



Original article

Preoperative predictors of adherence to multidisciplinary follow-up care postbariatric surgery

Soroush Larjani, Hon. B.Sc.^{a,b}, Israel Spivak, Hon. B.Sc.^a, Ming Hao Guo, Hon. B.Sc.^a,
Babak Aliarzadeh, M.D., M.P.H.^a, Wei Wang, R.N., M.N., N.P. (Adult)^a,
Sandra Robinson, R.N., M.N., N.P. (Adult)^a, Sanjeev Sockalingam, M.D., F.R.C.P.C.^{a,c},
Mary-Anne Aarts, M.D., M.Sc., F.R.C.S.C.^{a,c,*}

^aThe University of Toronto Bariatric Collaborative, Toronto, Canada

^bDivision of General Surgery, Toronto East General Hospital, Toronto, Canada

^cDepartment of Psychiatry, University Health Network, Toronto, Canada

Received October 31, 2015; accepted November 9, 2015

Abstract

Background: Long-term multidisciplinary care after bariatric surgery is important for weight maintenance and management of co-morbidities. Despite this, the rate of attendance to follow-up appointments is universally low.

Objective: To identify patient factors that contribute to adherence to follow-up care after bariatric surgery.

Setting: Three university-affiliated hospitals in Canada

Methods: A cohort study of 388 patients who underwent bariatric surgery from January 2011 to December 2011 was performed. This program mandates multidisciplinary follow-up care at 3, 6, and 12 months, and annually thereafter. Patients' socioeconomic, psychosocial, and medical and psychiatric co-morbidities were recorded prospectively. Adherence to follow-up care was defined as having attended the majority of clinic visits (3 or 4 out of 4); all other patients were considered nonadherent.

Results: The mean age of patients was 45.0 years, 81.2% were female, and the majority underwent a gastric bypass (91.8%) versus a sleeve gastrectomy (8.2%); 62.1% of patients were adherent to follow-up appointments. Patients older than 25 years had a higher adherence rate than those who were younger (63.2% versus 37.5%, $P = .040$). Patients with full-time or part-time employment had a significantly higher adherence rate than those who were unemployed or retired (65.6% versus 50.0%, $P = .017$, odds ratio 1.9). Patients with obstructive sleep apnea (OSA) before surgery had higher follow-up adherence than those without OSA (62.2% versus 37.8%, $P = .044$). In multivariate analysis, employment remained an independent predictor of follow-up adherence ($P = .017$).

Conclusion: Employment was the strongest predictor of attendance to follow-up clinic. Patients with OSA and older patients were also more likely to return consistently for scheduled follow-up. (Surg Obes Relat Dis 2016;■:00–00.) © 2016 American Society for Metabolic and Bariatric Surgery. All rights reserved.

Keywords:

Bariatric surgery; Patient compliance; Predictors; Weight loss

*Correspondence: Mary-Anne Aarts, M.D., M.Sc., F.R.C.S.C., Division of General Surgery, Toronto East General Hospital, 650 Sammon Avenue, Suite K401, Toronto, Ontario, Canada, M4C 5M5.

E-mail: maat@tegh.on.ca

Bariatric surgery is a highly effective treatment option for morbidly obese patients in terms of both weight loss and resolution of obesity-related co-morbidities [1–3]. Optimal weight loss is typically achieved by 18–24 months after

surgery [4]; however, long-term weight loss and maintenance is variable and not always achieved. Up to 50% of patients experience weight regain and return of related co-morbidities within 5–10 years of their surgery [4–6]. Studies have found that patients with higher rates of clinical follow-up attendance are more likely to have long-term weight loss and resolution of co-morbidities [7–11]; therefore, follow-up attendance and long-term adherence are highly recommended for bariatric patients and associated with desirable long-term outcomes [12].

Attrition is a known problem in postoperative bariatric patients, and rates vary considerably between different bariatric centers. Attrition rates have been reported to be as low as 3% and as high as 63% [13,14]. Although it is clear that follow-up attrition contributes to poor long-term outcomes, little is known of the patient factors and characteristics that contribute to and predict attrition [15]. In the current literature, only a handful of studies have focused on this matter and varying results have been reported [13]. Therefore, identifying such factors and barriers to follow-up adherence is imperative in identifying at risk patients; with this knowledge, additional support can be provided to this patient population to facilitate follow-up attendance, reduce potential complications, and ensure sustained weight loss.

The aim of this study was to identify predictors of adherence to follow-up clinic after bariatric surgery in a publicly-funded healthcare system.

Methodology

Study population

This was a cohort study of prospectively collected data on patients who underwent bariatric surgery (laparoscopic Roux-en-Y gastric bypass or sleeve gastrectomy) from January 1, 2011 to December 1, 2011 through the University of Toronto Bariatric Surgery Collaborative. This program consists of an interprofessional team of surgeons, psychiatrists, psychologists, nurse practitioners, dietitians, and social workers, who assess patients for bariatric surgery and provide bariatric aftercare for up to 5 years postsurgery in a single clinic. Patients undergo surgery at 1 of 3 university-affiliated hospitals and then return to the multidisciplinary clinic for all scheduled follow-up visits. The program was accredited as a level 1A bariatric surgery center of excellence by the American College of Surgeons at the time of its inception.

Eligible patients were between 18 and 65 years of age with a body mass index (BMI) >40 or BMI >35 with co-morbidities of obesity and met National Institutes of Health's criteria for bariatric surgery [16]. Patients consenting to participate in prospective data collection completed a questionnaire about their socioeconomic status and data was collected on their psychosocial status at baseline. This study

was granted approval by the institution's Research Ethics Board.

Bariatric surgery assessment process

Before undergoing surgery, baseline co-morbidities were assessed by a nurse practitioner or medical internist, and a psychiatrist or psychologist evaluated all patients for any history of psychiatric illness along with any ongoing psychiatric co-morbidities using the Mini International Neuropsychiatric Interview (MINI) [17].

Before undergoing surgery, all patients were given details about the clinic follow-up regimen and were verbally asked and agreed to commit to 5 years of follow-up in the multidisciplinary bariatric clinic. The follow-up regimen includes a 1 month postsurgery visit followed by a multidisciplinary team assessment at 3 months, 6 months, 12 months, and then annually thereafter. At each time interval patients are assessed and counseled by a nurse practitioner, dietitian, and a social worker or psychologist within the program who were also involved in assessing patients preoperatively. At each visit patients are assessed with respect to their diet, stressors, co-morbidities, medications, weight, and blood work. An attempt is made to book all appointments with the team members for the patient on the same day. There is also an option for patients who need to travel to follow up through teleconference via the health center in their local community. When needed, further appointments are made for interval follow-up by team members including a bariatric surgeon or specialized psychiatrist. As part of the routine procedure in the program, patients who miss appointments are called to reschedule their appointment. Three telephone calls are made, and if no contact is made by phone, a letter is sent to the patient's home address instructing him or her to contact the clinic to make an appointment.

Data collection

Patients' demographic characteristics, physical characteristics, socioeconomic status, and health status were collected from the study's prospectively maintained database. Patient demographic variables included age, gender, education level, employment, marital status, and distance to clinic. Employment status was categorized into 2 groups on the basis of occupational time commitment: working versus nonworking. The working group included those with full- and part-time occupation status, and the nonworking group included those who were retired or unemployed. Travel distance to clinic was categorized into 4 groups: 0–49 km, 50–100 km, 101–500 km, and >500 km to reflect geographic areas and proximity to the city center. Variables describing patients' physical characteristics included height, weight, and BMI. Patients' medical co-morbidities were collected, including asthma or chronic obstructive

Download English Version:

<https://daneshyari.com/en/article/6111141>

Download Persian Version:

<https://daneshyari.com/article/6111141>

[Daneshyari.com](https://daneshyari.com)