

## Bariatric surgery

We read with great interest the fourth paper<sup>1</sup> in the Series about bariatric surgery (February, 2014). In this valuable paper, David Cummings and Ricardo Cohen correctly underlined the limitations and the outdated nature of the 1991 National Institutes of Health Consensus Statement that still governs the use of bariatric surgery worldwide, limiting its use to very obese people [A: we suggest briefly reiterating the limits here for nonspecialist readers]. We agree with the authors that there is now sufficient evidence to update this statement. Class 1 obesity (BMI 30–35 kg/m<sup>2</sup>) conveys an increased risk of comorbidities, impairs physical and mental-health-related quality of life, and is associated with an increased psychosocial burden, particularly in women. The need for effective and safe therapies for class 1 obesity is therefore great and has not yet been met by non-surgical approaches.

The International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) recognises its responsibility to develop evidence-based position statements to guide its members, and health-service providers generally, regarding new and emerging topics related to bariatric surgery [A: we have used 'bariatric surgery' throughout – OK?]. Extension of the indications for bariatric surgery beyond traditional boundaries defined by age, BMI, extent of comorbidities, and operative risk is such a topic. In the past year [A: to confirm, since May/June, 2013? (your letter will appear in the June issue)], a multidisciplinary IFSO expert working group led by IFSO president elect 2013–14, Luigi Angrisani, developed a position statement entitled "Bariatric Surgery in Class I Obesity".<sup>2</sup> The scope of the group was to critically review the current knowledge about the epidemiology, health risks, and current therapies for class 1 obesity, review the evidence for bariatric surgery in people with class 1 obesity, examine the

broader issues involved in extension of bariatric surgery to people with class 1 obesity from the perspective of health-care prioritisation and delivery, and develop practical recommendations for clinicians.

Obese patients with the same BMI can have very different levels of health, risk, and quality of life. Individual patients with class 1 obesity can have a comorbidity burden similar to, or even greater than, that of patients with more severe obesity. Therefore, the IFSO working group concluded that the denial of bariatric surgery to a patient with class 1 obesity suffering from a clinically significant obesity-related health burden and not achieving weight control with non-surgical therapy, simply on the basis of BMI, does not seem clinically justified. A clinical decision should be based on a more comprehensive assessment of the patient's current overall health and on a more reliable prediction of morbidity and mortality than that provided by BMI alone [A: rephrasing ok?].

After a careful review of available data about safety and efficacy of bariatric surgery in patients with class 1 obesity, the panel reached a consensus on ten clinical recommendations. The IFSO position statement has been discussed and approved by the IFSO Executive Board and published in *Obesity Surgery*, the official journal of the federation, in April 2014.<sup>2</sup>

We hope that this effort will fuel the ongoing discussion about the extension of bariatric surgery beyond current BMI cutoff points, and stimulate the adoption of more advanced and updated clinical recommendations.

We declare no competing interests. [A: correct? If not, please details of COIs]

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- 1 Cummings DE, Cohen RV. Beyond BMI: the need for new guidelines governing the use of bariatric and metabolic surgery. *Lancet Diabetes Endocrinol* 2014; **2**: 175–81.
- 2 Busetto L, Dixon J, De Luca M, Shikora S, Pories W, Angrisani L. Bariatric Surgery in Class I Obesity. *Obes Surg* 2014; **24**: 487–519. [A: added reference correct?]