

Weight-loss surgery may soon be widely used

Advancements in procedures that are usually a last resort for the obese are making them potentially suitable for moderately overweight and diabetic people.

By Shari Roan

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After spending the majority of her 48 years trying, and failing, to slim down, Veronica Mahaffey was still 50 pounds overweight -- not morbidly obese by a long shot, but still far from the size she wanted. Worried about her health, she called a San Diego weight-loss surgery clinic last spring and asked for help.

She was told no.

At 185 pounds and with a body mass index of 28, the Ramona mother of four was not heavy enough to meet medical guidelines or insurance company qualifications for weight-loss surgery. Those standards require a BMI of 40 or higher, or 35 or higher for people with a related medical problem such as diabetes or sleep apnea.

"People would say, 'You look fine.' But I couldn't get into normal-size clothing. That's not fine," Mahaffey said. "And then I was told I was going to have to gain weight to qualify for surgery. That doesn't make sense."

Ultimately, she got the surgery through a clinical trial of one of several new weight-loss procedures. Now 10 pounds from her goal weight of 135, she says she looks better, feels better and is confident she'll no longer have to fight her weight.

Her experience may soon be shared by thousands of Americans.

Usually reserved for the most obese people, weight-loss surgery is unlikely to be a last-ditch option much longer. Technological advancements are turning it into a one-hour, incisionless procedure -- making it more attractive to moderately overweight adults like Mahaffey; overweight and obese teenagers; and normal-weight people with difficult-to-control diabetes. Several new procedures are already in human clinical trials.

"I see surgery playing a bigger role," said Judith Stern, a professor of nutrition and internal medical at UC Davis, ". . . because the weight-loss drugs we have now are lousy."

The need for new treatments is impossible to ignore.

A New England Journal of Medicine study published last month concluded that obesity rates would soon negate life-span gains achieved through declining smoking rates. And a report released in November from the American Public Health Assn. and other groups projected that healthcare costs related to obesity would quadruple in 10 years, accounting for 21% of healthcare

spending.

Bariatric surgery, many doctors say, should be a bigger part of the solution.

"We're seeing increased disability due to obesity among a younger population," said Dr. John Baker, president of the American Society for Metabolic & Bariatric Surgery. "We can't afford to wait. As a tool to bring down costs and the burden of disease, bariatric surgeons have the most effective tool in medicine today."

Other health professionals are aghast at the idea of even more Americans yearly undergoing the surgery. Bariatric surgery rates have already doubled in the last six years, resulting in 220,000 procedures in 2008, according to the American Society for Metabolic & Bariatric Surgery. And even the simplest procedures are not without risks.

"The fact that bariatric surgery is the only efficient method of long-term weight loss is true," said Dr. Blandine Laferrere, a diabetes expert at Columbia University College of Physicians and Surgeons in New York. "But does that mean everyone who is overweight should have it? I don't think so, because none of these procedures is benign."

Supportive studies

Many studies already attest to the effectiveness and increasing safety of the most popular weight-loss surgeries among morbidly obese people. Depending on the type of surgery used, patients lose 50% or more of their excess body weight and maintain that loss for as long as 10 years after surgery. In comparison, the most recent studies on long-term use of weight-loss medications show a typical weight loss of 5 to 22 pounds over one year with some side effects.

Other [research](#) has found that bariatric surgery cures Type 2 diabetes in a majority of patients studied, as well as improving symptoms related to sleep apnea and heart disease, such as high cholesterol and blood pressure.

"When we first started doing bariatric surgery, most of the family practitioners were very much against it," said Dr. Gregg K. Nishi, a bariatric surgeon at Cedars-Sinai Medical Center. "Now they send their patients to us in droves because we cure their medical problems. As we develop new noninvasive procedures that are safe, I think the popularity will grow."

The improvements in traditional bariatric surgery, combined with patient interest, have led to a surge in investigational new procedures, as well as discussions on whether more people could benefit from surgery.

"Investigators are working on ways to make these operations more effective, safer, less invasive and lower-cost," said Dr. Philip Schauer, director of the Bariatric and Metabolic Institute at the Cleveland Clinic.

Furthest along in clinical trials is a noninvasive technique called TOGA, or transoral gastroplasty. In the procedure, a surgeon inserts a flexible tube through the mouth into the

stomach and then uses staples to create a pouch that limits the amount of food that can be consumed. Cedars-Sinai is one of nine medical centers testing the technique, created by a Palo Alto company called Satiety Inc. A previous small study showed that patients lost an average of almost 25 pounds after three months with no major complications reported. Long-term data aren't yet available.

"Patients feel great afterward," Nishi said. "They don't have any of the pain you have with laparoscopic [minimally invasive] surgery." He expects that, when perfected, the procedure will take one hour, and the patient can go home shortly afterward.

The most common weight-loss surgeries -- laparoscopic gastric bypass and gastric banding, which restrict stomach size so that patients feel full more quickly -- usually require one to three days in the hospital.

Mahaffey underwent a similar procedure called POSE (for Primary Obesity Surgery, Endolumenal), which is designed for people who need to lose only a moderate amount of weight.

"People 50 pounds overweight are the ones we should treat, before the problem gets worse," said the surgeon who performed the procedure, Santiago Horgan of UC San Diego.

In a noninvasive technique still in the early stages of development, a device is placed in the upper part of the small intestine to create a barrier between food and the wall of the intestines, thus mimicking the effect of gastric bypass surgery. Called the EndoBarrier, it could help patients lose weight before a more invasive weight-loss procedure or to help resolve Type 2 diabetes, of which obesity is a primary cause. The device is expected to cost about half as much as gastric banding and one-quarter as much as gastric bypass.

Growing acceptance

Lowering the cost of surgery will be key to offering an effective weight-loss option to thousands, or millions, more people, Schauer said. The costs of traditional weight-loss surgery vary widely across the nation, with an average cost in California of \$52,224, according to a HealthGrades report released in July.

"Many experts believe if we get a procedure close to the \$10,000 range, then we could dramatically expand both access and insurance coverage," he said.

Whether insurance companies will welcome the idea of more people receiving bariatric surgery remains to be seen.

Weight-loss surgery is now covered by insurance only for those patients who have premium benefits and a BMI of 40 or higher, or a BMI of 35 or higher with obesity-related medical problems. Standard health plans typically don't include bariatric surgery.

Surgery may be cost-effective if it cures diabetes and prevents heart disease, joint problems and other illnesses linked to obesity, Baker said. A 2008 study in the *Journal of Managed Care* found

that insurers fully recover their costs for bariatric surgery two to four years after the procedure due to reduced health problems in the patient.

The patient pool for bariatric surgery is already beginning to widen. Insurance companies tend to follow the lead of the Centers for Medicare & Medicaid Services, and in February, the federal agency announced that it would approve payment of surgery for people with Type 2 diabetes and a BMI of at least 35.

In November, a consortium of influential medical groups, including the Obesity Society, composed of researchers who study all aspects of obesity, published a consensus statement recognizing the "legitimacy" of bariatric surgery as a dedicated treatment for some patients with Type 2 diabetes and noted that surgery may be suited for people with Type 2 diabetes who are not yet morbidly obese -- those with a BMI of 30 to 35.

"There is mounting evidence that for someone with a BMI of 30 with diabetes that is not well-controlled, surgery is a good option," Schauer said. A BMI of 30, for example, would reflect someone who is 5 foot 8 and 197 pounds.

"Surgery is grossly under-used," added Dr. John Kral, an obesity expert at State University of New York Downstate Medical Center in Brooklyn. "If these procedures prove safe enough, people are going to start having them before their eating behavior gets out of hand."

Risks remain

Nutritionists are not enthusiastic. They reject the notion that surgery should take the place of dieting and exercise.

"People with a BMI of 33, for example, don't weigh a lot," said Stern, an advisory board member for Weight Watchers International. "Is that worth the risks of surgery, the side effects, the potential for problems? I'm absolutely opposed to bariatric surgery under a certain BMI, such as 37 with co-morbidities."

Paul Ernsberger, an associate professor of nutrition at Case Western Reserve University School of Medicine, has studied the long-term complications of weight-loss surgery. While the surgical procedure itself has become quite safe, he said, too many patients suffer problems later, such as nutritional deficiencies, diarrhea, regurgitation and bowel obstructions.

According to the Agency for Healthcare Research and Quality, 19% of patients experience dumping syndrome, which is involuntary vomiting or defecation. Complication rates involving ulcers, wound problems, hemorrhage, deep-vein thrombosis, heart attacks and strokes range from 2.4% to 0.1%.

"Changes in laparoscopic technique may make a shorter hospital stay, but the long-term complications are still there," Ernsberger said.

Weight-loss surgery is too risky to do purely for cosmetic results, the motivating factor for some

patients, Ernsberger said. "Are we interested in people's health, or are we interested in their weight?" he said. "Surgery can help with obesity-related health problems, but so can pills."

Baker said the American Society for Metabolic & Bariatric Surgery does not advocate surgery for cosmetic purposes alone, adding that it should always be accompanied by changes in nutrition and physical activity.

For people with a BMI of 25 to 30, which is considered overweight but not obese, diet and exercise changes should still be the treatment of choice, Baker said. "Even people who have surgery still have to focus on those things. You have to change your lifestyle and habits for any weight-loss program."

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