

Correspondence

Advice to a Patient Seeking Bariatric Surgery

To the Editor:

It is not easy finding a primary care physician; it is more difficult finding a specialist for a particular problem. It is important to choose carefully, for your life may depend on it. How does one choose? Even physicians face this dilemma from time to time.

During my training at the Hammersmith Hospital, London Postgraduate School of Medicine in the 1950s, I attended a symposium on the subject of colon and rectal cancer. One of the sessions was devoted to the choice of operation for rectal lesions, and the debate centered on the level of the lesion at which anterior resection could be performed safely and with prospect for cure: was abdomino-perineal resection superior? On the panel was the Professor and Chairman of the Department of Pathology who was a wise and seasoned doctor. When he was asked his opinion, he answered by stating that if he were the patient, he would choose his surgeon carefully by personal knowledge and recommendations of his clinician associates. He would leave the choice of operation to the surgeon to decide based on the surgeon's experience and the findings at operation. He would want him to have a quiet evening before the operation, and he would make him promise not to televise the procedure!

In regard to bariatric surgery, there are now several different operations facing the prospective patient. The jejuno-ileal bypass is obsolete; it may, however, have a very limited indication in the 800-lb individual as a first stage procedure to obtain enough weight reduction to enable conversion to a gastric bypass a year or so later. The JI bypass was replaced by the gastric bypass introduced by Edward Mason in 1967. John Alden introduced stapling to the procedure in 1977, making the operation easier and therefore safer. In due time, numerous alternatives were introduced, among them stapling the stomach leaving a gap in the staple-line, vertical banded gastroplasty, biliopancreatic diver-

sion, duodenal switch, gastric banding and adjustable gastric banding. In the past several years, all of these operations have been performed laparoscopically, adding another decision to the mix.

I am aware of patients who have changed surgeons while deciding which procedure to choose, who have come to grief as a result of that change. A 35-year-old truck-driver who was very stocky, extremely overweight and suffered from sleep apnea was advised by the first surgeon whom he consulted to lose at least 10% of his weight to make the surgery that much safer for him. He was impatient and found a surgeon who had had a modest experience with bariatric patients who operated on him at his presenting weight. There were numerous complications immediately postoperatively, and he died in hospital. The first surgeon's opinion regarding preliminary weight loss, expressed in a letter to the primary care physician, was subpoenaed in the malpractice trial which ensued and which the operating surgeon lost.

Another patient consulted a very seasoned bariatric surgeon with an excellent track record who suggested, because of her super-obese size, that she undergo an open gastric bypass. She chose instead to to have a laparoscopic procedure, which "would be less painful and would provide a speedier recovery" by a surgeon with much lesser experience. The operation went badly and she died on the table from complications.

A third patient was accepted by her surgeon, who had been involved with bariatric surgery for a considerable time and had many hundreds of successful patients. He was planning an open Roux-en-Y gastric bypass, his operation of choice. Her insurance carrier, presumably to reduce costs, directed her to a surgeon who had a modest experience with bariatrics, to undergo a laparoscopic gastric bypass. She developed complications from the operation

which were not diagnosed early, and she suffered a very prolonged stay in hospital requiring several additional procedures. After about 3 months, her insurance benefits ran out and she had to be transferred to a county facility to undergo additional operations to close fistulas and ostomies.

My advice to the patient seeking bariatric surgery is as follows. Make sure you choose a reputable surgeon who has had a significant experience in the field; try to stay local (close to your home). Ensure your surgeon(s) will be available at all times after the operation, because complications do occur even in the best of circumstances. Enquire about support groups which can be very helpful and request refer-

ral to other patients treated by the same surgeon. As to which operation to choose, the experience of the surgeon is paramount. Having chosen the surgeon with whom you are comfortable and whom you trust, be advised by him/her as to the operation that has produced the best results in his/her practice. Remember too that the surgery, combined with regular exercise, is only the BEGINNING of a life-long change required for a good and sustained result.

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