Standardizing or Tailoring Bariatric Surgery

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It is well known how obesity has a complex and multifactorial pathogenesis and represents a major risk factor for various metabolic, cardiovascular, respiratory, articular, and gastrointestinal diseases.

On this regard, it is clear how evaluation and treatment of obese patients must to be interdisciplinary and integrated.

Moreover, bariatric surgery consists of different types of operations carried out through different techniques, the main ones being of restrictive or malabsorptive.

In a previous letter [1], we focused on the need of standardization in bariatric surgery in relation to the age of the patient.

Facing the heterogeneous aspects of obesity and its overall and surgical treatment, we may ask whether it is still worthwhile to talk about and look for standardization or it is better to consider bariatric surgery as a patient-tailored treatment.

It is undoubtedly mandatory to look for standardization of different surgical techniques to allow reproducibility and comparability and to minimize complications.

Nevertheless, if we mainly consider the indications of each type of procedure, do we really feel a need for standardization? Or maybe, are we asked to strictly tailor the best surgical procedure on the specific features of the patient?

The obese patient may present sometimes a kaleidoscopic variety of clinical features that must be taken into account when planning the better surgical treatment. Classic anthropometric parameters, with all the limits of sensitivity related to BMI, are not the only ones that must be considered [2]. Eating habits, age, psychologic profile, related morbidity, ASA score, presence of hiatal hernia and gastroesophageal reflux, gastritis, gastric precancerous lesions, symptomatic cholelithiasis, bowel inflammatory disease, and previous abdominal surgery must also be taken into account.

All the above-cited issues may impact on the choice of the more appropriate therapeutic way to follow and particularly of the more appropriate surgical procedure available.

Sequentiality of treatment is another element to evaluate in the complex and articulated decision-making process.

Obesity is a chronic disease; hence, its treatment cannot be a one-shot procedure limited in time. Redo surgery must not be considered always a failure of the primary surgery but in many cases must be interpreted as a normal step-by-step pathway in obesity treatment, above in all in young patients.

In conclusion, we must discern the need of surgical technique standardization from the need to standardize the choice of surgical procedure type that we want to propose to the patients. The high complexity of the obese patients suggests that the type of surgery must be carefully calibrated on their overall clinical features evaluated during preoperative workup.

The aim of standardizing the indications supposing the use of algorithms seems at least difficult to perform and quite far from everyday clinical practice.

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