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Surgery for morbidly obese patients?

EDITORIAL

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Surgical treatment continues to be a good option for patients with morbid obesity, despite the promising results from pharmacotherapy.

Bariatric surgery has been practised in Norway since the 1970s and 80s. The procedures were carried out using laparotomy, with large incisions and often limited visibility in the abdominal cavity. This resulted in a high incidence of early and late complications and long post-operative hospital stays. Post-surgery weight loss also varied, and bariatric surgery was therefore discontinued in the early 1990s (1, 2).

After the introduction of laparoscopy, new surgical techniques were developed that led to fewer complications and shorter hospital stays. Meanwhile, the incidence of obesity in the population was also increasing. Bariatric surgery was therefore reintroduced in Norway just after the turn of the millennium. Following the directive by the Ministry of Health and Care Services in 2004 for regional health authorities to establish treatment options for patients with morbid obesity, the number of bariatric operations increased dramatically (3, 4). A large proportion of bariatric procedures were also performed at private hospitals, accounting for 36 % in 2022 (4).

Since 2004, two surgical methods have been dominant. Gastric bypass involves disconnecting/rerouting the stomach and small intestine, allowing food to flow directly into the jejunum. Longitudinal gastrectomy (gastric sleeve), the most frequently used surgical method globally, entails removal of a large portion of the stomach along its length. The third most common surgical method for obesity is mini-gastric bypass, where a portion of the stomach is separated and attached to the upper part of the small intestine. In Norway, this method accounts for 16 % of all bariatric procedures (4).

In this issue of the Journal of the Norwegian Medical Association, Richardsen et al. at Oslo University Hospital present the results of their own experiences with using the surgical method over a five-year period (5). The retrospective analysis of prospectively collected data with a two-year post-surgery follow-up is based on patient data registered in a local quality register approved by the hospital's data protection officer. The results demonstrate that this surgery is comparable to other studies in terms of length of hospital stay, complication frequency, weight loss and reduction in obesity-related secondary diseases.

The records in the quality database at Oslo University Hospital were forwarded to the Scandinavian Obesity Surgery Registry Norway (SOReg-N), which was given national status in 2015 (4). The registry collects data from health authorities in all four health regions. In 2022, 18 hospitals, including four private ones, reported their results.

The national quality register serves as a tool for hospitals to document surgery outcomes and compare them with those of other hospitals. Its purpose is to map the extent and quality of bariatric surgery in Norway and to study changes in weight, disease status and self-perceived health for up to ten years after bariatric surgery. The data from the registry are primarily intended for use in quality assurance and improvements in patient care but can also be used for research.

> ***«Surgical treatment of morbid obesity continues to be a good option for achieving significant weight loss, improving quality of life and reducing obesity-related secondary diseases»***

Severe obesity is a chronic progressive disease, and progression can occur even if the patient has undergone bariatric surgery. Patients with morbid obesity report poorer health-related quality of life, and a primary goal of bariatric surgery is to improve this. The registry is therefore designed to include follow-ups at six weeks and then one, two, five and ten years after surgery.

Inclusion in SOReg-N requires the patient's written consent, and achieving full coverage will therefore be a challenge. However, experiences so far indicate that the vast majority of bariatric patients want to be included in the registry. Coverage has been lowest among non-native Norwegian speakers, and an information letter and consent form were drawn up in several languages two years ago.

Quality registers are only as good as the data entered, and low coverage and data that are not quality assured limit their value. Using different surgical methods can lead to varying long-term outcomes. Patients' health-related quality of life is often linked to the type of surgery they have undergone. It is therefore crucial to have a robust registry that can capture differences between groups as well as changes in quality of life over time.

Pharmacotherapy for obesity as a supplement to therapeutic lifestyle changes has shown promising results. However, there is no long-term follow-up of pharmacotherapy, and it appears that the effects only last as long as the medications are taken (6). Surgical treatment of morbid obesity continues to be a good option for achieving significant weight loss, improving quality of life and reducing obesity-related secondary diseases. Nonetheless, surgical treatment must also be viewed from a long-term perspective, as adverse effects often involve various nutritional deficiencies that require lifelong correction.

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