Introduction

INTRODUCTION

Obesity is becoming the plague of the twenty-first century . With overweight becoming the norm in most Western countries and developing countries, two-thirds of adults su ff er from over weight or obesity (Table 68.1). Every clinician and definitely every surgeon faces the condition and its associated diseases, such as type 2 diabetes, as part of their practice. According to the W orld Health Organization (WHO), overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. For adults, WHO defines overweight 2 as a body mass index (BMI) of 25 /uni00A0 kg/m or more and obesity 2 as a BMI of 30 /uni00A0 kg/m or more. Severe obesity increases the risk of cancer, is associated with multiple other diseases, a ff ects quality of life and reduces life expectancy by 5–20 years. Severe and complex obesity is a phrase commonly used for 2 patients with BMI ≥ 35 /uni00A0 kg/m and obesity-related disease, or 2 BMI ≥ 40 /uni00A0 kg/m by itself (Table 68.2). Overweight and obesity can be considered normal physio logical responses to the current food environment. Few people Bariatric surgery comes from the Greek ‘baros’ (meaning weight/pressure) and ‘iatric’ (the medicine or surgery thereof). with obesity have a single identifiable genetic or hormonal MC4R deficiency represents the most common genetic basis. form of severe obesity , with heterozygous mutations in MC4R detected in up to 5% of patients with severe, early-onset obe - - sity . Surgeons encounter the challenge of obesity on a daily basis as it a ff ects the treatment of nearly every abdominal pathology in terms of approach and outcomes. Obesity is a heterogeneous disease and the response of individuals seeking treatment to di ff erent therapeutic modali - ties is variable. Currently there are no available robust tools to predict this response. T herefore a trial of options is required. The principles of therapeutic interventions for all other dis - eases are applicable, including escalation of treatment, cessa - tion of modalities that are not e ff ective and addition of therapy when the response is insu ffi cient or transient. Lifestyle modifi - cations, supervised interventions, pharmacotherapy , bariatric surgery and bariatric surgery combined with pharmacother - apy are a vailable interventions. It is important to stress that the - response is a biological phenomenon and not a volitional one.

a,b TABLE 68.1 De /f_i nitions of overweight and obesity. 2 Adult weight status BMI (kg/m) Normal 18.5–24.9 Overweight 25.0–29.9 Class 1 obesity 30.0–34.9 Class 2 obesity 35.0–39.9 Class 3 obesity ≥ 40.0 2 Body mass index (BMI) = weight (kg)/height (m) a Obesity for children is de /f_i ned as BMI at or above the 95th centile. b ‘Super-obesity’ is a term commonly used to describe BMI 2 ≥ 49.9 /uni00A0 kg/m . Multidisciplinary assessment and multimodal treatment • The common operations and how they work • How to assess and treat perioperative complications • Follow-up, nutritional supplements and biochemical • monitoring TABLE 68.2 Conditions that are associated with severe and complex obesity. Type 2 diabetes Hypertension Dyslipidaemia Obstructive sleep apnoea Arthritis and functional impairment Gastro-oesophageal re /f_l ux disease Non-alcoholic fatty liver disease/non-alcoholic steatohepatosis Polycystic ovary syndrome Clinical depression Various cancers, in particular endometrial cancer

ulation of the stomach and/or small bowel to achieve weight loss and control of obesity-related disease.

Revision #1
Created 2025-12-31 15:25:22 UTC by Omar Ayman
Updated 2025-12-31 15:25:22 UTC by Omar Ayman