The EAES Clinical Practice Guidelines on Obesity Surgery (2005)


Introduction

Obesity is an increasingly serious health problem in nearly all Western countries [76, 108, 320]. Although various preventive and conservative treatment options are available, it has been estimated that obesity-related illnesses, such as diabetes mellitus, knee osteoarthritis, systemic hypertension and heart failure, are responsible for an estimated 3–6% of total health care costs [6, 230, 279]. A recent study on the association between different grades of obesity and the number of life-years lost indicated that life expectancy can be up to 20 years shorter in severe obesity [104]. The consequences of obesity are by far more severe than those of smoking or alcohol [319].

Definition and classification of obesity is based primarily on the body mass index (BMI), calculated as weight divided by the square of height with kilograms per square meter as the unit of measurement [17]. For Caucasians, a BMI of 30–35 is considered as class 1 obesity, 35–40 as class 2, and over 40 as class 3. Morbid obesity is usually defined as a BMI of over 40 or a BMI over 35 in combination with comorbidities [238]. In addition, some surgeons speak of super- and mega-obesity, if a patient’s BMI exceeds 50 or 70, respectively. Alternatively, absolute or relative increases in body weight may be used to define obesity.

Given the enormous importance of morbid obesity and the limited efficacy of dietetic and pharmacological treatments, surgical treatment has become increasingly popular. The number of procedures performed has more than doubled within a few years [64, 78, 289]. This dramatic growth can be attributed in part also to the introduction of new surgical techniques, e.g. the adjustable silicone gastric band (AGB), and the rise of laparoscopic surgery. Traditionally, there are two types of operations for morbid obesity: Gastric restrictive operations (where food intake is restricted) and malabsorptive operations (where aliments are diverted from absorption via a gastrointestinal shortcut). Both types of obesity surgery are now being performed laparoscopically [38]. The aim of these guidelines is to systematically review the clini-
cal effectiveness of the various surgical procedures and to support surgeons and other physicians in the provision of high-quality care for morbidly obese patients.

**Methods**

**Selection of Topics and Experts**

Considering the current controversy regarding the best surgical treatment for morbid obesity, the Scientific Committee and the Executive Board of the EAES decided to provide the surgical community with evidence-based guidelines. The aim and focus of these guidelines cover key questions regarding effective and efficient surgical treatment of obesity, including patient selection, choice of surgical technique, management of complications and follow-up.

A panel was appointed to develop clinical practice guidelines and consisted of representatives from key disciplines, i.e. surgeons specialized in obesity treatment, general surgeons, nutritionists, and epidemiologists from across Europe. Experts were selected according to scientific and clinical expertise, geographical localisation, and membership in societies pertaining to laparoscopic obesity surgery. The Obesity Management Task Force of the European Association for the Study of Obesity (EASO) was represented at the complete process by one nominated delegate (N.F.).

Guideline development started with a list of key questions, which all experts were asked to answer. In May 2004, the panel convened to review and discuss the range of answers on the basis of the scientific evidence. The nominal group process was used to develop statements that were agreeable for all or at least the majority of panel members. A preliminary position paper was compiled and presented to the audience at the EAES congress in June 2004. All comments from the audience were discussed and a final version of the guidelines was agreed on consensually. The project was funded by the EAES. All panelists had to document and sign their relationships to commercial stakeholders in order to rule out possible conflicts of interest.

**Literature Searches and Appraisal**

According to the hierarchy of research evidence, we tried to locate randomized controlled trials (RCTs, i.e. level 1b evidence) dealing with the key questions. When RCTs were of low quality or completely lacking, non-randomized controlled clinical trials (CCTs, i.e. level 1b evidence) were included. Whenever level 1 and 2 evidence was scarce, case series with comparison of pre- and postoperative status (i.e. level 4 evidence) were used. However, it should be noted that for some studies our grading of evidence led to differ-