BARIATRIC AMBULATORY SURGERY

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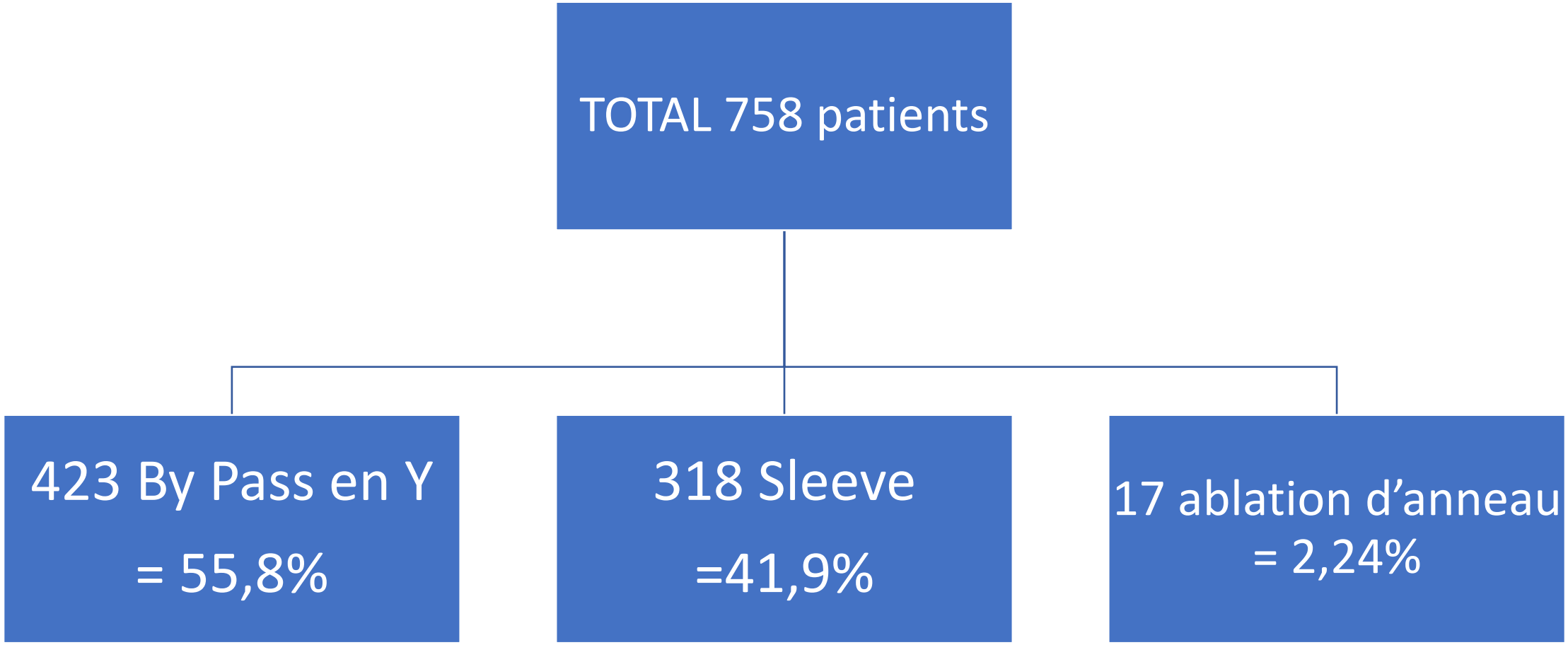
Ambulatory Bariatric Surgery : A monocentric single surgeon prospective observational study

- Methods : Non randomized prospective observational study lead between September 2017 and June 2024
- Monocentric, single-operator
- Patients meeting both criterias for surgical care of obesity and criterias for ambulatory stay in anesthesia
- Standardised protocols of anesthesia, surgery, pain management, and vomitting


TOTAL 758 patients
423 By Pass en Y
= 55,8%
318 Sleeve
=41,9%
17 ablation d'anneau
= 2,24%

Inclusion criterias for ambulatory

- BMI between 35 and 55kg/m^2
- Age between 18 and 59
- Well Motivated and consenting patients for ambulatory management
- Accompanied and well surrounded patients

Exclusion criterias for ambulatory

- Uncontrolled ASA 3, ASA 4
- « Re-do » surgeries
- Unforseen events during surgery
- Patients that could not be discharged the same day
- Unfavorable psychosocial conditions
- Severe Sleep Apnea with CPAP machine
- Uncontrolled diabetes
- Active smoker
- Immunodepression
- Major abdominal surgery history
- Trip home – clinique > or = 45min

After exclusion

178 exclus des 758 patients

= 580 patients en ambu soit 76,5**%** **ambu**

280/423 By Pass en Y = 66,1%

285/318 Sleeve = 89,6%

15/17 ablation d'anneau = 88,2%

- Ratio F/M = 66,7% (506 F, 252 M)
- Mean age = 37,2 (19-59)
- Average BMI = 43,8 kg/m² (36,3-52,7)
- comorbidities :

- Hypertension 27,6%
- Type 2 diabetes (non-insulin dependent diabetes mellitus) controlled 16,01% (n=121)
- Dyslipidemia 11,1% (n=83)
- Metabolic syndrome 8,5% (n=65)

- Average Length of Stay (LoS) in Post-anesthesia care unit (PACU) = 89,5' (32-245')
- Total average LoS in ambulatory = 655' (595-705')
- General satisfaction survey = 87% (n=659)

Readmission and complications

- 2 upper limb septic thrombophlebitis (n=0,26%), treated with antiseptic dressing and antibiotics
- 6 gastric fistulas after sleeve gastrectomy (6/285 or n= 2,10%) 5 treated by combination of laparoscopic drainage and endoscopic double pigtail catheter and the 6th by radiological and endoscopic drainage
- 5 post sleeve gastrectomy hemorrhages on a row of clips revealed by malaise and cold sweats at D1 (n=4) and D2 (n=1), 4 were treated by revisional laparoscopy to evacuate the hemoperitoneum (4/285, n=1,40%) and the 5th needed transfusion and stoppage of LMWH (low molecular weight heparin)
- 3 hemorrhages of the gastrojejunal segment revealed by hematemesis(2 at D1 and 1 at D2 from a Roux-en-Y By pass) treated endoscopically and stoppage of LMWH (3/280, n=1,07%)
- 4 post Roux-en-Y By Pass surgery fistulas (4/280, n=1,42%), 2 at D3, 1 at D4, and 1 at D6 (3 went through coelioscopy for drainage and double pigtail catheter and 1 through radiological drainage with double pigtail catheter)

Conclusion

- The low rate of complications and readmissions (20/580 = 3,44% with 12 surgical revision = 2,06%) did not question the decision for ambulatory management (mortality rate = 0%)
- Ambulatory bariatric surgery is feasible after verification of eligibility criterias, good education ahead, case to case pros/cons analysis, considering the size of the structure, an organized and secured protocol for management, a team availability, and the capacity to manage post surgical complications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