

Clinical practice guidelines of the European Association for Endoscopic Surgery (EAES) on bariatric surgery: update 2020 endorsed by IFSO-EC, EASO and ESPCOP.

Guideline ID: 2970

Published: 2020 Jun

European Association for Endoscopic Surgery (EAES)

Di Lorenzo N, Antoniou SA, Batterham RL, et al. Clinical practice guidelines of the European Association for Endoscopic Surgery (EAES) on bariatric surgery: update 2020 endorsed by IFSO-EC, EASO and ESPCOP. Surg Endosc. 2020 Jun;34(6):2332-2358. [58 references]
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Overview

Guideline Objective

To summarize the latest evidence on bariatric surgery

Patient Population

Adult (age >18) patients with body mass index (BMI) >35 kg/m² who are considered fit for surgery and with no contraindications to laparoscopic surgery, unless otherwise indicated

Recommendations

Recommendation Statements

Note:

- This guideline has an extension of the recommendations. Refer to [*EAES Rapid Guideline: Systematic Review, Network Meta-analysis, CINeMA and GRADE Assessment, and European Consensus on Bariatric Surgery – Extension 2022.*](#)
- Position statements do not constitute recommendations.

Indication for Bariatric Surgery

- Laparoscopic bariatric surgery should be considered for patients with BMI ≥ 40 kg/m² and for patients with BMI ≥ 35 –40 kg/m² with associated comorbidities that are expected to improve with weight loss. (**Strong recommendation**)
- Laparoscopic bariatric/metabolic surgery should be considered for patients with $\geq$ BMI 30–35 kg/m² and type 2 diabetes and/or arterial hypertension with poor control despite optimal medical therapy. (**Strong recommendation**)

Preoperative Work-up

- No recommendation can be made for either routine *H. pylori* eradication or no eradication prior to bariatric surgery on the basis of available evidence. (**Conditional recommendation for either intervention or comparator**)
- Preoperative dietitian consultation should be considered for patients undergoing bariatric surgery. (**Strong recommendation**)
- Esophagogastrosocopy can be considered as a routine diagnostic test prior to bariatric surgery. (**Conditional recommendation**)
- Psychological evaluation can be considered before bariatric surgery. A previous diagnosis of binge eating or depression may not be considered as an absolute contraindication to surgery. (**Conditional recommendation**)

Perioperative Management

- Screening for obstructive sleep apnea using the STOP-BANG criteria can be considered prior to bariatric surgery. (**Conditional recommendation**)
- Perioperative continuous positive airway pressure (CPAP) should be considered in patients with severe obstructive sleep apnea syndrome who are undergoing

bariatric surgery. (**Strong recommendation**)

- No recommendation can be made on the dose and duration of pharmacological thromboprophylaxis in patients after bariatric surgery. (**Conditional recommendation for either intervention or comparator**)
- Inferior vena cava filter is not recommended for thromboprophylaxis in patients undergoing bariatric surgery. (**Strong recommendation**)
- No recommendation for either an Enhanced recovery after surgery (ERAS) protocol or standard care can be made on the basis of available evidence. (**Conditional recommendation for either intervention or comparator**)
- Perioperative multimodal analgesia with minimal opioid usage may be considered in patients undergoing bariatric surgery. (**Conditional recommendation**)

Non-bypass Procedures

- Adjustable gastric banding surgeries are associated with a high rate of reoperations for complications or conversion to another bariatric procedure for insufficient weight loss in the long term (**Position statement**)
- Sleeve gastrectomy may be preferred over adjustable gastric banding for weight loss and control/resolution of metabolic comorbidities (**Conditional recommendation**)
- Sleeve gastrectomy may offer improved short-term weight loss and resolution of type 2 diabetes compared to gastric plication. No significant differences are observed at mid-term. Long-term comparative data on weight loss and metabolic effects are, however, lacking. (**Position statement**)
- There is insufficient evidence to recommend routine stapler line reinforcement^a to reduce the leak rate (**Position statement**)
- Staple line reinforcement^a in sleeve gastrectomy should be considered to reduce the risk of perioperative complications^b (**Strong recommendation**)
- A bougie size <36F compared to a bougie sized ≥36F may be recommended for calibration in sleeve gastrectomy as it is associated with greater weight loss in the mid-term. (**Conditional recommendation**)

- More extensive antral resection (2–3 cm from the pylorus versus >5 cm antral preservation) potentially offers greater weight loss in the short term without a significant increase in post-operative complications. Long term data are, however, lacking. **(Position statement)**

a Buttress, glues, suturing, clips

b Overall mortality, bleeding

Bypass procedures

- Roux-en-Y gastric bypass (RYGB) should be preferred over adjustable gastric banding. **(Strong recommendation)**
- RYGB results in greater weight loss and control/remission of insulin resistance and type 2 diabetes compared to gastric plication. **(Position statement)**
- RYGB offers similar mid-term weight loss and control/remission of metabolic comorbidities compared to sleeve gastrectomy. Long-term comparative data are, however, lacking. **(Position statement)**
- RYGB can be preferred over sleeve gastrectomy in patients with severe gastroesophageal reflux disease and/or severe esophagitis. **(Conditional recommendation)**
- No recommendation for either biliopancreatic diversion with duodenal switch (BPD/DS) or sleeve gastrectomy can be made on the basis of available comparative evidence. **(Conditional for either intervention or comparator)**
- With regard to mid-term weight loss there is no difference between BPD/DS and RYGB. BPD/DS is superior to RYGB for control/remission of type 2 diabetes. Long-term comparative data are, however, lacking. **(Position statement)**

One Anastomosis Procedures

- One anastomosis gastric bypass (OAGB) may offer greater short-term weight loss compared to RYGB, gastric plication, adjustable gastric banding and sleeve gastrectomy. Long-term comparative data are, however, lacking. The effect on nutritional deficiencies remains controversial. **(Position statement)**
- No recommendation on single-anastomosis duodeno-ileal switch (SADI-S) compared with OAGB, BPD/DS, RYGB or sleeve gastrectomy can be made on the basis of available evidence. **(Conditional for either intervention or comparator)**

Revisional Surgery

- No evidence-based criteria for indication to revisional bariatric/metabolic surgery are available to date. (**Position statement**)
- The panel advises that the clinical decision to proceed to revisional bariatric/metabolic surgery be based on a complete multidisciplinary assessment of the patient, as recommended for the primary procedure. (**Position statement**)

Postoperative Care

- Scheduled multidisciplinary post-operative follow-up should be provided to every patient undergoing bariatric/metabolic surgery. (**Strong recommendation**)
- Treatment with ursodeoxycholic acid could be considered during the weight loss phase to prevent gallstones formation. (**Conditional recommendation**)
- Micro and/or macronutrients supplementation is recommended after bariatric surgery according to the type of the procedure and to the deficiencies documented during the follow-up. (**Strong recommendation**)
- Proton-pump inhibitor (PPI) therapy should be given to patients undergoing bypass procedures for the prevention of marginal ulcers. (**Strong recommendation**)
- Postoperative nutritional and behavioral advice should be provided to patients undergoing bariatric surgery. (**Strong recommendation**)
- Pregnancy following bariatric surgery should be delayed during the weight loss phase. (**Strong recommendation**)

Investigational Procedures

- For duodenal-jejunal bypass sleeves, aspiration devices, gastric electrical stimulation, vagal blockade, and duodenal mucosal resurfacing, the quality of evidence was too low to provide any recommendations. (**Position statement**)
- Endoluminal suturing procedures may have a role in the treatment of patients with obesity with BMI $<40 \text{ kg/m}^2$ (**Position statement**)

Evidence Rating Scheme

Summary effect measures, interval estimates, and risk of bias parameters were considered for assessment of the quality of evidence as per Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) methodology. Refer to *Supplementary Files 8-50* in the "Supporting Documents" field for GRADE Evidence Profiles where overall quality of evidence was assessed on each outcome of interest.

Recommendation Rating Scheme

Predefined parameters were taken into account to formulate recommendations. More specifically, importance of the problem, desirable/undesirable effects and their balance, the certainty (quality) of evidence, patient values and preferences, acceptability to key stakeholders, cost of implementation and feasibility of incorporating the intervention into practice were assessed. The panel provided for each PICO question:

- A strong recommendation for the intervention or the comparator, or
- A conditional recommendation for the intervention or the comparator, or
- No recommendation (conditional recommendation for either the intervention or the comparator).

If no recommendation could be formulated on a PICO question, the panel had the option to draft a position statement. Position statements reflect the opinion of the panel, are not necessarily based upon research evidence, and should not be considered formal, evidence-based recommendations.

Related Content

Supporting Documents

- [Detailed Guideline Development Methodology.](#)
- [PICO Questions.](#)
- [Guideline Searches Summary.](#)
- [Guideline Search Strategies.](#)

- [PRISMA Flowcharts.](#)
- [Results of Online Survey.](#)
- [Results of External Review Using AGREE II Instrument.](#)
- [Supplementary Files 8-50: GRADE Evidence Profiles.](#)
- [EAES Rapid Guideline: Systematic Review, Network Meta-analysis, CINeMA and GRADE Assessment, and European Consensus on Bariatric Surgery -- Extension 2022; 2022.](#)

Implementation Tools

No implementation tools available.

Patient Education

No patient education materials available.

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TRUST Scorecard

Composition of Guideline Development Group (GDG)

Multidisciplinary GDG Members

Yes

Methodologist Involvement

Yes

Incorporation of Patient and Public Perspective



Systematic Review of Evidence

Literature Search



Study Selection



Evidence Synthesis



Foundations for Recommendations

Strength of Evidence Grade



Description of Benefits and Harms of Recommendations



Summary of Evidence Supporting Recommendations



Strength of Recommendations Rating



Clear Articulation of Recommendations



Funding Source

Yes

Disclosure and Management of Financial Conflicts of Interests



External Review



Updating

