

Clinical Science

Weight loss outcomes among patients referred after primary bariatric procedure



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Conversion

Abstract

BACKGROUND: Bariatric patients may not always obtain long-term care by their primary surgeon. Our aim was to evaluate weight loss outcomes in patients who had surgery elsewhere.

METHODS: We conducted a retrospective analysis. Postreferral management included nonsurgical, revision, or conversion. Primary outcomes were percent excess weight loss (%EWL) overall, according to original operation, and based on postreferral management.

RESULTS: Between 2001 and 2013, there were 569 patients. Mean follow-up was 3.1 years. Management was 42% nonsurgical, 41% revision, and 17% conversion. Overall, mean %EWL was 45.3%. Based on original surgery type, %EWL was 41.2% for adjustable gastric banding vs 58.3% for Roux-en-Y gastric bypass ($P \leq .0001$). Management affected %EWL (41.2% nonsurgical vs 45.3% revision vs 55.1% conversion, $P \leq .0001$).

CONCLUSIONS: Patients referred after bariatric surgery can achieve satisfactory weight loss. This differs based on surgery type and management strategy.

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The obesity epidemic continues to grow worldwide.¹ Bariatric surgery remains a highly effective treatment for morbid obesity, with long-term durability.² To maintain its efficacy, surgery requires periodic follow-up, with frequency of visits depending on procedure type, comorbidity status, and patient characteristics.³ There are no firmly established guidelines on specific timing or frequency of patient follow-up. Nonetheless, it is generally accepted that the surgeon performing the primary bariatric procedure will be the provider to oversee the patient's long-term surgical follow-up. As such, it can be challenging to manage a patient who has undergone surgery before referral. There are certain instances in which patients

Table 1 Demographic characteristics of the study cohort (n = 569)

| | |
|--------------------------|-------------|
| Age (years) | |
| Mean (SD) | 38.3 (11.5) |
| [Range] | [18–68] |
| Sex, n (%) | |
| Female | 457 (80) |
| Male | 112 (20) |
| Race, n (%) | |
| Caucasian | 388 (68) |
| African American | 61 (11) |
| Hispanic | 36 (6) |
| Asian | 2 (<1) |
| Native American | 1 (<1) |
| Other | 60 (11) |
| Unknown | 21 (4) |
| BMI (kg/m ²) | |
| Mean (SD) | 46.3 (7.3) |
| [Range] | [35.1–88.6] |
| Surgery type, n (%) | |
| AGB | 441 (78) |
| RYGB | 118 (21) |
| BPD-DS | 5 (1) |
| SG | 3 (<1) |
| Banded bypass | 2 (<1) |

AGB = adjustable gastric banding; BMI = body mass index; BPD-DS = biliopancreatic diversion with duodenal switch; RYGB = Roux-en-Y gastric bypass; SD = standard deviation; SG = sleeve gastrectomy.

seek a different surgeon for follow-up after their primary procedure, including patient or surgeon relocation, unsatisfactory care, complications, or change in insurance status.

There is a paucity of research in the current literature regarding outcomes among patients referred elsewhere after bariatric surgery. The few articles that address the subject of postbariatric surgical care focus mainly on the team vs individual approach, as well as differences between providers in coordinating follow-up care.^{4,5} Singhal et al⁴ compared the follow-up care between surgeon and dietician for patients undergoing laparoscopic adjustable gastric banding (AGB) and found that dietician-led follow-up care was an effective way to manage weight loss. Another study focused on the use of an individual surgeon vs surgical team approach in the perioperative care of patients undergoing laparoscopic Roux-en-Y gastric bypass (RYGB), and found that a team-based approach was more optimal.⁵ One group investigated the feasibility of combined group and individual visits, and found group visits to be well received by patients and a viable option for postoperative care.⁶

Our practice has received a number of self-referrals among patients having previously undergone primary bariatric surgery elsewhere. This presents a unique challenge in providing long-term care for such patients. As such, we sought to investigate the weight loss outcomes among patients undergoing primary bariatric surgery with subsequent referral to our practice. Specifically, our aim was to

determine whether patients can achieve adequate weight loss after referral, and also to compare the effectiveness among different postreferral management strategies.

Patients and Methods

We conducted a retrospective review of an Institutional Review Board-approved, prospective database of patients referred to our practice who initially underwent primary bariatric surgery elsewhere from 2001 to 2013. The time of referral was identified as our first encounter with the patient. Postreferral visits (ie, patient encounters in our practice) were defined as any patient interaction with our comprehensive weight management program, including outpatient visits, emergency room encounters, inpatient admissions, and operations. Office visits included appointments with our nurse practitioners, physician assistants, dietitians, and medical bariatrician, as well as with our surgeons. Finally, the end date was the most recent follow-up with the patient at the time of data collection.

Data collected included demographic information, preoperative weight/body mass index (BMI), date and type of primary operation, referral date and reason, weight and BMI at referral and at last follow-up, and number of postreferral visits. Inclusion criteria were age greater than or equal to 18 years and BMI greater than or equal to 35 kg/m². To obtain representative results, we excluded patients who were referred to our practice within 60 days of their original surgery, as this was deemed too short of a postoperative period to be able to meaningfully compare outcomes. We also excluded those patients who were followed in our practice for less than 60 days for similar reasons. In addition, those patients who were converted to another bariatric procedure before being referred to our practice were also excluded.

Patients were subsequently categorized according to postreferral management strategy: (1) nonsurgical, (2) revision, or (3) conversion. Nonsurgical management was defined as interventions not requiring an operation, including percutaneous gastric band adjustments, dietary counseling, appetite suppressant therapy, and/or enrollment in a medical weight loss program. The revision category included any surgical intervention aimed at modifying the original bariatric procedure. Finally, the conversion group consisted of those patients undergoing surgery aimed at changing the type of bariatric procedure to a new one.

Ideal body weight used for percent excess weight loss (%EWL) was calculated using the Robinson formula from the Metropolitan Life Insurance Tables.^{7,8} Primary outcomes were %EWL overall, %EWL according to original operation, and %EWL based on postreferral management strategy. A subset analysis was performed, which compared weight loss outcomes between prereferral and postreferral time periods. In this analysis, we focused on those patients with weight loss “failure.” The rationale for this is that those patients who had successful weight loss had such

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