

Plastic surgery as a follow-up to weight-loss surgery can yield good results. Should provision of such surgery be expanded?

## A better life for recipients of weight-loss surgery?

The difficulty of achieving lasting weight loss has led to the provision of weight-loss surgery. Nutrient absorption is decreased by reducing stomach capacity or closing off parts of the small intestine (1). Individuals with a body mass index (BMI) of 40 kg/m<sup>2</sup> or above, or BMI > 35 kg/m<sup>2</sup> and comorbidity, can be offered publicly funded surgery. In addition, a large number of interventions are performed by private healthcare providers without support from the public purse.

When a person gains weight, fat accumulates for the most part subcutaneously. Upon massive weight loss, there is a limit to how much the skin is able to contract and individuals are often left with flaps of skin which can rub against one another and cause intertrigo, infection and odours. Such problems can be reduced or eliminated by plastic surgery in which the excess skin is trimmed away and efforts are made to improve body proportions. In this issue of the *Journal of the Norwegian Medical Association*, Gunnarson and co-workers present a review of the knowledge base for post-bariatric plastic surgery (2). They show that good results can be achieved with such treatment, but that the existing knowledge base is inadequate. The demand for surgery currently exceeds capacity, and for many, obtaining an offer of surgery proves as challenging as passing through the eye of a needle.

There is agreement that there must be a «medical indication» in order for corrective plastic surgery to be paid for with public funds. According to the guidelines of the Norwegian Society of Plastic Surgeons, the patient should have difficulties such as pain, infection or impaired movement (3). Their weight must have been stable for at least six months, and a minimum of two years should have elapsed since the weight-loss surgery. Reduction of BMI is emphasised. The risk of complications with post-bariatric plastic surgery is higher than for equivalent procedures in patients who have not undergone weight-loss surgery (4). The interventions often create large wounds and with them a risk of skin necrosis, infection, bleeding and deep vein thrombosis.

According to figures from the Norwegian Society for Bariatric Surgery, there were 2 948 cases of bariatric surgery in Norway in 2012 (5). The number is greater now, and private clinics are also operating on more patients. Of those who undergo weight-loss surgery, 70–90% wish to have plastic surgery afterwards (1). However, many are not offered this – the percentage who undergo surgery varies from 14% to 47% (4). Gunnarson and co-workers point out that many are refused body contouring surgery because their BMI is > 28 kg/m<sup>2</sup>. The Norwegian Society of Plastic Surgeons adopted new guidelines in autumn 2014 (3), which state that pre-surgical BMI should not normally exceed 35 kg/m<sup>2</sup>, and should preferably be between 25 and 30 kg/m<sup>2</sup>. The results of body contouring surgery are usually better with a low BMI (4).

The BMI required to qualify for post-bariatric body contouring surgery varies from country to country. In the UK, BMI should as a rule be 28 kg/m<sup>2</sup> or lower (6); in Sweden it should be ≤ 25 kg/m<sup>2</sup>, although this requirement can be waived (7). In the other Nordic countries, the required BMI has been in the range of 30 to 32 kg/m<sup>2</sup>. Only a minority achieve a BMI of 30 kg/m<sup>2</sup> or lower after weight-

loss surgery (2) and, according to the new Norwegian guidelines, this should not disqualify patients from body contouring surgery (3). This patient population is not entitled to priority health care (8), but such rights can be granted on an individual basis. Those who have lost a lot of weight often have more than one problem area and would like several surgical procedures to be performed. Prioritisation of this patient group has differed between the various health authorities and between hospitals (9). The new guidelines from the Norwegian Society of Plastic Surgeons do not guarantee equal treatment either, as they are recommendations and are not binding.

Health authorities should engage more with post-bariatric surgery. It is reasonable to consider such surgery in the context of the recently presented report on priorities in health care (10). The National Council for Priority Setting in Health Care has considered the surgical treatment of obesity in Norway, but plastic surgery needs have not been addressed in detail (11). Denmark has developed a set of national guidelines (12). Norwegian hospitals have waiting lists for a number of plastic surgery procedures, including cleft lip and palate repair (9, 13). With increasing numbers undergoing weight-loss surgery (3), difficult questions may arise over prioritisation, and hospital practices must therefore be carefully monitored. Those patients whose needs are greatest must be given priority, irrespective of which group they belong to.

For those who have undergone weight-loss surgery, plastic surgery can be an important step toward a better life. A national regulatory framework should be established to ensure correct prioritisation, and effective and uniform plastic surgery provision for the population.

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