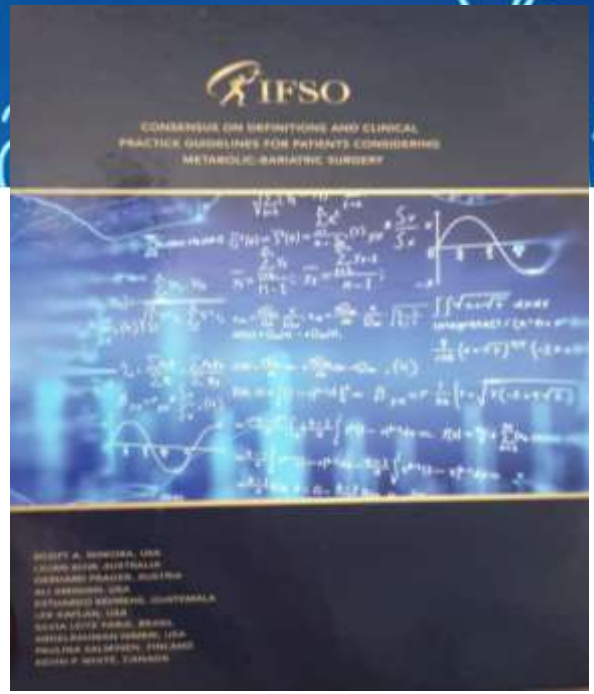


# IFSO Consensus conference 2023: Standardized reporting and definitions


IFSO 1.9.2023
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# Disclosures

- Lecture fees: Novo Nordisk
- Employment: University of Turku, Turku University Hospital, private practice Terveystalo
- PI: SLEEVEPASS, APPAC
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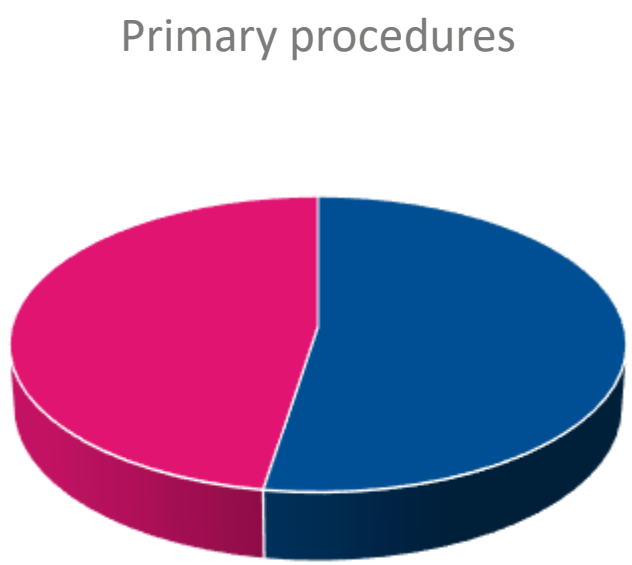
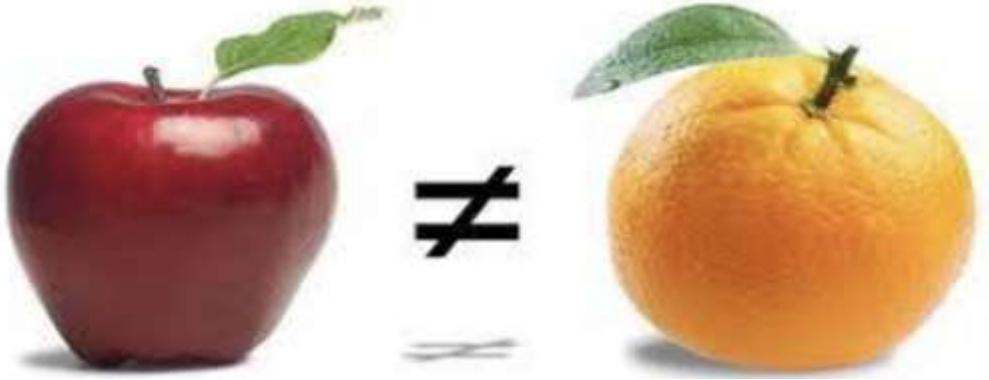



TYKS Turku University Hospital

# IFSO Consensus 2023



- 136 statements, 15 on definitions
- 43 experts in obesity management: 26 bariatric surgeons, 4 endoscopists, 8 endocrinologists, 2 nutritionists, 2 councellors, an internist and a pediatrician + a Delphi-statistician (MD)
- Expert criteria: Obesity management as a major focus of their practice, considered experts by IFSO, have over 10 years of exeprience managing patients with obesity, fluent in written and spoken English

# IFSO Consensus results (unpublished data)

- Definition statements (100%, 15/15): mean consensus level 90.1%
- MBS statements (80%, 68/85): mean consensus level 79.6%
- Reporting definitions: 13
  - E.g., suboptimal initial response, baseline weight (with or without AOMs), initial surgical weightloss, conversion surgery, revision surgery, description of procedures by anatomical features
- Reporting standards: 2
  - Suboptimal initial clinical response
  - Late postoperative clinical deterioration

# Reporting definitions / percentage consensus (unpublished data)

1. A suboptimal initial response to metabolic/bariatric surgery is demonstrated either by inadequate weight loss **OR** by an unusually modest improvement in a significant obesity complication. / **100%**
2. A late post-operative clinical deterioration is demonstrated either by recurrent weight gain **OR** by worsening of a significant obesity complication that occurs after an initially adequate post-operative clinical response. / **97.4%**
3. The degree to which the clinical response to metabolic/bariatric surgery is suboptimal or there is a late post-operative clinical deterioration can vary widely from patient to patient. The severity of the suboptimal response should guide clinical treatment. / **97.5%**

# Reporting definitions / percentage consensus (unpublished data)

4. The baseline weight for assessing weight loss after MBS should be a weight determined before starting preoperative weight reduction./ **95.3%**
5. In patients who have been treated with AOM before undergoing MBS, who STOP it at the time of or shortly after surgery, the baseline weight for assessing the effect of surgery on bodyweight should generally be a weight determined BEFORE the AOM was started./ **95.3%**
6. In patients who have been treated with AOM before undergoing MBS and CONTINUE this medication post-op., the baseline weight used to assess the effect of surgery on body weight should generally be measured on the day of surgery./ **88.4%**
7. The initial surgical weight loss (defined as maximum weight loss within the first 2 years after MBS) should be determined in a manner that excludes any post-plateau weight loss caused by adding AOM, any endoscopic intervention, or any calorie-restricted diet./**84.2%**

# Reporting definitions / percentage consensus (unpublished data)

8. Surgical or endoscopic procedures to convert to a new type of metabolic/bariatric operation (**conversion surgery**) and those to re-establish normal anatomy (**reversal surgery**) should be clearly distinguished and considered separately from procedures to modify or enhance the effects of a previous operation (**revision or modification surgery**). / **97.5%**
9. Modification or revision procedures are typically designed to optimize the effectiveness of previous operations, while conversion procedures most commonly introduce additional mechanisms of therapeutic action. / **95.0%**

# Reporting definitions / percentage consensus (unpublished data)

10. The term “obesity complication” mostly describes diseases, conditions, and symptoms for which there is published evidence that obesity is a contributing cause or exacerbating factor. When such a causative relationship has not been established or accepted, the associated disorder is more accurately labelled an obesity comorbidity./ **80.5%**
11. When considering the effects of MBS on intestinal nutrient absorption, diminished absorption (hypo-absorption or malabsorption) of micronutrients should be clearly distinguished from the hypo-absorption or malabsorption of macronutrients or ingested calories./ **85.7%**

# Reporting definitions / percentage consensus (unpublished data)

12. Characterization of the absorptive effects of an MBS procedure should not be used to imply that these effects are the mechanisms of action of weight loss associated with the operation. It is preferable to describe such procedures by their anatomical features (e.g., "bypass," "diversion," or more generally, "gastrointestinal") rather than by their inferred mechanism of action./ **95.1%**
13. Characterization of the changes in the physical structure of the gut produced by an MBS procedure – including the size & shape of GI segments or anastomoses – should not be used to imply that these changes "restrict" food intake as a mechanism of associated weight loss. It is preferable to describe such procedures by their anatomical features (e.g., "gastrectomy," "banding" or, more generally, "gastric") rather than by their inferred mechanism of action./**95.1%**

# Reporting standards / percentage consensus (unpublished data)

14. In general, a suboptimal initial clinical response to MBS is demonstrated either by total body weight or BMI loss of less than 20% **OR** by inadequate improvement in an obesity complication that was a significant indication for surgery. / **85.0%**
15. In general, a late post-operative clinical deterioration after MBS is demonstrated either by recurrent weight gain of more than 30% of the initial surgical weight loss **OR** by worsening of an obesity complication that was a significant indication for surgery. / **71.8%**

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IFSO Consensus on definitions and clinical practice guidelines

# Thank you!