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Guidelines for the Delivery of Obesity Surgery

Clinical Guidelines Committee
Royal College of Surgeons in Ireland

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Guidelines for the delivery of Obesity Surgery, Royal College of Surgeons in Ireland

These guidelines represent the views of the Royal College of Surgeons in Ireland (RCSI) on the use of surgery to aid weight reduction for people with morbid obesity and were arrived at after careful consideration of the available evidence. In the absence of credentialing, health professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of health professionals to make appropriate decisions in the circumstances of each individual patient, in consultation with the patient.

Definition - for the purpose of these guidelines, people are defined as having morbid obesity if they have a body mass index (BMI) either equal to or greater than 40 kg/m^2 or greater than 35 kg/m^2 in the presence of significant co-morbid conditions that could be improved by weight loss.

With the availability of minimally invasive techniques, there is a potential for the patient to consider this type of surgery as minor. It is incumbent upon the bariatric surgeon to warn the patient of the potential benefits and longer term implications of surgery as well as the associated risks, including serious complications and postoperative mortality.

The evidence would suggest that surgery can be recommended as a treatment option for people with morbid obesity, who fulfil the previously identified BMI criteria, providing all of the following criteria are also fulfilled :

1. this type of surgery should be considered only for people who have been receiving intensive management in a specialised hospital obesity clinic;
2. individuals should be aged 18 years or over;
3. there should be evidence that all appropriate and available non-surgical measures have been adequately tried, but have failed to maintain weight loss;
4. there should be no specific clinical or psychological contra-indications for this type of surgery;

5. individuals should be generally fit for anaesthesia and for surgery;
6. individuals should understand the need for long-term follow-up.

Patients who demand this type of surgical approach and who do not fit the above guidelines should be considered as having the procedure carried out for cosmetic or lifestyle reasons.

There is no doubt that surgery should only be undertaken after comprehensive multidisciplinary assessment. In addition, arrangements should be made for appropriate healthcare professionals to provide preoperative and postoperative counselling and support to individuals being considered for surgery. Each patient, therefore, should have access to a specialist team consisting of a specialist dietician and a dedicated nurse (ideally a specialist gastric surgery nurse). Each team should also include a physician with a special interest in obesity to assess the patient for surgery, a specialist bariatric surgeon, a specialist anaesthetist and, where appropriate, a radiologist. In addition, psychological support during preoperative and postoperative assessment and for counselling of patients should be provided.

The importance of informed consent cannot be underestimated. The choice of surgical intervention should be made jointly by the individual and the specialist surgeon after considering the best available evidence, the facilities and equipment available and the experience of the surgeon, who will perform the operation.

Given the paucity and uncertainty in the data available, it is problematic to compare different surgical procedures. Surgery does, however, appear from the limited evidence available to be cost effective compared with conventional treatment. Therefore, we believe that all specialists that offer or want to offer surgery for people with morbid obesity should establish and maintain a database of these patients. Each patient record on the database should include evidence of surgical procedure undertaken and the short-term and long-term outcomes, including complications, mortality, co-morbidity, long-term weight loss and impact on quality of life, and that the criteria for this type of surgery were met by the patient.

Postoperative care is crucial. Care should be available to manage complications as they occur and patients should receive dietary and, where appropriate, psychological advice to help them modify their eating habits to maintain weight loss and to prevent complications such as vomiting, dumping syndrome and diarrhoea. It is, therefore, imperative, that postoperatively these patients should have available to them expert Consultant surgical care from those Consultant Surgeons who have had experience in the management of acute postoperative surgical complications following surgery for morbid obesity. Likewise, any hospital delivering this service must put in place adequate structures to ensure ongoing post-operative care both emergently and planned.

Surgeons purporting to offer this type of surgery should, as a minimum requirement, be on the Register of Medical Specialists in the Division of General Surgery and should, in addition, have undertaken specialist training in bariatric surgery at some stage in their career.

We believe that there is evidence to suggest that a minimum volume of this type of procedure is likely to lead to maintenance and indeed improvement of surgical skills. Although no evidence exists to suggest exact numbers, we believe that surgeons in this field should be performing an adequate number of procedures per annum.

Hospitals and private institutions that wish to deliver this type of service should pay due cognisance to these guidelines.

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