Opinion

Upon the need for a new paradigm for bariatric emergencies and complications

Keywords: obesity, surgical treatment, bariatric, paradigm, diabetes

Abbreviations: ASMBS, american society for metabolic and bariatric surgery; LSG, laparoscopic sleeve gastrectomy; LRYGB, laparoscopic roux-en-y gastric bypass; LAGB, laparoscopic adjustable gastric banding

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Morbid Obesity is a worldwide epidemic and is believed to become the largest public health burden of the 21st century.[1] The usage of diet, weight reduction medications, eating habit modifications or pharmacotherapy has been found to be inefficient, while surgical treatment is considered the only proven treatment to reduce and maintain the weight loss[2] in short and long term.[3] Close to 200,000 patients in the US underwent bariatric procedures in 2015 according to the American Society for Metabolic and Bariatric Surgery (ASMBS).[4] Current common bariatric procedures include Laparoscopic Sleeve Gastrectomy (LSG), Laparoscopic Roux-en-Y Gastric Bypass (LRYGB), and Laparoscopic Adjustable Gastric Banding (LAGB).[5]

Choosing the appropriate bariatric procedure for each patient is challenging. Also challenging is the complexity of the procedures and the unique complications attached to each. Campanile et al.[6] have discussed the acute complications after bariatric and they believe, that an orderly stepwise approach to the bariatric patient with an emergency condition, is advisable. One must remember that abdominal pain is the most common reason for bariatric patients to present to the emergency department and can represent a diagnostic challenge to emergency room physicians. Due to the unique altered anatomy following the procedures there are specific complications related to each individual procedure. Certain complications in bariatric surgery patients can have a high rate of morbidity and mortality. An improved understanding of bariatric procedures and their complications will allow for improved vigilance and management.[7] The obese patient tends to mask abdominal illness and even catastrophes due to the thick abdominal wall and ample reserves these patients have–thus for example, if we remember that in a normal person bleeding more than a liter can cause shock, in an obese patient due to the larger blood volume this amount can be doubled.

Many obese patients suffer from diabetes which puts them in a state of immune suppression, which means they are unable to mount an immunological response (i.e. no fever), and a higher chance of wound infection.

Just like in the 1980s, physicians and surgeons across North America began to reevaluate how the most severe traumas were triaged and treated; we need to have a new way of evaluating and treating patients undergoing bariatric surgery. In trauma care a new paradigm has started to rule the realm–The Advanced Trauma Life Support, or ATLS. ATLS started in the mid 70's as a way of imbuing medical personnel with a common algorithm, and more important than that a common language. We believe that a similar approach should be administered for bariatric patients, making the treatment more efficient and giving the care takers a common language and practices, which will enable them to give the best treatment, with the least hazard to these patients and in an effective and efficient way.

One must remember that the number of bariatric procedures done annually is on the rise, and patients undergoing these procedures are able to travel worldwide, and if we will not have a common language and common understanding of the pathophysiology of the different operations, patients are at increased risk for morbidity and even mortality. It is up to us to build now a new scheme, relevant for bariatric patients at large, with a complication and procedure specific attitude, just as we have a basic theme for all trauma patients, with specific algorithm for each and every organ injured in ATLS. Due to the complexity of the bariatric patients, as well as the procedures used in this realm, one cannot rely upon the clinical experience and knowledge of each physician that might see these patients, and it is up to us–bariatric surgeons, general surgeons and emergency medicine physician–to formulate and base a pathway that is specific for patients post bariatric surgery, that will on the one hand give us all a common language, and on the other hand let us give a more efficient treatment to these patients, thus lowering the morbidity and mortality.

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Conflict of interest

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