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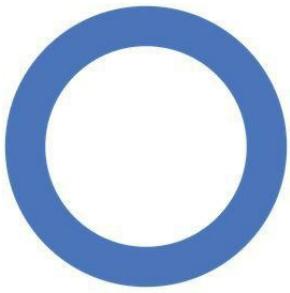
Obesity Surgery - Who Should Get Priority?



According to new research published in The Lancet Diabetes & Endocrinology, obese patients with type 2 diabetes, especially those with recent disease onset, should be prioritised for obesity surgery over those without type 2 diabetes.

Most healthcare systems typically prioritise obesity surgery on the basis of a person's BMI. Those with the highest BMI get top priority while those with lower BMIs and comorbidities such as type-2 diabetes have to wait.

Some recommend that it should be a person's diabetes status that should be used to determine who needs bariatric surgery as compared to a decision based on BMI alone. However, since the long-term effect of bariatric surgery in obese patients based on their diabetes status has not been comprehensively assessed, therefore it is difficult to determine the effectiveness of such an approach.

The SOS study conducted in Sweden with 2010 adults who underwent obesity surgery and 2037 matched controls recruited between 1987 and 2001 showed that accumulated drug costs over 15 years did not differ between the surgery and control group in patients without diabetes at the time of surgery. However, the costs were lower in surgery patients who had prediabetes (on average, -US$3329 per patient) or diabetes (-$5487 per patient). It is important to note that hospital costs remained high for both groups of patients and no differences in outpatient costs were observed.

As compared to patients without diabetes, costs of surgery, inpatient and outpatient hospital care and prescription drugs were higher. Costs were also higher for patients who had prediabetes but not in patients with diabetes. In addition, obesity surgery for patients with diabetes can have positive impact on remission rates because diabetes that occurs after bariatric surgery because patients require fewer medicines and hospital appointments. Diabetes complications are also lessened.

“We show that for obese patients with type 2 diabetes, the upfront costs of bariatric surgery seem to be largely offset by prevention of future health-care and drug use. This finding of cost neutrality is seldom noted for health-care interventions, nor is it a requirement of funding in most settings. Usually, buying of health benefits at an acceptable cost (eg, £20 000 per quality-adjusted lifeyear in the UK) is the economic benchmark adopted by payers when new interventions are assessed. Bariatric surgery should be held to the same economic standards as other medical interventions.” says Dr Martin Neovius of Karolinska Institutet.

In a linked comment, Dr Ricardo Cohen, Director of the Center of Excellence for Metabolic and Bariatric Surgery, Hospital Oswaldo Cruz, São Paulo, Brazil, also emphasises that BMI should not be the only indicator used to prioritse bariatric surgery. Individuals that do not have their diabetes under control could benefit from such an intervention, irrespective of their BMI.

Source: University of Gothenburg

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