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**NEW EVIDENCE PROMPTS UPDATE  
TO METABOLIC AND BARIATRIC SURGERY CLINICAL GUIDELINES**

**GAINESVILLE, FL – April 5, 2013** – Significant new scientific evidence published over the last four years has prompted three major medical societies to change its guidance on who should get metabolic and bariatric surgery and which methods should be used.

The [new guidelines](#) from the American Society for Metabolic and Bariatric Surgery (ASMBS), the American Association of Clinical Endocrinologists (AACE) and The Obesity Society (TOS) were published in the latest issues of *Surgery for Obesity and Related Diseases*, *Endocrine Practice*, and *Obesity*, the official peer-reviewed journals of each of the societies. The original clinical guidelines from the three organizations first appeared in 2008.

"Bariatric or metabolic surgery is among the most studied surgical interventions in medicine and this ever-increasing mountain of evidence continues to show that these procedures are the most successful and durable treatment for obesity and several related diseases," said Daniel B. Jones, MD, MS, FACS, professor of surgery, Harvard Medical School and one of a 12-member panel that developed the guidelines. "However, we've gleaned important new insights, cautions and best practices based on the thousands of studies that were published in medical journals in just the last four years alone and these are reflected in the new guidelines."

Among the 74 evidence-based recommendations is the reclassification of sleeve gastrectomy as a proven surgical option, rather than an investigational one; that surgical eligibility be expanded to include patients with mild to moderate obesity and diabetes or metabolic syndrome; that women should avoid pregnancy before surgery and for 12 to 18 months after surgery; and a team approach to perioperative care "is mandatory with special attention to nutritional and metabolic issues."

The guidelines also provide recommendations on patient screening and selection, pre- and post-operative management, selection of surgical method and criteria for hospital readmission after surgery.

**Sleeve Gastrectomy No Longer Considered Investigational**

Laparoscopic sleeve gastrectomy joins laparoscopic adjustable gastric banding, laparoscopic Roux-en-Y gastric bypass and laparoscopic biliopancreatic diversion BPD, BPD/duodenal switch as primary bariatric and metabolic procedures for patients requiring weight loss and/or metabolic control. Research demonstrates sleeve gastrectomy has benefits comparable to these other procedures in terms of weight loss, resolution of obesity-related conditions and rate of complications.

The guidelines do not recommend one primary procedure over another as each procedure poses different risks and benefits. It is recommended that the surgical method chosen should be based on specific patient goals and motivations, and surgeon and institutional expertise and experience. However, laparoscopic procedures are preferred over open procedures due to lower early postoperative morbidity and mortality.

Data have emerged on other procedures including gastric plication, electrical neuromodulation, and endoscopic sleeves, but the guidelines continue to classify them as investigational because of a lack of sufficient outcomes evidence.

### **Surgery for Patients with Mild to Moderate Obesity and Metabolic Disease**

According to the guidelines, patients with Body Mass Index (BMI) of 30-34.9 kg/m<sup>2</sup> with diabetes or metabolic syndrome may be offered a bariatric procedure, "although current evidence is limited by the number of subjects studied and lack of long term data demonstrating net benefit." It is further noted that there is currently insufficient evidence for recommending a bariatric surgical procedure specifically for glycemic control alone, lipid lowering alone, or cardiovascular disease risk reduction alone, independent of BMI criteria.

"These clinical guidelines provide evidence-based recommendations and information to help surgeons, primary care doctors and other health professionals make the most informed decisions for the benefit of patients," said Jaime Ponce, MD, ASMBS president.

### **About Obesity and Metabolic and Bariatric Surgery**

Obesity is one of the greatest public health and economic threats facing the United States.<sup>1</sup> Approximately 72 million Americans are obese<sup>2</sup> and, according to the ASMBS, about 18 million have morbid obesity. Obese individuals with a BMI greater than 30 have a 50 to 100 percent increased risk of premature death compared to healthy weight individuals as well as an increased risk of developing more than 40 obesity-related diseases and conditions including Type 2 diabetes, heart disease and cancer.<sup>3,4</sup>

Metabolic/bariatric surgery has been shown to be the most effective and long lasting treatment for morbid obesity and many related conditions and results in significant weight loss.<sup>5,6,7</sup> In the United States, about 200,000 adults have metabolic/bariatric surgery each year.<sup>8</sup> The Agency for Healthcare Research and Quality (AHRQ) reported significant improvements in the safety of metabolic/bariatric surgery due in large part to improved laparoscopic techniques.<sup>9</sup> The risk of death is about 0.1 percent<sup>10</sup> and the overall likelihood of major complications is about 4 percent.<sup>11</sup>

### **About the ASMBS**

The ASMBS is the largest organization for bariatric and metabolic surgeons and integrated health professionals 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 people with severe obesity. For more information, visit: [www.asmb.org](http://www.asmb.org).

### **About the American Association of Clinical Endocrinologists (AACE)**

The American Association of Clinical Endocrinologists (AACE) represents more than 6,500 endocrinologists in the United States and abroad. AACE is the largest association of clinical endocrinologists in the world. The majority of AACE members are certified in Endocrinology and Metabolism and concentrate on the treatment of patients with endocrine and metabolic disorders including diabetes, thyroid disorders, osteoporosis, growth hormone deficiency, cholesterol disorders, hypertension and obesity. For more information about AACE, visit the AACE website at [www.aace.com](http://www.aace.com), become a fan on Facebook at [www.facebook.com/theaace](https://www.facebook.com/theaace) or follow AACE on Twitter at [www.twitter.com/theaace](https://www.twitter.com/theaace).

## About The Obesity Society (TOS)

The Obesity Society (TOS) is the leading scientific society dedicated to the study of obesity. TOS is committed to encouraging research on the causes, treatment, and prevention of obesity as well as to keeping the scientific community and public informed of new advances in the field. For more information, please visit [www.obesity.org](http://www.obesity.org).

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<sup>1</sup>Flegal, K. M., Carroll, M. D., Ogden, C. L., et al. (2002). Prevalence and trends in obesity among US adults, 1999-2000. *Journal of the American Medical Association*. 288(14) pp. 1723-1727 Accessed March 2012 from <http://aspe.hhs.gov/health/prevention/>

<sup>2</sup>Chronic Disease Prevention and Health Promotion – Centers for Disease Control and Prevention. (2011). Obesity; halting the epidemic by making health easier at a glance 2011. Accessed February 2012 from

<http://www.cdc.gov/chronicdisease/resources/publications/AAG/obesity.htm>

<sup>3</sup>Office of the Surgeon General – U.S. Department of Health and Human Services. Overweight and obesity: health consequences. Accessed March 2012 from [http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact\\_consequences.html](http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences.html)

<sup>4</sup>Kaplan, L. M. (2003). Body weight regulation and obesity. *Journal of Gastrointestinal Surgery*. 7(4) pp. 443-51. Doi:10.1016/S1091-255X(03)00047-7. Accessed March 2012 from

<http://edulife.com.br/dados%5CArtigos%5CNutricao%5CObesidade%20e%20Sindrome%20Metabolica%5CBody%20weight%20regulation%20and%20obesity.pdf>

<sup>5</sup>Weiner, R. A. (2010). Indications and principles of metabolic surgery. *U.S. National Library of Medicine*. 81(4) pp.379-394.

<sup>6</sup>Chikunguw, S., Patricia, W., Dodson, J. G., et al. (2009). Durable resolution of diabetes after roux-en-y gastric bypass associated with maintenance of weight loss. *Surgery for Obesity and Related Diseases*. 5(3) p. S1

<sup>7</sup>Torquati, A., Wright, K., Melvin, W., et al. (2007). Effect of gastric bypass operation on framingham and actual risk of cardiovascular events in class II to III obesity. *Journal of the American College of Surgeons*. 204(5) pp. 776-782. Accessed March 2012 from

<http://www.ncbi.nlm.nih.gov/pubmed/17481482>

<sup>8</sup>American Society for Metabolic & Bariatric Surgery. (2009). All estimates are based on surveys with ASMBS membership and bariatric surgery industry reports.

<sup>9</sup>Poirier, P., Cornier, M. A., Mazzone, T., et al. (2011). Bariatric surgery and cardiovascular risk factors. *Circulation: Journal of the American Heart Association*. 123 pp. 1-19. Accessed March 2012 from <http://circ.ahajournals.org/content/123/15/1683.full.pdf>

<sup>10</sup>Agency for Healthcare Research and Quality (AHRQ). Statistical Brief #23. Bariatric Surgery Utilization and Outcomes in 1998 and 2004. Jan. 2007.

<sup>11</sup>DR 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>