UNIVERSITÀ DEGLI STUDI DI PALERMO

A.O.U. POLICLINICO PAOLO GIACCONE

MeCre

IL RUOLO DEL CHIRURGO D'URGENZA

G. Salamone

U.O. C. CHIRURGIA GENERALE E D'URGENZA

Review > JAMA. 2020 Sep 1;324(9):879-887. doi: 10.1001/jama.2020.12567.

Benefits and Risks of Bariatric Surgery in Adults: A Review

David E Arterburn [1], Dana A Telem [2], Robert F Kushner [3], Anita P Courcoulas [4]

Affiliations + expand

PMID: 32870301 DOI: 10.1001/jama.2020.12567

Observations: There are approximately 252 000 bariatric procedures (per 2018 numbers) performed each year in the US, of which an estimated 15% are revisions. The 1991 National Institutes of Health guidelines recommended consideration of bariatric surgery in patients with a body mass index (calculated as weight in kilograms divided by height in meters squared) of 40 or higher or 35 or higher with serious obesity-related comorbidities. These guidelines are still widely used; however, there is

Review > Surg Obes Relat Dis. 2024 May;20(5):425-431. doi: 10.1016/j.soard.2024.01.012. Epub 2024 Feb 1.

American Society for Metabolic and Bariatric Surgery 2022 estimate of metabolic and bariatric procedures performed in the United States

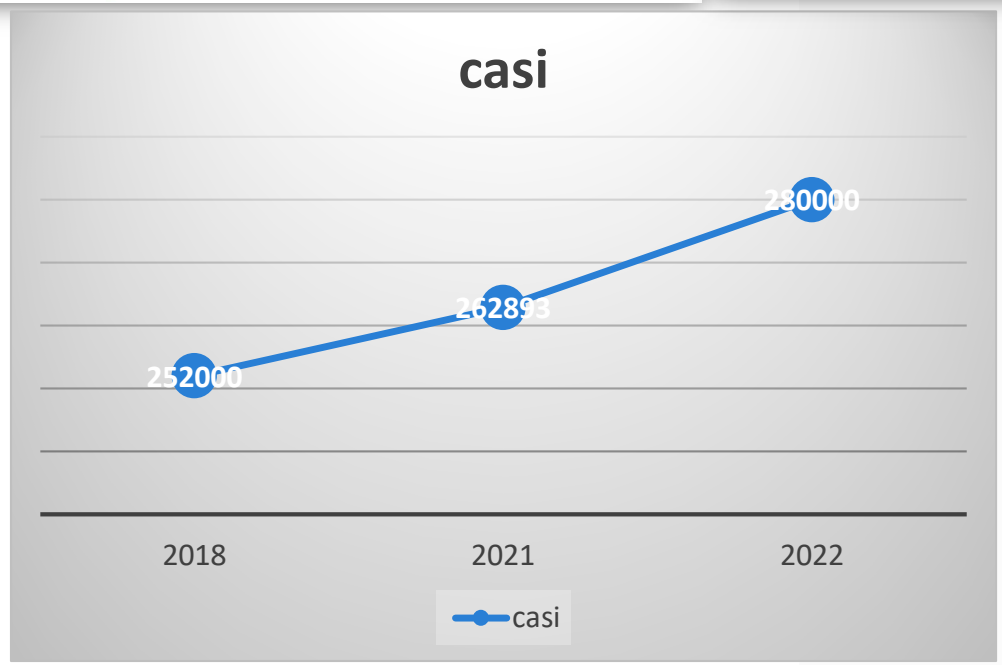
Benjamin Clapp [1], Jaime Ponce [2], John Corbett [3], Omar M Ghanem [4], Marina Kurian [5], Ann M Rogers [6], Richard M Peterson [7], Teresa LaMasters [8], Wayne J English [9]

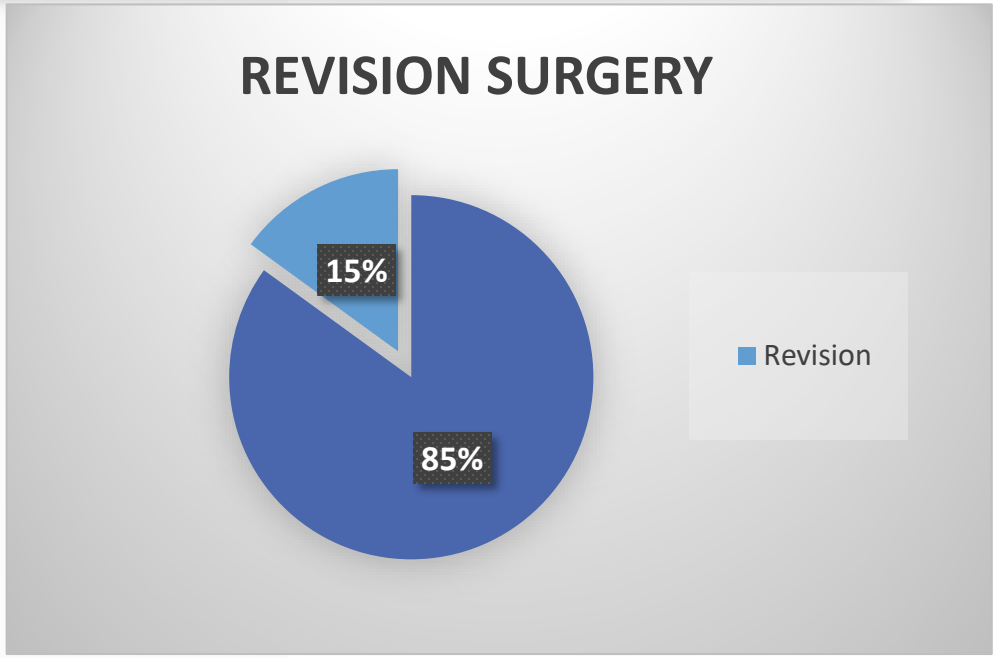
Affiliations + expand

PMID: 38448343 DOI: 10.1016/j.soard.2024.01.012

Results: Compared with 2021, the total number of MBS performed in 2022 increased from approximately 262,893 to 280,000. The sleeve gastrectomy (SG) continues to be the most commonly performed procedure. The gastric bypass procedure trend remained relatively stable. The percentage of revision procedures and biliopancreatic diversion with duodenal switch procedures increased slightly. Intragastric balloon placement increased from the previous year. Endoscopic sleeve gastroplasty increased in numbers.

Conclusions: There was a 6.5% increase in MBS volume from 2021 to 2022 and a 41% increase from 2020, which demonstrates a recovery from the COVID-19 pandemic. SG continues to be the most dominant MBS procedure.





Assenza di centri di riferimento

Obes Surg. 2023 Mar;33(3):930-937. doi: 10.1007/s11695-022-06435-9. Epub 2023 Jan 24.

Evolution of Bariatric Surgery in Italy in the Last 11 Years: Data from the SICOB Yearly National Survey

Paolo Gentileschi [1 2], Bruno Sensi [3], Leandro Siragusa [1], Roberto Sorge [4], Eliana Rispoli [5], Luigi Angrisani [6], Elisa Galfrascoli [7], Emanuela Bianciardi [8], Maria Paola Giusti [7], Maurizio De Luca [9], Marco Antonio Zappa [7]; SICOB Survey Collaborative Group

Collaborators, Affiliations + expand

PMID: 36690866 PMCID: PMC9871429 DOI: 10.1007/s11695-022-06435-9

Results: Median response rate was 92%. AGB declined from 36% of procedures in 2011 to 5% in 2021 ($p < 0.0001$). SG increased from 30% in 2011 to 55% in 2021 ($p < 0.0001$). RYGB declined from 25 to 12% of procedures ($p < 0.0001$). OAGB rose from 0% of procedures in 2011 to 15% in 2021 ($p < 0.0001$). BPD underwent decrease from 6.2 to 0.2% in 2011 and 2021, respectively ($p < 0.0001$). Main non-malabsorptive procedures significantly decreased while overall bypass procedures remained stable. There were significant differences among regions in performance of SG, RYGB, and OAGB.

Conclusions: BS in Italy evolved significantly during the past 10 years. AGB underwent a decline, as did BPD and GP which are disappearing and RYGB which is giving way to OAGB. The latter is rising and is the second most-performed procedure after SG which has been confirmed as the preferred procedure by Italian bariatric surgeons.

110 CENTRI SICOB

CRITERI	Centro di Eccellenza	Centro Accreditato	Centro Affiliato
Il centro segue i criteri di selezione dei pazienti (PDTA formalizzato)	SI	SI	SI
Il centro inserisce la sua casistica nel Registro Nazionale SICOB	SI	SI	SI
Il centro dispone di un follow-up dei pazienti superiore al 50%, regolarmente inserito nel Registro Nazionale SICOB	SI	SI	SI
Il Responsabile dell'evento è iscritto e partecipa alla SICOB da più di tre anni	SI	NO	NO
Il centro dispone di un team multidisciplinare iscritto alla società (Chirurgo - Nutrizionista - Psicologo/Psichiatra)	SI	SI	SI
Il centro esegue un numero minimo di procedure chirurgiche riconosciute dalla SICOB pari a	4	3	2
Il centro ha un volume minimo di attività annuo pari a casi	100	50	25
Il centro ha un volume minimo di Re-Do surgery Annuo	15	-	-
Il centro dispone di terapia intensiva nella struttura di ubicazione del Centro	SI	SI	Si oppure è disponibile in convenzione con altra struttura

World J Emerg Surg. 2020 Jan 6;15(1):2. doi: 10.1186/s13017-019-0281-y.

The Operative management in Bariatric Acute abdomen (OBA) Survey: long-term complications of bariatric surgery and the emergency surgeon's point of view

Belinda De Simone [1], Luca Ansaloni [2], Massimo Sartelli [3], Yoram Kluger [4], Fikri M Abu-Zidan [5], Walter L Biffl [6], Arianna Heyer [7], Federico Coccolini [8], Gian Luca Baiocchi [9]; OBA trial supporters; Fausto Catena [10]

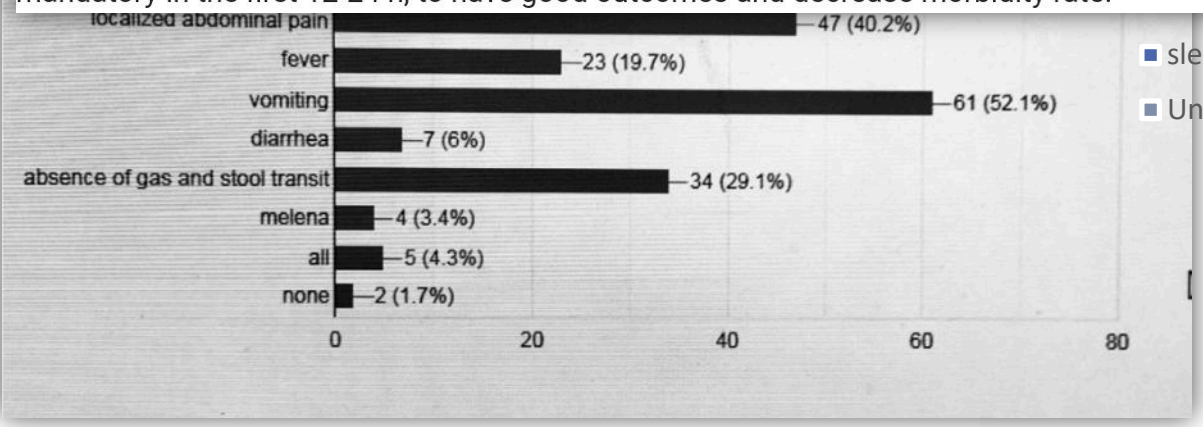
Collaborators, Affiliations + expand

PMID: 32005129 PMCID: PMC6945511 DOI: 10.1186/s13017-019-0281-y

Table 1 Type of bariatric surgery previously undergone by patient presenting with acute abdominal pain

Type of bariatric surgery	Number of answers	%
Sleeve gastrectomy	45/117	38.5

Conclusions: The aim of this WSES web survey was to highlight the current management of patients previously submitted to bariatric surgical procedures by ES. Emergency surgeons must be mindful of postoperative bariatric surgery complications. CT scan with oral intestinal opacification may be useful in making a diagnosis if carefully interpreted by the radiologist and the surgeon. In case of inconclusive clinical and radiological findings, when symptoms fail to improve, surgical exploration for bariatric patients presenting acute abdominal pain, by laparoscopy if expertise is available, is mandatory in the first 12-24 h, to have good outcomes and decrease morbidity rate.



MOTIVI CHE PORTANO IL PAZIENTE IN SALA OPERATORIA IN URGENZA

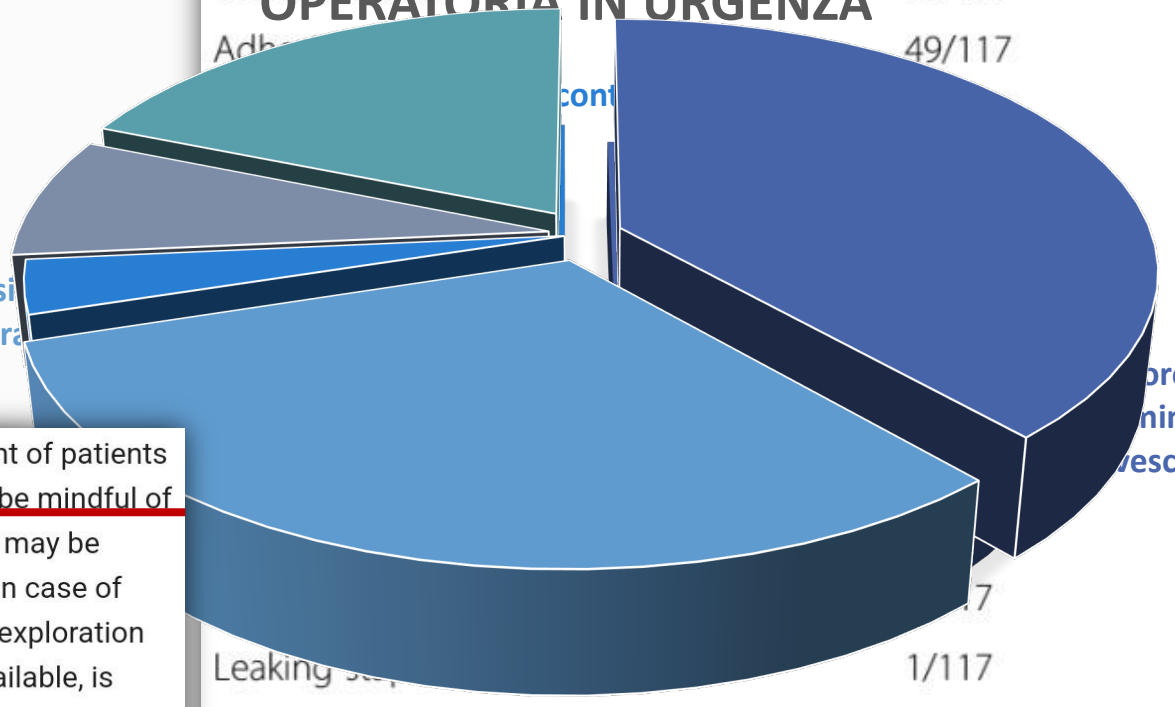


Table 6 Common intra-operative findings in bariatric patients

Intraoperative findings	Number of answers	%
Internal hernia	58/117	49.5
Adh	49/117	41.8
		12.8
		7.6
		7.6
		4.2
		3.4
		0.85
		0.85
	7	2.5
Leaking	1/117	0.85
Cholecystitis	1/117	0.85
Bleeding, abscesses	1/117	0.85
Perforation	1/117	0.85
Bleeding, mesenteric thrombosis	1/117	0.85

Surg Obes Relat Dis. 2020 Oct;16(10):1483-1489. doi: 10.1016/j.soard.2020.05.023. Epub 2020 May 28.

Predictors of postoperative emergency department visits after laparoscopic bariatric surgery

Shravan Leonard

Affiliations + ex

PMID: 32636172

Results: Of 276,07
18,088 (6.6%) wer
Multivariable forw
95% CI, 21.30-23.2
infection (AOR, 7.2
.001), and surgical

Conclusions: Post
laparoscopic baria
decrease postope

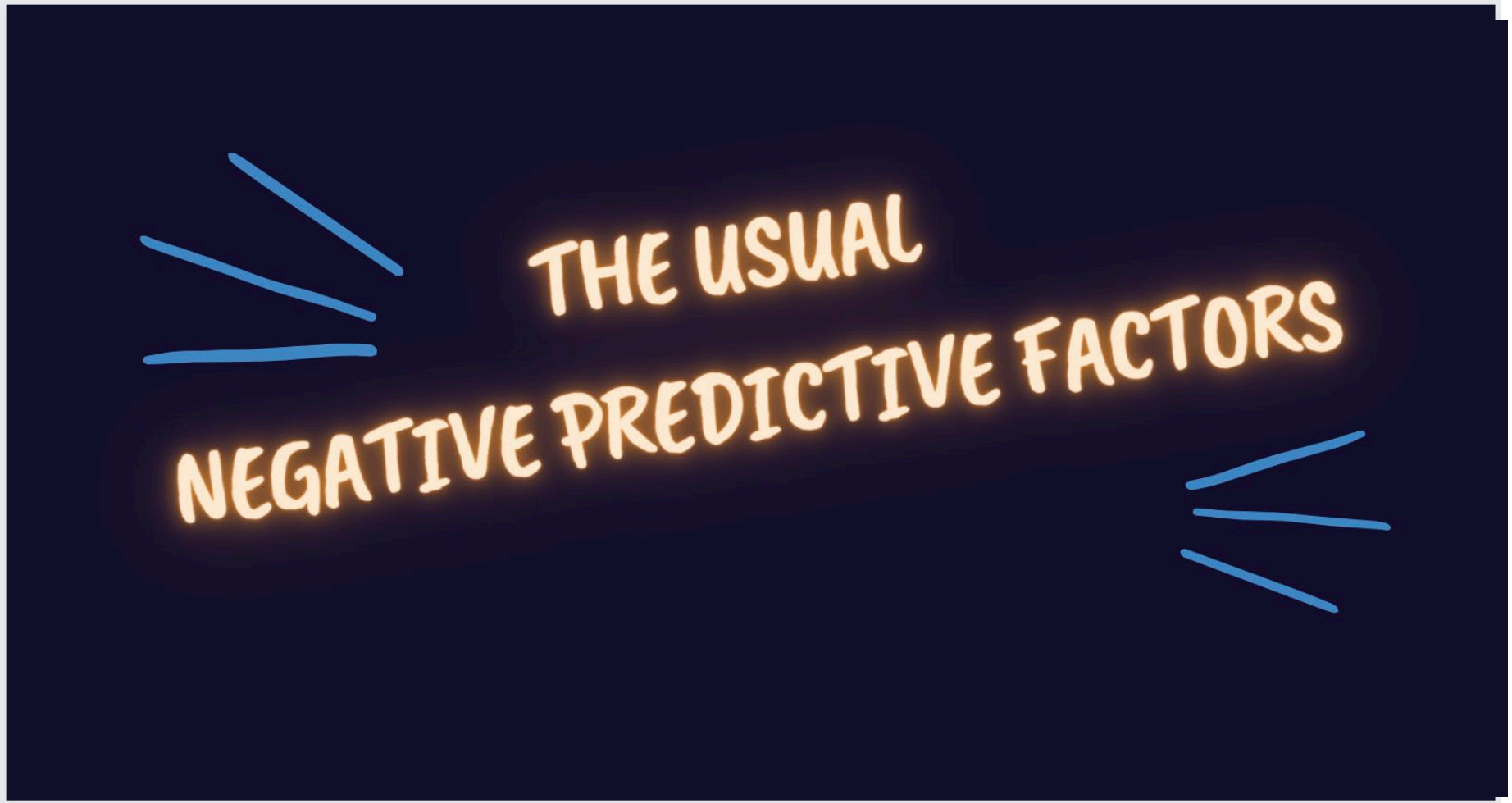


Table 2
Perioperative facto
laparoscopic Roux

Operative factors			
Procedure type			
LSG			
LRYGB			
Revision/conversic			
Drain placement d			
Operation length,			
Length of stay, d			
Postoperative com			
Treatment for deh			
Surgical site infect			
VTE	1063 (.4%)	286 (1.6%)	<.001
Pneumonia	439 (.2%)	129 (.7%)	<.001
UTI	561 (.2%)	386 (2.1%)	<.001
Reintervention within 30 d	2645 (1.0%)	834 (4.6%)	<.001
Wound disruption	109 (.0%)	44 (.2%)	<.001

ED = emergency department; LSG = laparoscopic sleeve gastrectomy; LRYGB = laparoscopic Roux-en-Y gastric bypass; VTE = venous thromboembolism; UTI = urinary tract infection.

Data are presented as counts or means with percentages or standard deviations, as appropriate.

Table 3
Multivariable forward logistic regression models demonstrating associations of variables with emergency department visits after laparoscopic bariatric surgery, laparoscopic sleeve gastrectomy, and laparoscopic Roux-en-Y gastric bypass

Multivariable forward logistic regression model			
Variables	AOR (95% CI)		
	Total	LSG	LRYGB
LRYGB versus LSG	1.41 (1.36–1.47)*		
			.86 (.84–.88)*
			.80 (.74–.86)*
			1.39 (1.29–1.49)*
			1.28 (1.18–1.40)*
			1.36 (1.18–1.57)*
			1.17 (1.10–1.23)*
			1.25 (1.14–1.37)*
			1.38 (1.20–1.58)*
			1.40 (1.17–1.69)*
			16.33 (15.19–17.56)*
			3.31 (2.85–3.84)*
			2.29 (1.77–2.96)*
			2.06 (1.52–2.79)*
Reintervention within 30 d	1.80 (1.63–2.00)*	1.92 (1.65–2.24)*	1.76 (1.55–2.01)*
Wound disruption	4.63 (3.09–6.96)*	7.80 (4.64–13.13)*	2.68 (1.44–4.98)*

AOR = adjusted odds ratio; LSG = laparoscopic sleeve gastrectomy; LRYGB = laparoscopic Roux-en-Y gastric bypass; BMI = body mass index; ASA = American Society of Anesthesiologists class; GERD = gastroesophageal reflux disease; T2D = type 2 diabetes; IDT2D = insulin-dependent type 2diabetes; NIDT2D = noninsulin-dependent type 2 diabetes; COPD = chronic obstructive pulmonary disease; VTE = venous thromboembolism; UTI = urinary tract infection.

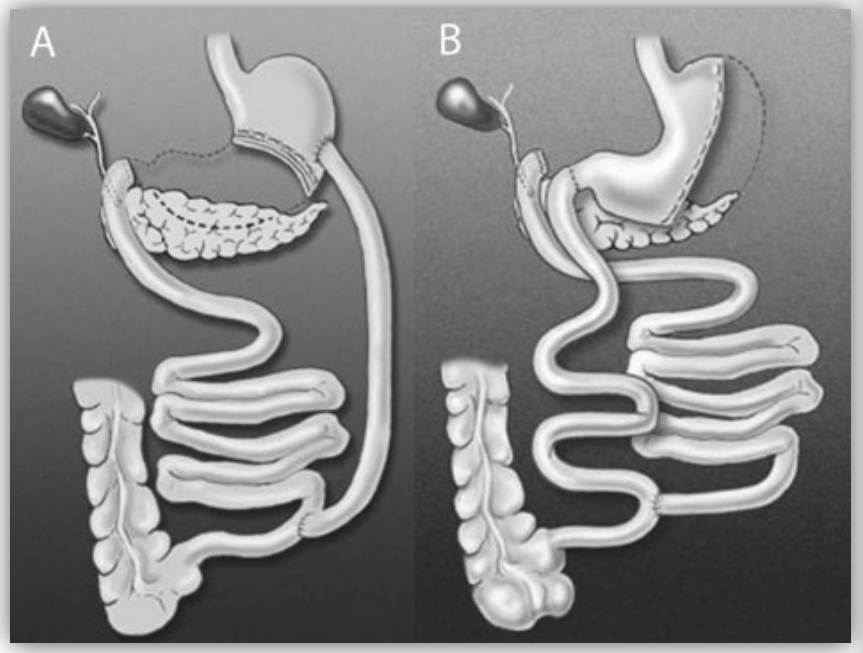
Blank cells = variable was not selected by that particular model.

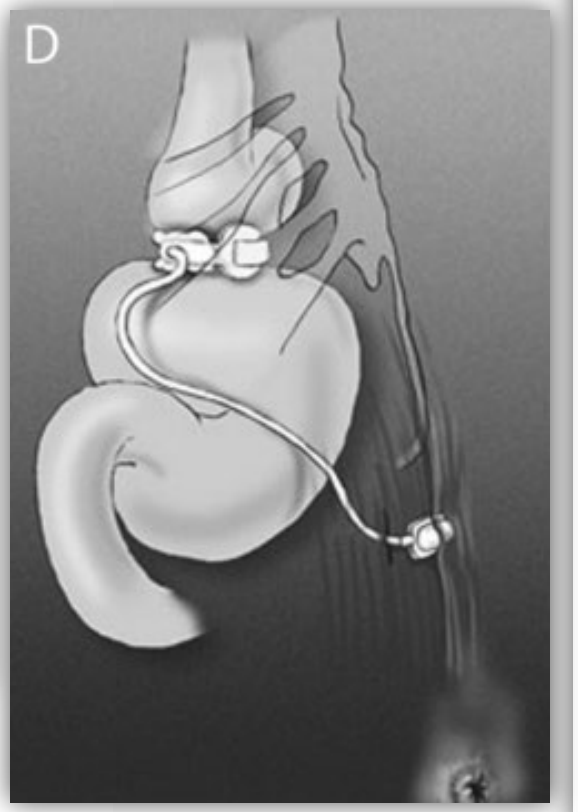
* $P < .05$.

Practice Guideline > World J Emerg Surg. 2022 Sep 27;17(1):51.
doi: 10.1186/s13017-022-00452-w.

Operative management of acute abdomen after bariatric surgery in the emergency setting: the OBA guidelines

Belinda De Simone [1], Elie Chouillard [2], Almino C Ramos [3], Gianfranco Donatelli [4], Tadeja Pintar [5], Rahul Gupta [6], Federica Renzi [7], Kamal Mahawar [8], Brijesh Madhok [9], Stefano Maccatrozzo [10], Fikri M Abu-Zidan [11], Ernest E Moore [12], Dieter G Weber [13], Federico Coccolini [14], Salomone Di Saverio [15], Andrew Kirkpatrick [16], Vishal G Shelat [17], Francesco Amico [18], Emmanouil Pikoulis [19], Marco Ceresoli [20], Joseph M Galante [21], Imtiaz Wani [22], Nicola De' Angelis [23], Andreas Hecker [24], Gabriele Sganga [25], Edward Tan [26], Zsolt J Balogh [27], Miklosh Bala [28], Raul Coimbra [29], Dimitrios Damaskos [30], Luca Ansaloni [31], Massimo Sartelli [32], Nikolaos Pararas [19], Yoram Kluger [33], Elias Chahine [2], Vanni Agnoletti [34], Gustavo Fraga [35], Walter L Biffl [36], Fausto Catena [34]





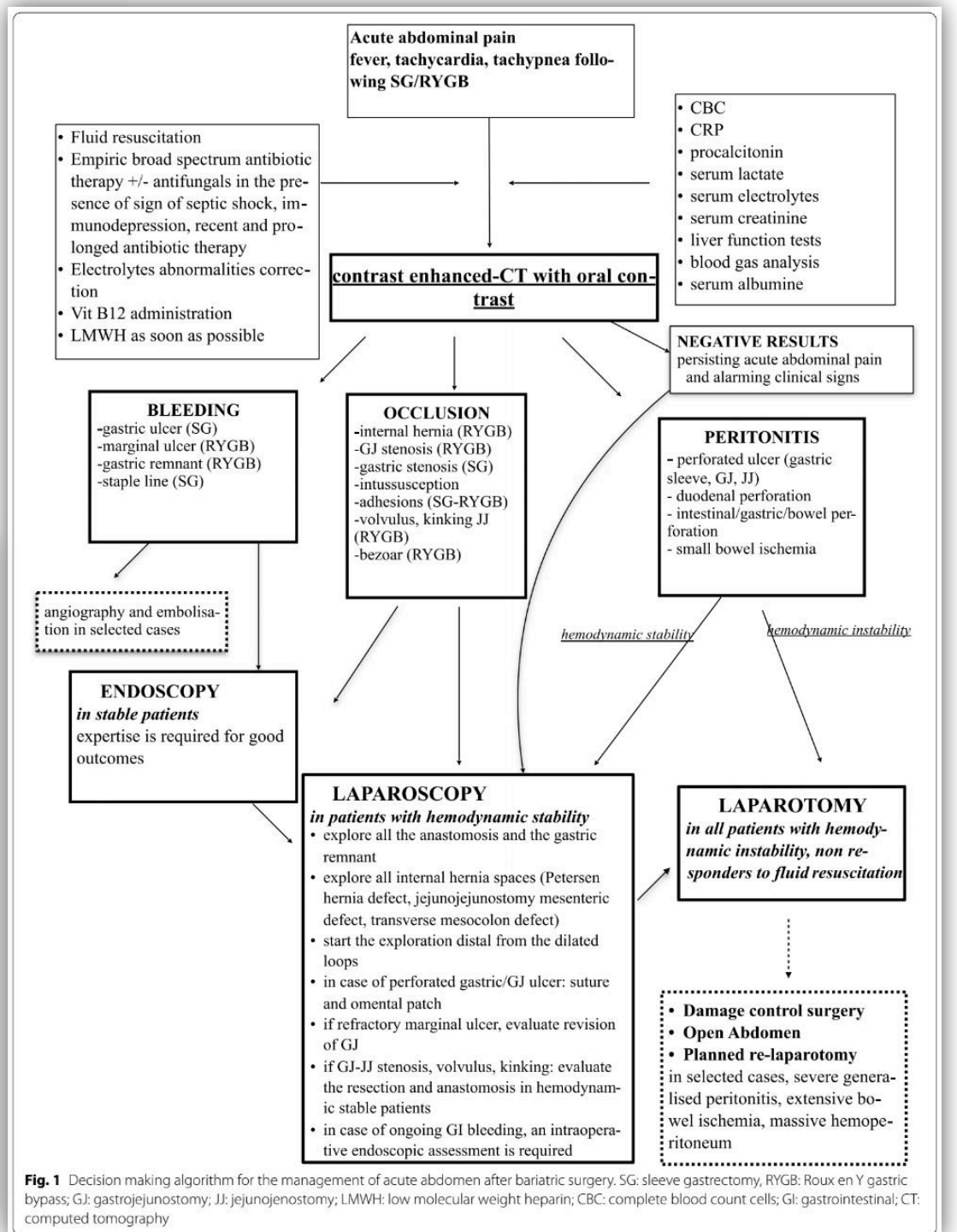
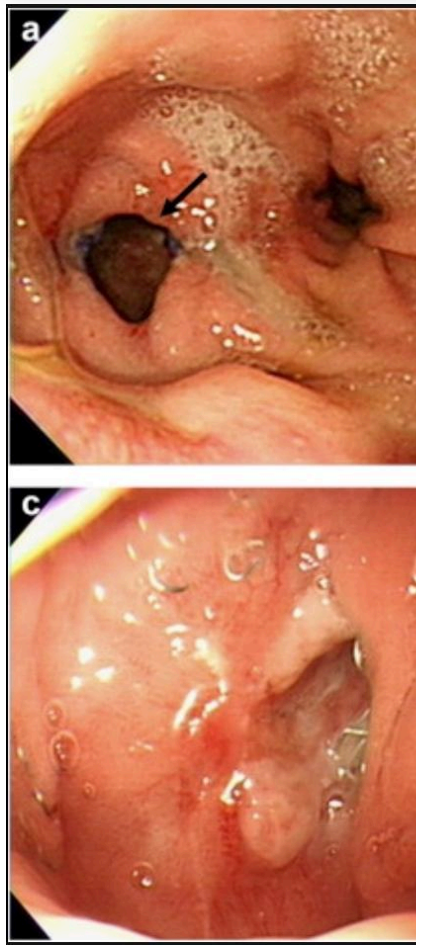


Fig. 1 Decision making algorithm for the management of acute abdomen after bariatric surgery. SG: sleeve gastrectomy, RYGB: Roux en Y gastric bypass; GJ: gastrojejunostomy; JJ: jejunojenostomy; LMWH: low molecular weight heparin; CBC: complete blood count cells; GI: gastrointestinal; CT: computed tomography

Review > Ann R Coll Surg Engl. 200
Epub 2009 Apr 2.

Complications of bari emergency managem

S J W Monkhouse [1], J D T Morgan, S A M
Affiliations + expand
PMID: 19344551 PMCID: PMC2749388



Specialist bariatric management options
Band revision or replacement; conversion to alternative bariatric procedure
Endoscopic stent, re-operation with resection and re-anastomosis
Removal of band. Conversion to alternative procedure
Balloon dilatation; emergency laparotomy; revisional bariatric surgery
Cautious re-fills; band removal and conversion to alternative procedure
Specialist endoscopy; consideration of laparotomy
Out-patient bariatric follow-up

CONCLUSIONS

Obesity is the pathology within pathologies and needs a multidisciplinary approach to bring the patient to the surgical procedure only at the end of a proper diagnostic course.

The patient undergoing bariatric surgery have both short-term and long-term complications.

The lack of ubiquity of accredited bariatric centers with emergency department availability often delivers these patients to the emergency surgeon.

The clinical approach to Bariatric Acute Abdomen is not easy.

Only a multidisciplinary approach, including the bariatric surgeon, allows proper management of the obese patient with long-term complication.

Thanks