Bariatric surgery

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1 Bariatric surgery is indicated for patients with a body mass index (BMI) of 40 kg/m² and higher

Based on a systematic review, bariatric surgery can also be considered for those with a BMI of 35 kg/m² and higher and one or more comorbid diseases, such as hypertension, type 2 diabetes mellitus and obstructive sleep apnea. Some suggest considering bariatric surgery for those with recent-onset type 2 diabetes at a BMI of 30 kg/m² and higher.^{1,2} Roux-en-Y gastric bypass and sleeve gastrectomy are the most common bariatric surgeries in Canada and are typically performed laparoscopically.

2 Bariatric surgery is the most effective means of sustained weight loss

Based on long-term clinical trial data, mean weight loss five years after gastric bypass was 23 kg, compared with 5 kg with medical treatment.² Before surgery, patients are assessed by a comprehensive multidisciplinary team that evaluates and optimizes obesity-related comorbidities, both medical and psychosocial; looks for causes of obesity; and identifies patients who are not good candidates for bariatric surgery (e.g., who have severe and untreated psychiatric disease or a complex surgical history).

3 Bariatric surgery is associated with reductions in comorbidities such as diabetes, metabolic syndrome, obstructive sleep apnea and hypertension

Following bariatric surgery, about one-quarter of patients with type 2 diabetes achieve a glycosylated hemoglobin of less than 6% and decreased use of insulin and oral antihyperglycemic medications.² Other benefits include reduced rates of hypertension, obstructive sleep apnea and dyslipidemia at 3–5 years after surgical intervention.^{2,3}

4 The risk of short-term complications varies

The risk of a major complication (obstruction, hemorrhage, venous thromboembolic event) in the first 30 days after surgery is about 5%, and depends on comorbidities, preoperative functional status, type of procedure being performed, and surgeon and hospital expertise.⁴ Short-term complications include bleeding, surgical-site infection, incisional and ventral hernia, and anastomotic leaks.^{2,4}

5 Micronutrient deficiencies can occur after gastric bypass

The following investigations should be ordered within about four weeks after surgery (and in the months thereafter) to assess for micronutrient deficiencies: 24-hour urinary calcium, vitamin B12, folic acid, iron studies, 25-vitamin D, parathyroid hormone and vitamin A.⁵ Other tests (e.g., copper, zinc, selenium, thiamine) can be considered if patients have clinical signs or symptoms that suggest deficiencies.⁵

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