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PRACTICE

10-MINUTE CONSULTATION

Bariatric surgery

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This is part of a series of occasional articles on common problems in primary care. *The BMJ* welcomes contributions from GPs.

An obese 34 year old man with a body mass index of 37.4, type 2 diabetes, and hypertension presents wanting advice on weight loss. He is concerned about his lack of progress despite adhering to a six month primary care led weight loss regime. He has heard of weight loss surgery being offered by the NHS and wants to know if he is eligible.

What you should cover

- Ask the patient about what weight loss measures he has tried so far. For example:
  -How has he modified his diet and physical activity?
  -Has he tried weight support or management programmes?
- Check dates of any prescriptions issued for drug interventions.
- Check attendance (current or future) at a tier 3 weight management service, which may affect eligibility for bariatric surgery in England (table⇓).[1]
- Assess whether any clinically beneficial weight loss has been achieved. As this is not defined in the guidelines, we suggest the following:
  Objective improvements—Body mass index, waist circumference, improved blood pressure control, better glycaemic control.
  Subjective improvements—Energy levels, mobility, general health and wellbeing.
- Assess eligibility for surgery (table⇓).
- Assess the patient for comorbidities that may affect his eligibility for surgery, including cardiovascular, respiratory, kidney, or liver disease.
- Check that he does not have uncontrolled alcohol or drug dependency—ask about alcohol and drug use, check medical records, and administer AUDIT-C questionnaire to screen for alcohol misuse if concerns exist.[2]

What you should do

- Outline the available surgical options:
  -There are two main types of surgery, almost always done via keyhole (laparoscopic) surgery: one that restricts how much can be eaten (restrictive) and one that limits absorption from the gut (malabsorptive).
  -Commonly offered procedures include sleeve gastrectomy (restrictive), gastric banding (restrictive), and gastric bypass (combination of restrictive and malabsorptive).
  -Surgery may involve a stay in hospital of up to a few days.
  -Each type of surgery has its own specific complications, and the surgical team will explain these in greater detail, but direct the patient to appropriate online resources.[3 4]
- Discuss possible benefits of surgery[5]:
  Weight loss—On average 25% loss of body weight, depending on the procedure (bypass ~30%, banding ~18%). Warn that weight loss may be transient, with some weight gain recurring after two years.
  Some comorbidities may improve—However, this is not inevitable. For example, type 2 diabetes may require less or no insulin, obstructive sleep apnoea may not require nocturnal continuous positive airway pressure, lipid profile may improve (although patients may still need a statin if they have concurrent ischaemic heart disease), and hypertension may be better controlled.
  Lower mortality—29-40% lower risk of death from any cause compared with no surgery.
  Better quality of life—Studies show overall improvement, with greater improvement in physical functioning than in mental state.
- Discuss the short term postoperative risks:
  -Perioperative mortality is low (<0.3%) and depends on the type of operation (bypass > banding) and patient related factors (comorbidities, age).

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The bottom line

Refer patients for bariatric surgery if they have body mass index >35 with associated obesity conditions (type 2 diabetes, hypertension, obstructive sleep apnoea) and have failed to control their weight with non-surgical efforts

Consider referral at a lower body mass index if the patient is of Asian origin, has new onset type 2 diabetes, or both

-Complication (4-25%) and reoperation rates (22-26%) vary depending on operation type and patient related factors (history of thromboembolism, obstructive sleep apnoea, extremes of body mass index, or impaired functional status).[5]

-Encourage the patient to find out more himself and offer sources of information.

- Discuss long term postoperative complications:

-Following a successful operation and recovery, patients may still experience complications including nutritional deficiencies (iron, vitamin B_{12}, folic acid, vitamin D), which require lifelong monitoring and replacement when needed.

-Patients will not be able to eat the same amount and type of food as before. This is difficult to predict. They will have to see what works best for them, although they will be given advice and support by the specialist team.

-For gastric banding, failure rates of 30-50% are common and revision surgery is not routinely offered on the NHS.

-Warn patients who have had or are having bypass about the risk of dumping syndrome (postprandial feeling of faintness, sweating, and palpitations that may be accompanied by bloating, nausea, and diarrhoea caused by rapid movement of food, especially sugar, from the stomach into the duodenum), hypoglycaemic events, and lower alcohol tolerances.

-Excess skin can result from weight loss, and its removal is not offered on the NHS.

-The surgical team will discuss operation type specific complications with them.

- Impress on the patient the need for long term follow-up. This includes regular follow-up for at least two years with the surgical team and a lifelong commitment to annual monitoring with the GP, with review of symptoms and complications, weight, nutrition, and mineral and vitamin concentrations, with replacement treatment if necessary.
- If potentially eligible, and the patient remains keen, refer him for bariatric surgery. The patient has the ultimate responsibility to decide about his care, but remind him that eligibility decisions also lie with the surgical team. In this case, the patient would be eligible as he meets all the criteria
- Provide written information. The Patient.co.uk and NHS Choices websites offer detailed information for patients about the entire process,[3 4] empowering them to make informed treatment decisions.

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Table

Table 1| Bariatric surgery eligibility criteria in England (as defined by NICE guideline)[1]

Body mass index	Extra eligibility criteria	6 month NSI requirement*
≥27.5	Asian origin and recent onset T2DM	No
≥30	Recent onset T2DM	No
≥35	Obesity related comorbidity†	Yes
≥40	None	Yes
≥50	None	No

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