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Surgery for Obesity and Related Diseases ■ (2014) 00–00

SURGERY FOR OBESITY
AND RELATED DISEASES

Original article

The role of bariatric surgery in morbidly obese patients with inflammatory bowel disease

Andrei Keidar, M.D.^{a,*}, David Hazan, M.D.^b, Eran Sadot, M.D.^a, Hanoch Kashtan, M.D.^a, Nir Wasserberg, M.D.^a

^aDepartment of Surgery, Beilinson Medical Center, Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

^bCarmel Medical Center, Bruce Rappaport Faculty of Medicine, The Technion, Haifa, Israel

Received April 29, 2014; accepted June 30, 2014

Abstract

Background: Bariatric surgery is considered as being contraindicated for morbidly obese patients who also have inflammatory bowel disease (IBD). The aim of our study was to report the outcomes of bariatric surgery in morbidly obese IBD patients.

Methods: The prospectively collected data of all the patients diagnosed as having IBD who underwent bariatric operations in 2 medical centers between October 2006 and January 2014 were retrieved and analyzed.

Results: One male and 9 female morbidly obese IBD patients (8 with Crohn's disease and 2 with ulcerative colitis) underwent bariatric surgery. Their mean age was 40 years, and their mean body mass index was 42.6 kg/m². Nine of them underwent a laparoscopic sleeve gastrectomy and 1 underwent a laparoscopic adjustable gastric band. Eight patients had obesity-related co-morbidities, including type 2 diabetes, hypertension, sleep apnea, osteoarthritis, etc. After a median follow-up of 46 months (range 9–67), all of the patients lost weight, with an excess weight loss of 71%, and 10 out of 16 obesity-related co-morbidities were resolved. There was 1 complication not related to IBD, and no IBD exacerbation.

Conclusion: Bariatric surgery was safe and effective in our morbidly obese IBD patients. The surgical outcome in this selected patient group was similar to that of comparable non-IBD patients. (Surg Obes Relat Dis 2014;■:00–00.) © 2014 American Society for Metabolic and Bariatric Surgery. All rights reserved.

Keywords:

Morbidly obese; Inflammatory bowel disease; Laparoscopic sleeve gastrectomy; Laparoscopic adjustable gastric banding; Co-morbidities

The prevalence of obesity has increased over the last few decades and is now considered a global epidemic [1]. Although obesity is traditionally considered unusual in patients with inflammatory bowel disease (IBD), it has been reported to be on the increase in this patient population as well [2,3], with significantly higher rates for Crohn's disease (CD) than for, ulcerative colitis (UC) patients. A

recent observational Scottish study found that 18% of the IBD population was obese (body mass index [BMI] > 30 kg/m²) in comparison to 23% of the Scottish population as a whole [2]. Another report revealed that weight has been increasing over time from 1991–2008 in CD patients, as evidenced by baseline data from randomized clinical trials [4]. Although IBD is not considered a “classical” obesity-related co-morbidity, both entities share a cause-and-effect relationship and are associated with increased inflammatory reaction [5]. There is some evidence that overexpressed obesity-related inflammatory cytokines may actually induce

*Correspondence: Andrei Keidar, M.D., Department of Surgery, Beilinson Medical Center, Jabotinsky 39, Petach Tikva, Israel.
E-mail: keidar66@yahoo.com

IBD [4]. Moreover, several studies showed increased morbidity among obese IBD patients, including a higher hospital admission rate, more frequent anoperineal complications and increased disease activity [6,7]. Other published data indicated that obese IBD patients are subject to higher rates of complications after IBD-related surgical interventions, and that those complications were because of obesity co-morbidities as well as anatomic considerations [8,9].

Bariatric surgery is reported to be the most effective option for weight loss in the severely obese, and the number of patients undergoing surgery for weight loss is dramatically increasing [1,10]. When it comes to severely obese IBD patients, however, surgeons are reluctant to carry out any non-IBD related intestinal operation because of the probable higher rates of short- and long-term complications [11]. This is especially applicable to bariatric procedures [12], and therefore evidence in the literature on the outcome of obesity surgery in patients with IBD is sparse and mostly derived from small numbers of case reports [13]. We report the outcomes of surgically induced weight loss in a series of 10 morbidly obese IBD patients.

Methods

Patients and study design

The data collection was approved by the Research Ethics Committee of both participating medical centers, and patient consent was waived. The records of all the patients diagnosed as having IBD who underwent bariatric operations in 2 hospitals were retrieved from the prospectively collected data throughout the study period (from October 2006 to January 2014).

All of the morbidly obese patients referred to our obesity clinics for potential surgical treatment undergo a multidisciplinary evaluation by a dietician, psychologist, and a bariatric surgeon. In addition, they all attend a lecture that includes a comprehensive description of the indications, risks, and benefits of the different types of bariatric procedures. The indications for surgery included a BMI >40 kg/m² or >35 kg/m² together with at least 1 severe obesity-related co-morbidity (type 2 diabetes, hypertension, sleep apnea, osteoarthropathy, etc.) and the failure of previous conservative attempts to lose weight. The choice of the procedure was made according to the individual characteristics of the patient, such as age, BMI, health-related conditions, previous operations, medications, degree of self-discipline, eating habits (“addiction” to sweets, binge eating), anatomic conditions (e.g., large hiatal hernia), and individual preferences of the candidate when there was more than one option.

The diagnosis of IBD was established by an appropriate clinical picture, endoscopic findings and occasionally by pathologic examination. A prerequisite before proceeding with the decision for performing bariatric surgery was a

letter of referral from the treating gastroenterologist, which included a detailed explanation of the clinical manifestations, extent of the disease, complications, and treatment. Special emphasis was placed on an endoscopic report describing the extent of bowel involvement. Each patient underwent preoperative blood tests consisting of complete blood count, routine blood chemistry, liver and kidney function tests, lipid profile, albumin, transferrin, iron, ferritin, folic acid, vitamin B12, parathyroid hormone, calcium and phosphorus, preoperatively. The same tests were performed postoperatively. Anthropometric measurements included weight, height, BMI, and percent excess weight loss (%EWL).

Operative technique

Only 2 types of bariatric operations were performed in the current series, laparoscopic adjustable gastric banding (LAGB) and laparoscopic sleeve gastrectomy (SG). The pneumoperitoneum was created by insertion of the optic trocar to the left of the midline above the umbilicus. After insufflation, additional 12-mm working trocars were introduced under direct vision. Dissection was performed with 5-mm ultrasonic shears (Ethicon Endosurgery, Cincinnati, OH). LAGB was performed by a pars flaccida technique, using a Swedish band (Obtech, Johnson & Johnson, Cincinnati, OH) without suture band fixation. The SG was performed using 5 ports. The omentum adjacent to the whole length of the greater curvature and splenic short gastric vessels were divided by a harmonic scalpel (Ethicon Endosurgery). Different sizes of gastric bougies were inserted into the pylorus. The longitudinal stomach division started at 2 cm proximally to the pylorus by consecutive application of an endoscopic stapler (blue and green load, EndoGIA 45 mm, or Echelon golden load, Ethicon Endosurgery) parallel to the bougie, up to the gastroesophageal junction. A gastric tube (sleeve) <100 cc in volume was placed, and the remaining 80% of the stomach was excised. The staple line was inverted by placing a sero-serosal continuous polydioxanone suture in patients operated by author DH but not by author AK. Diluted half-strength methylene blue dye (50 cc) was used to test for leaks. The duodenum was clamped, and irrigating the sleeve usually caused the dye to overflow back to the patient’s mouth. The excised stomach was removed by enlarging the peritoneal and fascial opening of the 12-mm trocar and by pulling the entire bulk from the antrum without the need for a protecting bag. The enlarged fascial opening was closed with a single figure-of-8 Maxon No. 1 suture, and a drain was left along the suture line through one 5-mm port for 2 days. On postoperative day (POD) 1, the patients underwent a Gastrografin[®] X-ray study to rule out leaks, after which they were started on sips of clear liquids. None of these tests showed an obstruction on the POD 1 contrast swallow studies

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