

BMI, 41; 27 y/o; PCOS. How do you help her lose weight (again)?

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Consider bariatric surgery first for severely obese women

I stopped wasting time with lifestyle fixes and drugs that don't work for these patients. You should, too.

■ **For women who are severely obese** (body mass index [BMI], >40) diet hardly ever produces long-term weight loss.

■ **When these patients are planning pregnancy**, laparoscopic gastric banding offers more flexibility in adjusting the size of the gastric pouch than Roux-en-Y surgery.

For the past 30 years, I resolutely advised my severely obese patients to diet, exercise, and take the weight loss medications—metformin, sibutramine, orlistat—that I prescribed. I enlisted the aid of nutritionists, exercise trainers, counselors, endocrinologists, and general internists. But, except for the rare success, my approach was a miserable failure.

I was disappointed that most of my severely obese patients stayed that way.

Recently, however, I took a new direction in managing obese patients, and now I'm filled with optimism and hope. I routinely refer my patients whose BMI is >40 to a bariatric surgery center. Their success with weight loss after bariatric surgery has been remarkable.

Surgery isn't undertaken lightly or quickly

In the surgical program with which I work, an eligible patient must spend 6 months in a nutrition and exercise program supervised by the bariatric surgery

center before she is eligible for surgery. During that time, she is evaluated exhaustively for any nutritional, metabolic, and psychological issues that might interfere with the success of surgery or make surgery too risky. She receives extended counseling and discusses, in detail, risks and benefits of the surgery. The program works with her health insurance company to justify the planned surgery.

After surgery, the bariatric center builds on its established relationship with the patient by monitoring response to therapy and screening for nutritional deficiencies.

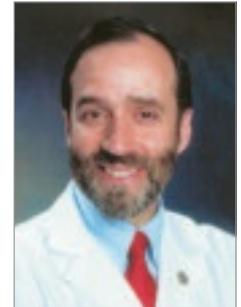
I am impressed with the results: Bariatric surgery is remarkably effective in helping my patients shed 25% to 50% of body weight. I've concluded that bariatric surgery is the gold standard for treating weight loss in severely obese women.

Consistent conclusions

Many studies report the superiority of bariatric surgery over lifestyle interventions for severe obesity.

Confirmation from Sweden

In the Swedish Obese Subjects (SOS) Trial, men with a BMI of >34 and women with a BMI of >38 were offered bariatric surgery (gastric banding, gastropasty, or gastric bypass; n = 2,010) or standard medical and behavioral



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My patients' success losing weight after bariatric surgery has been remarkable

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therapy (n = 2,037). The study was initiated in 1987, with substantial long-term follow-up of subjects. Mean age of subjects was 48 years; mean BMI was 41.

Two years after entry, subjects' weight had increased by a mean of 0.1% in the medical-behavioral therapy group and had decreased by a mean of 23% in the bariatric surgery group. Among the 1,703 subjects available for analysis 10 years after entry, weight had increased by a mean of 1.6% in the medical-behavioral therapy group and had decreased by a mean of 16% in the bariatric surgery group.¹

The surgery group demonstrated greater improvement than the medical-behavioral therapy group in blood glucose and blood pressure control and had a greater increase in the serum level of high-density lipoprotein-C and a greater decrease in serum uric acid. The surgery group also reported an increase in the quality of life compared with the medical-behavioral group.²

Death rate is an important outcome. In the SOS trial, the surgery group had 24% fewer deaths than the behavioral-medical therapy group.³ In another large cohort study from the United States, the death rate among 7,925 patients who had undergone bariatric surgery was compared with the death rate among 7,925 control patients who were matched for age, sex, and BMI.⁴ Over 7.1 years of follow-up, the death rate was 40% lower in the surgical group than among controls. Death from diabetes was reduced by 92% and death from coronary artery disease was reduced by 56% in the surgery group.

Value in diabetes, too

Randomized clinical trials also support the use of bariatric surgery for obese patients who have diabetes. In one study, 60 patients with diabetes and obesity (BMI, 30 to 40) were randomized to gastric banding or conventional diabetes therapy, including weight loss and antihyperglycemia medications.

Remission of diabetes was achieved by 73% of subjects in the surgery

group and by 13% of subjects in the medical-behavioral therapy group. Surgical patients lost 21% of body mass; medical-behavioral patients, 1.7% of body mass. Remission correlated highly with magnitude of weight loss.⁵

Meta-analysis is supportive

Examination of more than 140 studies of bariatric surgery concluded that there was substantial evidence of benefit from bariatric surgery in obese subjects with a BMI of >40.⁶

Which procedures, for which patients?

Restrictive procedures, such as vertical banded gastroplasty and laparoscopic adjustable gastric banding, are typically associated with fewer surgical complications and more gradual and less ultimate weight loss than **malabsorptive procedures**, such as jejunioileal bypass, biliopancreatic diversion, and duodenal switch.

The Roux-en-Y gastric bypass is a combined restrictive operation (the small gastric pouch limits oral intake) and malabsorptive operation (small-bowel reconfiguration increases dumping physiology and malabsorption).

The adjustable gastric band has an internal, inflatable balloon that can be adjusted through an abdominal port to a greater or lesser degree of constriction. For a woman with this procedure who becomes pregnant, constriction can be lessened to increase nutritional intake.

What about complications?

Complications of bariatric surgery vary with patients' comorbidities, the technical skill and experience of the surgical team, and the type of procedure. Thirty-day operative mortality rates have been estimated at approximately 0.1% for restrictive procedures; 0.5% for gastric bypass; and 1.1% for biliopancreatic diversion and for duodenal switch.⁷

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FAST TRACK

Meta-analysis of more than 140 studies shows substantial benefit from bariatric surgery when BMI is >40

INSTANT POLL

Failed weight loss: Take the next step

Your patient is a 27-year-old woman who has a body mass index of 41 and polycystic ovary syndrome. Her medications are an estrogen-progestin oral contraceptive and metformin, 1,500 mg/day.

She has tried to lose weight many times, without lasting success. She has consulted with nutritionists, personal trainers, and endocrinologists. The next step is yours:

- 6 more months of intensive diet and exercise
- sibutramine
- orlistat
- referral to a bariatric surgery program

Choose your course of action by taking the INSTANT POLL at www.obgmanagement.com

See what your peers would do when INSTANT POLL RESULTS are published in an upcoming issue

About 15% of patients who undergo laparoscopic adjustable gastric banding require a second operation for complications such as stomal obstruction, band erosion, band slippage, port malfunction, esophagitis, and infection.⁸

Many patients develop nausea and vomiting after bariatric surgery; if nausea and vomiting are accompanied by fever or severe abdominal pain, the patient should be thoroughly evaluated for a surgical emergency, such as bowel obstruction.

The most common nutritional abnormalities in patients who undergo bariatric surgery are iron, vitamin B₁₂, folate, and thiamine deficiencies.

Pregnant women. Pregnancy should be avoided for 12 to 18 months, or until weight loss reaches a plateau, in any

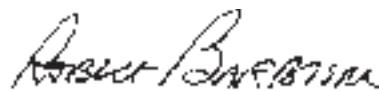
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woman who has undergone gastric banding. Several pregnant women died after bariatric surgery because intervention was delayed during a developing surgical emergency, such as bowel obstruction.⁹

Don't delay! This epidemic has major health impacts

Obesity in the obstetric population is associated with an increased rate of gestational diabetes, preeclampsia, congenital malformations, macrosomia, and cesarean section. In the gynecologic population, obesity is associated with an increased rate of fibroids, endometrial cancer, breast cancer, polycystic ovary syndrome, and infertility.

Behavioral therapy and medical therapy are unlikely to cure a patient who is severely obese. Again: I urge you to *stop wasting your time* with ineffective interventions for your patients whose BMI tops 40! Refer them to a bariatric surgery center instead, and reap the rewards.


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