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**NATIONAL STUDY FINDS OUTPATIENT BARIATRIC SURGERY MAY LEAD TO
HIGHER MORTALITY AND COMPLICATIONS**

**Releasing Patients Same Day as Surgery, Sooner than National Average
Leads to 13-Fold Increase in 30-day Mortality**

ORLANDO, FL – June 15, 2011 – A new study of nearly 52,000 patients found that people who had gastric bypass surgery and were discharged from the hospital sooner than the national average of a two-day length of stay, experienced significantly higher rates of 30-day mortality and complications. The findings* were presented here at the 28th Annual Meeting of the American Society for Metabolic & Bariatric Surgery (ASMBS).

Stanford University researchers found patients discharged on the same day of surgery were 13 times more likely to die than patients who left after two days (risk adjusted), and were 12 times more likely to have serious complications (1.9% vs. 0.16%). Patients who spent more time in the hospital but were discharged in less than 24 hours after an overnight stay, were two times more likely to die than patients who left after two days of recovery. The overall 30-day mortality rate was 0.1 percent for patients who stayed in the hospital for two or more days, and about 0.8 percent for those who were discharged on the same day of surgery.

“This study shows what a difference a day makes,” said John Morton, MD Associate Professor of Surgery and Director of Bariatric Surgery at Stanford Hospital & Clinics at Stanford University, one of the co-authors of the study. “Bariatric surgery is safer than ever, but discharging patients too soon after surgery may be pushing the envelope too far and may have serious consequences.”

The data was obtained from the Bariatric Outcomes Longitudinal Database (BOLD™), the world's largest and most comprehensive repository of clinical bariatric surgery patient information. Participants in the ASMBS Bariatric Surgery Center of Excellence® (BSCOE) program are required to enter prospective data into BOLD on all bariatric surgery patients.

“Length of stay appeared to be the leading risk factor ahead of age, gender, race, body mass index (BMI) and obesity-related conditions,” added Dr. Morton.

There is an increasing focus on length of stay in bariatric surgery following an update to the [Milliman Care Guidelines](#)[®], which recommended shortening the length of stay for gastric bypass to cut costs and improve resource utilization. These guidelines are used by many hospitals and health plans to determine care and length of stay.

The ASMBS responded to those guidelines in October 2010 expressing concern for the shortened length of stay citing a lack of evidence demonstrating patient benefit and safety (http://www.asmb.org/Dr_Rifkin_Milliman_October_1_2010.pdf).

“A two-day length of stay appears reasonable for most people and results in a safety profile that rivals gallbladder or hip replacement surgery. To reduce it further may put patients at an increased chance of unnecessary risk,” added Dr. Morton, who chairs the ASMBS Access to Care Committee. “A patient should be discharged based on his or her individual risk profile. We counsel our patients to avoid drive-thru fast food, and also advise against drive-thru gastric bypass.”

Bariatric surgery has been shown to be the most effective and long lasting treatment for morbid obesity and many related conditions.¹ People with morbid obesity have BMI of 40 or more, or BMI of 35 or more with an obesity-related disease such as Type 2 diabetes, heart disease or sleep apnea. Recently the FDA approved the use of an adjustable gastric band for BMI 30 and above, recognizing that there is an increase in mortality and medical complications of obesity at even this level of obesity.

According to the ASMBS, more than 15 million Americans have morbid obesity. Studies have shown patients may lose 30 to 50 percent of their excess weight 6 months after surgery and 77 percent of their excess weight as early as one year after surgery.²

The federal government estimated that in 2008, annual obesity-related health spending reached \$147 billion,³ double what it was a decade ago, and projects spending to rise to \$344 billion each year by 2018.⁴ The Agency for Healthcare Research and Quality (AHRQ) reported significant improvements in the safety of bariatric surgery due in large part to improved laparoscopic techniques and the advent of bariatric surgical centers of excellence. The overall risk of death from bariatric surgery is about 0.1 percent⁵ and the risk of major complications is about 4 percent.⁶

In addition to Dr. Morton, study co-authors include Eric DeMaria MD, Deborah Winegar PhD, Bintu Sherif MS, Neil Hatcher MD, all from Surgical Review Corporation, Robin Blackstone MD FACS FASMBS, from Scottsdale Bariatric Center, and Bruce M. Wolfe MD FASMBS, from Oregon Health Sciences.

About the ASMBS

The ASMBS is the largest organization for bariatric surgeons in the world. It is a non-profit organization that works to advance the art and science of bariatric surgery and is committed to educating medical professionals and the lay public about bariatric surgery as an option for the treatment of morbid obesity, as well as the associated risks and benefits. It encourages its members to investigate and discover new advances in bariatric surgery, while maintaining a steady exchange of experiences and ideas that may lead to improved surgical outcomes for morbidly obese patients. For more information about the ASMBS, visit www.asmb.org

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***PL 110: Is Ambulatory Laparoscopic Roux En Y Gastric Bypass From the Bariatric Outcomes Longitudinal Database (BOLD) Associated with Higher Adverse Events?**

John M. Morton, Surgery, Stanford University; Eric DeMaria, Deborah Winegar, Bintu Sherif, Neil Hatcher, Surgical Review Corporation; Robin Blackstone, Scottsdale Bariatric Center; Bruce M. Wolfe, Surgery, Oregon Health Sciences

¹ RA Weiner. "Indications and Principles of Metabolic Surgery." U.S. National Library of Medicine. 2010; 81(4):379-94

² AC Wittgrove et al. "Laparoscopic Gastric Bypass, Roux-en-Y: Technique and Results in 75 Patients With 3-30 Months Follow-up." *Obesity Surgery*. 1996. 6:500-504.

³ EA Finkelstein. "Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates." *Health Affairs*. 2009. 28(5):822-831.

⁴ K Thorpe. America's Health Rankings. "The Future Costs of Obesity." 2009.

⁵ Agency for Healthcare Research and Quality (AHRQ). Statistical Brief #23. Bariatric Surgery Utilization and Outcomes in 1998 and 2004. Jan. 2007.

⁶ Flum et al. "Perioperative Safety in the Longitudinal Assessment of Bariatric Surgery." *New England Journal of Medicine*. 2009. 361:445-454. <http://content.nejm.org/cgi/content/full/361/5/445>