There have been several recent articles in the Journal of the American Medical Association (JAMA) 1-3, that raised newspaper and television comments regarding the safety of weight-loss surgery, several of which were not justified.

Comparing the Numbers

The risk of death following weight-loss surgery in the non-Medicare studies 1,2 were much better than had previously been reported from Washington State in October 2004. The report by Santry et al 1 from the National In-patient Sample (NIS) noted a 0.1 to 0.2 percent in-patient mortality nationwide and the Zigmund et al study 2 noted an 0.18 percent in-patient mortality, and a 0.33 percent 30-day mortality for the State of California using the State’s Patient Discharge Database for gastric bypass. These are much lower than the previous report by Flum and Dellinger from Washington State, 4 which noted a 1.9 percent 30-day mortality following weight-loss surgery.

Like these recent reports from JAMA, the earlier Flum and Dellinger study received negative press coverage stating that the mortality of weight-loss surgery was much greater than single series studies suggested 5. Yet, the mortality in California is actually lower (0.1-0.2 percent vs. 0.5 percent in-patient risk of death) than many of the case series reports.

Why the discrepancy between the mortality in these two states? Could the better results be due to centers which perform greater numbers of bariatric surgeries and are therefore more proficient in their technique and patient care? Or, are there more ill Medicare and Medicaid patients in the Washington State database? Are the California surgeons operating on lower risk patients?

Obesity-Related Diseases

The Charlson Index was used to determine obesity-related illnesses in these reports. This measurement shows that 50-60 percent of the morbidly obese patients in these studies had no obesity-related diseases; whereas, it is clear that almost 100 percent of severely obese patients have one or more obesity-related conditions. Therefore, it is impossible to determine the degree of illness in these patients before their obesity surgery in order to compare these reports. Collection of this information is extremely important and will be undertaken by the American Society for Bariatric Surgery (ASBS) Centers of Excellence (COE) program.

Risk for Medicare Patients

The study by Flum et al 3 regarding the risk of death in Medicare patients found a much higher mortality in these patients than previously reported for bariatric surgical procedures 5. This is no surprise, since 90 percent of patients who undergo weight-loss surgery with Medicare coverage are social security disabled and are under the age of 65. These are the sickest patients, almost certainly a consequence of their obesity, and they therefore have the greatest risk of surgery.

It may cost more for these patients to undergo surgery than the surgeon or the hospital are reimbursed for, which may be one of the reasons that they are under-represented in the Santry et al study 2. In fact, according to MedPAR data, the age-adjusted risk of death after laparoscopic and open cholecystectomy (gallbladder surgery) from 2001 to 2003 were higher than the risk of gastric bypass surgery. Of greater concern, is the increased risk of death with obesity surgery noted by Flum et al in those more than 65 years of age. Several studies noticed an increased mortality associated with age 6-8. However, the data may not be as grim as the press reported. The Flum et al study noted that those centers who have the highest number of Medicare cases (and it may be presumed the greatest number of bariatric procedures regardless of status) had a 1.1 percent 30-day mortality rate in those more than 65
years of age, a very reasonable number in this age group. In a series study of patients more than 60 years of age, 19 of which were more than 65 years of age, there were no deaths at one year after surgery. In another series of 27 patients, 13 had a laparoscopic gastric bypass and were more than 65 years of age.

**Risk after Surgery**

Lastly, there are serious concerns regarding the study by Zigmund et al, which noted a marked increase in hospital visits in the three years after weight-loss surgery as compared to the three years preceding weight-loss surgery. There are three groups in this study which warrant further comment and account for more than 50 percent of the hospital visits after surgery.

Early readmissions for complications related to nausea and vomiting (15-20 percent) are probably associated with pressures from health insurance companies for early hospital discharge. The second group (15-20 percent) are those who are readmitted for incision related problems (hernias and wound infections) and are almost certainly related to the high frequency of open weight-loss surgery during the time period of this study. These complications have been virtually eliminated with the currently laparoscopic approach. The third group (another 20-30 percent) is for patients who have undergone plastic surgical or orthopedic procedures following their weight-loss surgery. The orthopedic operations, such as hip and knee replacement, are more likely to be successful following a surgically induced weight-loss. Lastly, the costly and life-threatening readmissions for serious medical conditions, such as chest pain, coronary artery disease, congestive heart failure, obstructive lung disease and cellulitis, were all decreased following weight-loss surgery. Readmissions for life-threatening complications of the surgery (leak, internal hernia) are of concern, but represent a minority of the cases. Again, this study noted that surgery performed at a low volume medical center was more likely to result in hospital readmissions.

**ASBS Centers of Excellence**

These studies confirm other reports that surgeons who perform a significant number of cases at hospital centers with a dedicated staff and appropriate numbers of surgical procedures have noted much lower risks of deaths and complications. We recommend that patients who undergo obesity surgery have their operation at an ASBS Center of Excellence, which mandates these centers to perform more than 125 cases a year with surgeons who perform more than 50 cases a year and have processes and facilities designed to optimize the care of the bariatric patient. Outcomes of these Centers will be collected on an annual basis and the Center will have to be re-designated one to three years after the initial approval.

There is no other effective treatment for severely obese patients. Bariatric surgery performed in an approved high volume Center of Excellence can provide profound improvements in obesity co-morbidities and quality of life, at a reasonable cost and with a very low risk of death and complications.

**About the Author:**

Harvey Sugerman, MD, is a retired bariatric surgeon. Formerly, he was Chief of the General Surgery/TRAUMA Division at Virginia Commonwealth University in Richmond, VA. He is the immediate Past-President of the American Society for Bariatric Surgery and was a non-voting member of the Medicare Coverage Assessment Committee on Bariatric Surgery. He is currently the Chairman of the Bariatric Surgery Review Committee which evaluates applications for Bariatric Surgery Centers of Excellence under contract to the American Society for Bariatric Surgery. Dr. Sugerman is a member of the Obesity Action Coalition.

**References:**

The mission of the Obesity Action Coalition is to elevate and empower those affected by obesity through education, advocacy and support.

About the OAC

The Obesity Action Coalition is a non profit patient organization dedicated to educating and advocating on behalf of the millions of Americans affected by obesity. By strictly representing the interests and concerns of obese patients, the OAC is a unique organization with a patient-focused approach to obesity. To learn more about the OAC, visit www.obesityaction.org or contact the National Office at (800) 717-3117.

OAC Resources

Through education and advocacy, patients need to get involved to help drive change in the obesity community. The OAC provides several beneficial resources for patients, as well as professionals.

- OAC Introductory Brochure
- Obesity Action Alert
- OAC News
- State-specific Guides to Advocating for Improved Access to Obesity Treatments
- Weight-loss Surgery Coverage Fact Sheet
- The OAC Web site: www.obesityaction.org

All OAC resources are complimentary and may be ordered in bulk. To request materials or an order form, please contact the OAC National Office at (800) 717-3117 or send an email to info@obesityaction.org.

OAC membership

Membership in the Obesity Action Coalition allows the patient voice to be heard in the fight against obesity. By building a coalition of members, consisting of patients, family members and professionals, the OAC strives to educate and advocate on behalf of the millions who are affected by obesity. Membership benefits include:

- Official charter membership card/certificate
- OAC News - the OAC’s quarterly newsletter
- Subscription to Obesity Action Alert - a monthly e-newsletter
- Representation through advocacy in addition to information on advocacy issues concerning patients
- Patient/Family Member: $20
- Allied Health Professional Member: $50
- Physician Member: $100
- Surgeon Member: $150
- Institutional Member: $500 (Bariatric surgery centers, weight-loss management centers, etc.)*
- Chairman’s Council: $1,000 and up*

* Different benefits apply. Contact the OAC National Office for more info.

Membership Application

Name: ________________________________
Company Name: _______________________
Address: ______________________________
City: _____________ State: ______ Zip: ___________
Phone: ________________________________
E-mail: ________________________________

Payment Information

Enclosed is my check made payable to the Obesity Action Coalition for $ ________.
Please charge my credit card for my membership fee of $ ________.

Please mail to: Obesity Action Coalition
4511 North Flamingo Ave, Suite 250
Tampa, FL 33614
Or fax to: (813) 873-7838 If you have questions about OAC membership, please contact the National Office at (800) 717-3117.

*Different benefits apply. Contact the OAC National Office for more info.

Credit Card #: __________________________
Expiry: _________ Name on Card: ____________
Signature: ________________________________