

Original article

Safety and efficacy of laparoscopic adjustable gastric banding in patients aged seventy and older

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Abstract

Background: Life expectancy is increasing, with more elderly people categorized as obese. The objective of this study was to assess the effects of laparoscopic adjustable gastric banding (LAGB) on patients aged ≥ 70 years.

Methods: This was a retrospective analysis of patients aged ≥ 70 years who underwent LAGB at our university hospital between 2003 and 2011. The data included age, weight, body mass index (BMI), and percentage excess weight loss (%EWL) obtained before and after gastric banding. Operative data, length of stay, postoperative complications, and resolution of co-morbid conditions were also analyzed.

Results: Fifty-five patients aged ≥ 70 years (mean 73 years) underwent gastric banding between 2003 and 2012. Mean preoperative weight and BMI were 123 kilograms and 45 kg/m^2 , respectively. On average, each patient had 4 co-morbidities preoperatively, with hypertension ($n = 49$; 86%), dyslipidemia ($n = 40$; 70%), and sleep apnea ($n = 31$; 54%) being the most common. Mean operating room (OR) time was 49 minutes, with all patients discharged within 24 hours. There was 1 death at 4 years from myocardial infarction, no intensive care unit admissions, and no 30-day readmissions. Mean %EWL at 1, 2, 3, 4, and 5 years was $36 (\pm 12.7)$, $40 (\pm 16.4)$, $42 (\pm 19.2)$, $41 (\pm 17.1)$, $50 (\pm 14.9)$, and $48 (\pm 22.6)$, respectively. Follow-up rates ranged from 55/55 (100%) at 6 months to 7/9 (78%) of eligible patients at 5 years and 2/2 (100%) at 8 years. Complications included 1 band slip at year 5, 1 band removed for intolerance, and 1 port site hernia. The resolution of hypertension, dyslipidemia, sleep apnea, lower back pain, and non-insulin-dependent diabetes was 27%, 28%, 35%, 31%, and 35%, respectively.

Conclusions: LAGB as a primary treatment for obesity in carefully selected patients aged ≥ 70 can be well tolerated and effective with moderate resolution of co-morbid conditions and few complications. (Surg Obes Relat Dis 2014;10:284–290.) © 2014 American Society for Metabolic and Bariatric Surgery. All rights reserved.

Keywords:

Elderly; Obesity; Gastric banding; Safety; Bariatric

As the population of the United States ages, more elderly people are categorized as being clinically obese [1]. Obese patients experience shorter life expectancy and poorer

quality of life compared with age-matched peers [2]. This is because of the effects of co-morbidities, such as hypertension, type 2 diabetes, joint pain, and sleep apnea. Elderly obese patients also require considerably more resources, medications, and interventions as a result of obesity-related illnesses. Weight loss surgery results in improved social functioning and quality of life [3]. Although bariatric

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surgery is widely accepted as a treatment for obese patients, there is reluctance in some centers to perform surgery on patients >65 years. This may be because of a perceived fear over surgical safety in this age group and potentially fatal perioperative complications. A recent systematic review and meta-analysis of bariatric surgery in patients >55 years concluded that 30-day mortality for laparoscopic adjustable gastric banding (LAGB) was .18%, which is similar to mortality rates in the younger population [1]. Most published research studies in the bariatric literature have classified “elderly” for bariatric surgery as either age >55 years or age >65 years, with no consensus on accepted upper age limits for offering surgery. There is also a paucity of data regarding outcomes in patients aged ≥ 70 years undergoing bariatric surgery. Although no one particular bariatric surgery is risk free, LAGB would seem a safe choice in the older population given its safety profile, relatively low morbidity and mortality rates, and shorter operating times compared with other bariatric procedures such as gastric bypass or sleeve gastrectomy [4]. The procedure can be performed as a day case, limiting the total hospitalization time, although most elderly patients have an overnight stay for monitoring postanesthesia. The primary purpose of this study was to analyze the safety of LAGB, its effect on weight loss, as well as established co-morbid conditions in patients aged seventy and older in our center.

Methods

A retrospective review was undertaken of all patients aged ≥ 70 years who underwent laparoscopic adjustable gastric banding surgery in our hospital between 2003 and 2011. All patients preoperatively met the National Institutes of Health consensus development conference criteria for bariatric surgery. All surgeries were performed by 1 of 3 board certified bariatric surgeons. Patient demographic characteristics and clinical data were entered prospectively into our database (Minnesota Database for Bariatrics; Exemplo Medical, Eden Prairie, MN), and records were reviewed retrospectively. Demographic details including age, sex, weight (kilograms), height (cm), body mass index (BMI) (kg/m^2), and percentage excess weight loss (%EWL) were recorded.

Excess weight loss was measured as actual weight loss divided by starting weight minus ideal weight. Clinical details such as co-morbidities, daily medication use, and previous surgery also were recorded for each patient. Each patient underwent extensive preoperative surgical testing, including full blood analysis, electrocardiogram, chest x-ray, upper GI barium contrast study, and upper gastrointestinal endoscopy if indicated. In addition, all patients aged ≥ 70 were required to undergo assessment by a cardiologist and pulmonologist before surgery. Each patient also was required to undergo psychological evaluation

by 1 of 2 affiliated psychologists and any underlying psychological issues addressed before undergoing surgery. Patients also met with a nutritionist and were prescribed a 14-day protein shake diet to shrink the liver and facilitate gastric band placement.

The LAGB was placed using 5 trocars via the pars flaccida technique in 42 patients. The remaining 13 patients had their LAGB placed via a single-incision technique through the umbilicus. The band was placed 1–2 cm below the gastroesophageal junction and secured in place with monofilament suture of the cardia and fundus below the band to the pouch above the band. If found, hiatal hernias were repaired, also using Prolene suture. The band port was placed and sutured to the anterior abdominal wall to the right of the midline to allow for future band fills and adjustments. Contrast esophagram was obtained in the first postoperative week to confirm correct band position and check pouch size. Most patients were discharged on postoperative day 1, having been advised to maintain a liquid diet for the first 10 days. During the following 10 days, patients were advanced to pureed foods and then to solid foods. The first band fill was carried out 6 weeks postoperatively, and the amount inserted was dependent on band type. Adjustments were performed in the office without the use of fluoroscopy. Subsequent adjustments were determined on the basis of appetite, weight loss, and satiety. Patients were reviewed in the office every 4–6 weeks in the first year, every 3 months in the second year, and every 6 or 12 months thereafter.

Operative data recorded included operative time in minutes, band type and size, and whether a hiatal hernia repair was carried out simultaneously (if one was found, as is our normal practice). Length of stay (LOS) in days, intensive care unit (ICU) admission, postoperative complications, further surgery, and readmission rates were recorded for each patient in the database. Death within 30 days or 1 year of surgery, readmission within 30 days, and attendance at our emergency department was recorded for each patient. At each postoperative office visit, weight, height, BMI, and blood pressure were recorded. Blood was drawn for full blood panel, comprehensive metabolic panel, and lipids. Data regarding preexisting co-morbidities was evaluated looking at improvement, resolution, or worsening of these conditions. Current medications and use of medical devices, such as continuous positive airways pressure (CPAP) machines for those with sleep apnea, also were recorded for all patients. Each patient had an annual esophagram undertaken to check the position of the band and exclude slippage or pouch dilation. Data were expressed as mean $\pm$ SD.

Results

From January 2003 to January 2012, 55 patients aged ≥ 70 years underwent LAGB surgery for the treatment

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