Ambulatory Bariatrics: Consideration beyond just VSGs

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Secretary of the Canadian Association of Bariatric Physicians and Surgeons (CABPS)
IFSO North American Chapter Board Member at Large

Conflict of interest

- Speaker for NovoNordisk
- Educational Grant from Medtronic
- Podcast sponsor by J&J

Where come the fear of ambulatory (day) surgery for bariatric surgery?

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Surgery for Obesity and Related Diseases 3 (2007) 134–140

SURGERY FOR OBESITY AND RELATED DISEASES

IFSO MELBOURNE 2024

Original article

Obesity surgery mortality risk score: proposal for a clinically useful score to predict mortality risk in patients undergoing gastric bypass

Eric J. DeMaria, M.D.[a,b,*], Dana Portenier, M.D.[b], Luke Wolfe, M.S.[a]

[a]*Virginia Commonwealth University, Richmond, Virginia*
[b]*Duke University Medical Center, Durham, North Carolina*

Received June 11, 2006; revised January 4, 2007; accepted January 21, 2007

- Prospective data
- 2075 patients
- 1995-2004
- Mortality rate in the literature (0% to 1.5%)

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Table 2
Results of multivariate logistic regression analysis modeling risk of mortality using hypertension, BMI ≥50 kg/m^2, gender, risk of PE, and age ≥45 years as predictors

Risk factor	Odds ratio	95% Confidence interval
BMI ≥50 kg/m^2	3.600	1.442–8.988
Male gender	2.795	1.320–5.916
Hypertension	2.783	1.105–7.009
Risk of PE	2.623	1.124–6.121
Age ≥45 y	1.642	0.775–3.480

Abbreviations as in Table 1.

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Table 3
Mortality rates according to number of co-morbidities used in multivariate model

Co-morbidity (n)	Patients (n)	Deaths (n)	Mortality rate (%)
0	356	0	0
1	601	3	0.50
2	596	7	1.17
3	403	12	2.98
4	101	6	5.94
5	18	3	16.67

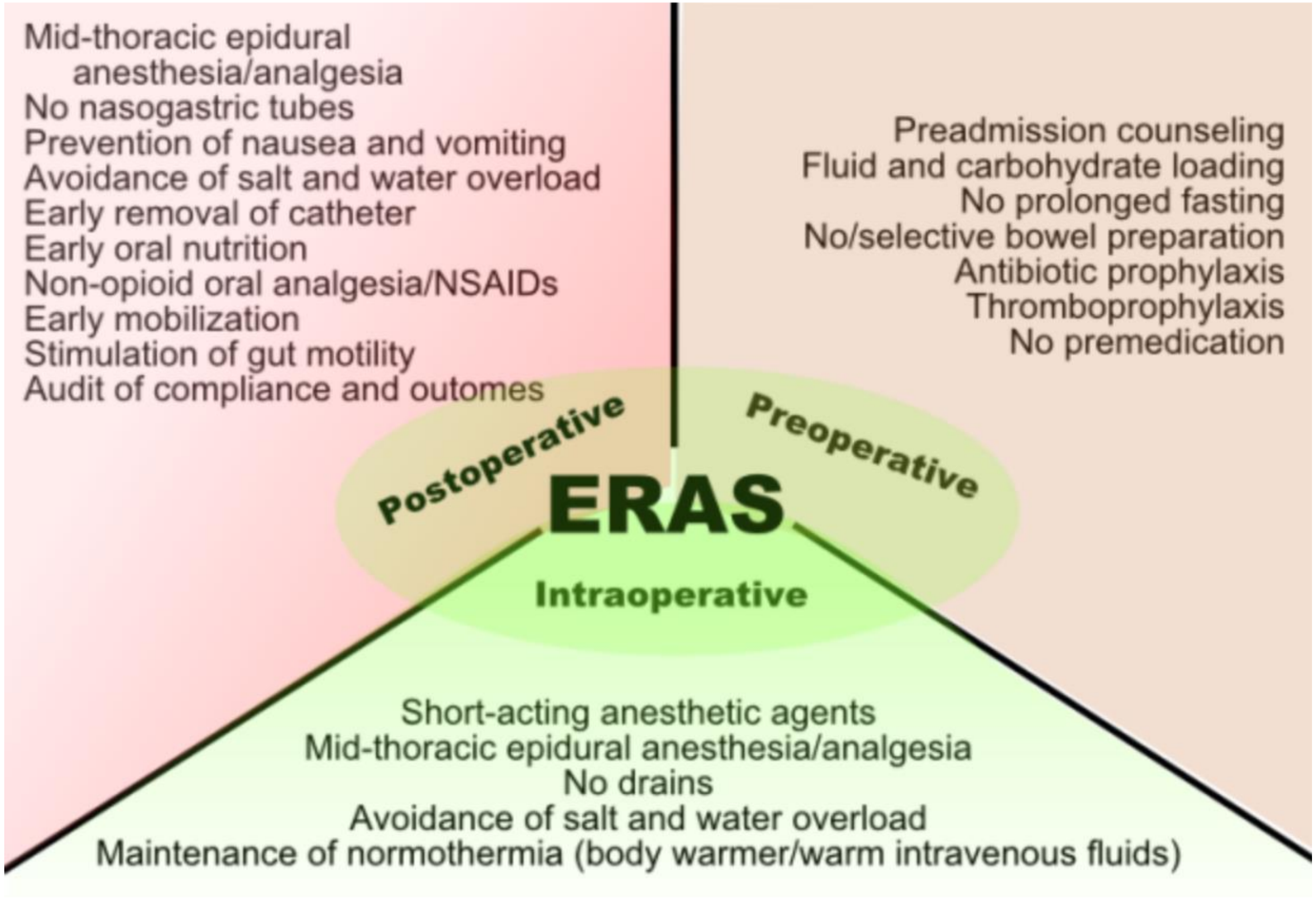
Mortality rates significantly different from each other using Fisher's exact test.

ANNALS OF SURGERY

IFSO MELBOURNE 2024

Changes in Utilization of Bariatric Surgery in the United States From 1993 to 2016 (February 2020 Volume 271 - Issue 2 - p 201-209)

- 1 903 273 patients!
- 100% open to 98% laparoscopic
- Complications from 11.7% to 1.4%
- Mortality from 1% to 0.04%


Mid-thoracic epidural anesthesia/analgesia
No nasogastric tubes
Prevention of nausea and vomiting
Avoidance of salt and water overload
Early removal of catheter
Early oral nutrition
Non-opioid oral analgesia/NSAIDs
Early mobilization
Stimulation of gut motility
Audit of compliance and outomes
Preadmission counseling
Fluid and carbohydrate loading
No prolonged fasting
No/selective bowel preparation
Antibiotic prophylaxis
Thromboprophylaxis
No premedication
Postoperative
Preoperative
ERAS
Intraoperative
Short-acting anesthetic agents
Mid-thoracic epidural anesthesia/analgesia
No drains
Avoidance of salt and water overload
Maintenance of normothermia (body warmer/warm intravenous fluids)

Reason for longer hospital stay

30%	Pain
20%	Nausea
15%	Weekness
20%	Organisation

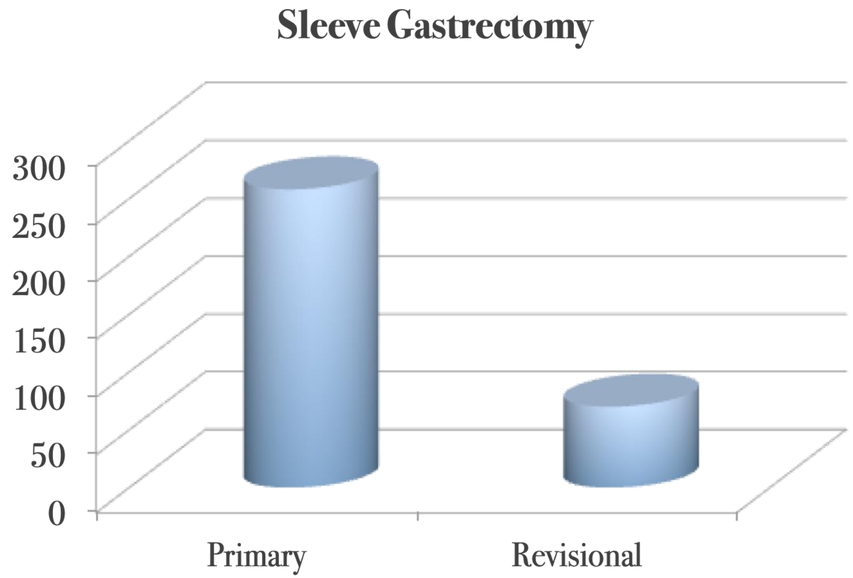
OBES SURG (2016) 26:1429–1435
DOI 10.1007/s11695-015-1984-0

ORIGINAL CONTRIBUTIONS

Fully Ambulatory Laparoscopic Sleeve Gastrectomy: 328 Consecutive Patients in a Single Tertiary Bariatric Center

Fabio Garofalo[1] · Ronald Denis[1] · Omar Abouzahr[1] · Pierre Garneau[1] · Radu Pescarus[1] · Henri Atlas[1]

- From August 2012 to February 2015
- 980 patients underwent LSG
- 328 (33%) responded to ambulatory criteria



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Exclusion Criteria

Patient characteristics

Age ≥ 55 y.o.
BMI ≥ 55 Kg/m^2
ASA score ≥ IV
OS-MRS‡ grade C
Insulin-dependent diabetes
Poorly controlled hypertension

Table 1 Patient characteristics

Characteristics	Patients (n=328)
Age (year)	38.4 (±8.5)[a]
Body mass index (kg/m^2)	44.5 (±5.6)[a]
ASA score	2.3 (±0.5)[a]
Women (%)	86.6
Female/male ratio	6/1
Comorbidities (%)	54.3
Hypertension (%)	21.6
Type II diabetes (%)	12.5
Sleep apnea (%)	10.1
Hyperlipidemia (%)	6.4
Ambulatory surgery	
Length of stay (hours)	8.1 (6–10)[b]
Overnight hospitalization (%)	1.8
Readmission (%)	8.5

[a] Mean±standard deviation

[b] Mean and range

Preoperative Phase

Patients selection

Inclusion criteria
Exclusion criteria

Patients preparation

Low-calorie diet (2 weeks)
Nutritional course
Counseling

Surgical Phase

Anesthesia protocol

Induction: Propofol (200/250 mg)
Maintenance: Desflurane (1 MAC)
Muscular relaxant: Rocoronium (50 mg)
Reverse: Neostigmine (2.5 mg)
Glycopirolate (0.5 mg)
Narcotics: Morpine (15 mg)
Fentanyl (250 mcg)
Antiemetics: Ondansetron (8 mg)
Dexamethasone (8 mg)

Surgical protocol

Antibiotic prophylaxis (Cefazolin 2 g)
Heparine 5000 UI sc before surgery
Pneumatic compression stockings
Experienced surgeon
Standardized laparoscopic technique
Local anesthesia (Bupivacaine 0.5%)

Postoperative Phase

Recovery room

Vital signs
Pneumatic compression stockings
IPP: Pantoloc (40 mg)
Antalgia: Hydromorphone (1-2 mg)
Antiemetics: Dimenhydrinate (50 mg)
Ondansetron (4 mg)

Discharge protocol

PACU* modified criteria: score >10/14
Prescription: Enoxaparine (40 mg)
Hydromorphone (2 mg)
Dimenhydrinate (50 mg)
Docusate sodium (200 mg)
Pantoprazole (40 mg)
Telephone contact 24 hours post-op.

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Discharge: PACU modified criteria

Modified Criteria	Points
Oxygenation*	
SpO2 > 92% on room air	2
SpO2 > 90% on oxygen	1
SpO2 < 90% on oxygen	0
Circulation	
BP +/- 20% of normal	2
BP +/- 20-50% of normal	1
BP > 50% of normal	0
Consciousness*	
Fully awake	2
Arousable on calling	1
Not responsive	0
Nausea & vomiting	
None or mild: tx with antiemetics PO	2
Moderate: tx with antiemetics IV	1
Severe: persistent with Tx	0
Pain*	
None or mild pain (VAS: 0-4)	2
Moderate pain (VAS: 5 -7)	1
Severe pain (VAS: 7-10)	0

Modified Criteria	Points
Wound	
Dressing clean	2
Dressing stained (minimal bleeding)	1
Dressing soaking wet (active bleeding)	0
Miction	
Miction	2
Anuric, comfortable	1
Anuric, uncomfortable	0

DISCHARGE: score >10

Oxygenation
Consciousness
Pain

→ Score must be 2 for discharge

Aldrete JA, J Clin Anesth 1995

OBES SURG (2016) 26:1429–1435
DOI 10.1007/s11695-015-1984-0

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Lenght of stay (hours)	8.1 (6-10)
Overnight hospitalisation	6 (1.8%)
Readmission	28 (8.5%)

Reason for readmissions

Table 2 Cause for readmissions within 30 days postoperatively

Cause of readmission	Number of patients
Nausea/vomiting	13 (3.9 %)
Abdominal pain	7 (2.1 %)
Pneumonia	2 (0.6 %)
Pancreatitis	1 (0.3 %)
Urinary tract infection	1 (0.3 %)
Pain related to intra-abdominal hematoma	3 (0.9 %)
Gastric staple line leak	2 (0.6 %)

Dindo-Clavien Classification	Type of complications	Patients (n=33/328)
Grade I		**27 (8.2%)**
	Nausea and vomiting	16 (4.9%)
	Abdominal pain	7 (2.1%)
	Intra-abdominal hematoma	2 (0.6%)
	Somnolence	1 (0.3%)
	Acute pancreatitis	1 (0.3%)
Grade II		**3 (0.9%)**
	Pneumonia	2 (0.6%)
	Urinary tract infection	1 (0.3%)
Grade IIIa		**2 (0.6%)**
	Gastric leak	2 (0.6%)
Grade IIIb		**1 (0.3%)**
	Intra-abdominal bleeding	1 (0.3%)
Grade IV		**None**
Grade V		**None**

Garofalo F, Denis R, Abouzahr O, Pescarus R, Garneau P, Atlas H; **Obes Surg 2015**

Primary LSG: 258 (78%)
Revisional LSG: 70 (22%)

Percutaneous drain and endoscopic stent

Laparoscopic treatment

J Minim Invasive Surg Sci. In press(In press):e44931. doi: 10.5812/minsurgery.44931.

Published online 2017 February 25. **Research Article**

Neuromuscular Blockade, Bariatric Surgeon Satisfaction, and Quality of Patient Recovery

Pierre Y. Garneau,[1,*] Fabio Garofalo,[1] Valerie Deslauriers,[1] Simon L. Bacon,[2] Ronald Denis,[1] Radu Pescarus,[1] Henri Atlas,[1] Marc Delisle,[3] and Isabelle Tremblay[4]

[1]Department of Surgery, Division of Bariatric Surgery, Hopital du Sacre-Coeur de Montreal, 5400 boul Gouin O., Montreal, QC, H4J 1C5, Canada
[2]Centre de Medecine Comportementale de Montreal, Hopital du Sacre-Cœur, Montreal, University of Montreal, Montreal, Quebec, Canada
[3]Rockland MD Surgical Centre, Montreal, Quebec, Canada
[4]Anesthesia Department, Hopital du Sacre-Coeur de Montreal, 5400 boul Gouin O., Montreal, QC, H4J 1C5, Canada

Method

- Prospective study
- From January to August 2015
- 50 ambulatory patients with laparoscopic sleeve gastrectomy
- Revision surgery were excluded

Demographic

Characteristics	Patients (n=50)
Age (year)	38.8
BMI(Kg/m^2)	43.9
ASA score	2.3
Female	84%
OS-MRS class A	41 (82 %)
OS-MRS class B	9 (8%)
Comorbidities (total)	**46%**
Hypertension	26%
Type II DM	2%
Sleep Apnea	24%
Hyperlipidemia	8%

Laparoscopic time

Two groups

- 11 patients (22%) in deep NMB
- 39 patients (78%) in moderate NMB

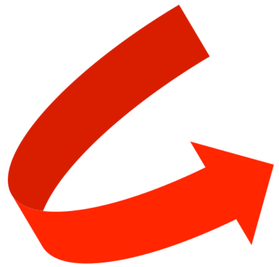
Neuromuscular blockade

Adjusted (age, sex, BMI)	Moderate NMB	Deep NMB	P value
Laparoscopy time	53.5 (±2.8)	35.8 (±5.2)	.005
Total surgical time	67.2 (±2.8)	48.6 (±5.2)	.003
Additional doses of blocker	0.69 (±0.14)	0.06 (±0.27)	.048

Mean total surgical time was 63 minutes (range: 35 to 128)

Nausea

- Women had more episodes of nausea (mean=1) compared to men (mean=0.14) (p=0.004).
- Women took more anti-nausea drugs (mean=1.24) vs men (mean=0.13) (p=0.006)
- Younger individuals took more anti-nausea drugs compared to older individuals (p=0.015).



Young women should potentially be placed as first case during an ambulatory surgery day

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Resultats

Length of stay (hours)	**7.25* (6 - 11)****
Overnight hospitalisation	**0%**
Readmission	**0%**

* Mean and ** Range

OK, whats next after > 4000 sleeves as a day surgery?

Studer *et al. BMC Surgery* (2024) 24:204
https://doi.org/10.1186/s12893-024-02461-9

BMC Surgery

RESEARCH Open Access

Fully ambulatory robotic single anastomosis duodeno-ileal bypass (SADI): 40 consecutive patients in a single tertiary bariatric center

Anne-Sophie Studer[1*], Henri Atlas[1], Marc Belliveau[2], Amir Sleiman[1], Alexis Deffain[1], Pierre Y Garneau[1], Radu Pescarus[1] and Ronald Denis[1]

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- Started in April 2021
- 37 F, 3 M
- Mean age 40.3
- Medium time after sleeve 54 months (21-146)
- Mean operative time 128 minutes

RESEARCH Open Access

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Table 1 Eligibility criteria for ambulatory management

Inclusion criteria	Exclusion criteria
Age < 55 yo with BMI ≤ 50 kg/m^2	Age ≥ 55yo and BMI > 50 kg/m^2
Age < 45 yo with BMI ≥ 50 and < 55 kg/m^2	Age ≥ 45 yo and BMI ≥ 55 kg/m^2
ASA score I or II, or III if cleared by internist,	ASA score ≥ IV
Moderate or severe obstructive sleep apnea syndrome if well controlled with CPAP	Obesity Surgery Mortality Risk [24, 25] score grade C
Obesity Surgery Mortality Risk [24, 25] score grade A or B	Insulin-dependent diabetes
Residence within 40 km from hospital	Poorly controlled hypertension
	Complex previous abdominal surgeries

RESEARCH Open Access

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Bariatric history:

Gastric lapband	7 (17.5%)
Gastric plication	1 (2.5%)
LSG	40 (100%)
Ambulatory /Overnight hospitalisation	27/13 (67.5/32.5%)
Median delay between SG and SADI	54 months (min-max: 21-146)
Mean pre-operative BMI before SG	47.7 (±7.1) min-max 31-66

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Table 2 Institution's protocol for ambulatory intraoperative medication and management

Anesthesia Protocol	Surgical Protocol	Recovery Room Protocol	Discharge Protocol
Induction: Propofol 200-400 mg Ketamine 0.5 mg/kg Dexmedetomidine 0.3–0.5 mcg/kg Lidocaine 2 mg/kg Magnesium 30 mg/kg **Maintenance**: Sevoflurane(1 MAC) or BIS guided TIVA* **Muscle relaxant**: Rocuronium (70-120 mg) **Reverse**: Neostigmine 2.5 mg-4 mg) Glycopirolate 0.5 mg-1.2 Or Sugammadex 2 mg/kg **Narcotics**: Dilaudid 0.5–1.5 Morphine 2-5 mg Fentanyl 0-150mcg **Antiemetics**: Ondansetron 4 mg Dexamethasone 10 mg **Cristalloids**: Bolus 15 cc/kg	**Antibiotic prophylaxis**: Cefazolin 2 g **Antithrombotics**: Heparin 5000 UI SC before surgery **Intermittent compression stockings** **2 experimented surgeons available** **Standardised** Laparoscopic & Robotic technique **Local anesthesia**: Bupivacaïne 0.5%	**Vital Signs** **Intermittent compression stockings** **PPI**: Pantoloc 40 mg **Analgesia**: Acetaminophen 975 mg Hydromorphone 1-2 mg **Antiemetics**: Dimenhydrate 50 mg Ondansetron 4 mg	**PACU**** modified criteria: score > 10/14 **Prescription**: Enoxaparine 40 mg daily Hydromorphone 1 mg every 6 h if needed (max 7days) Dimenhydrinate 50 mg (every 6 h if needed max 7 days) Docusate sodium 200 mg (twice a day, if needed max 7 days) Pantoprazole 40 mg daily, for 1 month) **Vitamin supplements** **Telephone contact 24 h post-op**

* Bispectral Index Monitoring guided Total Intravenous Anesthesia ** Post–Anesthesia Care Units

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Table 5 Dindo-Clavien's classification of surgical complications

Grade	Type of complication	Length of stay (days)	*n* counts (%)
I	Abdominal pain	0	3 (7.5%)
	Nausea and vomiting	*NA*	0 (0%)
II	Parietal cellulitis	0	1 (2.5%)
IIIa	Infected intra-abdominal hematoma	10	1 (2.5%)
IIIb	Duodenal leak and peritonitis	24	1 (2.5%)

NA: Not Applicable

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Surgery for Obesity and Related Diseases ■ (2024) 1–8

SURGERY FOR OBESITY AND RELATED DISEASES

Original article

Anastomotic metabolic and bariatric surgeries with same-day discharge: 30-day outcomes of a cohort from a high-volume center in Canada

Alexis Deffain, M.D.[a,*], Ronald Denis, M.D.[a], Heba Alfaris, M.D.[a], Karim Ataya, M.D.[a], Samah Melebari, M.D.[a], Marc Belliveau, M.D.[b], Adam Di Palma, M.D.[a], Pierre Garneau, M.D.[a], Anne-Sophie Studer, M.D.[a]

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Received 2 May 2024; accepted 8 August 2024

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- Between April 2021 an November 2023
- 208 patients (191 F, 17 M)
- 76% had a previous sleeve
- Mean age 41.4
- Mean BMI 41.9

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Received 2 May 2024; accepted 8 August 2024

	SADI	RYGB	OAGB	SASI
# cases	92	72	35	9
BMI	50	44	51	42
Revisional	100%	33%	94%	100%
Robotic	76%	7%	54%	100%
Operative time	133 min.	109 min.	89 min.	113 min.
HH repair	26%	25%	20%	22%
Overnight stay	5.4%	1.4%	5.4%	0
Readmission	5.4%	6.9%	2.9%	11%
Leak	1			
Bowel obstruction		2		
Hematoma	1			

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IFSO MELBOURNE 2024

Highlights

- Codified strategy for same-day discharge (SDD) anastomotic metabolic and bariatric surgeries (MBS) contributes to favorable early outcomes.
- To obtain SDD management, patient selection criteria must be strictly adhered to.
- SDD seems feasible for anastomotic MBS if performed at a high-volume center.
- SDD management expands access to surgical care in the era of enhanced recovery after bariatric surgery.

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Do we have new concept to improve intra-operative care?

Low-pressure versus standard-pressure pneumoperitoneum for laparoscopic cholecystectomy: a systematic review and meta-analysis

Jie Hua, M.D.[a,b,1], Jian Gong, M.D.[a,1], Le Yao, M.D.[a], Bo Zhou, M.D.[a], Zhenshun Song, M.D., Ph.D.[a,*]

The American Journal of Surgery (2014)

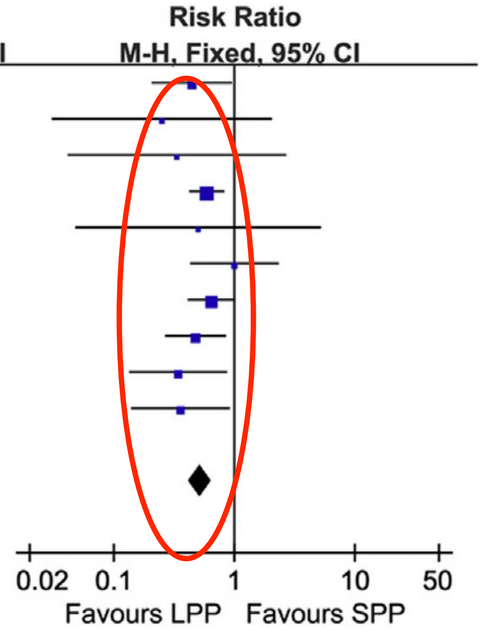
- 1263 patients
- Surgical outcome mesure
  - traditional intra-abdominal pressure (12-15 mmHg)
  - low pressure (<10 mmHg)

Post-op shoulder pain

Study or Subgroup	LPP Events	LPP Total	SPP Events	SPP Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Barczynski et al, 2003	8	74	18	74	11.7%	0.44 [0.21, 0.96]
Chok et al, 2006	1	20	4	20	2.6%	0.25 [0.03, 2.05]
Ibraheim et al, 2006	1	10	3	10	2.0%	0.33 [0.04, 2.69]
Kandil et al, 2010	23	50	39	50	25.4%	0.59 [0.42, 0.82]
Kanwer et al, 2009	1	30	2	30	1.3%	0.50 [0.05, 5.22]
Perrakis et al, 2003	7	20	7	20	4.6%	1.00 [0.43, 2.33]
Sandhu et al, 2009	20	70	31	70	20.2%	0.65 [0.41, 1.02]
Sandoval et al, 2009	10	34	21	34	13.7%	0.48 [0.27, 0.85]
Sarli et al, 2000	5	46	14	44	9.3%	0.34 [0.13, 0.87]
Yasir et al, 2012	5	50	14	50	9.1%	0.36 [0.14, 0.92]
Total (95% CI)		**404**		**402**	**100.0%**	**0.53 [0.42, 0.66]**
Total events	81		153			

Heterogeneity: Chi² = 5.85, df = 9 (P = 0.75); I² = 0%

Test for overall effect: Z = 5.77 (P < 0.00001)



- **20% if low pressure**
- **38% if standard pressure**

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ORIGINAL CONTRIBUTIONS

Preoperative Transversus Abdominis Plane (TAP) Block with Liposomal Bupivacaine for Bariatric Patients to Reduce the Use of Opioid Analgesics

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	TAP block	No block	p
Intraveinous hydromorphine	69%	96%	p <0.0001
Oral opioïd	47%	75%	p <0.0001

Conclusion

- Ambulatory bariatric surgery is safe and secure in selected patient, even for surgery with anastomosis
- Young women require more anti-nausea drug
- Low abdominal pressure decrease post op abdominal pain
- Preoperative TAP decrease the amount of post op opioids

Thank you
(Merci!)

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