

The background of the slide is an abstract composition of curved, overlapping shapes in shades of blue and white. The shapes create a sense of depth and movement, with some areas appearing to be in shadow and others brightly lit. The overall effect is clean and modern.

***Outpatient
Bariatric
Surgery....
Why Do It?***

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***NO
DISCLOSURES***



***OUTPATIENT
BARIATRIC
SURGERY....
CAN IT BE DONE?***

Outpatient Weight Loss Surgery: Initiating a Gastric Bypass and Gastric Banding Ambulatory Weight Loss Surgery Center

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Abstract

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Background:

Ambulatory surgery or outpatient surgery is becoming increasingly common. In 2002, 63% of all operations performed in the United States were ambulatory procedures. Bariatric procedures performed in the United States have increased from 16,200 in 1992 to approximately 205,000 in 2007. In 2002, our center began offering laparoscopic Roux-en-Y gastric bypass (LRYGB) procedures on an outpatient basis for select candidates at an ambulatory surgery center (ASC). We subsequently added laparoscopic adjustable gastric band procedures (LAGB) in 2005.

Methods:

Between 2002 and 2008, 248 LRYGB and LAGB patients were carefully selected for ASC surgery by the bariatric surgeon and medical director. Extensive preoperative education was mandatory for all surgical candidates.

Results:

Since 2002, we have performed 248 bariatric cases at the ASC, including 38 LRYGB and 210 LAGB procedures. In this overall experience, 5 patients (2%) required readmission within 30 days of surgery, and 98.6% of LAGB patients were discharged the same day; 62% were discharged after a 4-hour to 6-hour stay in the ASC. All LRYGB patients remained in the ASC overnight and were discharge within 24 hours of their procedure. Weight loss results have been excellent.

Conclusion:



Advances in Surgery



Can Bariatric Surgery Be Done as an Outpatient Procedure?

[Todd M. McCarty, MD](#)

DOI: <https://doi.org/10.1016/j.yasu.2006.05.006>

Reference

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Article info

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Articles

Obesity is now a worldwide pandemic affecting numerous countries across the globe. In fact, obesity seems to spare only the developing countries. This ever-expanding waist line of the global community (recently termed globesity) has spawned an intense interest in medical treatments for obesity, and in turn has generated a dramatic increase in the number of bariatric operations performed worldwide. In the United States, being overweight or obese currently affects two thirds of the population, is a leading cause of preventable death, and is responsible for approximately 10% of total annual health care costs. This health problem currently corresponds to approximately 23 million US citizens who are morbidly obese and qualify for bariatric surgery. Although approximately 30,000 bariatric operations were performed in the United States in 1998, this number ballooned to approximately 140,000 in 2004 [[1](#)], a staggering 367% increase. If one considers that approximately 200,000 cholecystectomies were performed in the United States in 2004, this makes bariatric surgery one of the most common general surgery procedures performed in many communities across the nation. This dramatic

Comparison of safety and utilization outcomes in inpatient versus outpatient laparoscopic sleeve gastrectomy: a retrospective, cohort study

Stephen P Fortin ¹, Iftexhar Kalsekar ², Stephen Johnston ³, Ayse Akincigil ⁴

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PMID: 32811709 DOI: [10.1016/j.soard.2020.07.012](https://doi.org/10.1016/j.soard.2020.07.012)

Abstract

Background: Laparoscopic sleeve gastrectomy (LSG) is the most common type of bariatric surgery performed in the United States and may be performed on an outpatient basis. Limited literature exists comparing outcomes of outpatient and inpatient LSG, and study results are conflicting.

Objectives: To compare safety and utilization outcomes of outpatient versus inpatient LSG.

Settings: Retrospective, multihospital database study (Optum Pan-Therapeutics Database).

Methods: Patients 18 years of age and older who underwent LSG between October 1, 2015, and December 31, 2018, were identified from the Optum Pan-Therapeutics Database and classified as having undergone outpatient or inpatient surgery. Nearest neighbor propensity score matching and generalized estimating equations accounting for procedural physician-level clustering were used to compare the following outcomes between outpatient and inpatient LSG: all-cause 30-day patient morbidity, hospital readmission, readmission length of stay, bariatric reoperation, and mortality.

Results: We identified 22,945 patients (outpatient: 1542; inpatient: 21,403) meeting the study inclusion criteria. After propensity score matching, the inpatient and outpatient groups contained 1542 and 13,903 patients, respectively. Bariatric reoperation (n = 13) and mortality (n = 5) were rare events occurring in <.1% of all cases. Compared with the inpatient group, the outpatient group had a statistically significant lower readmission length of stay (4.63 versus 3.23 days; P = .0057). Otherwise, there was no significant association between procedure setting and 30-day overall morbidity (4.8% versus 5.3%; P = .5775) or hospital readmission (2.6% versus 2.1%; P = .1841).


Conclusions: Safety and utilization outcomes were similar between outpatient and inpatient LSG, and outpatient LSG was associated with shorter hospital readmission length of stay.

Keywords: Bariatric surgery; Day-case; Laparoscopic sleeve gastrectomy; Outpatient; Safety outcomes; Utilization outcomes.





Original article

Laparoscopic sleeve gastrectomy as day-case surgery (without overnight hospitalization)

Lionel Rebibo M.D.^a, Abdennaceur Dhahri M.D.^a, Rachid Badaoui M.D.^b,
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<https://doi.org/10.1016/j.soard.2014.08.017> 

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Abstract

Background

Day-case surgery (DCS) has boomed over recent years, as has laparoscopic sleeve gastrectomy (SG) for the treatment of morbid obesity. The objective of this study was to evaluate the safety and feasibility of day-case SG.

Methods



Outpatient Sleeve Gastrectomy

Original article

Safety and efficacy of outpatient sleeve gastrectomy: 2534 cases performed in a single free-standing ambulatory surgical center

[Peter Billing M.D., F.A.C.S.](#)  , [Josiah Billing B.S.](#), [Eric Harris M.D., F.A.C.S.](#), [Jedediah Kaufman M.D., F.A.C.S.](#), [Robert Landerholm M.D., F.A.C.S.](#), [Kurt Stewart M.D.](#)

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<https://doi.org/10.1016/j.soard.2019.03.003> 

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Abstract

Background

Sleeve gastrectomy (SG) is currently the most widely performed operation for treatment of morbid obesity. SG leads to significant weight loss and reduction in weight related comorbidities. Procedures performed in ambulatory surgical centers (ASC) can provide several advantages over hospital-based surgery. We present results of 2,534



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Surgery for Obesity and Related Diseases

Volume 14, Issue 10, October 2018, Pages 1442-1447



Original article

Does the future of laparoscopic sleeve gastrectomy lie in the outpatient surgery center? A retrospective study of the safety of 3162 outpatient sleeve gastrectomies

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[Christopher Hart M.D., F.A.C.S.](#)^e... [Benjamin Horsley E.M.T.](#)^a

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*Sleeve
Gastrectomy;
Does the future lie
in the surgery
center?*

Original article

Bariatric surgeon perceptions of the safety of same-day sleeve gastrectomy in the state of Massachusetts

Cristian Echeverri M.D.^a, Meaghan Collins M.D.^b, Tammy Kindel M.D.^c, Anthony Petrick M.D.^d, Daniel B. Jones M.D.^{a*}

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<https://doi.org/10.1016/j.soard.2022.10.026>

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Abstract

Background

During the past 2.5 years, select bariatric surgeons in the Commonwealth of Massachusetts have been implementing same-day sleeve gastrectomy (SDSG). Key reasons for this change have been to reduce risks associated with hospitalization in the context of the

Methods

This prospective cohort study was conducted among bariatric surgeons practicing in the Commonwealth of Massachusetts. An anonymous web-based questionnaire was distributed using the Research Electronic Data Capture software. A total of 58 bariatric surgeons in Massachusetts were identified and successfully contacted based on registration with the Massachusetts Board of Registration in Medicine, membership in the American Society for Metabolic and Bariatric Surgery, and internet search.

Results

A total of 33 bariatric surgeons in Massachusetts completed the survey, yielding a response rate of 56.9%. Among the respondents, 75.76% have not performed SDSG, reporting patient safety as the major concern, and 24.24% had performed SDSG in the past.

Conclusion

Survey responses showed no significant differences in surgeon perception between SDSG and hospitalization after surgery. Optimal patient selection was an important factor influencing surgeons' decisions with regard to performing SDSG. However, bariatric surgeons in Massachusetts are reluctant to perform SDSG.

WHAT DO SURGEONS THINK ABOUT OUTPATIENT SURGERY?

Same-day discharge on laparoscopic Roux-en-Y gastric bypass patients: an outcomes review

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Affiliations + expand

PMID: 31552506 DOI: [10.1007/s00464-019-07139-5](#)

Abstract

Introduction: The objective of this research was to study safety and outcomes in patients who underwent laparoscopic Roux-en-Y gastric bypass (LRYGB) on an ambulatory outpatient basis. As the prevalence of morbid obesity increases, more patients are opting for surgical weight loss as a means to combat their chronic disease. There are several studies demonstrating the safety and feasibility of select patients undergoing LRYGB on a 23-h outpatient basis, but few studies exist regarding the safety and efficacy of these procedures being performed on an ambulatory outpatient basis.

Methods: A retrospective review was completed on all patients who underwent a laparoscopic gastric bypass procedure from 2008 to 2018 at a single outpatient ambulatory surgery center. Median BMI was 46.7 kg/m². Inclusion criteria included age > 18 and < 65, ASA class less than 3, completion of a bariatric surgery preparation program, no history of major cardiovascular events, and no prior major open abdominal operations. Exclusion criteria included males > 55 years, BMI > 55 for men, and BMI > 60 for women. Operations included primary LRYGB procedures. We determined 30-day post-operative morbidity and mortality for all patients.

Results: There were 398 patients who underwent a LRYGB on an ambulatory basis. After thorough chart review, a total of 362 patients were included. The majority were women (315, 87%). The median age was 42 (range 19-65). Seven (1.93%) patients were directly admitted to the hospital, while 13 (3.59%) patients were admitted to the hospital after initial discharge. There were 3 (0.83%) leaks, 4 (1.11%) bleeds requiring transfusion, no wound infections, 1 (0.28%) obstruction, one (0.28%) venous thrombotic event and/or pulmonary embolism, and 9 (2.49%) reoperations. There were zero deaths.

Conclusions: This study demonstrates that laparoscopic Roux-en-Y gastric bypass is both feasible and safe when performed on select patients on an ambulatory outpatient basis.



***OUTPATIENT
AMBULATORY
GASTRIC BYPASS
SURGERY??***

*WHAT DO SURGEONS
THINK NOW??*

A stack of books and folders is positioned on the left side of the slide. The stack includes several books with different colored covers (yellow, red, brown) and a large stack of manila-colored folders. The books are stacked on top of the folders. The entire scene is set against a plain white background.

Can It Be Done?

- Sasse, Kent; Outpatient Laparoscopic Gastric Bypass Surgery 2002
- McCarty, Todd; Gastric Bypass On an Outpatient Basis
- Billing, Peter; 2534 cases performed in an Ambulatory Surgical Center
- Surve, Amit, Cottam, Dan; Does the future of sleeve lie in the outpatient surgery center?
- Duncan, Titus; Same-day discharge on lap Roux-en Y gastric bypass patients

A photograph of chess pieces on a light-colored surface. In the center foreground, a single red piece stands out prominently. Behind it and to the sides, several white pieces are arranged in a line, receding into the background. The entire scene is framed by a white double-line border.

***SHOULD IT BE
DONE.....??***

Outpatient Gastric Bypass

Why Do It....?

1. Lower Risk of Hospitalization-Related Complications

2. Faster recovery

3. Reduced risk of hospital-acquired infections

4. Enhanced patient experience

5. Reduced Disruption to Daily Life

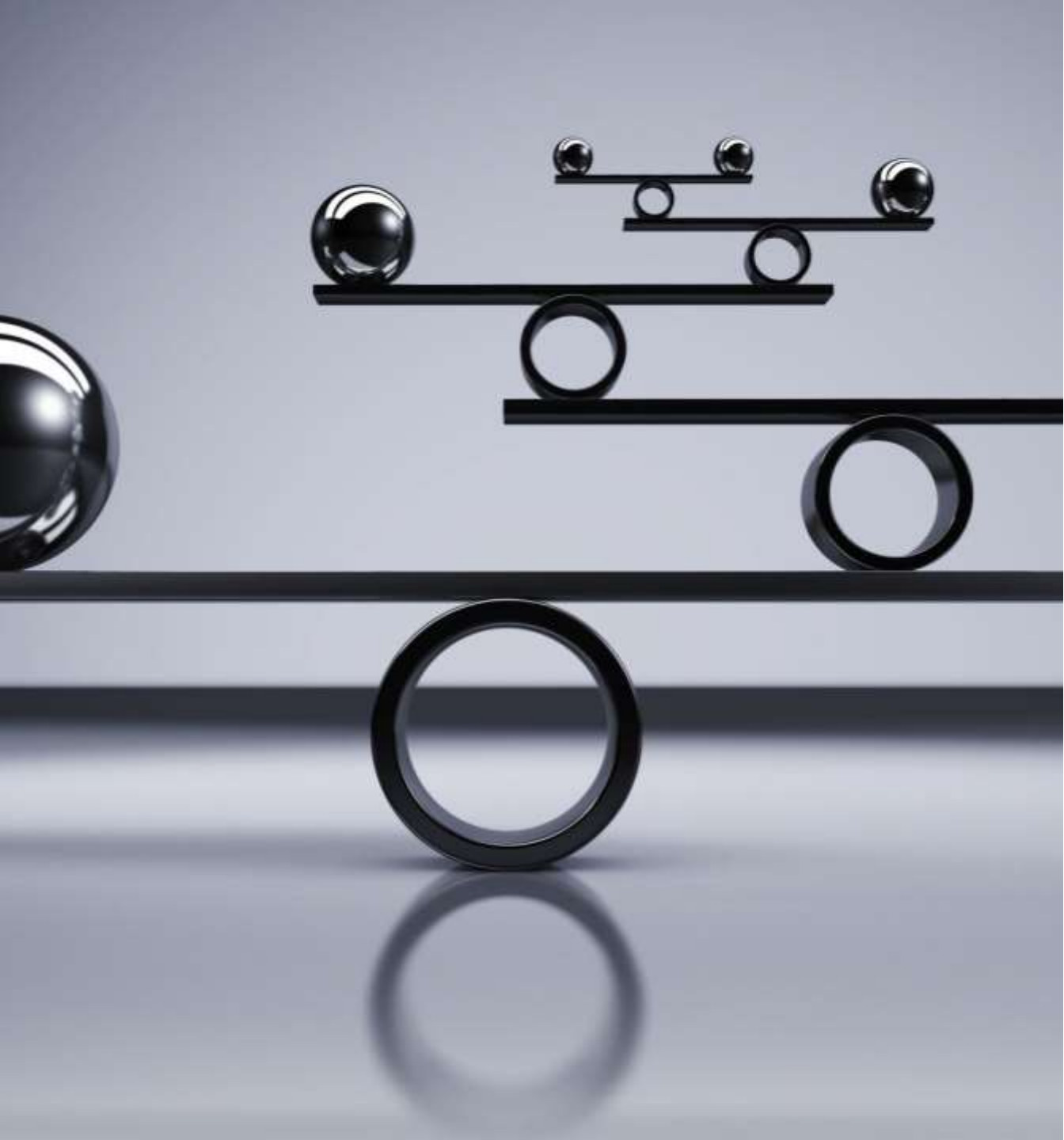
6. Cost-efficiency

Outpatient Bariatric Surgery... What are the disadvantages??

- Lack of monitoring
- Complications
- Lack of Immediate Access to life-saving personnel & measures

What are the Complications?

- **Leak**
- **Bowel Obstruction**
- **Bleeding**
- **MI, pulmonary embolism, death**



Do the Benefits Outweigh the Risks?

- Faster enhanced recovery,
- Decreased hospital complications
- Enhanced patient experience
- Lower cost; improved patient access

vs.

- Bleeding
- Leak
- Obstruction
- Death

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Original Contributions | [Published: 10 August 2021](#)

Characterizing Timing of Postoperative Complications Following Elective Roux-en-Y gastric Bypass and Sleeve Gastrectomy

[Anna S. Mierzwa](#) , [Valentin Mocanu](#), [Gabriel Marcil](#), [Jerry Dang](#), [Noah J. Switzer](#),
[Daniel W. Birch](#) & [Shahzeer Karmali](#)

[Obesity Surgery](#) **31**, 4492–4501 (2021) | [Cite this article](#)

1230 Accesses | [Metrics](#)

Abstract

Purpose

With the growing prevalence of bariatric procedures performed worldwide, it is important to understand the timing of postoperative complications

EARLY AND LATE POSTOPERATIVE COMPLICATIONS FOLLOWING BARIATRIC SURGERY AND THEIR DISTRIBUTION OVER 30 DAYS; MEAN DAYS (SD), NUMBER OF EVENTS (%)

- Patient Data Source
Clinical data for patients undergoing elective bariatric surgery was extracted using the MBSAQIP data registry from 2017 to 2018. Bariatric procedures performed in over 800 accredited centers in Canada and the USA are entered into the MBSAQIP database, making this the largest clinical bariatric database in North America
- Patient Demographics
A total of 316,314 patients who underwent elective, primary RYGB ($n = 79,248$; 25.1%) and SG ($n = 237,066$; 74.9%) in 2017 and 2018 were identified in the MBSAQIP database
Demographics

	Days to complication	0–3 days	4–6 days	7–10 days	11–14 days	>14 days
Early						
Transfusion within 72 h	1.4 (1.1)	1645 (98.7)	17 (1.0)	1 (0.1)	2 (0.1)	2 (0.1)
MI	4.7 (6.4)	36 (58.1)	9 (14.5)	7 (11.3)	4 (6.5)	6 (9.7)
Cardiac arrest requiring CPR	6.4 (8.5)	31 (36.9)	14 (16.7)	8 (9.5)	9 (10.7)	22 (26.2)
Ventilator	6.6 (6.6)	56 (33.5)	44 (26.4)	27 (16.2)	14 (8.4)	26 (15.6)
Pneumonia	6.9 (6.9)	211 (41.7)	116 (22.9)	61 (12.1)	46 (9.1)	72 (14.2)
Progressive renal failure	8.1 (8.1)	67 (37.2)	28 (15.6)	28 (15.6)	11 (6.1)	46 (25.6)
Acute renal failure	8.2 (7.6)	73 (43.7)	21 (12.6)	9 (5.4)	24 (14.4)	40 (24.0)
Septic shock	8.3 (6.9)	53 (31.0)	39 (22.8)	31 (18.1)	15 (8.8)	33 (19.3)
CVA	8.3 (7.5)	12 (27.9)	12 (27.9)	6 (14.0)	4 (9.3)	9 (20.9)
Peripheral nerve injury	8.4 (7.4)	5 (27.8)	3 (16.7)	2 (11.1)	3 (16.7)	5 (27.8)
Late						
Coma > 24 h	10.1 (10.3)	0	3 (50.0)	1 (16.7)	0	2 (33.3)
Sepsis	10.9 (7.6)	52 (17.9)	54 (18.6)	50 (17.2)	43 (14.8)	92 (31.6)
<i>C. diff</i>	11.3 (7.8)	46 (13.1)	73 (20.7)	79 (22.4)	46 (13.1)	108 (30.7)
Wound disruption	11.7 (7.6)	24 (15.7)	12 (7.8)	29 (19.0)	33 (21.6)	55 (36.0)
Organ space SSI	11.7 (7.9)	101 (16.6)	101 (16.6)	102 (16.8)	90 (14.8)	215 (35.3)
Deep SSI	12.4 (6.6)	5 (3.2)	10 (10.3)	55 (35.5)	30 (19.4)	49 (31.6)
PE	12.7 (7.8)	44 (13.2)	44 (13.2)	53 (15.9)	59 (17.7)	133 (39.9)
Superficial SSI	13.2 (6.9)	33 (2.8)	143 (11.9)	344 (38.7)	253 (21.1)	426 (35.5)
UTI	14.0 (8.4)	99 (9.5)	134 (12.9)	159 (15.3)	143 (13.8)	504 (48.5)

MI, myocardial infarction; CPR, cardiopulmonary resuscitation; CVA, cerebral vascular accident; SSI, surgical site infection; UTI, urinary tract infection; *C. diff*, *Clostridioides difficile*; PE, pulmonary embolus. Bold label categorizes complications into early (< 10 days) and late (> 10 days)

Barrier 3: The high cost of surgery dissuades interested patients

Our consumer surveys have revealed that cost is the most important factor dictating a consumer's decision to seek surgical services (it's a stronger decision driver than travel time or following a

referral). Of patients who have considered bariatric surgery but do not follow through, 40% said the main reason for not receiving surgery was the cost

—likely due to a national shift toward high-deductible health plans and the fact that some states mandate only limited coverage for bariatric

99% OF ELIGIBLE PATIENTS PATIENTS DON'T GET BARIATRIC SURGERY

Hospital planners and marketers face a significant challenge in growing bariatric surgery volumes: Prospective patients tend to underestimate their obesity, and very few of those eligible choose weight loss surgery as a solution. In fact, information presented at the 2017 Obesity Week conference suggested less than 1% of eligible patients get weight loss surgery.

To tap into bariatric surgery growth, planners and marketers need to mitigate the barriers that prevent patients from seeking surgery. Read on for three common barriers to surgery, and how you can overcome them.

Barrier 1: Providers fail to reinforce surgery as a weight loss option

Introducing the Wellness Spectrum

***WHO WOULD BE
THE OPTIMAL
PATIENTS FOR
OUTPATIENT
SURGERY??
AND WHO
SHOULD DO IT???***



Patient Selection

- 1. Age < 60
- 2. BMI < 60
 - Males age < 50; BMI < 55
- 3. No serious comorbid conditions
 - ie...renal, cardiac, or pulmonary impairments excluded
- 4. Major open abdominal surgeries excluded
- 5. Family support structure
- 6. Capacity to understand





Outpatient bariatric surgery reduces the risk of nosocomial infections



Promotes better sleep in a familiar environment



Enhances emotional well-being



Is more cost effective



Fosters an environment for increased access to care for those with limited finances

Conclusions