

Bariatric Surgery in Class I Obesity – A Position Statement from the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) 2014

Abstract

Class I obesity conveys an increased risk of comorbidities, impairs physical and mental health-related quality of life, and it is associated to an increased psychosocial burden, particularly in women. The need for effective and safe therapies for class I obesity is great and not yet met by nonsurgical approaches. Eligibility to bariatric surgery has been largely based on body mass index (BMI) cut points and limited to patients with more severe obesity levels. However, obese patients belonging to the same BMI class may have very different levels of health, risk, and impact of obesity on quality of life. Individual patients in class I obesity may have a comorbidity burden similar to, or greater than, patients with more severe obesity. Therefore, the denial of bariatric surgery to a patient with class I obesity suffering from a significant obesity-related health burden and not achieving weight control with nonsurgical therapy simply on the basis of the BMI level does not appear to be clinically justified. A clinical decision should be based on a more comprehensive evaluation of the patient's current global health and on a more reliable prediction of future morbidity and mortality. After a careful review of available data about safety and efficacy of bariatric surgery in patients with class I obesity, this panel reached a consensus on ten clinical recommendations.

Executive Summary and Final Recommendations

Class I obesity [body mass index (BMI) 30–35 kg/m²] conveys an increased risk of comorbidities, impairs physical and mental health-related quality of life, and it is associated to an increased psychosocial burden, particularly in women. The need for effective and safe therapies for class I obesity is great and not yet met by nonsurgical approaches.

Eligibility to bariatric surgery has been largely based on BMI cut-points and limited to patients with more severe obesity levels (BMI > 40 kg/m² or BMI 35–40 kg/m² with obesity-related comorbidities). However, obese patients belonging to the same BMI class may have very different levels of health, risk, and impact of obesity on quality of life. Individual patients in class I obesity may have a comorbidity burden similar to, or greater than, patients with more severe obesity. Therefore, the denial of bariatric surgery to a patient with class I obesity suffering from a significant obesity-related health burden and not achieving weight control with nonsurgical therapy simply on the basis of the BMI level does not appear to be clinically justified. A clinical decision should be based on a

more comprehensive evaluation of the patient's current global health and on a more reliable prediction of future morbidity and mortality.

After a careful review of available data about safety and efficacy of bariatric surgery in patients with class I obesity, this panel reached a consensus on these recommendations:

(1) The impact on health of class I obesity varies greatly between subjects. However, the physical, psychological and social health burden imposed by class I obesity may be great at an individual level.

(2) Nonsurgical therapies may achieve a clinically meaningful weight loss in a significant number of patients with class I obesity, but this weight loss is maintained in the long term only in a smaller proportion of them.

(3) Bariatric surgery is a highly effective weight loss strategy in patients with class I obesity at least in the medium term. Adverse event's rate in class I obese patients appears to be the same than in morbid obesity.

(4) Access to bariatric surgery should not be denied to a patient with class I obesity associated to significant obesity-related co-morbidity simply on the basis of the BMI level, which alone is an inaccurate index of adiposity and a poor health risk predictor. Patients with class I obesity who are not able to achieve adequate weight loss after a reasonable period of nonsurgical therapy should be considered for bariatric surgery.

(5) Bariatric surgery should be considered in patients with class I obesity on an individual basis and after a comprehensive clinical evaluation of the patient's global health and a prediction of its future disease risk. The use of bariatric surgery in patients with class I obesity should be considered only after failure of proper nonsurgical therapy.

(6) Indication to bariatric surgery in class I obesity should be based more on the comorbidity burden than on BMI levels. Comorbidities should be evaluated considering their likely response to surgery and in relation to how they can be treated by established medical therapies.

(7) The use of bariatric surgery should be avoided in patients with class I obesity and advanced obesity related or obesity-unrelated comorbidities (frailty patients), in which intentional weight loss may not have any beneficial effect on prognosis or may be harmful.

(8) The use of bariatric surgery cannot be currently recommended in children/adolescents or in elderly obese patients with class I obesity.

(9) National and regional health providers need to consider the current evidence favoring the application of bariatric surgery in class I obesity in the context of local health resources and deliver services that are locally appropriate.

(10) Published literature on bariatric surgery in class I obesity is small and hampered by many factors related to poor study design, short follow-up, and diversity of clinical definitions. Accrual of controlled long-term data is strongly advised. The introduction in clinical practice of novel procedures and new devices should be guided by the results of appropriately designed research protocols conducted with the highest levels of ethical behavior.