

Virtual Mentor

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PERSONAL NARRATIVE

Through the Physician's Eyes: Evaluating Patients for Gastric Bypass Surgery

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Media coverage of singer Carnie Wilson's gastric bypass surgery has brought the topic to the attention of many and probably will prompt a surge of requests for the procedure. It is reasonable to assume that not all who respond to ads offering the surgery or request it from a surgeon will be suitable candidates. We asked 2 physicians who specialize in treating patients with obesity to discuss the topic, addressing specifically how they determine patient eligibility for the surgery and what its risks and benefits are.

For nearly 40 years, doctors and patients have turned to surgical options in an attempt to produce sustained weight loss. Since its introduction nearly 3 decades ago, the Roux-en-Y gastric bypass has become the gold standard for evaluating surgical treatments for morbid obesity. Improvements in surgical techniques and pre-, peri-, and post-operative management have resulted in reductions in complications and surgical mortality and improved durability of the gastric bypass. When patients inquire about the possibility of bypass surgery for morbid obesity, they must be well informed of the risks of the surgical procedure and the benefits that they can expect to achieve. The surgery poses considerable risks, with frequently quoted operative mortality rates ranging from 0.5-1.5 percent, and major complications ranging from 5 to 10 percent. Several large, recently published studies of laparoscopic gastric bypass have reported mortality rates less than 0.5 percent.

Balancing these risks are the potential benefits, which are substantial. Nearly 1 in 3 Americans is obese, a condition which is a major contributing factor towards the development of diabetes, hypertension, hyperlipidemia, and atherosclerotic heart disease. Obesity is also associated with an increase in mortality rates, the risk of death increasing with the increase in Body Mass Index (BMI). Fifteen percent of those classified as obese fall into the category of extreme or morbid obesity, as defined by a BMI greater than 40. Myriad other medical conditions result from, or are exacerbated by, this excessive weight, including gastroesophageal reflux disease, urinary incontinence, venous stasis disease, low back pain and osteoarthritis, hepatic steatosis, obstructive sleep apnea, pseudotumor cerebri, and the obesity hyperventilation syndrome consisting of pulmonary hypertension, right heart failure, hypoxemia, and hypercapnea. Unfortunately, medical therapy, whether dietary, pharmacological, or behavioral, is unsuccessful in producing sustained weight loss in over 95 percent of patients who are morbidly obese.

With surgery, type II diabetes may be reversed in up to 90 percent of patients; the effects on hyperlipidemia are marked. Resolution or improvement in all of the aforementioned conditions can be expected. What other single operation or treatment can cure or improve more than 15 diseases or co-morbid illnesses? The risks and benefits of surgery must be individualized for each patient. I often find that the patients with the highest peri-operative risk are those with the most to gain. A homebound oxygen-dependent patient with biventricular failure would be considered a prohibitive operative risk for most other operations, but when faced with the alternative—no effective therapy—a gastric bypass is a sound and, most often, a greatly beneficial choice. Having counseled more than 1,000 prospective weight loss surgery patients, I have found less than 1 percent for whom the risk of surgery is too great.

While the overwhelming majority of morbidly obese patients could benefit from weight loss surgery, not all are appropriate candidates. A patient's mental approach to gastric bypass is the key to optimal success as well as satisfaction. They must understand that they will never eat "normally" again. Patients must learn to eat small portions, chew well, eat slowly, and stop when they are full. Overeating will result in discomfort and vomiting. Some foods may not be tolerated. Eating, for many patients with morbid obesity, has served as a coping mechanism or crutch in times of stress. The weight loss surgery candidate must be willing to make this break with food and if they do not, they are likely to be unhappy despite weight loss, which will often be less than average.

Unfortunately, preoperative psychological testing has been unable to accurately select, with a few exceptions, who will fail and who will succeed following a bariatric surgical procedure. Psychological counseling is, however, a very important part of the postoperative adaptation phase for many patients. I have found that personalized preoperative counseling with a patient, discussing the changes that can be expected following surgery, is the best way to determine who is an appropriate candidate for a gastric bypass. I may meet with a patient on 3 occasions to discuss risks, benefits, and lifestyle changes prior to surgery.

The decision to proceed usually resides with the patient. Patients are strongly encouraged to start a regular exercise program preoperatively, are given intensive dietary counseling, and are asked to try to lose 10 to 15 pounds prior to surgery. Many experienced bariatric surgeons require preoperative weight loss prior to surgery in an attempt to eliminate patients less likely to comply with post operative dietary and activity instruction. While such a process may improve results, it may also exclude many patients who would benefit from a weight loss procedure. One of my patients, for example, is 39 years old and weighed more than 600 pounds. He was homebound, cared for by his elderly parents, and had developed severe congestive heart failure and the obesity hypoventilation syndrome. His blood gas values, in room air, were PaO₂ of 37 mm Hg and PaCO₂ of 76 mm Hg. Although this patient strongly desired a gastric bypass, it was clear from our discussions that

he was unlikely to exercise regularly and dietary compliance would be a problem. He is now 4 years post op and has lost more than 200 pounds. He still will not exercise, and dietary compliance remains a constant challenge. Nevertheless, his cardiorespiratory difficulties have resolved and he is able to care for his, now severely disabled, parents.

My most frequent reason for denying gastric bypass surgery is that a prospective patient fails to meet minimum weight criteria as established by the NIH consensus guidelines. I have watched a patient purposefully gain 40 pounds to meet eligibility criteria, and I stress that this is not acceptable. Patients who are not candidates for surgery should be placed in comprehensive weight loss management programs. Although success comparable to surgery is unlikely, even modest reductions in weight will result in improvements in diabetes and hyperlipidemia. Accepting a patient for gastric bypass surgery means I am taking on the patient for the remainder of his or her life. Optimal success depends on much more than a well performed surgical procedure. Lifelong emotional support, dietary counseling, and nutritional monitoring are keys to any weight loss surgery program. We have never advertised our services, but are scheduling new patients more than a year in advance. Successful, happy patients are the best advertisement.

Resources

A major criterion of eligibility for gastric bypass surgery is Body-Weight Index (BMI). You can compute your BMI: $\text{Weight [in kilograms]} / (\text{Height [in meters]})^2$ at the National Institutes of Health (<http://nhlbisupport.com/bmi/bmicalc.htm>).

Citation

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