Positive and negative effects of bariatric surgery research paper sample

Health & Medicine, Obesity

Bariatric surgery (weight loss surgery) is a term used to define a number of surgical interventions used to treat extremely obese patients. In the past decade, many patients have chosen bariatric surgery as a treatment option for obesity. In 1998, doctors performed 13, 000 procedures compared to over 220, 000 in 2008 (Farraye & Forse 13). It is highly likely that this trend will continue because of the growing epidemic of obesity in the developed world. This paper holds the position that bariatric surgery is effective for treating morbid obesity but medical practitioners should not glorify it as a cure because it is expensive and causes complications that can lead to death.

Medical experts consider bariatric surgery to be one of the best weight loss interventions for morbidly obese patients with other obesity related comorbid conditions . The surgery involves creating a restricted of malabsorptive bowel (Farraye & Forse 6) . This means that surgeons cut or clamp the patient’s bowel to reduce the capacity. They also bypass the longest part of the small intestines where most of the nutrients are absorbed to reduce the amount of nutrients the patient receives from consumed food. The operations based on these theories are laparoscopic adjustable gastric band, laparoscopic biliopancreatic diversion with duodenal switch or without the switch (Korenkoy 14). Others include the laparoscopic vertical sleeve gasterectomy and the laparoscopic Rouxe-en-Y gastric bypass (Korenkoy 16). Laparoscopy is a surgical method that allows doctors to access the surgical site using small incisions (Korenkoy 10; Farraye & Forse 11) . Laparoscopy benefits the patient by minimizing wounds and reducing postoperative pain.

Each of the mentioned procedures has its pros and cons considering that every surgery carries the risk of death and that bariatric surgery patients often surfer from heart disease and diabetes. There is no conclusive scientific evidence on the risks and benefits of bariatric surgery because there are outstanding controversies on how to measure success outcomes and inconsistent methods of monitoring post surgery benefits.

The United States National Institute of Health approved bariatric surgery for people with a body mass index of 40 and above (BMI 40) as well as people with a BMI of 35 and above but with pre-existing comorbidities like diabetes, obstructive sleep apnea and hypertension (Parsons, Wilma & Taylor 67). The association of bariatric surgeons agrees that BMI is the best criteria for selecting surgery patients. New studies have shown that patients with a BMI of 35 to 40 without coexisting comorbidities can also benefit from bariatric surgery (Parsons et al 81). In practice, patients with BMI 30 comorbidities can qualify for surgery.

According to Farraye & Forse (33), childhood has doubled in the last decade and tripled among adolescents. Medical stakeholders are embroiled in a moral debate weather to allow children and adolescents to undergo bariatric surgery. Doctors have a professional obligation to provide the best medical options for their patients at every stage of treatment. Children and adolescents do not possess the mental capacity required to make an informed decision on bariatric treatment. The law allows parents to make such decisions on behalf of their children. However, there is increasing concern that parents are opting for weight loss surgery out of desperation to see their children’s’ health improve (Parsons et al 101) . The issue of

informed consent for children and adolescents is still a hotly debated topic. Before surgery, doctors are required to all the short term and long-term effects of the surgery including the risk of bleeding, blood clots, stroke and even death (Schauer, Schirmer & Brethauer 201). Before undergoing surgery, the patient should have exhausted all other options and undergone psychological evaluation to determine that they can handle the demands of surgery and postoperative commitments.

For morbidly obese patients with several life threatening obesity related complications, the benefits of weightless surgery outweigh the risks. Already, such patients usually lead a poor quality of life due to lack of mobility coupled with constant health complications (Farraye & Forse 18). Other than the initial high cost of the procedure, the economics seem to be in favor of Bariatric surgery in the long run.

The first benefit of bariatric surgery is that the restrictive and malabsorptive procedures lead to weight loss. Most patients lose the most weight in the first 10 months after the surgery, at an average rate in 3 to 8 years and some continue to lose beyond 10 years (Parsons et al 131). Studies have shown that each of the available bariatric procedures has between 50% and 80% excess weight loss range (Parsons et al 133)

The second advantage is that bariatric surgery reduces the mortality rate that would have occurred form obesity related complications. Hypertension, cancer, heart disease, diabetes and stroke are some of the most common causes of death for morbidly obese persons. Studies have shown that surgery reduces mortality from such conditions by 23. 7% because it is an effective weight loss tool (Korenkoy 45). Patients suffering form hypertension

before surgery report significant improvements within the first three months of surgery. There are observable improvements in cardiac conditions, cholesterol levels and sugar levels in such patients because of their continuing weight loss (Parsons et al 145).

Morbidly obese patients have a host of weight related pains and aches. Some develop pressure sores from lying down immobile for hours. Others have breathing disorders the most common being asthma and sleep apnea (Schauer, Schirmer & Brethauer 211). All these conditions improve drastically after surgery because they are cause directly by excessive weight. Stress and other depression related symptoms also reduce because of improved body image.

Various studies conducted on the mortality of patients after bariatric surgery show that less than 2% die from postoperative complications (Parsons et al 146). The risk of death from gastric bypass surgery is much lower than that of cancer, diabetes, hypertension, heart disease, stroke and even accidents (Parsons et al 146). More people die from suicides associated with depressions than those who die from the complications of weight loss surgery (Parsons et al 148).

Just like any other form of surgery, the risk of complication in bariatric surgery is real. The operation area is close to the spleen, which is prone to injury and bleeding (Schauer, Schirmer & Brethauer 215). Patients with known heart and lung conditions are at a greater risk of heart attack or lung failure respectively during the surgery. Some patients endure a prolonged hospital stay due to operative and postoperative complications leading to increased medical costs. The standard length of hospitalization is 2 to 3 days

(Schauer, Schirmer & Brethauer 215).

Patients that have a recorded history of blood clots face the risk of pulmonary embolism, heart attack, stoke and deep vein thrombosis during and after surgery (Schauer, Schirmer & Brethauer 222 . Infections can also occur on the surgical site. The surgery wound and the abdominal cavity can develop sepsis requiring additional treatment and prolonged hospital stays. Death is always a possibility with all forms of surgery including bariatric surgery. Although most surgeons use laparoscopy, there is medical guarantee that some patients will not die from unforeseen complications. The most common cause of death is infections, heart failure and pulmonary embolisms (Schauer, Schirmer & Brethauer 234).

On a practical level, the increasing demand for bariatric surgery means that there are very few qualified doctors to operate on patients (Schauer, Schirmer & Brethauer 239). This means that more bariatric surgery candidates are operated by unqualified doctors in general hospitals instead of specialized units. Research has revealed that patients operated on by general surgeons reported more complications and longer recovery times than patients operated on by specialist bariatric surgeons.

Long-term effects include metabolic bone disease also known as osteopenia. This condition is particularly prevalent in patients of the Roux-en-Y gastric bypass surgery (Schauer, Schirmer & Brethauer 235). The procedure tampers with the duodenum, which has the largest concentration of calcium absorber and which is necessary for health bones. The lack of adequate absorption of calcium causes secondary hyperparathyroidism. Hyperparathyroidism decreases bone mass and increases bone turnover

leading to fragile bones prone to breakage.

Presently, weight loss is still the most effective and medically sustainable treatment option for patients with morbid obesity. These individuals must commit to long term lifestyle changes to guarantee the success of the surgery in the postoperative period. The demand for bariatric surgery is likely to increase in the future because of the growing number of morbidly obese individuals and the recorded success rate of the procedure. The associated costs, potential complications and long-term commitment to lifestyle changes are of little deterrence to the patients.

In the future, patients with a BMI lower than 30 and especially those with diabetes will qualify to undergo bariatric surgery. This is because the procedure has helped some patients to recover fully from type II diabetes. Children and adolescents could also benefit from the procedure but under strict consent requirements.

Despite all its benefits, bariatric surgery should not a cure for obesity. Health stakeholders should embark on vigorous health education and lifestyle coaching to teach people how to make healthy lifestyle choices. Obesity remains a public health epidemic that should be prevented rather than cured using bariatric surgery.

Work cited

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