Consensus of Asian Diabetic Surgery Summit (ADSS) and APBSS

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2005 APBSG consensus meeting has modified the indication of bariatric surgery for Asian people to

1. Obese patients with their BMI over 37
2. Obese patients with their BMI over 32 in the presence of diabetes or other two significant obesity related co-morbidities.
3. Have been unable to lose or maintain weight loss by dietary or medical measures.
4. Age of patient > 18 years and < 65 years.
   * Under special circumstance and inconsideration with a pediatrician, bariatric surgery may be used in children under age 18

2010 ADSS meeting in Taipei has proposed the indication of metabolic surgery for Asian diabetes people

1. Metabolic surgery should be recommended for diabetes patients with their BMI over 37
2. Metabolic surgery should be considered for diabetes patients with their BMI over 32 and not well controlled (HbA1c > 7.5%) after intensive medical treatment.
3. Metabolic surgery may be considered for diabetes patients with their BMI over 27 with many co-morbidities and not well controlled (HbA1c > 7.5%) after intensive medical treatment.
4. Age of patient > 18 years and < 70 years, with acceptable surgical risk and without end-organ damage.
   *The patient should be cared and followed by multi-discipline medical team and pre-operative B-cell function evaluation is indicated

Concensus of Diabetic Surgery Summit (DSS)
Impact on Asian population

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Background: The purpose of the Summit, led by Prof. Rubino is to formulate new consensus for surgical intervention for Type II diabetes mellitus in western population. It created tremendous impact on Asian population and in response to DSS guidelines, ADSS and ACOMOMS guidelines were developed specifically for Asian population.
Method: Multidisciplinary voting delegates around the world gathered at Roma in March 2007 for the 1st DSS. During the meeting, available scientific evidence were examined and discussed by the entire group. Consensus for diabetic surgery for western population was established.
Results and Conclusions:

1. GI surgery should be considered for the treatment of T2DM in acceptable surgical candidates with BMI >35kg/m2 who are inadequately controlled by lifestyle and medical therapy.
2. A surgical approach may also be appropriate as a non-primary alternative to treat inadequately controlled T2DM in suitable surgical candidates with mild-to-moderate obesity (BMI 30-35 kg/m2). RYGB may be an appropriate surgical option for diabetes treatment in this patient population.
3. Although novel GI surgical techniques (eg, duodenal-jejunal bypass, ileal interposition, sleeve gastrectomy, endoluminal sleeves) show promising results for the treatment of T2DM in early clinical studies, they should currently be used only in the context of IRB-approved and registered trials.
4. To improve quality of medical evidence, the development of standards for measuring clinical and physiological outcomes of surgical treatment for T2DM is a high priority.
5. Randomized controlled trials are strongly encouraged to assess the utility of GI surgery to treat T2DM.
6. Development of a standard registry/database is a high priority for research in this area. In addition to clinical trials, animal studies can provide useful information about the efficacy and mechanisms of GI metabolic surgery to treat T2DM.

National report of treatment of obesity and metabolic disorder from (India).

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Asian Indians exhibit unique features of obesity; excess body fat, abdominal adiposity, increased subcutaneous and intra-abdominal fat, and deposition of fat in ectopic sites (liver, muscle, etc.). Obesity is a major driver for the widely prevalent metabolic syndrome and type 2 diabetes mellitus (T2DM) in Asian Indians in India and those residing in other countries. Based on percentage body fat and morbidity data, limits of normal BMI are narrower and lower in Asian Indians than in white Caucasians. A consensus statement, was published for revised guidelines for diagnosis of obesity, abdominal obesity, the metabolic syndrome, physical activity, and drug therapy and bariatric surgery for obesity in Asian Indians after consultations with experts from various regions of India belonging to the various medical disciplines representing reputed medical institutions, hospitals, government funded research institutions, and policy making bodies.

According to National Family and health Survey (NFHS), approximately 7.1% of Indian population is under obesity risk. Almost 65% of adult urban Indian are –either over weight, obese or have abdominal obesity. The highest incidence is observed in North western (Punjab) part of India (M: F- 30.3/37.5%), followed by South (M: F-24.3/34%) and North east (M: F-17.3/21%).

With an estimated 50.8 million people living with diabetes, India has the world's largest diabetes population, followed by china with 43.2 million. The prevalence of type II DM in adult population ranges from 9% to 16%, with 14.2 % of male and17.5 of female.

The Obesity and Metabolic Surgery Society of India was established in 2001. The indication for surgery is generally in accordance with guidelines using the WHO standard for obesity on Asia, i.e. BMI >37.5/32.5 with co-morbidities. There are few no of bariatric and metabolic surgeries carried out outside the standard guidelines for obesity surgery but they are mainly as part of some clinical trials.

There are about 80 surgeons (certified general, GI surgeons with training and experience) performing bariatric surgery regularly in India, carrying out 2000 procedures per year.

There are 5 high volume centres and few of them applied for centre of excellence (ICE) certification from ASMBS.OSSI is jointly working with SRC to develop centre of excellence in India. Cost of bariatric treatment depends upon

the types and location of the operative procedure. We accept and operate the international patients.

Refrences:-

- IDF-Diabetes Atlas, 4th edition, Oct 2009.
- G. Vijaykumar et.al; JAPI, Aug 2009, Vol-57.
- A. Mishra, P.Chowbey, BM Makkar, NK Vikram et.al; JAPI, Feb 2009.

Consensus of OSSANZ National Report from Australia

President, Obesity Surgery Society of Australia and New Zealand
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The OSSANZ Bariatric Surgical Standards (OBSS) was developed to ensure that all surgeons who undertake to perform Bariatric Surgery within any Health Service (Public or Private) are properly credentialed and have the scope of providing a quality bariatric surgical service in accordance with both their level of skill and experience and the capability of the Health Service.The following are the recommended OSSANZ Bariatric Surgical Standards for defining the scope of clinical practice for Bariatric Surgery.

An Australian standard has been developed to guide the process of credentialing and defining the scope of clinical practice (www.safetyandquality.org).

These recommendations have been developed to ensure the delivery of high quality bariatric service within any Health Service. It is recommended that these OBSS assists Credentialing Committees of Health Services to ensure their bariatric surgeons are performing operations commensurate with their skill and are also providing a quality bariatric service to their patients as defined below.

These OBSS apply to all surgeons who are practicing or considering bariatric surgery. They are guidelines recommended for Credentialing Committees of Health Services in the certification and recertification of bariatric surgeons in Australia and New Zealand.

For surgeon members, the process of their application for clinical practice of bariatric surgery (operation specific) within any Health Service should be of the following 3 categories:

1. Provisional Bariatric Surgical Accreditation

Provisional Bariatric Surgical is the first step for surgeons with FRACS or equivalent, who wish to become fully accredited Bariatric Surgeons in any Health Service. This is the agreed step to be taken when undergoing and completing training in bariatric surgery, and mentoring of cases, before being accredited as Bariatric Surgeon for a specific bariatric procedure:

a. Nominated by 2 surgeons experienced in Bariatric Surgery.
b. Successful completion of, and proof of, approved Bariatric Surgery Training or a Bariatric Course.
c. Documentation of minimum of 3 mentored cases by another Bariatric Surgeon, with written approval by the mentor.
d. The surgeon may then proceed to documenting 20 bariatric cases, (Logbook) which is to be forwarded to, and to be approved, by the Credentialing committee.
e. Agree to contribute to the OSSANZ Bariatric Registry.

2. Full Bariatric Surgical Accreditation

Bariatric Surgical Service is applied for after fulfilling the requirements of the Provisional Bariatric Surgical Accreditation.

a. Has fulfilled the criteria of Provisional Bariatric Surgeon and received the necessary written approvals.

b. Maintains and updates clinical skills and bariatric knowledge which includes one bariatric surgical meeting (national or international) yearly.
c. Continues to contribute to the ongoing OSSANZ Bariatric Registry and follow-up.
d. Maintains surgical skills by at least 20 bariatric operations annually.
e. Reviewed/renewed triennium.

3. Grandfather Clause

Surgeons already performing Bariatric surgery will need to provide the following when applying for recertification as Bariatric Surgeons by their Health Service

a. Fully qualified and recognized General Surgeon
b. Evidence of successful completion of a Bariatric Course or Training
c. Evidence/experience and explanation of Bariatric Training
d. Name of 2 referees - experienced in Bariatric Surgery.
e. Evidence of having performed 100 Bariatric Cases and complication rate

JSSO Consensus Statement 2010

Chairman of the JSSO guideline committee, Isao Kawamura

JSSO, as a body member of IFSO, had been formulating its guidelines for about 3 years in order to enact them. These were completed and released as Statement 2010 in 2010. The basis of the guidelines was established by complying with the IFSO guidelines 2008, in consideration of the state of affairs in Japan and characteristics of obesity patients. However it also takes account of the flexibility to handle future revision if necessary. The first feature of JSSO is the fact that surgeons should have an idea the treatment of morbidily obese patients lasts a lifetime, does not end with surgical treatment only. Those are compared to lines and points. In other words, the treatment of morbid obesity needs multidisciplinary treatment with a team which includes physicians, psychiatrists, dieticians, counselors and so on. Surgical indications characterize the second feature of JSSO. Indications for bariatric surgery is applied for the patients with BMI ≧35, because the criterion of Japanese obesity is defined by BMI≧25. We have defined the indication for metabolic surgery by BMI≧32 and have positioned it as clinical study. It obliges a through follow-up for the patients under the rigid registration system. Our report mainly consists of these details.

ACMOMS I

Muffazal Lakdawala

Abstract

Background: The Asian consensus guidelines were the outcome of a two day deliberation that was organized in Trivandrum, India on the 9th and 10th August 2009.

Methods: Asian Consensus Meeting on Metabolic Surgery (ACMOMS) was the first ever meeting of its kind in Asia where 52 professionals involved in the field of bariatric surgery, metabolic surgery, diabetes, and medical research from countries across Asia and the GCC met at Trivandrum, India to vote for and create a new set of guidelines for the Asian phenotype, which were different from the NIH guidelines set for bariatric surgery. The aim was to set culturally, geographically, and genetically relevant standards for the management of obesity and metabolic syndrome.

Results: It is known that Asians have higher adiposity for a given level of obesity, and this is visceral obesity as compared to other populations. Currently, worldover guidelines set by NIH in 1991 are being followed for bariatric surgery. Surgeons believe that NIH guidelines need to be revisited and modified. It is in light of these observations that the genesis of ACMOMS took place. At ACMOMS, it was recommended that the NIH guidelines are not suitable for Asians, and the BMI guidelines should be lowered for indication of surgery. Waist or waist-hip ratio must gain significance as compared to BMI alone for Asians. The recommendations were as under:

- Bariatric/Gastrointestinal Metabolic surgery should be considered as a treatment option for obesity in people with Asian ethnicity with a BMI more than 35 kg/m2 with or without co-morbidities.
- Bariatric/Gastrointestinal Metabolic surgery should be considered as a treatment option for obesity in people with Asian ethnicity above a BMI of 32 kg/m2 with co-morbidities.
- Bariatric/Gastrointestinal Metabolic surgery should be considered as a treatment option for obesity in people with Asian ethnicity above a BMI of 30 kg/m2 if they have central obesity (waist circumference more than 80 cm in females and more than 90 cm in males) along with at least two of the additional criteria for metabolic syndrome: raised triglycerides, reduced HDL cholesterol levels, increased LDL levels, high blood pressure and raised fasting plasma glucose level.
- Any surgery done on diabetic patients with a BMI less than 30 kg/m2 should be strictly done only under study protocol with an informed consent from the patient. The nature of these surgeries should be considered as yet purely experimental only as part of research projects with prior approval from the ethics committee.

Conclusions: The collective recommendations were submitted as a report to the executive committee for approval. These guidelines have now been accepted by the Asia Pacific Metabolic and Bariatric Surgery Society (APMBSS) and IFSO Asia Pacific Chapter and have been published in the journal of Obesity surgery.