rue des Blancs-Manteaux 75004 Paris, telephone: 33 1 42 71 17 57, website: <www.cnao.fr>, e-mail: <cnao@wanadoo.fr>.

- HAS website: www.has-sante.fr

* The list of links is not exhaustive and is given for information purposes only. The HAS cannot be held liable for the information contained on these sites.