Bariatric weight-loss surgery

Our expert service

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Introducing Aberdeen Surgical

Aberdeen Surgical is a private consortium of experienced general surgeons, committed to providing simple and flexible access to personal surgical care.

Supported by our own specialist team of nurse practitioners and experienced managerial colleagues, we offer a unique combination:

- expert advice for GPs and healthcare professionals
- a fast-track surgical care service for patients.

Specialising in modern minimal invasive techniques – including bariatric weight-loss procedures – we have an excellent reputation.

In partnership with BMI Healthcare (Albyn Hospital Aberdeen, Fernbrae Dundee and Edinburgh clinics) we provide consultant and medical advice, admissions, treatment and surgery in clean, safe and modern hospital environments.

Key benefits

- Rapid response. Our team of surgeons, plus specialists and support staff, means we respond promptly to enquiries.
- Guaranteed theatre time, through our close relationship with Albyn BMI.
- Patient focus. At every stage from initial contact to follow-up care, we put the individual needs of the patient first.
- Choice. We offer the best surgical treatment for the individual, at their convenience, including options that may not be available to them on the NHS. We also enable them to decide when they want to be treated, and by whom.

Our expertise in weight-loss surgery

Aberdeen Surgical is delighted to be able to provide a specialist obesity service, aiding and supporting both patients and healthcare providers.

We can help you develop the scope, standard and speed of weight-loss options you provide for your patients. We believe our service may be particularly helpful as NHS resources in general are very limited for all forms of obesity management.

A growing issue

Obesity is a problem of epidemic proportions, and there is an alarming rise in the incidence of severely obese individuals. Scottish Health Survey (2003) revealed that 25% of the adult population is obese (body mass index (BMI) greater than 30kg/m^2) and 2% is morbidly obese (BMI greater than 40kg/m^2).

Bariatric surgery is the most effective method available to reduce obesity in severely obese individuals, leading to significant improvement in a number of metabolic, mechanical and psychological comorbidities.

Our expertise

Our bariatric surgery team is led by Duff Bruce FRCS (Gen Surgery) Consultant General and GI Surgeon.

Duff is a graduate of the University of Aberdeen, and has 24 years experience in general surgery, gained in north-east Scotland, Australia and USA. Since 2002, he has worked in Aberdeen as a consultant general surgeon. Duff is one of the leading exponents of bariatric surgery in Scotland and is chairman of the Scottish charity The Severe and Complex Obesity Treatment Service (SCOTS) which advises on the provision and development of services to manage this patient group.

All our clinicians are actively involved in the management and/or surgery of weight-loss patients. Our practice works with a team of partner services representing skilled dieticians, nutritional and metabolic physicians, eating disorder psychologists, anaesthetists and theatre staff.

Referring a patient: your checklist

The decision to use bariatric surgical techniques cannot be taken lightly. This guide gives healthcare professionals an overview of referral considerations.

Indications

- **The Scottish Intercollegiate Guideline Network (SIGN) obesity and diabetes guidelines are typical of the indications for weight-loss surgery worldwide. They recommend considering bariatric surgery for individuals with a BMI over 35kg/m^2 (where there is significant comorbidity that would be expected to improve with weight loss, such as Type 2 Diabetes mellitus).**
- Individuals should have been offered appropriate dietetic, pharmacological, psychological and/or behaviour-change measures. And they should have failed to achieve or maintain adequate, clinically-beneficial weight-loss for at least six months.
- Patients must be generally fit for anaesthesia and surgery.
- All severely obese persons being considered for bariatric surgery must commit to long-term follow-up.
- The National Institute of Clinical Excellence (NICE) has suggested that it may be appropriate to consider surgery as a first-line option (instead of lifestyle interventions or drug treatment) for adults with a BMI over 50kg/m^2, depending on clinical assessment.

Contraindicatons

- Individuals medically unfit for general anaesthesia and abdominal surgery carry high risk of morbidity or mortality.
- A history of poor compliance with medical treatment, appointment keeping or follow-up instructions can prove dangerous following bariatric surgery.
- Psychological contraindications to bariatric surgery include active or recent (within the past 12 months) psychosis; history of multiple suicide attempts within the past five years; alcohol or substance abuse; or borderline personality disorder.
- Binge eating disorders and the use of food as emotional coping strategies may delay progression to surgery, pending mental health intervention.
- People with a learning disability or significant cognitive impairment may need extra support in implementing the diet and lifestyle modifications essential to safe bariatric surgery outcomes.

The surgical procedures we offer

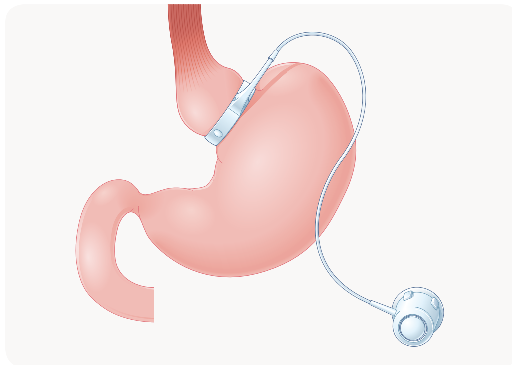
We offer expertise in the two most common procedures – adjustable gastric bands and the Roux-en-Y gastric bypass – plus a number of other techniques.

Adjustable gastric band

This laparoscopically-positioned device restricts the amount of food entering the stomach. It is placed just below the gastro-oesophageal junction, allowing the formation of a small gastric pouch of about 30ml volume into which the oesophagus opens.

The inner aspect of the band contains an inflatable silicone balloon that is connected to a subcutaneous port. Over the weeks or months following surgery, this is used to fill or remove fluid, thereby tightening or relaxing the restriction the band causes.

Band insertion carries a lower risk of morbidity and mortality than bypass procedures, but also results in a lower level of weight-loss. It does not suit those unable to significantly control their diet. Close follow-up and several adjustments of the band may be needed to achieve optimum performance.

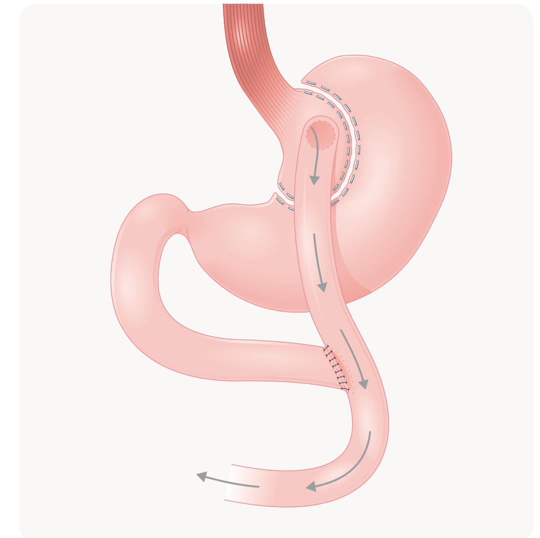


Roux-en-Y gastric bypass

A more involved procedure than band insertion. The stomach is divided to leave a small proximal pouch. The small intestine is divided about 100cm from the duodeno-jejunal flexure and the distal part of the intestine is anastomosed to the small stomach pouch. The distal end of the divided proximal small bowel is then anastomosed lower down the small intestine.

The small stomach pouch may have a restrictive effect, but the bypass component results in malabsorption of food. Furthermore, changes in gut hormone release result in a decrease in appetite, hunger and eating behaviour.

This procedure results in better weight-loss than band surgery, but malabsorption – for example of vitamin B12 and calcium – is common. There is also more potential for surgical complications, and the ‘dumping syndrome’ is common: lightheadedness, palpitations and diarrhoea within 30 minutes of sugary intake.



Sleeve gastrectomy

A more novel intervention than either banding or bypass. The stomach size is radically reduced by dividing it longitudinally, removing most of the greater curve. A thin tube of stomach (along the lesser curve leading to the intact gastric antrum) is left, preserving the stomach's emptying system.

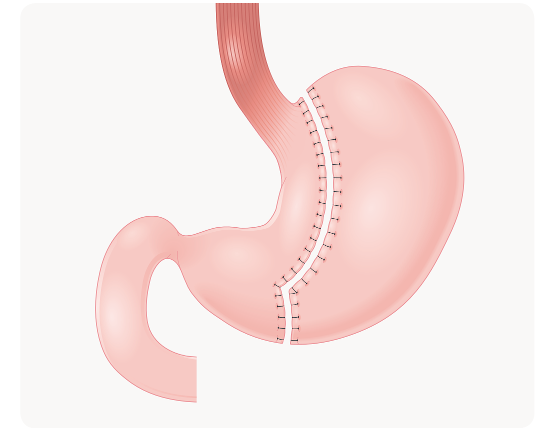
Removing a large part of the stomach usually restricts food intake and appetite. There also seems to be a secondary hormonal action, caused by a reduction of serum ghrelin after the procedure. Weight-loss, diabetic control and complication-related results are similar to more conventional procedures. However, due to its short pedigree (less than five years), no comments can be made regarding long-term outcomes.

In patients who have stabilised at a decreased weight, one that still leaves them with significant comorbidity, it can later be converted to a gastric bypass or duodenal switch. However, many of these patients won't need further surgery.

To date, sleeve gastrectomy has primarily been for high-risk patients, as it's a potentially staged procedure and is technically easier with some evidence of recovery benefit in such patients. Increasingly it's offered or requested as a primary or sole procedure to non high-risk groups.

We offer it to high-risk patients, or to patients who request it and who understand that long-term outcomes aren't yet known.

It's likely this procedure will find its place in the menu of procedures offered regularly. With experience, indications for allocation will be refined.



Surgical techniques

All procedures are performed laparoscopically unless there are adhesions, problems after previous surgery or intraoperative issues.

Revisional

We provide expertise in the management of clinical, nutritional and surgical issues resulting from existing surgical procedures and in revisional surgery if required.

Other Procedures

Vertical banded gastroplasty
This provides a fixed restriction via a band around part of the stomach, and the rest of the stomach being closed off with staples. It is seldom now offered as a primary procedure.

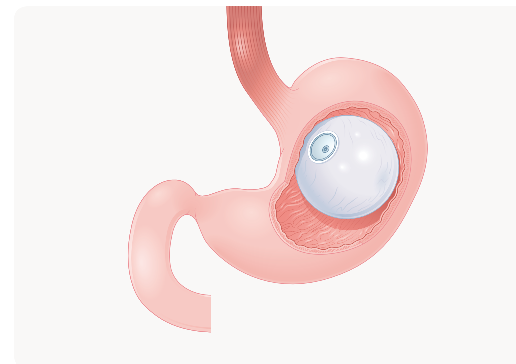
Other malabsorptive procedures
The Roux-en-Y bypass procedure is the most common bariatric procedure worldwide, but there are other procedures to achieve greater malabsorption, such as bilio-pancreatic diversion or duodenal switch procedure, that are occasionally used.

Intragastric balloon

This endoscopically-placed device consists of an Inert balloon of 500 - 700ml volume, which severely restricts the amount of food that can be ingested. Such devices can only be placed for a maximum of six months, after which it must be removed. Severe vomiting often occurs in the initial stages after the balloon is placed.

These devices may suit individuals whose medical condition and extreme BMI make laparoscopic surgery very risky. Once they have lost some weight with a balloon, a bypass or other procedure may be possible.

Increasingly the intragastric balloon is being offered as a standalone treatment for weight-loss in those who have a BMI above 30 and who would like rapid control of weight for a period yet do not wish to make the step toward definitive surgery. This works best for those with lower BMIs, in this range. Patients must understand that the expectation would be that within six months, the average patient will lose approximately 25% of their excess body weight (approximately 5kg/m^2 BMI decrease) but for most the effect is only transient and by two years only 15% will have any significant residual weight-loss.



Our pre-operative assessments

Before any bariatric procedure, we assess the patient, irrespective of how they are referred. This follows a standardised, rigorous manner. Our multi-disciplinary assessment is delivered at private facilities in Grampian, Tayside and Edinburgh with plans for extension of this network.

Medical evaluation

This covers basic information relating to height, weight and BMI, as well as co-morbidities including diabetes, hypertension, cardiovascular disease, sleep apnoea, hepatobiliary, renal and endocrine status, musculoskeletal problems and other relevant issues. Adequate treatment may be needed prior to planning weight-loss surgery.

The medical planning process incorporates setting realistic targets and devising appropriate strategies before and after surgery.

Dietetic assessment

This covers issues such as meal pattern, portion sizes, food choices, snacking behaviour and comfort-eating, all in the context of the patient's readiness to change and ability to significantly modify their diet.

Specialist bariatric dietetic review is an ongoing process, running throughout the patient's journey through bariatric surgery. It involves continual assessment and education.

Psychological examination

The main aim is to identify any potential contraindications for surgery. As well as a clinical interview, we use a range of standardised psychometric measures. For example: depression, anxiety and eating disorder pathology.

The clinical interview incorporates motivation for surgery, weight history, current eating behaviours (including eating disorder screening), body image, lifestyle issues (including occupational, family and other psychosocial factors), psychopathology (previous history and current presentation), developmental history, coping skills and knowledge and expectations of the surgical process.

Nursing issues

Several issues related to self-care and daily life are also closely intertwined with patient information and education. Additionally, specific practical matters may need addressing – ie skin care.

Specialised surgical nursing matters related to bariatric procedures and ward care may vary depending on the procedure planned.

Anaesthetic evaluation

All patients with a BMI high enough to make bariatric surgery appropriate require special anaesthetic care.

Some individuals, particularly those with a very high BMI, may need additional inpatient evaluation pre-operatively.

Our post-operative support

At Aberdeen Surgical we provide patients with a personalised programme of aftercare support and advice. Working with GPs and other healthcare providers, we aim to help patients achieve the result they want from surgery.

Early post-operative period

Patients are usually in hospital for 1–3 days after a band placement, and 3–5 days after gastric bypass.

Intensive dietetic intervention, which begins before the surgical procedure, is reinforced on the ward before the patient leaves hospital.

Many individuals undergoing bariatric procedures are on several medications for various problems. We work closely with the ward pharmacist to ensure appropriate doses and formulations (eg suspensions) are available to patients after restrictive or malabsorptive procedures.

For minor surgical issues in the initial period, such as those related to wound healing, patients have access to ward staff after they go home.

Band fills

Patients with a gastric band are reviewed 4–6 weeks after surgery for radiological filling of the reservoir to tighten the restriction. Subsequent adjustments are made as needed. Sometimes several are needed to achieve optimum restriction, and it is important that patients are well aware of this vital process.

Later post-operative period

All patients undergoing bariatric surgery need to be assessed and followed-up carefully for their nutritional status. Micronutrient deficiencies are more common with bypass procedures, but may occur with any procedure. Most patients with a gastric bypass will need vitamin B12 and calcium supplementation lifelong. Clinical and biochemical assessments are performed as needed, and no later than six months after the procedure. The absence of weight loss does not preclude vitamin or trace element deficiency.

Lifestyle change support is essential after weight-loss surgery. Severe obesity is a complex phenomenon, with numerous interlinked issues. Changing relationship to food and social or family dynamics, for example, can cause distress if appropriate preparation and support is not planned.

Get in touch

We pride ourselves on being readily available to GPs and healthcare providers. Please do not hesitate to get in touch if you would like advice or further information on our bariatric surgery services, or indeed Aberdeen Surgical in general.

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