TERAPIA CHIRURGICA DELL'OBESITA': CASO CLINICO

"GESTIONE TERAPEUTICA DEL PAZIENTE OBESO"
Verona, 25-26 gennaio 2008

Caso clinico

Un paziente vi chiede consiglio sull'opportunità di sottoporsi a terapia chirurgica per il trattamento della propria obesità.

- **MASCHIO - 65 anni**

- Stato civile: Celibe
- Attività lavorativa: Ristoratore
- Fumo: Mai fumato
- Potus: Beve vino solo saltuariamente
- Attività Fisica: sedentario

Caso clinico

- **ANTROPOMETRIA e OBIETTIVITA'**

- Altezza: 1.72 m
- Peso: 118 kg
- BMI: 39.9 kg/m2
- Circonferenza vita: 134 cm
- Netta distribuzione viscerale
- Cuirconferenza collo: 45 cm

- Dispnoico al minimo sforzo; dispnoico da supino
- PAO 145/95 mmHg
- CUORE: toni validi, ritmici, pause libere
- POLMONE: fini rantoli crepitanti bibasali
- ADDOME: epatomegalia 3-4 cm
- ARTI: succulenza pretibiale

Caso clinico

- **ANAMNESI PATOLOGICA**

- IPERTENSIONE ARTERIOSA DA PIU' DI 15 AA
- DIABETE TIPO 2 IN TERAPIA CON ADO DA CA 5 AA.
- OSAS IN TERAPIA CON VENTILAZIONE NOTTURNA (c-PAP)

- **TERAPIA FARMACOLOGICA**

- Ramipril 10 mg / die
- Norvasc 10 mg / die
- Lasix 50 mg / die
- Metformina 1500 mg / die

Caso clinico

- **ESAMI BIOUMORTALI**

- Glicemia 140 mg/dl; HbA1c 7.2%
- Colesterolo totale 185 mg/dl
- Colesterolo-HDL 36 mg/dl
- Trigliceridi 257 mg/dl
- Uricemia 9.2 mg/dl
- AST: 32 U/L; ALT 62 U/L
- Ematocrito 49.0

Caso clinico – domanda 1

Il paziente è eligibile per la terapia chirurgica dell'obesità?

Indications to bariatric surgery (NIH Consensus Development Conference Statement) Bethesda, March 25-27, 1991.

- BMI > 40 kg/m^2
  (BMI > 35 kg/m^2 if complicated obesity).
- Age : 18-60 years.
- Longstanding obesity (> 5 years).
- Previous failure of medical therapy.
- Able to participate to long-term follow-up.

Am J Clin Nutr 1992;55:615S

Inter-disciplinary European guidelines on surgery of severe obesity (IFSO-EC, EASO, IOTF, ECOG)

Bariatric surgery in those aged above 60

Indication for bariatric surgery should be considered individually.

The Proof of a favorable risk benefit must be demonstrated in elderly or ill patients before surgery is contemplated in such individuals.

In elderly patients, the primary objective of surgery is to improve QoL, even though surgery is unlikely to increase lifespan.[46]

Int J Obesity 2007;31:569-77

Caso clinico – domanda 2

Quale tipo di intervento chirurgico consiglierereste ?

TERAPIA CHIRURGICA: OPZIONI

- Restrizione gastrica:
  - Gastroplastica Verticale
  - Bendaggio Gastrico Regolabile
- Restrizione gastrica + by-pass duodeno-digiunale:
  - Bypass gastrico
- Restrizione gastrica + malassorbimento:
  - Diversione bilio-pancreatica
  - Duodenal switch

BARIATRIC SURGERY
Systematic Review and Meta-analysis

	%EWL	Deaths
Banding	40-50%	0.1%
Gastric Bypass	55-65%	0.5%
BPD or Duodenal switch	65-75%	1.1%

Buchwald et al. JAMA 2004;292:1724

Death rates and causes of death after bariatric surgery for Pennsylvania residents, 1995 to 2004.

Table 3. 30-Day Case Fatality Rate by Age (Natural Deaths)

Age, y	No. of Patients	No. of Deaths at 30 Days	% Dead (95% CI)
< 24	603	4	0.66 (0.18-1.69)
25-34	3349	13	0.39 (0.21-0.66)
35-44	5369	44	0.82 (0.60-1.10)
45-54	5147	52	1.01 (0.75-1.33)
55-64	2022	31	1.53 (1.04-2.18)
≥ 65	193	6	3.10 (1.14-6.79)
Total	16 683	150	0.90 (0.76-1.05)

Abbreviation: CI, confidence interval.

Omalu et al. Arch Surg 2007;142:923

Obesity in older adults: technical review and position statement of the American Society For Nutrition and NAASO, The Obesity Society

- Very few studies have provided information [about the effectiveness and safety of bariatric surgery] on older subjects.
- The results from several case series (...) suggest that perioperative morbidity and mortality is greater, whereas relative weight loss and improvement in obesity-related medical complications are lower, in older than in younger patients.
- Nonetheless, bariatric surgery resulted in considerable weight loss and marked improvements in obesity-related medical complications and physical dysfunction in the older patients.
- The LAGB may be a better choice than the RYGB for selected older patients, because the LAGB is associated with fewer serious complications and a lower mortality rate.
- However, the safety and efficacy of these procedures have not be compared in randomized trials in older subjects.

Villareal al. Am J Clin Nutr 2005,82:923

Altri punti da valutare

Segni e sintomi di scompenso cardiaco congestizio.

- Cardiopatia ipertensiva (PAO mal controllata)
- OSAS in c-PAP (probabilmente non ottimale)

CALO DI PESO PRE-OPERATORIO

Caso clinico

Il paziente viene sottoposto a bendaggio gastrico regolabile, con buon calo ponderale.

Torna da voi per un consiglio in quanto ha ricominciato a riaumentare di peso

- **ANTROPOMETRIA**

- Altezza: 1.72 m
- Peso: 88 kg
- BMI: 29.7 kg/m2
- aumento di 6 kg negli utlimi 3 mesi.

Caso clinico

- **ANAMNESI PATOLOGICA**

- Ridotta terapia anti-ipertensiva (PAO 130/90 mmHg)
- Migliorato controllo metabolico (HbA1c 6.2%)
- Sospeso c-PAP dopo controllo polisonnografico

- **TERAPIA FARMACOLOGICA**

- Ramipril 10 mg / die
- Metformina 1000 mg / die

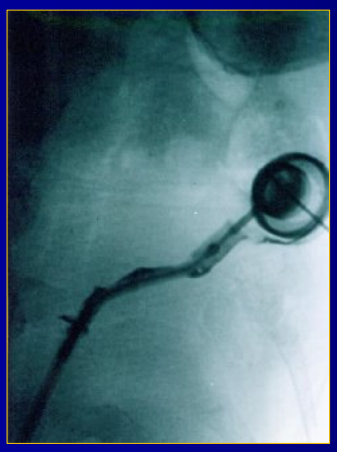
Caso clinico – domanda 3

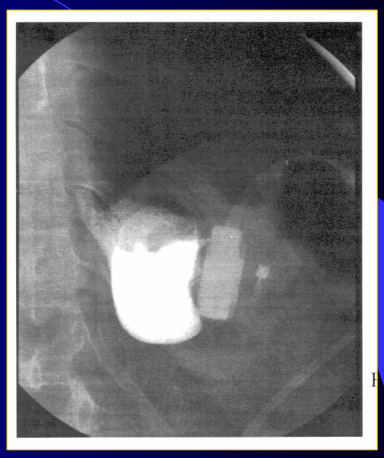
Come può essere spiegato un aumento ponderale in paziente trattato con bendaggio gastrico regolabile ?

Recupero ponderale post gastric banding

CONSIDERA SEMPRE LA POSSIBILITA' DI UNA COMPLICANZA SPECIFICA

- System leaks - Port-tube deconnection
- Pouch dilatation – Stomach slippage



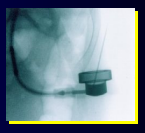


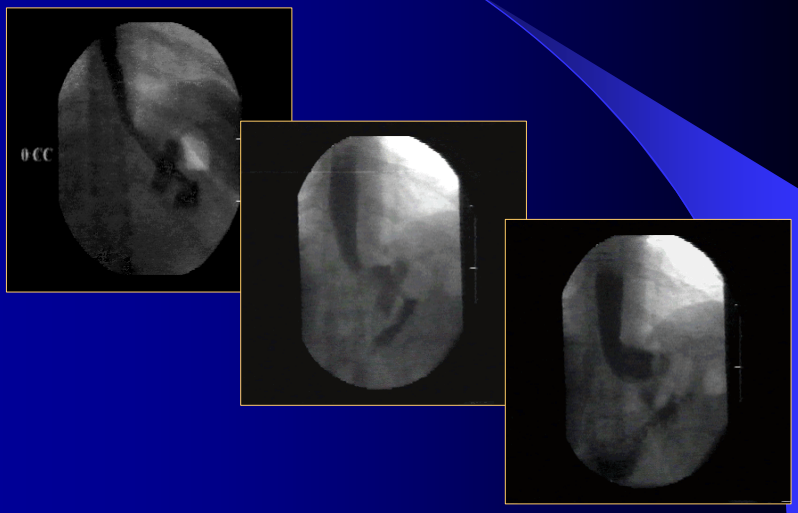
Recupero ponderale post gastric banding

MALADAPTIVE-EATING

- SOFT-CALORIES SYNDROME
- NIBBLING - GRAZING

LAP-BAND System
Post-operative management





Nibbling - Grazing

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

- **Patients with disturbed eating patterns (BED or "grazing") identified before surgery.**

"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".