

efficacy range. Weight loss may be sustained without a rise from the weight nadir.

OPERATIVE MORTALITY AND MORBIDITY

Operative mortality for biliopancreatic diversion and duodenal switch when performed by skilled surgeons is about 1%. Operative morbidity is about 5%.

LONGTERM COMPLICATIONS

On occasion, these procedures are associated with diarrhea. Some patients report malodorous stools and flatus. Long-range complications can consist of vitamin, mineral, and nutrient deficiencies, in particular, protein deficiency. These contingencies need to be anticipated and properly managed by dietary supplements with about 75 to 80 g of dietary protein and B vitamins, calcium, and iron. Biliopancreatic diversion may be associated with postoperative dumping; the duodenal switch is not.

PREOPERATIVE CARE

The bariatric surgery patient needs to be well-informed, motivated, willing to participate in longterm care, change dietary patterns, and embrace a revised lifestyle. The bariatric patient is best evaluated and subsequently cared for by a team approach involving the surgeon, a nurse practitioner or nurse, a dedicated dietician, office personnel (scheduling and triage), and other specialists when needed. Availability of a support group is recommended, as is distribution of literature describing procedures, postoperative diets, exercise, and so forth. Availability of a full spectrum of expert consultants (eg, cardiologists, pulmonologists, psychiatrists and psychologists) is mandatory.

PERIOPERATIVE CARE

Expert anesthesiology support, knowledgeable in the specific problems of the bariatric patient, is necessary. The anesthesiology support includes an understanding of patient positioning, blood volume and cardiac output changes, airway maintenance, and drug pharmacokinetics in the morbidly obese. It is advisable to have preoperative, intraoperative, and

postoperative written protocols. The bariatric surgeon must be able to manage, and have coverage to manage, the postoperative patient and any problems and complications that may occur. A facility that practices bariatric surgery must be equipped with appropriate operating room equipment, including operating tables that can handle large patients; bariatric instruments, including large retractors, special staplers, long laparoscopic instruments; special equipment to transfer the patient; extra-large beds, commodes, chairs, and wheelchairs; and diagnostic facilities and equipment that can accommodate the morbidly obese patient.

POSTOPERATIVE CARE

Care of the postoperative bariatric surgery patient is recommended for the lifetime of the patient with at least three followup visits with the bariatric surgery team within the first year. Laparoscopic adjustable gastric banding will require more frequent visits for band adjustment. Postoperative dietary (including vitamin, mineral, and possibly liquid protein supplementation), exercise, and lifestyle changes should be reinforced by counseling, support groups, and working with the family physician. Favorable outcomes of bariatric surgery can lead to socioeconomic advancement, which may require patient guidance. Postoperative care may include planning for reconstructive operations after weight stabilization for certain patients.

CONCLUSION

Bariatric surgery, involving either open or laparoscopic techniques, is the most effective weight loss therapy available for patients with morbid obesity. Bariatric surgery results in marked and long-lasting weight loss and elimination or improvement of most obesity-related medical complications.

RECOMENDED READING

1. *Bussen DH. Update on obesity. J Clin Endocrinol Met 2008; 248: review*
2. *Cunneen. Review of meta analysis of comparison of bariatric surgery with a focus on laparoscopic adjustable gastric banding. Sur Obstet Realt Dis 2008; 4(3 supplement) S47-55.*
3. *Khalileh A, Malot I, Schwurger C et al. Laparoscopic Roux-en-Y gastric bypass for treatment of morbid obesity; experience with 50 patients. Isr Med Assoc J 2008; 10(50):350-5.*
4. *Gonzalez-Sanchez JA et al. Bariatric surgery patients: reasons to visit emergency department after surgery. Bol Asoc Med P R. 2007 Oct-Dec;99(4):279-83.*
5. *Hutter MM et al. Laparoscopic versus open gastric bypass for morbid obesity: a multicenter, prospective, risk-adjusted analysis from the National Surgical Quality Improvement Program. Ann Surg. 2006 May;243(5):657-62; discussion*

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