PRINCIPLES OF SETTING UP A BARIATRIC METABOLIC SUR

PRINCIPLES OF SETTING UP A BARIATRIC/METABOLIC SURGERY SERVICE

As for gastrointestinal cancer surgery where a number of di ff erent specialists routinely work together, it is now agreed that ‘bariatric physicians/internists’, dieticians, mental health professionals and nurse practitioners should be part of the 2 for team assessing and managing long-term care after bariatric - surgery (Table 68.4). The perioperative risk of surgery is low; however, outcomes can be improved further with appropriate multidisciplinary team (MDT) work-up. Using risk scores such - as the Edmonton Obesity Staging System (EOSS) and the Obesity Surgery–Mortality Risk Score (OS-MRS) can help the team discuss with patients the likely prognosis without surgery , and the risk of complications. The OS-MRS scores 2 one point for each of: age 45 or more; BMI 50 /uni00A0 kg/m or more; male gender (owing to central obesity); hypertension (owing to central obesity); and increased deep vein thrombosis (DVT)/ pulmonary embolism (PE) risk. The more points that are pres - ent, the greater the risk. Swedish registry data indicate that obstructive sleep apnoea (OSA) is a risk factor for anastomotic leak. Therefore OSA should be actively investigated as treat - ment with continuous positive airwa y pressure might reduce risk. Poorly controlled diabetes must also be considered a risk factor, as it is for all other operations. Better surgical results are likely in high-volume surgical units. IFSO and the American Society for Metabolic and Bar - iatric Sur gery (ASMBS) recommended 100–125 cases per year, and there should be at least two surgeons each performing 50 or more cases. Sur geons early in the learning curve (about 100 for gastric bypass) need to be mentored bef ore independent practice. Irrespective of the technical expertise of each sur - geon, higher volumes usually mean that there are su ffi cient

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Each unit should have expertise in a variety of surgical proce dures, including revisions. It is routine to put patients on a ‘liver shrinkage diet’ for at least 2 weeks before surgery , especially when there is central obesity , as this is associated with a large liver that can make surgery impossible. Male pa tients, especially those with central obesity , a very dense/hard abdomen, OSA/diabetes and BMI 2 >50 /uni00A0 kg/m , may need more, supervised, mandatory weight loss to make surgery safe. Although not stipulated in any national guidance, every successful bariatric unit depends on active patient support groups and preoperative education sessions, which are best run by bariatric nur ses and dieticians. These are invaluable in preparing patients for surgery , and it is

di ffi cult to conceive how a programme can run without them. Also, the ward and outpatient environment must be suitably equipped for patients with severe obesity . Summary box 68.3 Multidisciplinary assessment /uni25CF /uni25CF /uni25CF

Every patient should be assessed and managed by a coherent and well-functioning team of healthcare professionals with varied backgrounds and expertise Improved outcomes are usually achieved in high-volume specialised units Data collection and submission to national registries are recommended to provide quality assurance and long-term outcomes

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