Is Day Case Bariatric Surgery Feasible and Desirable?

Yes – I believe it is!!

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Medical Lead, Metabolic Obesity Service
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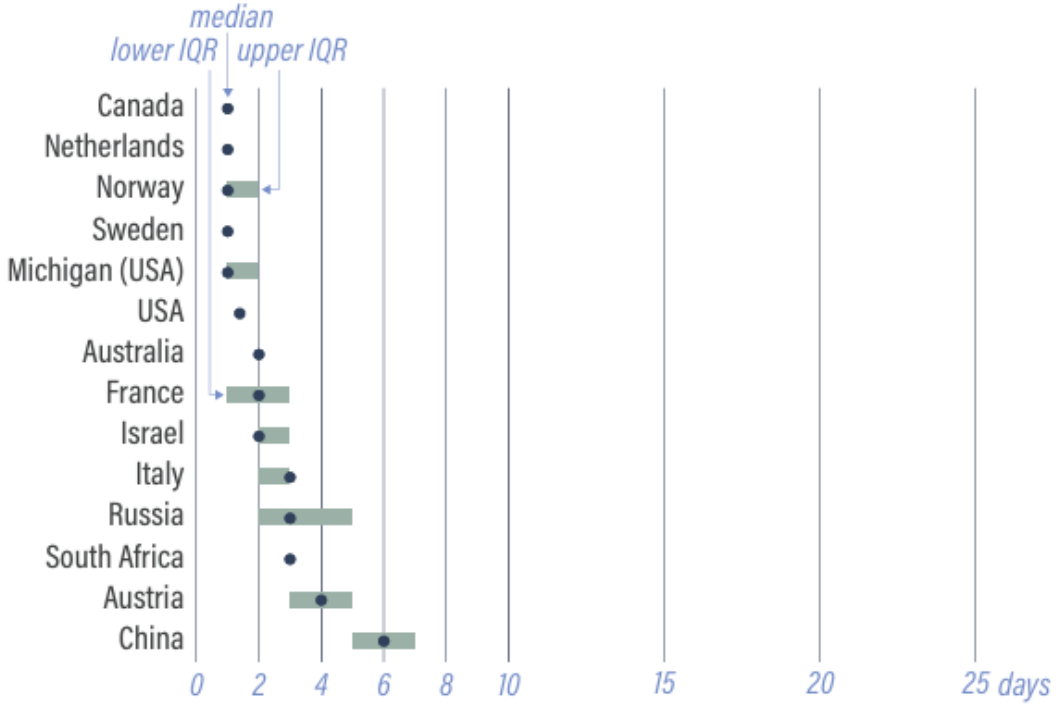
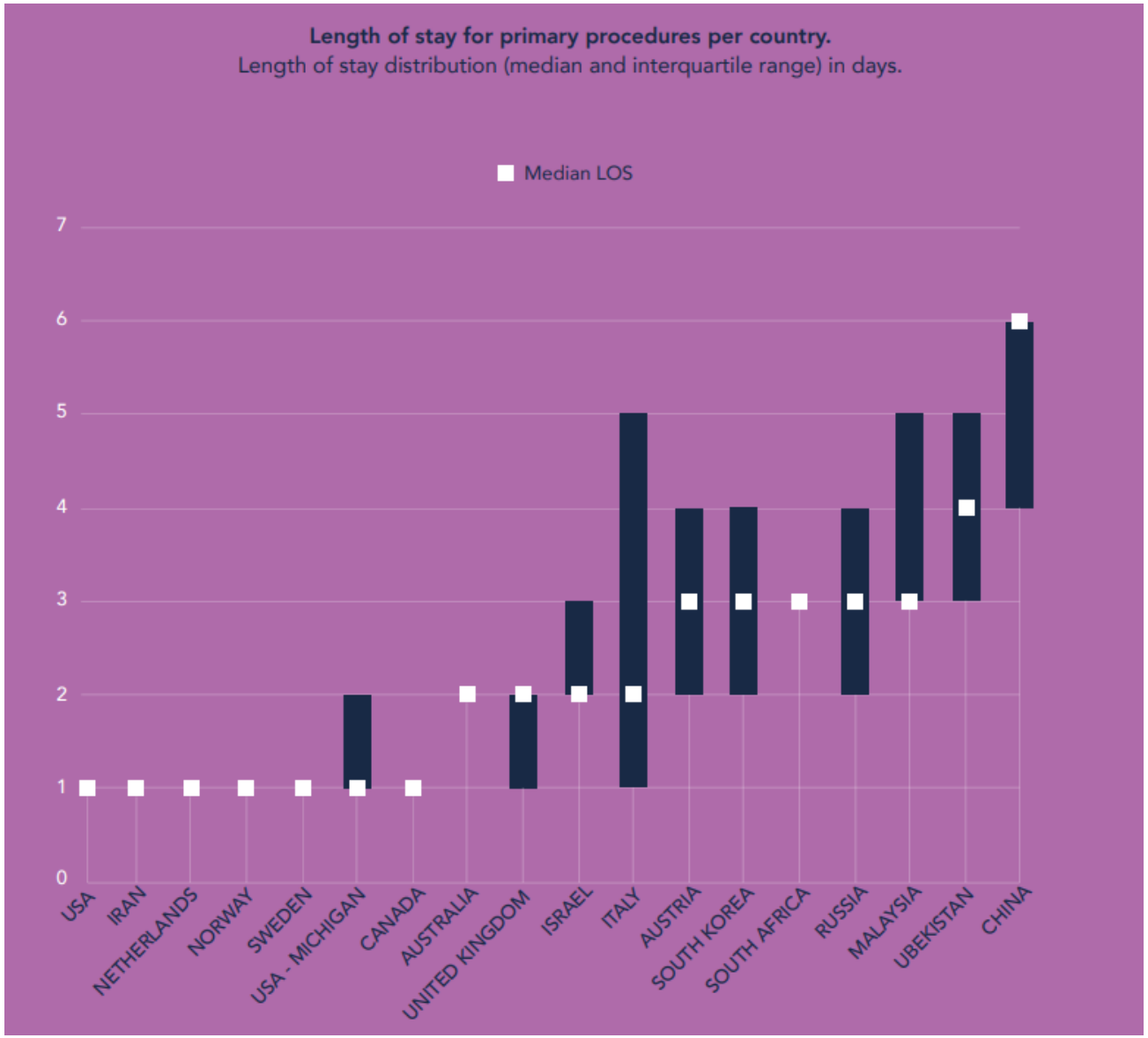
I have no potential conflict of interest to report

Length of stay for primary procedures per country

Length of stay distribution (median and interquartile range) in days





IFSO

8TH GLOBAL REGISTRY REPORT

Background Restrictions during the COVID-19 pandemic influenced a shift to same-day discharge in bariatric surgery. Current studies show conflicting findings regarding morbidity and mortality. We aim to compare outcomes for same-day discharge versus admission after bariatric surgery.

Surgical Endoscopy
https://doi.org/10.1007/s00464-024-11053-w

Outcomes of same-day discharge in bariatric surgery

Sydney Cooper[1] · Shivam Patel[1] · Matthew Wynn[1] · David Provost[1] · Monique Hassan[1]

Safety of gastric bypass with same-day discharge: a propensity score-matched analysis of the Dutch Audit for treatment of Obesity

Suzanne C. Kleipool, M.D.[a,*], Nini H. Jonkman, Ph.D.[b], Pim W. J. van Rutte, M.D., Ph.D.[a], Steve M. M. de Castro, M.D., Ph.D.[a], Ruben N. van Veen, M.D., Ph.D.[a]

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requiring overnight hospitalization. This strategy not only demonstrates efficacy but also has the potential to alleviate the burden on hospital capacity, especially in light of ongoing challenges such as local staff shortages and the recent impact of the COVID-19 pandemic [3–13]. Although there is no current international standard for the

Is Day only Bariatric Surgery Feasible?

SURGERY FOR OBESITY
AND RELATED DISEASES

Safety of same-day discharge after laparoscopic sleeve gastrectomy: propensity score–matched analysis of the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program Registry

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Received 17 August 2020; accepted 30 August 2020

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SURGERY FOR OBESITY AND RELATED DISEASES

Results: A total of 271,658 sleeve gastrectomy patients met the inclusion criteria. Of these, only 7825 (2.88 %) were day case surgery procedures. There was no mortality in the group. Day case surgery, compared with inpatient sleeve gastrectomy, was associated with a similar risk of a leak (.56% versus .40%; relative risk [RR], 1.419; 95% CI, .896–2.245; $P = .133$), bleeding (.38% versus .31%; RR, 1.250; 95% CI, .731–2.138; $P = .414$), 30-day reoperation (.81% versus .56%; RR, 1.432; 95% CI, .975–2.104; $P = .066$), and 30-day morbidity (1.15% versus 1.01%; RR, 1.139; 95% CI, .842–1.541; $P = .397$). Outpatients' SG increased the risk for 30-day readmission (3.35% versus 2.79%; RR, 1.202; 95% CI, 1.009–1.432; $P = .039$).

Conclusions: Sleeve gastrectomy in the outpatient setting as a day case surgery was associated with no mortality and no statistically significant risk of reoperation, leakage, or bleeding compared with patients admitted to inpatient units. The readmission rate was higher in the day case surgery group. (Surg Obes Relat Dis 2021;17:46–53.)

Table 3
Standardized differences in propensity score–matched sample

Variables	Standardized differences
Age, yr	.009
Body mass index, kg/m^2	.011
Sex, female	.018
Race, white	.011
Preoperative hypertension	.003
Preoperative diabetes mellitus	.013
Preoperative hyperlipidemia	.010
Preoperative obstructive sleep apnea	.004
Gastroesophageal reflux disease requiring medication (within 30 d before surgery)	.002
Previous percutaneous coronary interventions/percutaneous transluminal coronary angioplasty	.003
Preoperative vein thrombosis requiring therapy	.010
History of pulmonary embolism	.004
Preoperative renal insufficiency	.005
History of severe chronic obstructive pulmonary disease	.000
ASA class	.001
Steroid/immunosuppressant use for a chronic condition	.016
Current smoker within 1 yr	.012
Sleeve bougie size, Fr	.015
Sleeve distance to pylorus, cm	.002
Sleeve staple line reinforcement	.007
Medical specialty of the physician performing the principal operative procedure (bariatric surgeon)	.026
Sleeve oversewn	.030

ASA, American Society of Anesthesiologists.

Table 5
Reason for readmission for same-day versus 1–4 postoperative day discharge after laparoscopic sleeve gastrectomy

Reasons	Same-day discharge n = 262		1–4 postoperative day discharge n = 218	
	n	%	n	%
Nausea and vomiting, fluid, electrolyte, or nutritional depletion	106	40.46	70	32.11
Other	30	11.45	40	18.35
Abdominal pain, not otherwise specified	24	9.16	23	10.55
Anastomotic/staple line leak	18	6.87	14	6.42
Bleeding	13	4.96	7	3.21
Vein thrombosis requiring therapy	13	4.96	14	6.42
Other abdominal sepsis	11	4.20	6	2.75
Gallstone disease	7	2.67	3	1.38
Pneumonia	5	1.91	2	.92
Strictures/stomal obstruction	4	1.53	2	.92
GI perforation	3	1.15	2	.92
Intestinal obstruction	3	1.15	-	-
PE	3	1.15	5	2.29
Shortness of breath (without a diagnosis of PE)	3	1.15	3	1.38
Cardiac events	2	.76	1	.46
Gastro-gastric fistula	2	.76	-	-
Incisional hernia	2	.76	3	1.38
Internal hernia	2	.76	-	-
Nephrolithiasis	2	.76	1	.46
Other respiratory failure	2	.76	3	1.38
Anastomotic ulcer	1	.38	-	-
Chest pain (cardiac enzymes not required to be positive)	1	.38	5	2.29
Infection/fever	1	.38	5	2.29
Medication-related	1	.38	2	.92
Musculoskeletal pain	1	.38	-	-
Renal insufficiency	1	.38	2	.92
Wound infection/evisceration	1	.38	4	1.83
Bile reflux gastritis	-	-	1	.46

GI = gastrointestinal; PE = pulmonary embolism.

Surgical Endoscopy
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Outcomes of same-day discharge in bariatric surgery

Sydney Cooper[1] · Shivam Patel[1] · Matthew Wynn[1] · David Provost[1] · Monique Hassan[1]

Results 1225 patients met the inclusion criteria. In the gastric sleeve group, 852 subjects were outpatients and 227 inpatients. In the gastric bypass group, 70 subjects were outpatients, and 40 were inpatients. The mean age was 44.63 (17.38–85.31) years, and the mean preoperative BMI was 46.07 ± 8.14 kg/m^2. The subjects in the outpatient group had lower BMI with fewer comorbidities. The groups differed significantly in age, BMI, and presence of several chronic comorbidities. The inpatient and outpatient groups for each surgery type did not differ significantly regarding reoperations, IV fluid treatments, or 30-day mortality. The inpatient sleeve group demonstrated a significantly higher readmission percentage than the outpatient group (4.6% vs 2.1%; $p = 0.02882$). The inpatient bypass group showed significantly greater ER visits (21.7% vs 10%; $p = 0.0108$). The incidence of adverse events regarding the secondary outcomes was not statistically different.

Conclusion Same-day discharge after bariatric surgery is a safe and reasonable option for patients with few comorbidities.

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Received 14 November 2023; accepted 22 June 2024

Conclusion: Gastric bypass with SDD is safe, with no increased risk of short-term severe complications, reoperations, or mortality. However, SDD is associated with a higher 30-day readmission rate compared to patients who stay overnight in the hospital after surgery. (Surg Obes Relat Dis 2024;■:1–7.)

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ANZCA
FPM

PG15(POM) Guideline for the perioperative care of patients selected for day stay procedures 2018

4. Selection guidelines for DSP

In all cases, the ultimate decision as to the suitability of any patient for DSP is that of the anaesthetist who will be administering the anaesthesia. The decision as to the type of anaesthesia is the responsibility of the medical practitioner administering anaesthesia and will be based on the following:

- Selection of patients and anaesthesia considerations.
- Surgery/procedure considerations.
- Recovery (PACU) and discharge arrangements.
- Adequacy of resources, including personnel, of the DSP facility.
- Geographic location of the DSP Facility for example urban versus rural.
- Type of facility for example "free-standing" (this includes office/rooms-based facilities) or co-located/in close proximity to a tertiary/quaternary hospital.

5. Patient selection and anaesthesia factors

5.1 Patients should be of ASA physical status 1 or 2 or medically stable ASA 3 or 4 patients. Note that ASA physical status alone does not dictate acceptability as this will also be influenced by surgical/procedural factors and the facilities of the DSP unit. The psychosocial advantage of short duration stay in an unfamiliar environment is being increasingly recognised for the elderly but this has to be weighed up against optimal management of comorbidities. When considering whether DSP is appropriate for patients with significant medical issues, early consultation with the involved anaesthetist is essential.

5.2 Careful assessment of medical comorbidities should be undertaken in all patients with particular attention to allergies, obstructive sleep apnoea (OSA) or sleep disordered breathing as well as the potentially difficult airway. Such assessment is particularly relevant in obese patients. In any given healthcare facility a nominal BMI should be established above which patients would be referred for early consultation with an anaesthetist.

What are we particularly worried about?

Sleep apnoea – particularly untreated or un-identified
Unstable diabetes
Unstable hypertension
Coronary artery disease
Renal failure
Severe COPD
History of DVT/PE

Eur Arch Otorhinolaryngol (2012) 269:1865–1871
DOI 10.1007/s00405-012-1948-0

MISCELLANEOUS

Obstructive sleep apnea is underrecognized and underdiagnosed in patients undergoing bariatric surgery

M. J. L. Ravesloot · J. P. van Maanen · A. A. J. Hilgevoord · B. A. van Wagensveld · N. de Vries

conclusion, in this large patient series, 69.9% of patients undergoing BS meet the criteria for OSA. More than 40% of these patients have severe OSA. A mere 13.3% of the patients were diagnosed with OSA before being placed on the waiting list for BS. On statistical analysis, increased neck circumference, BMI and the ESS were found to be insufficient predictors of the presence of OSA. Polysomnography is an essential component of the preoperative workup of patients undergoing BS. When OSA is found, specific perioperative measures are indicated.

6. Surgical/procedural considerations

Increasingly complex surgical procedures are being performed as day stay procedures. The concept of "23 hour admission" in some facilities has enabled the conduct of more complex procedures that would normally have been undertaken as inpatient procedures.

The procedure/surgery to be performed should:

6.1 Have a minimal risk of postoperative haemorrhage.

6.2 Have a minimal risk of postoperative airway compromise.

6.3 Be amenable to postoperative pain controllable by outpatient management techniques.

6.4 Permit postoperative care to be managed by the patient and/or a responsible adult and any special postoperative nursing requirements met by day surgery, home or district nursing facilities.

6.5 Be associated with a rapid return to normal fluid and food intake.

6.6 Be scheduled taking into account the anticipated recovery period. Where a prolonged recovery is anticipated the procedure should be scheduled first on the list or as close to first as feasible.

Bariatric surgery is as safe as other common operations: an analysis of the ACS-NSQIP

Benjamin Clapp, M.D., F.A.C.S.[a], Kamal Abi Mosleh, M.D.[b], Amy E. Glasgow, M.H.A.[c], Elizabeth B. Habermann, Ph.D., M.P.H.[b,c,d], Barham K. Abu Dayyeh, M.D.[e], Konstantinos Spaniolas, M.D., F.A.C.S.[f], Ali Aminian, M.D., F.A.C.S.[g], Omar M. Ghanem, M.D., F.A.C.S.[b,*]

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Received 14 September 2023; accepted 28 November 2023

Results: A total of 1.6 million patients were included, with 11.1% undergoing MBS. The odds of readmission were marginally lower in the cholecystectomy (adjusted odds ratio [aOR] = .88, 95% confidence interval (CI) [.85, .90]) and appendectomy (aOR = .88, 95% CI [.85, .90]) cohorts. Similarly, odds of ELOS were among the lowest, surpassed only by same-day procedures such as cholecystectomies and appendectomies. The MBS group had significantly low odds of mortality, comparable to safe anatomical procedures such as hernia repairs. Infectious and thrombotic complications were exceedingly rare and amongst the lowest after MBS.

Summary of 30-d postoperative outcomes across all procedure groups

30-d outcomes											
Total (N = 1,643,291)	Lap MBS (N = 183,195)	Lap TAHBSO (N = 89,901)	Lap cholecystectomy (N = 386,882)	Lap appendectomy (N = 391,451)	Lap ventral hernia (N = 29,322)	Lap incisional hernia (N = 33,829)	Lap partial colectomy with anastomosis (N = 107,146)	Lap colectomy with coloproctostomy (N = 80,446)	Lap nissen (N = 18,701)	Hip arthroplasty (N = 322,418)	*P* value
Readmission											
Yes	7435 (4.1)	4164 (4.6)	15,363 (4.0)	13,398 (3.4)	836 (2.9)	1487 (4.4)	7753 (7.2)	6023 (7.5)	921 (4.9)	10,937 (3.4)	**<.001***
Reoperation											
Yes	2899 (1.6)	1838 (2.0)	3411 (.9)	3573 (.9)	268 (.9)	504 (1.5)	3798 (3.5)	3082 (3.8)	395 (2.1)	6048 (1.9)	**<.001***
Any SSI											
Yes	2544 (1.4)	4487 (5.0)	5439 (1.4)	12,972 (3.3)	363 (1.2)	481 (1.4)	6154 (5.7)	5047 (6.3)	173 (.9)	3968 (1.2)	**<.001***
Pneumonia											
Yes	561 (.3)	452 (.5)	1805 (.5)	1205 (.3)	111 (.4)	212 (.6)	1364 (1.3)	641 (.8)	205 (1.1)	1104 (.3)	**<.001***
Unplanned intubation											
Yes	345 (.2)	193 (.2)	867 (.2)	545 (.1)	93 (.3)	116 (.3)	819 (.8)	444 (.6)	97 (.5)	486 (.2)	**<.001***
DVT/thrombophlebitis											
Yes	552 (.3)	289 (.3)	532 (.1)	457 (.1)	61 (.2)	68 (.2)	706 (.7)	477 (.6)	50 (.3)	1176 (.4)	**<.001***
Pulmonary embolism											
Yes	318 (.2)	457 (.5)	421 (.1)	310 (.1)	51 (.2)	72 (.2)	423 (.4)	254 (.3)	55 (.3)	840 (.3)	**<.001***
UTI											
Yes	1038 (.6)	1923 (2.1)	2220 (.6)	1800 (.5)	142 (.5)	261 (.8)	1547 (1.4)	1315 (1.6)	167 (.9)	2824 (.9)	**<.001***
Sepsis/septic shock											
Yes	782 (.4)	1000 (1.1)	3981 (1.0)	14,529 (3.7)	122 (.4)	191 (.6)	3144 (2.9)	2410 (3.0)	127 (.7)	994 (.3)	**<.001***
Mortality											
Yes	178 (.1)	135 (.2)	908 (.2)	324 (.1)	77 (.3)	71 (.2)	904 (.8)	322 (.4)	55 (.3)	677 (.2)	**<.001***

Values listed in bold represent statistically significant results, $P < .05$.

Lap = Laparoscopic; MBS = Metabolic and bariatric surgery; TAHBSO = Total abdominal hysterectomy with bilateral salpingo-oophorectomy; SSI = Surgical site infection; DVT = Deep venous thrombosis; UTI = Urinary tract infection.

Values in parentheses are in percentages.

* Chi-Square.

7.3 Discharge or Transfer of Patient

Discharge planning and arrangements should occur prior to admission and be confirmed o admission.

The following criteria should be satisfied prior to patients being discharged home:

7.3.1 Stable vital signs.

7.3.2 Conscious state that is similar to pre-anaesthesia levels.

7.3.3 Mobility level that is similar to pre-anaesthesia levels with allowance for type of surger and/or regional anaesthesia techniques.

7.3.4 Adequate pain control.

7.3.5 Manageable nausea, vomiting or dizziness.

7.3.6 Tolerating oral fluids.

7.3.7 Minimal bleeding or wound drainage.

7.3.8 Patients at significant risk of urinary retention (central neural blockade, pelvic and other surgery) should have passed urine.

7.3.9 Written and verbal instructions for all relevant aspects of post-anaesthesia and surgical care have been provided to patients or their accompanying adult. It should be established that patients and/or their responsible person understand the requirements for post anaesthesia care and intend to comply with these requirements, particularly with regard to public safety. A contact place and telephone number for emergency medical care should be included.

7.3.10 Patients have received advice as to when to resume activities such as driving and decision making.

7.3.11 Analgesia has been provided where necessary, with clear written instructions on how and when medications should be used. Careful consideration should be given when prescribing opioids on discharge.

7.3.12 Advice has been provided on resumption of other regular medications.

7.3.13 Discharge has been authorised by a member of the medical team or trained nurse after discharge criteria have been satisfied.

7.3.14 A responsible adult is available to transport the patient and should accompany the patient home in a suitable vehicle. A train, tram, or bus is not suitable. For some patients it may be important to have an adult escort as well as the vehicle driver. A responsible person should be available to stay at least overnight following discharge from the unit. This person should be physically and mentally able to make decisions for the patient's welfare when necessary.

7.3.15 If the patient is to be transferred to an inpatient facility, the anaesthetist and/or the surgeon will be responsible for the patient until care has been transferred to another medical officer in accordance with *PS53(A) Position statement on the handover responsibilities of the anaesthetist*.

Is Day only Bariatric Surgery Desirable?

Absolutely

Why?

BEDS
Limited funding
Limited staff

Why don’t patients go home?

Surgical issues

- Bleeding

Anaesthetic

- Nausea and vomiting
- Pain
- Low saturations
- Unexplained tachycardia

Social

- No transport
- Live alone
- Inability to follow instructions eg ethnicity, intellectual impairment

Patient and operative factors influence delayed discharge following bariatric surgery in an enhanced recovery setting

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SURGERY FOR OBESITY AND RELATED DISEASES

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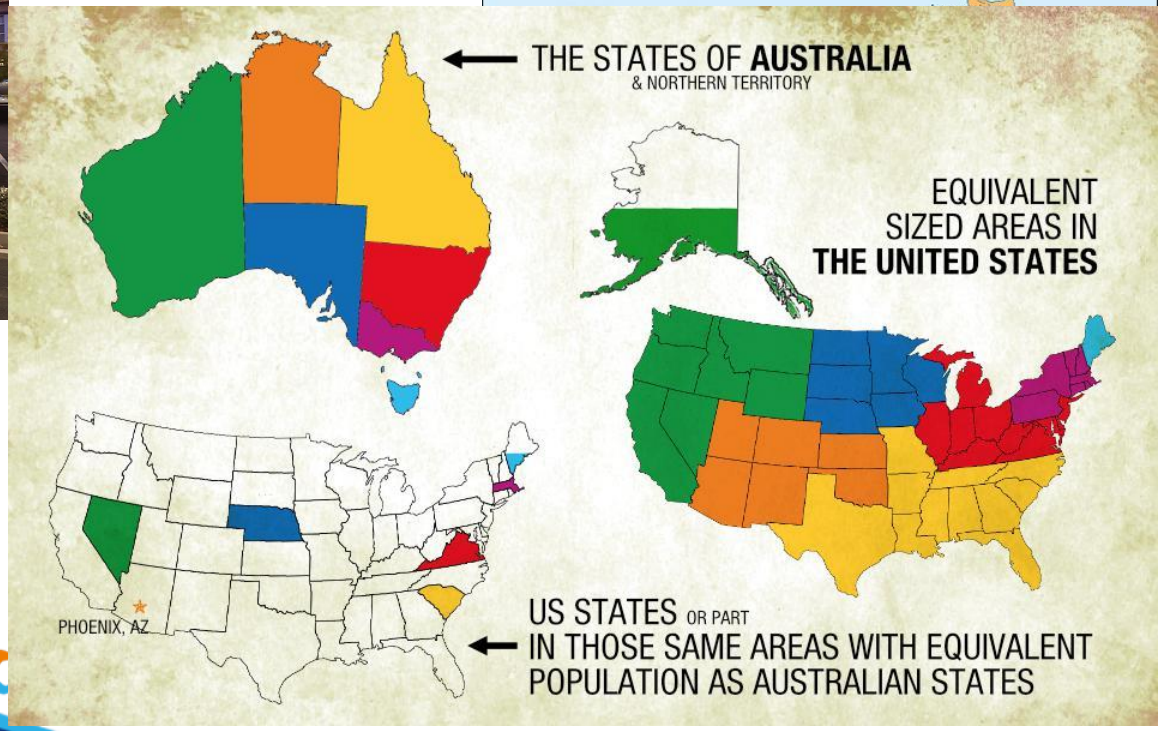


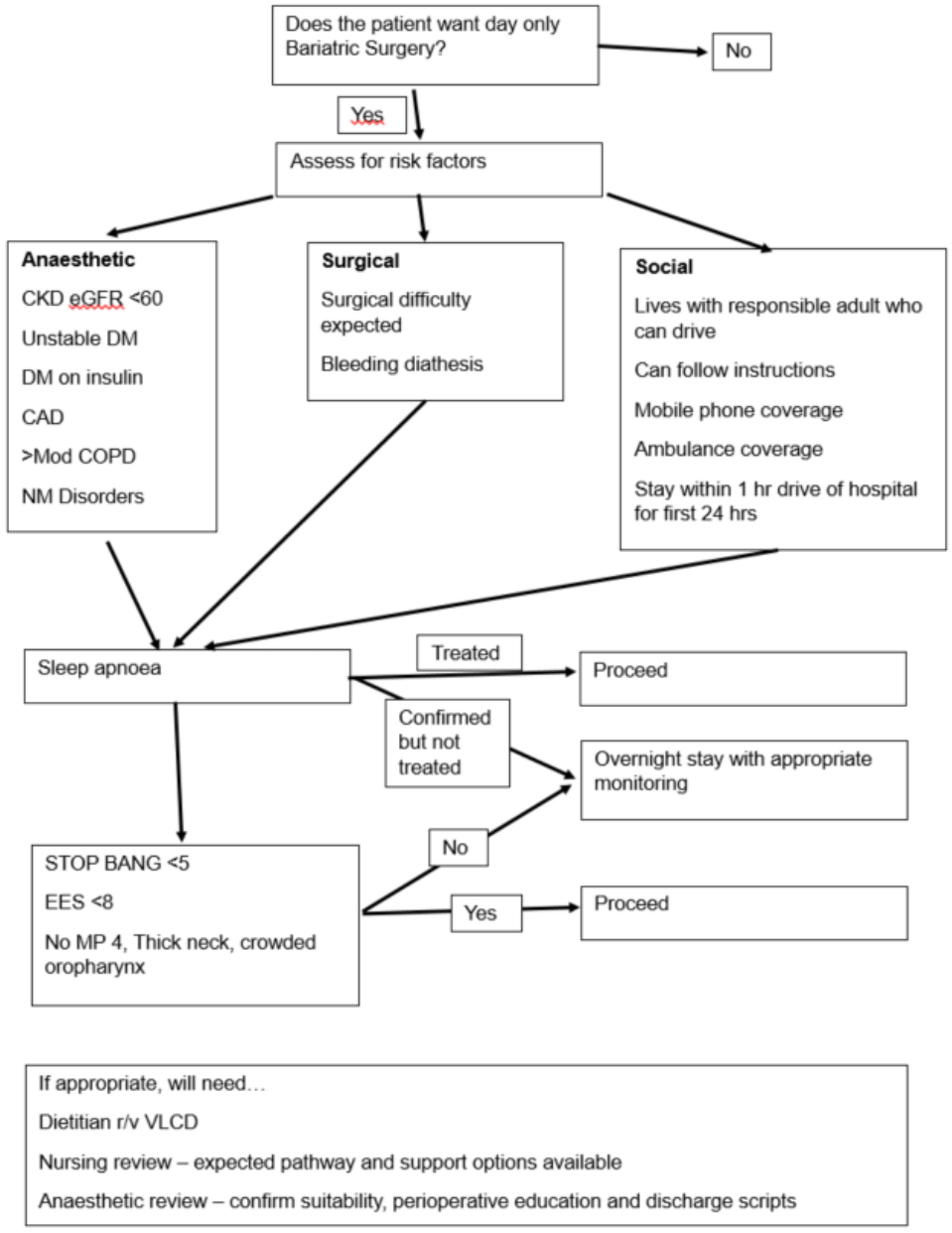
But is it practical?

IFSO
NAPOLI
2023

Engage

Evaluate

Educate



PART B: All UNSHADED boxes must be completed to meet SPECIFIC MULTIDISCIPLINARY DISCHARGE CRITERIA (to be completed by JMO, MOS or Criteria Led Discharge competent Registered Nurse)

MDT Agreed Milestones	Yes	No	N/A	Comment / Initial
1. Tolerating Fluids as per MOS standing order				
2a. Controlled Pain				
2b. Discharge script Pain relief provided				
3a. Controlled Nausea				
3b. Discharge script antiemetic provided				
4. Discharge script Proton Pump Inhibitor provided				
5. Discharge script anticoagulation as needed				
6. TED's in situ				
7. Wound & wound dressing clean & dry.				
8. Incentive Spirometer provided				
9. Cleared by MOS				

PART C: PATIENT CRITERIA (to be completed by JMO or Criteria Led Discharge competent Registered Nurse)

	Yes	No	
All observations Between the Flags or within acceptable limits for this patient			
Has not required a rapid response for the patient in the last 24 hours			
Nursing Discharge checklist complete			
Medical Certificate			

Locally

- Same day discharge program running March 2022
- 37 day only out of 113 total
  - 3 failed discharge – urinary retention, nursing
  - No bleeds, no nausea and vomiting, no pain issues
  - Similar rate of readmission, mainly for poor PO intake ~3%
  - Average LOS 12hrs v 30 hrs
  - BMI similar at 49.7 but less comorbidities

So is bariatric surgery desirable and feasible?

So is bariatric surgery desirable and feasible?

So is bariatric surgery desirable and feasible?

As long as you've got the right patient, medically, surgically and socially