



**XXVI
IFSO WORLD
CONGRESS
OF BARIATRIC
& METABOLIC SURGERY**



NAPLES, ITALY
AUGUST 30-SEPTEMBER 1, 2023

Congress President: **Prof. Luigi Angrisani**



The future of patients with class 2 obesity without comorbidity (A one-year prospective follow-up study)

Vahidirad Ali ¹, Ghelichli Mohadeseh ¹, Jangjoo Ali ², Nezhadrahim Ahmad ²

¹ Golestan University of Medical Sciences, IRAN

² Mashhad University of Medical Sciences, IRAN

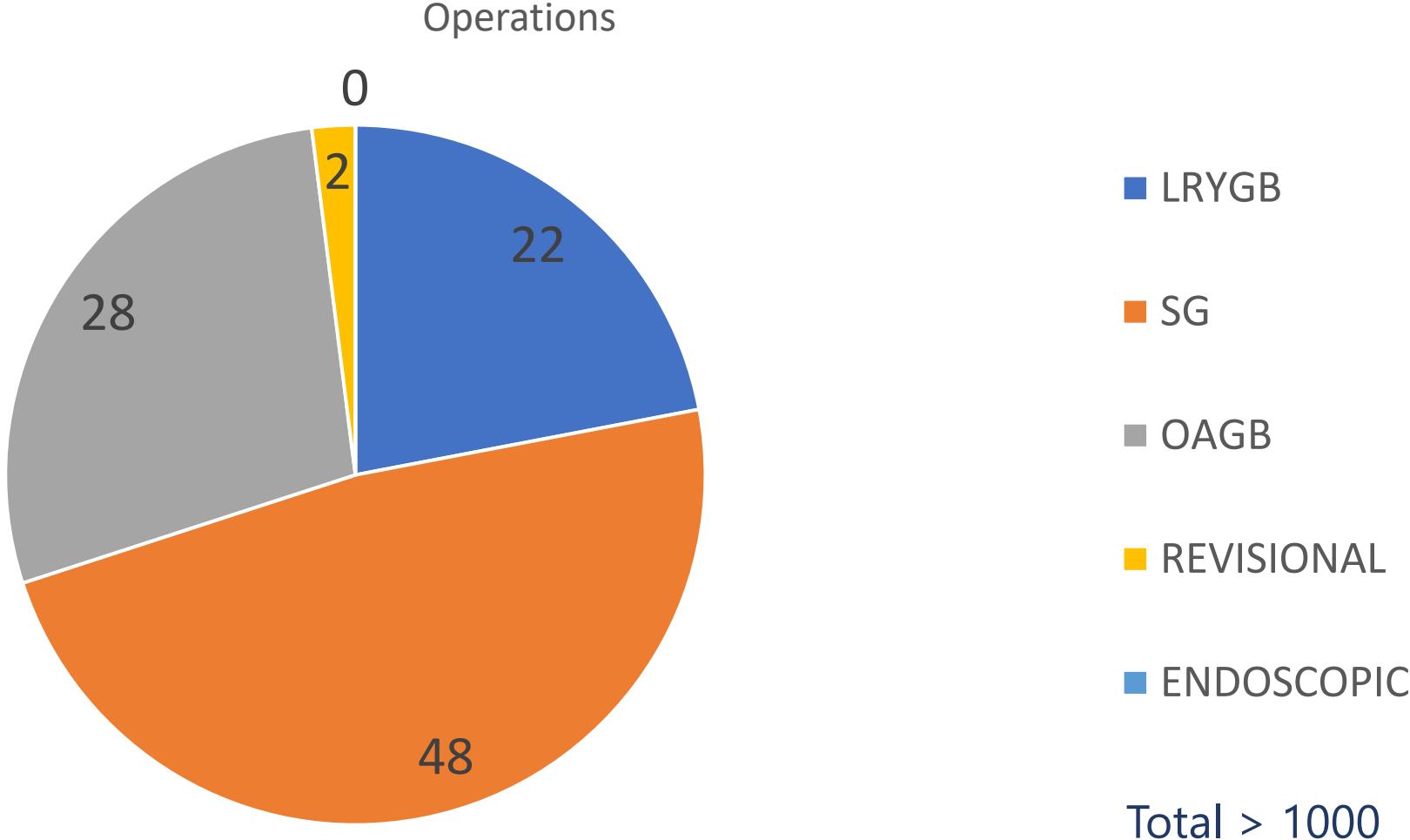


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CASE MIX DISCLOSURE



Background:

1991 NIH Consensus

Consensus Development Conference On Morbid Obesity



Obtaining a consensus on any subject is difficult, and during the conference on morbid obesity the 200 participants spent many hours of intense concentration and earnest discussion. At left, NIH Director Dr. Donald S. Fredrickson (l) discusses conference results with the chairman, Dr. Van Itallie.

very frequent small meals. Other procedures such as gastroplasty (a new variant of gastric bypass), vagotomy, and jaw-wiring also were discussed.

The most common, serious complications of jejunoileal bypass include oxaluria and high incidence of oxalate-containing kidney stones, unremitting diarrhea, development of various nutritional deficiencies, including protein malnutrition, and possibly accelerated gallstone formation. Life-threatening liver failure may also develop.

Unless they also receive long-term dietary management, some patients may regain much or all of their lost weight. Other long-term complications can include arthritis and metabolic bone disease. Many, but not all, of these complications can be prevented or mitigated by meticulous followup care.

No criteria are currently available to predict reliably whether surgical intervention will be successful in a given individual.

It was agreed that the development of a truly informed consent is essential. Also, it was emphasized that patients should receive a thorough explanation of the risks, benefits, and uncertainties, of both procedures.

The experts encouraged future clinical trials of the most promising new techniques and improvements of existing procedures. They also stressed the need for more attention, better understanding of the different types of obesity, the incidence of massive obesity, and the degree of risk associated with it. Also required are better techniques to identify early in life those individuals destined to become "super obese."

The summary and recommendations were prepared by panels of experts chaired by Dr. Theodore Van Itallie, professor of medicine, Columbia University, and Director of the NIAMDD-supported Obesity Center at St. Luke's Hospital Center, New York.

Principal conference organizers from NIAMDD were Dr. Benjamin T. Burton, associate director; Marilyn C. Hiller, special assistant for planning and evaluation; and Dr. Gladys Hirschman, staff physician.

A short summary of the conference will appear in the *Journal of the American Medical Association* in the near future, as well as in a number of other medical and surgical journals. The entire proceedings will be published in the *American Journal of Clinical Nutrition*.

Background:

More than 30 years ago, the National Institutes of Health (NIH) issued a statement regarding the indications for Metabolic and Bariatric Surgery (MBS) and since then, many providers and insurance institutions in many countries use this statement as standard criteria for MBS.





SURGERY FOR OBESITY
AND RELATED DISEASES

Surgery for Obesity and Related Diseases 1 (2005) 371–381

2004 ASBS Consensus Conference

Consensus Conference Statement

Bariatric surgery for morbid obesity: Health implications for patients,
health professionals, and third-party payers

Henry Buchwald, M.D., Ph.D., F.A.C.S.

For the Consensus Conference Panel



Appropriateness Criteria for Bariatric Surgery: Beyond the NIH Guidelines

Irina Yermilov^{1,2}, Marcia L. McGory¹, Paul W. Shekelle³, Clifford Y. Ko^{1,2} and Melinda A. Maggard^{1,4}

Careful selection of bariatric patients is critical for successful outcomes. In 1991, the NIH first established patient selection guidelines; however, some surgeons operate on individuals outside of these criteria, i.e., extreme age groups. We developed appropriateness criteria for the spectrum of patient characteristics including age, BMI, and severity of eight obesity-related comorbidities. Candidate criteria were developed using combinations of patient characteristics including BMI: $\geq 40 \text{ kg/m}^2$, 35–39, 32–34, 30–31, < 30 ; age: 12–18, 19–55, 56–64, 65+ years old; and comorbidities: prediabetes, diabetes, hypertension, dyslipidemia, sleep apnea, venous stasis disease, chronic joint pain, and gastroesophageal reflux (plus severity level). Criteria were formally validated on their appropriateness of whether the benefits of surgery clearly outweighed the risks, by an expert panel using the RAND/UCLA modified Delphi method. Nearly all comorbidity severity criteria for patients with BMI $\geq 40 \text{ kg/m}^2$ or BMI = 35–39 kg/m^2 in intermediate age groups were found to be appropriate for surgery. In contrast, patients in the extreme age categories were considered appropriate surgical candidates under fewer conditions, primarily the more severe comorbidities, such as diabetes and hypertension. For patients with a BMI of 32–34, only the most severe category of diabetes (Hgb A1c > 9 , on maximal medical therapy), is an appropriate criterion for those aged 19–64, whereas many mild to moderate severity comorbidity categories are “inappropriate.” There is overwhelming agreement among the panelists that the current evidence does not support performing bariatric surgery in lower BMI individuals (BMI < 32). This is the first development of appropriateness criteria for bariatric surgery that includes severity categories of comorbidities. Only for the most severe degrees of comorbidities were adolescent and elderly patients deemed appropriate for surgery. Patient selection for bariatric procedures should include consideration of both patient age and comorbidity severity.

Obesity (2009) 17, 1521–1527. doi:10.1038/oby.2009.78



Beyond BMI: the need for new guidelines governing the use of bariatric and metabolic surgery

Prof. David E Cummings, MD and Ricardo V Cohen, MD

Diabetes and Obesity Center of Excellence and Veterans Affairs Puget Sound Health Care System, University of Washington School of Medicine, Seattle, WA, USA (Prof D E Cummings MD); and The Center of Excellence in Bariatric and Metabolic Surgery, Oswaldo Cruz Hospital, São Paulo, Brazil (R V Cohen MD)

Abstract

Bariatric surgery use is largely governed worldwide by a 1991 National Institutes of Health consensus statement that advocates BMI as the primary operative criterion and restricts surgery to severely obese patients. These guidelines have been enormously valuable in standardising practice, thereby facilitating accumulation of a copious database of information regarding long-term surgical benefits and risks, from vast clinical experience and research. However, the National Institutes of Health recommendations had important limitations from the outset and are now gravely outdated. They do not account for remarkable advances in minimally invasive surgical techniques or the development of entirely new procedures. In the two decades since they were crafted, we have gained far greater understanding of the dramatic, weight-independent benefits of some operations on metabolic diseases, especially type 2 diabetes, and of the inadequacy of BMI as a primary criterion for surgical selection. Furthermore, there is now a substantial and rapidly burgeoning body of level-1 evidence from randomised trials comparing surgical versus non-surgical approaches to obesity, type 2 diabetes, and other metabolic diseases, including among only mildly obese or merely overweight patients. Herein, we present arguments to impel the development of new guidelines for the use of bariatric and so-called metabolic surgery to inform clinical practice and insurance compensation.



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Surgery for Obesity and Related Diseases 14 (2018) 1071–1087

SURGERY FOR OBESITY
AND RELATED DISEASES

ASMBS statements/guidelines

ASMBS updated position statement on bariatric surgery in class I obesity (BMI 30–35 kg/m²)

Ali Aminian^{a,*}, Julietta Chang^a, Stacy A Brethauer^a, Julie J. Kim^b, for the American Society for Metabolic and Bariatric Surgery Clinical Issues Committee

^a*Bariatric and Metabolic Institute, Department of General Surgery, Cleveland Clinic, Cleveland, Ohio*

^b*Harvard Medical School, Mount Auburn Hospital, Cambridge, Massachusetts*

Received 31 May 2018; accepted 31 May 2018





Original article

2022 American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO): Indications for Metabolic and Bariatric Surgery

Dan Eisenberg, M.D.^{a,*}, Scott A. Shikora, M.D.^b, Edo Aarts, M.D., Ph.D.^c,
Ali Aminian, M.D.^d, Luigi Angrisani, M.D.^c, Ricardo V. Cohen, M.D., Ph.D.^f,
Maurizio De Luca, M.D.^g, Silvia L. Faria, Ph.D.^h, Kasey P. S. Goodpaster, Ph.D.^d,
Ashraf Haddad, M.D.ⁱ, Jacques M. Himpens, M.D., Ph.D.^j, Lilian Kow, B.M.B.S., Ph.D.^k,
Marina Kurian, M.D.^l, Ken Loi, M.B.B.S., B.Sc. (Med)^m,
Kamal Mahawar, M.B.B.S., M.Sc.ⁿ, Abdelrahman Nimeri, M.D., M.B.B.Ch.^o,
Mary O’Kane, M.Sc., R.D.^p, Pavlos K. Papasavas, M.D.^q, Jaime Ponce, M.D.^r,
Janey S. A. Pratt, M.D.^{a,s}, Ann M. Rogers, M.D.^t, Kimberley E. Steele, M.D., Ph.D.^u,
Michel Suter, M.D.^{v,w}, Shanu N. Kothari, M.D.^x



Questions:

What is the result of not burdening insurance institutions and providers to accept MBS in patients with obesity class 2 without comorbidities?

Are these patients able to lose extra weight using non-surgical lifestyle modification methods?



Methods:

127 patients with class 2 obesity ($35 \leq \text{BMI} < 40$) without comorbidities were followed for one year without undergoing bariatric surgeries. All patients were warned about their excess weight and advised to lose weight and modify their lifestyle and follow a proper diet. They were warned about the risks and complications related to obesity. After one year, all the patients were invited for re-consultation and their conditions were evaluated in terms of metabolic status and excess weight.

Results:

- Mean primary BMI was 37.2 Kg/m². At the end of one-year follow up, 104 patients were evaluated. During one year, 23 patients presented with BMI_≥40 Kg/m² and underwent surgery.
- Mean BMI was 38.3 Kg/m² at one year.
- At the end of one year, 7 patients were newly diagnosed with type 2 diabetes, 11 patients were diagnosed with dyslipidemia and 6 patients with hypertension.
- At one year, a total of 21 patients (20.2%) had obesity related comorbidities.
- 11 patients reached BMI<35.

Conclusion:



<<<<Before

After >>>>



Conclusion:

Refusing insurance institutions and providers to accept patients with class 2 obesity without comorbidities, cause:

- increase in BMI, as well as disturbance in metabolic status and increase the risk of obesity related comorbidity, instead of leading to lifestyle modification and weight loss.
- A considerable number of patients, return with higher BMI and new obesity related comorbidity, seeking surgery
- Postponed surgery in these patients will probably be associated with more complications and weaker results.
- Health systems and insurance systems should update criteria for MBS in their regulations



Thank you ...

Ali Vahidirad, MD

Minimally Invasive, Metabolic and Bariatric Surgeon

Assistant professor of MIS-MBS

Golestan University of Medical Sciences, Gorgan, IRAN

