

I DCA come elemento prognostico nel paziente chirurgico.

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4° Congresso Sezione Regionale Triveneto
Società Italiana dell'Obesità – Udine 4 ottobre 2008

NIH Consensus Development Conference Statement Bethesda, March 25-27, 1991

INDICATIONS

- ♦ BMI > 40 kg/m²
(BMI > 35 kg/m² if complicated obesity).
- ♦ Age : 18-60 years.
- ♦ Longstanding obesity (> 5 years).
- ♦ Previous failure of medical therapy.
- ♦ Able to participate to long-term follow-up.

CONTRAINDICATIONS

- ♦ Treatable secondary obesity.
- ♦ Very high anaesthesiological risk.
- ♦ General conditions reducing life-expectancy.
- ♦ Severe psychiatric illnesses.
- ♦ Alcohol or drug abuse.
- ♦ **Bulimia Nervosa.**

BED: prevalenza in casistiche chirurgiche

Saunders et al., Obes Surg 1998

125 pazienti candidati a RYGB

Severe binge eating (BES>27) 33 %

Busetto et al., Obes Surg 2005

379 pazienti candidati a LAGB

Binge eating (DSM-IV) 34 %

BED: key-points in chirurgia bariatrica

- 1. Insorgenza di BED nel post-operatorio e outcome della chirurgia**
- 2. Diagnosi pre-operatoria di BED come predittore dell'outcome della chirurgia**
- 3. BED come possibile criterio per orientare la scelta della tecnica chirurgica**

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Definizione di Binge dopo chirurgia restrittiva

Criteri diagnostici DSM-IV:

- a) Eating, in a discrete period of time, **an amount of food that is definitely larger** than most peoples would eat during a similar period of time under similar circumstances.
- b) A sense of lack of control during the episodes.

Prevalence of BED after Gastric Bypass Surgery

- ◆ 6.4% complete BED criteria
- ◆ 11.5% after eliminating the criterion of "large amount of food"
- ◆ 67.9% involuntary vomiting without concern

De Zwann M et al. Obes Surg 2002;12:773

Presenza di episodi di BED nel post-operatorio

“Eating disturbances before and after vertical banded gastroplasty: a pilot study”. Hsu LK et al. Int J Eat Disord 1996; 19:23-34.

◆ 24 donne valutate 3.5 anni dopo VBG

→ “Patients currently diagnosed with an eating disturbance were most likely to exhibit weight regain than people without”.

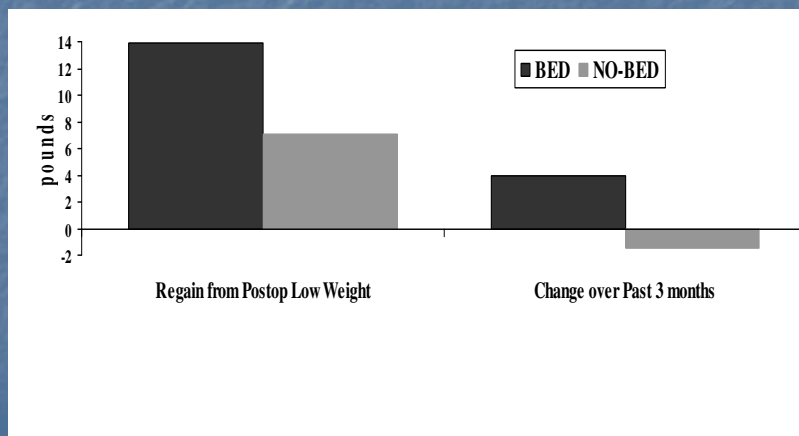
“Eating disturbances and outcome of gastric bypass surgery: a pilot study”. Hsu LK et al. Int J Eat Disord 1997; 21:385-390.

◆ 27 pazienti valutati 20.8±11.0 mesi dopo GBP

→ “Both current eating disturbance and weight regain were predicted by the interaction between presurgical eating disturbance status and length of time since surgery”.

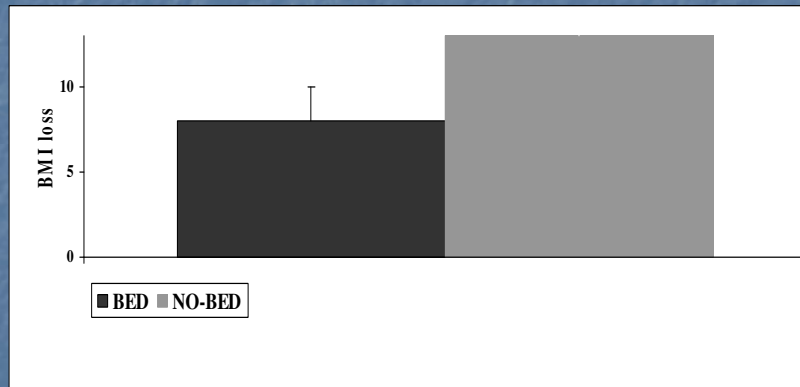
“Binge Eating among Gastric Bypass patients at long term follow-up”. Kalarchian MA et al. Obes Surg 2002;12:270-5.

◆ 99 pazienti valutati 2 - 7 anni dopo RYGB



**"Binge Eating and its relationship to outcome after LAGB".
Larsen JK et al. Obes Surg 2004;14:1111-17.**

◆ 109 pazienti valutati >2 dopo LAGB.

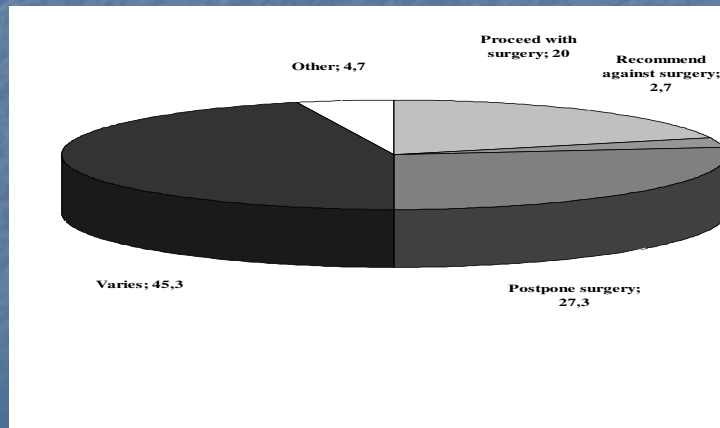


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"Surgical management of obese patients with eating disorders: a survey of current practice". Devlin. Obes Surg 2004;14:1252-7.

- ◆ 150 on 1356 ASBS members responding to e-mail survey
- 88.0% routinely inquire for binge eating disorder.



**"Grazing: A High-Risk Behaviour".
Saunders R. Obes Surg 2004;14:98-102.**

- ◆ Patients with disturbed eating patterns (BED or "grazing") identified before surgery.
- ◆ Patients offered with post-operative counselling.
- ◆ Follow-up > 12 months post-operatively.

→ "Many who had been binge eaters before surgery reported a shift to "grazing". Although this eating was often perceived as a binge, it involved the intake of smaller amount of food".

→ "Those who had been "grazers" saw this pattern return ... by 6 months after the gastric bypass".

"Grazing and loss of control related to eating: two high-risk factors following bariatric surgery". Colles S et al. Obesity 2008;16:615-22.

◆ 129 patients before and 1 year after LAGB.

→ BED frequency: before 31% - 1 year 22%.

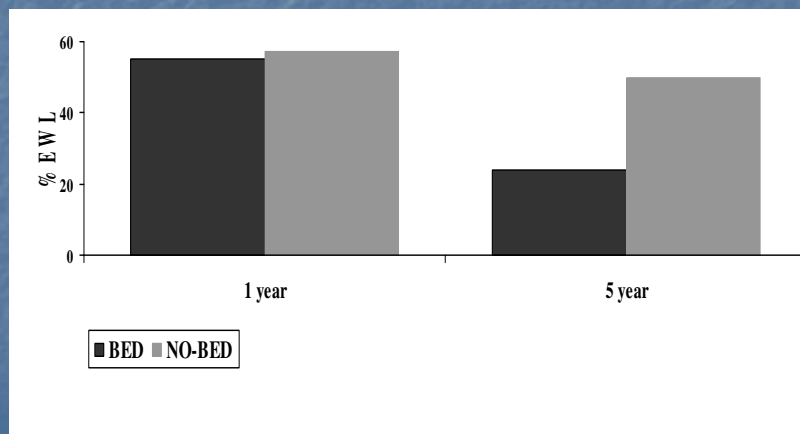
→ GRAZING frequency: before 26% - 1 year 38%.

→ Preoperative BED most frequently became GRAZERS (P=0.029).

→ BED and GRAZING after surgery showed high overlap and were associated with poorer %WL (P=0.008 and P<0.001, respectively).

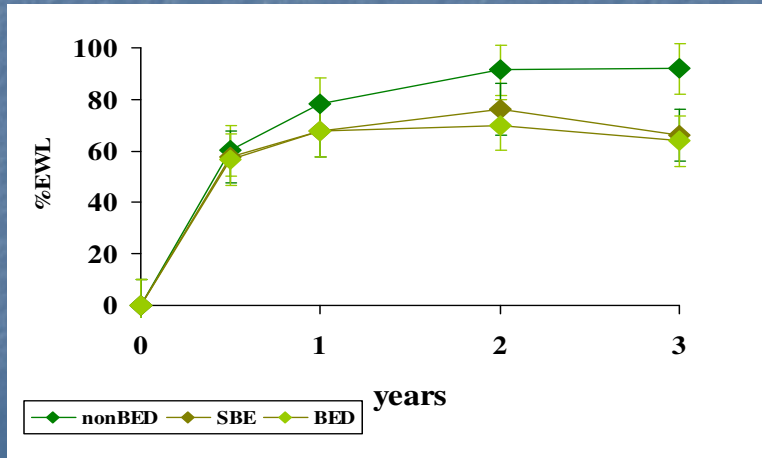
"Long-term results of VBG for morbid obesity: Binge Eating as a predictor of poor outcome". Pekkarinen et al. Obes Surg 1994;4:248-55.

◆ 27 VBG (10 BEDs and 17 non-BEDs according to BES)



"Eating behavior as a prognostic factor for weight loss after RYGB". Sallet et al. Obes Surg 2007;17:445-51.

♦ 43 non-BED, 129 SBE E 44 BED (structured interview).



"Binge Status and quality of life after gastric by-pass surgery: A one year study". Malone M et al. Obes Res 2004;12:473-81.

♦ 109 pazienti valutati prima e dopo RYGB.

→ % EWL after 12 months was EQUAL in BEDS and non-BEDS.

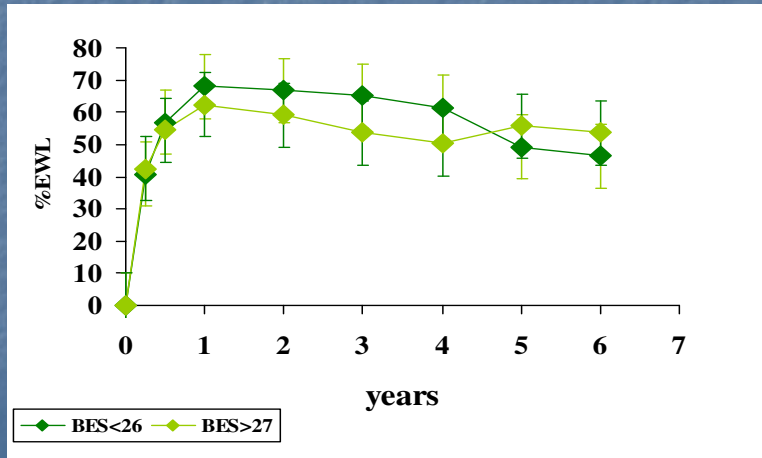
→ BES scores declined after surgery within all groups.

→ BDI scores declined in all groups, but remained higher in BEDs.

→ After surgery, there was no difference among in either physical or mental component scores of SF-36.

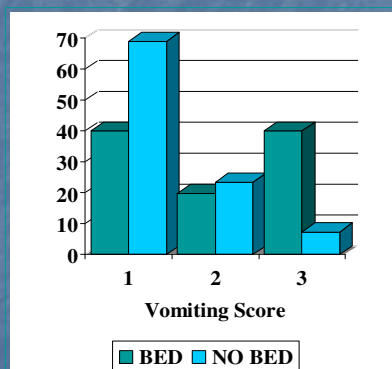
"Preoperative Binge Eating Status and RYGB: a long-term outcome study". Alger-Mayer et al. Obes Surg 2008 (in press).

◆ 157 pazienti con almeno 1 anno di follow-up dopo RYGB.



"Eating pattern in the first year following AGB for morbid obesity". Busetto et al. Int J Obesity 1996;20:539-46.

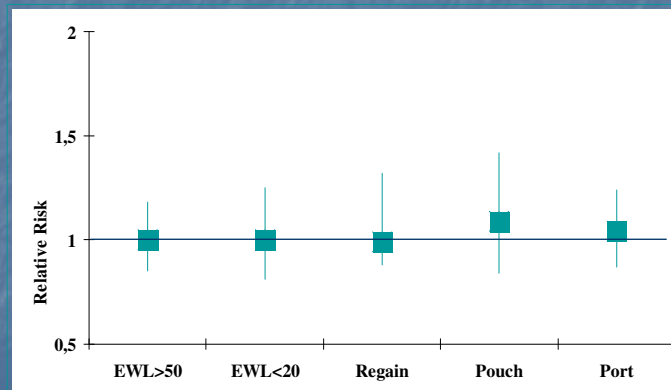
◆ 80 pazienti valutati prima e a 1 anno da AGB.



- ◆ Extremely high vomiting frequency in BEDs.
- ◆ Rate of neostoma stenosis five-fold higher than in non-BEDs (40% vs 8.5%).
- ◆ Similar one year weight loss.

"Outcome predictors in morbidly obese recipients of A LAGB". Busetto et al. *Obes Surg* 2002;12:83-92.

◆ 260 pazienti (28.8% BED) prima e 3 anni da LAGB.

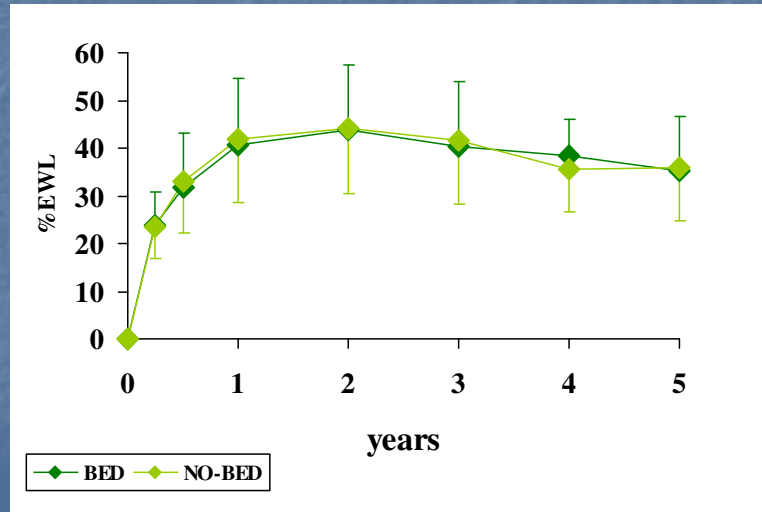


"Weight loss and post-operative complications in morbidly obese patients with BES treated with LAGB". Busetto et al. *Obes Surg* 2005;15:195-201..

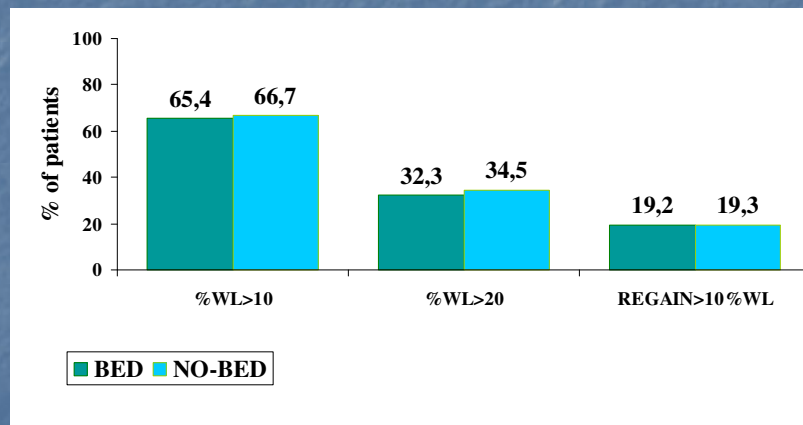
◆ 379 pazienti prima e fino a 5 anni da LAGB.

	BED	NO-BED
N.	130 (34.3%)	249 (65.7%)
Female Sex	79.2 %	71.5 % *
Age, years	36.0 ± 10.3	38.3 ± 10.8*
BMI, kg/m ²	47.6 ± 7.4	46.6 ± 7.3

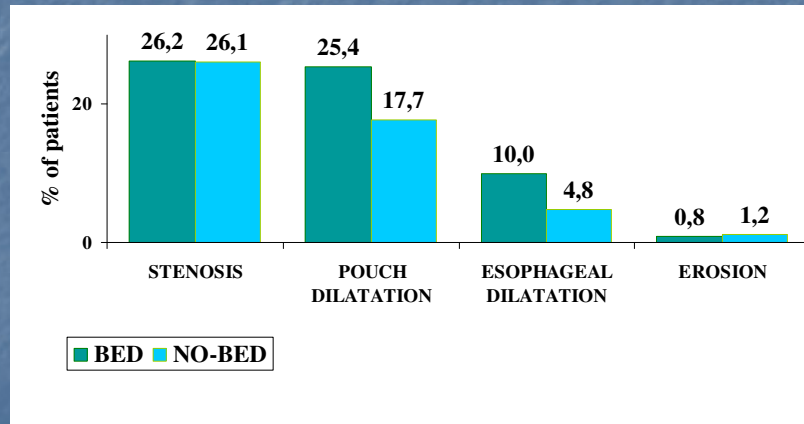
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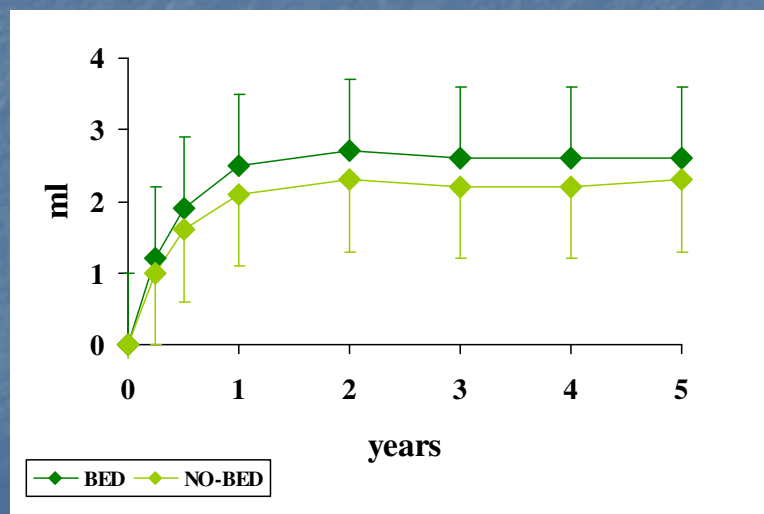
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BARIATRIC SURGERY Individualised Treatment

- Prader-Willi S. → Malabsorption
- MC4R variants → Gastric By-pas
- Sweet Eating → Gastric By-pass
- **Binge Eating** → **Gastric By-pass**
- Type 2 diabetes → Gastric By-pass
- Hyperlipidemia → Malabsorption
- Super-obesity → Gastric By-pass or Malabsorption

CONCLUSIONI

- 1.** La comparsa di episodi di BED dopo la chirurgia riduce la perdita di peso e favorisce il recupero ponderale.
- 2.** Il ruolo predittivo di una diagnosi pre-operatoria di BED sull'outcome della chirurgia è verosimilmente debole, soprattutto se il paziente viene inserito in un programma multi-disciplinare di trattamento.
- 3.** La presenza di BED nel pre-operatorio non sembra essere un criterio sufficiente per orientare verso uno specifico tipo di intervento.