

Bariatric surgery in Canada — bridging the gap

See related research by Martin et al. *Can J Surg* 2011;54:154-60

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In this issue, Martin and colleagues¹ compare publicly funded Roux-en-Y gastric bypass (RYGB) with adjustable gastric banding (AGB) performed in private clinics as options for the surgical management of obesity. Adjustable gastric banding is now the most common form of bariatric surgery in many parts of the world, including Australia, the United States and Canada. The safety and effectiveness of the AGB procedure has evolved rapidly and substantially over the past decade. Unfortunately there remains a great deal of misunderstanding about the procedure and the requirements for its success. Failure to understand the unique nature and requirements of AGB surgery has led to unjustified conclusions by authors not familiar with the procedure.

The study by Martin and colleagues is unfortunately representative of that view. Overall the study has flaws in design and execution, and draws conclusions not supported by the data.

The area of major concern is the authors' method of data collection. They chose to use a "mystery shopper" survey — a commonly used market research tool that has not been validated as a legitimate tool for clinical research. The authors chose to collect data from administrative or clerical staff who answer the phone, or occasionally from nurses. They intentionally avoided the surgeons or program administrators who would be more qualified to discuss the questions that were asked. The study methodology has obvious implications for the reliability and relevant nature of the results. This is particularly important when discussing issues of patient selection, assessment of risk and issues associated with postoperative care. As with any surgical practice, the primary function of the person answering the phone is limited to providing basic information and arranging for a consultation with the surgeon. The failure of the study to verify the qualifications of the individual providing the responses will affect the quality of the data obtained. As a result, any conclusions derived from this data must be questioned.

The authors report that the responses they received were sometimes vague or uncertain, and yet they used those responses to generate their results. The answers were vague because the staff likely did not have the in-depth knowledge required to answer the questions. How were vague and uncertain answers interpreted by the authors? How do the authors account for this vagueness or uncertainty in their reported results? How can a significant difference be identified using data with an unreliable source and vague result?

Another particularly important concern is the failure to adequately differentiate between the care involved in the provision of RYGB and AGB procedures. This again is likely due to a misunderstanding of the AGB procedure as it is currently performed. Many studies² have shown that these are very different procedures requiring different pre- and postoperative care. The nutritional issues associated with RYGB necessitate a more thorough nutritional workup prior to the procedure when compared with AGB. The potential risks associated with RYGB,³ including anastomotic leak, bleeding and other early complications, require an on-site critical care unit. The more invasive nature of RYGB necessitates more frequent preoperative evaluation by internists. Many papers, including one by my colleagues and I,⁴ describing thousands of

patients have shown that AGB can be safely performed in an outpatient setting without the need for on-site critical care support. The Centers of Excellence Program criteria⁵ established by the American Society for Metabolic and Bariatric Surgery and the Surgical Review Corporation require staff trained in advanced cardiac life support to be available but do not require an on-site critical care unit for ambulatory AGB surgery. Amson and colleagues⁶ in Victoria, BC, recently published data showing excellent safety and efficacy results with the AGB procedure.

The effectiveness of AGB surgery is enhanced by open and unlimited access to counselling and band adjustments. In many clinics, including the Surgical Weight Loss Centre, most of this care is provided by nurses rather than surgeons. The study by Martin and colleagues did not identify nurse visits as a separate category of postoperative visit and instead included them as a “wellness coordinator” visit. Again, this is likely due to a lack of understanding of how an effective AGB program is provided. The reported figure of 0.8 visits on average in the first year after surgery is a fraction of the actual visits delivered and is another indicator of the poor quality of the data collected in the study.

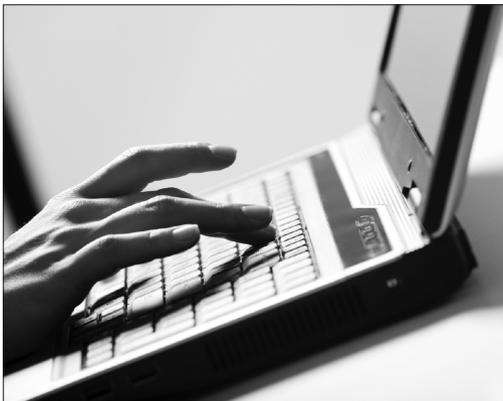
The authors conclude that further funding of public RYGB clinics is needed to address wait times and ensure equitable access to a high standard of care, which is a justified and worthy goal. It is an unfortunate fact that the demand for access to bariatric surgery is substantially greater than the current publicly funded programs are able to provide. Research published by my colleagues and I⁴ and many other studies like it have shown that AGB surgery can be provided in a safe and effective manner. The obese

population of Canada would be much better served with improved access to bariatric surgery using an approach that integrates the best that both public and private bariatric surgery can provide. Working together toward optimal care in both systems is preferable to the “us versus them” approach evident in the paper by Martin and colleagues.

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