

# OSSANZ BARIATRIC SURGICAL STANDARDS (OBSS)

## Background

The prevalence of obesity in the Western world continues to increase. Globally, WHO projects that by 2015, approximately 2.3 billion adults will be overweight and more than 700 million will be obese. In Australia, the 2008 Access Economics Report showed a prevalence of 23.5% for obesity in the adult Australian population and predicted that there will be 7.5 million obese Australians by 2028. In New Zealand, the prevalence of combined overweight and obesity in adult males has increased from 52.8% in 1982 to 70.9% in 2002/3.

It is now well established that conventional medical therapies do not achieve sustained weight loss. There are several surgical procedures performed with the intention of inducing weight loss. Of these, the procedures most commonly undertaken in Australia and New Zealand are laparoscopic adjustable gastric banding [LAGB], Roux-en-Y gastric bypass [RYGB] and sleeve gastrectomy [SG].

The Obesity Surgery Society of Australia and New Zealand (OSSANZ) are committed to promoting the highest quality of care for patients undergoing bariatric surgery in our countries. The following are the recommended OSSANZ Bariatric Surgical Standards (OBSS) that may be used to assist credentialing committees of any Health Service (Public or Private) in their assessment of surgeons wishing to perform bariatric procedures within their jurisdictions.

Bariatric surgery is a subspecialty of General Surgery. As such any surgeon seeking credentialing for Bariatric surgeon must have:

- FRACS in General Surgery (or recognized equivalent)
- RACS CME compliance certificates (or recognized equivalent)

All bariatric procedures require a similar surgical skill set to advanced upper gastrointestinal (GI) surgery. The surgeon should have good knowledge of upper GI pathology and its potential relationship to Bariatrics procedures. They all require the ability to operate safely around the oesophago-gastric region, by open and laparoscopic means. Because the patient is by definition morbidly obese, there is potentially more risk of adverse events than with other upper GI procedures, and there is a unique requirement for lifelong aftercare.

It would be expected that any surgeon who is undertaking bariatric surgery would be able to:

- recognise the relevant anatomy and its variations.
- competently mobilise the distal oesophagus and proximal stomach,
- repair a perforated oesophagus, or have a relationship with a team able to manage such a situation.
- resect the stomach.
- manage a hiatus hernia.
- undertake an anastomosis between small bowel and proximal stomach oesophagus.

Whilst each of the more commonly performed bariatric procedures require this common skill set, each has unique elements, and surgeons should be able to demonstrate training specific to each of the procedures that they wish to undertake. The level and intensity of required training will vary depending upon their previous experience in Bariatric and Upper Gastrointestinal Surgery.

It is suggested that surgeons seeking credentialing in Bariatric surgery:

- Provide evidence of training specific to bariatric surgery. This may include the following:
  - Formal fellowship programmes
  - Evidence of attendance at RACS approved workshops
  - Documentation of mentored cases in the procedure for which they are seeking approval
- Provide evidence of experience in, and commitment to, the life-long aftercare of the bariatric patient in a coordinated multidisciplinary environment.
- Maintains a personal database of patients treated by their practice.
- Maintains and updates clinical skills and bariatric knowledge which includes one bariatric surgical meeting (national or international) at least second yearly.
- Contributes to the bi-national Bariatric Surgery Quality and Safety Registry and commits to providing accurate follow-up information to the Registry.
- Maintains surgical skills by performing at least 20 bariatric operations annually.

It is important to recognise the importance of the treating institution having appropriate facilities to support bariatric surgery.

This includes but is not restricted to:

- Bariatric equipment on the wards and in theatres.
- Perioperative support appropriate to the procedure being performed. This support includes the provision of clear pathways for the diagnosis and management of complications including access to HDU/ICU.
- Contributes to the bi-national Bariatric Surgery Quality and Safety registry as it becomes available at local sites.