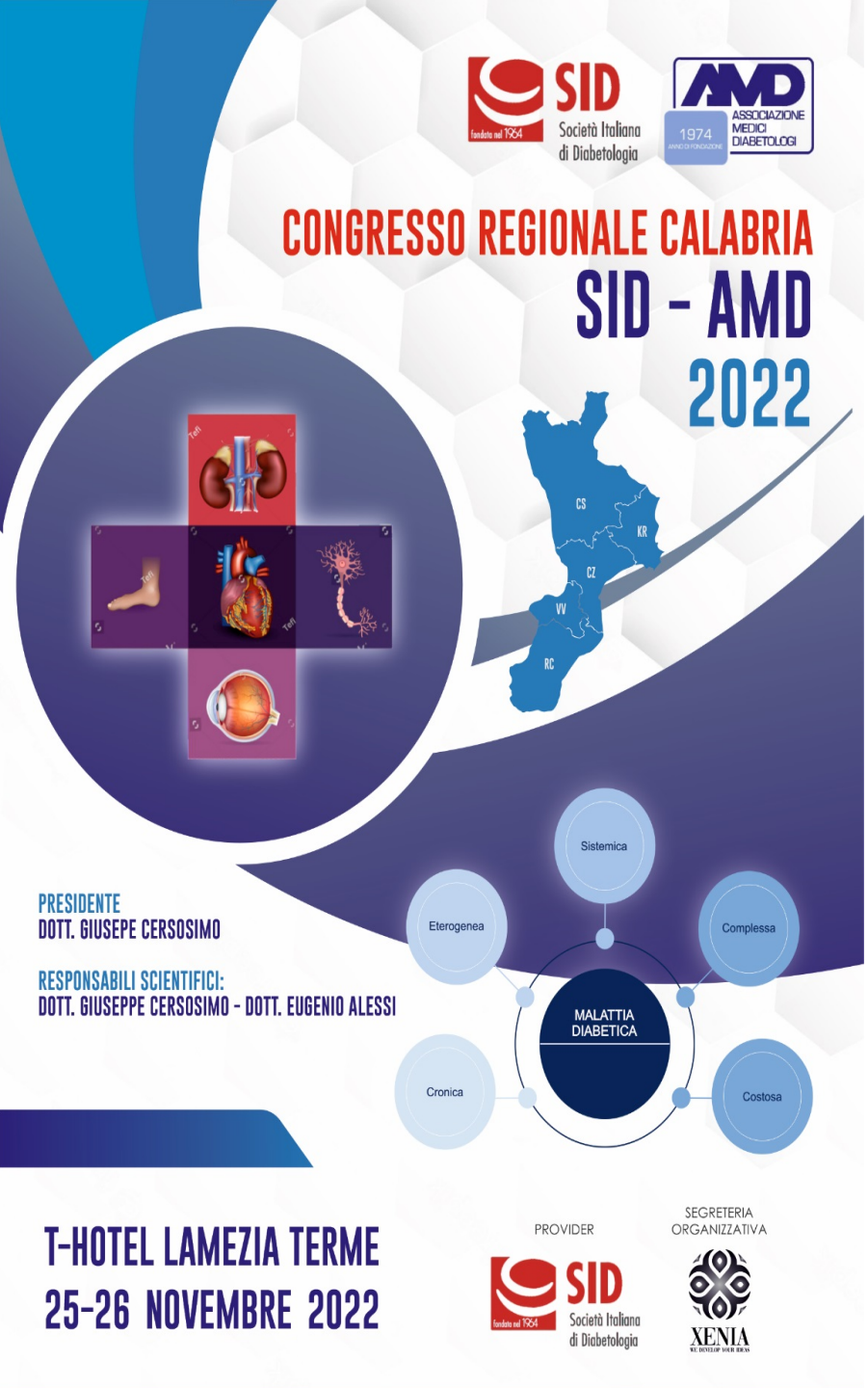


La Chirurgia Metabolica: quale ruolo ?

Dr. Ninni Urso

Responsabile
UOSD Chirurgia Bariatrica
AO Annunziata Cosenza

Il Dr. Antonino Urso dichiara di NON aver ricevuto negli ultimi due anni compensi o finanziamenti da Aziende Farmaceutiche e/o Diagnostiche

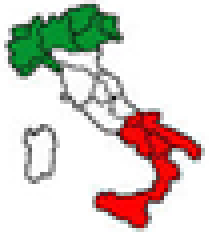
Dichiara altresì il proprio impegno ad astenersi, nell'ambito dell'evento, dal nominare, in qualsivoglia modo o forma, aziende farmaceutiche e/o denominazione commerciale e di non fare pubblicità di qualsiasi tipo relativamente a specifici prodotti di interesse sanitario (farmaci, strumenti, dispositivi medico-chirurgici, ecc.).

E’ ancora così ?

Le dimensioni del problema

L'Organizzazione Mondiale della Sanità l'ha definita nuova epidemia globale: **1,9 miliardi di persone adulte** sono **sovrappeso** e di queste **600 milioni sono obese** (WHO, 2015)

A livello europeo: **88 milioni di adulti** sono in **sovrappeso** e **24 milioni sono obesi**



In Italia: **5 milioni di obesi** (10,35%), **17 milioni** di persone in **sovrappeso** (35,6%) e circa 50.000 decessi attribuiti all'obesità

OBESITA' = MALATTIA

Aspettativa di vita < 5- 10 anni

Fattore di rischio cancro *(8% dei tumori femminili ; 3.6% di tutti i tumori)*

Europa: un decesso su 13 correlato al sovrappeso *(7,7% delle cause di morte)*

Italia: 52000 morti patologie correlate/ anno

A call to action on Obesity

Il 20%: in più del proprio peso ideale aumenta:

- **del 25% il rischio di morire di infarto**
- **del 10% di morire di ictus,**

Il 40%: in più del proprio peso ideale aumenta:

- **del 50% il rischio di morte per qualsiasi causa**
- **del 75% per ischemia cerebrale**
- **del 70% per infarto del miocardio.**

Alla luce di queste condizioni, anche la mortalità per diabete aumenta del 400%.

2015 Milan Declaration
A Call to Action on Obesity

vero e proprio **invito all'azione per riconoscere e trattare l'obesità, al fine di incoraggiare lo sviluppo e l'attuazione di programmi per la prevenzione, la diagnosi precoce e il trattamento.**

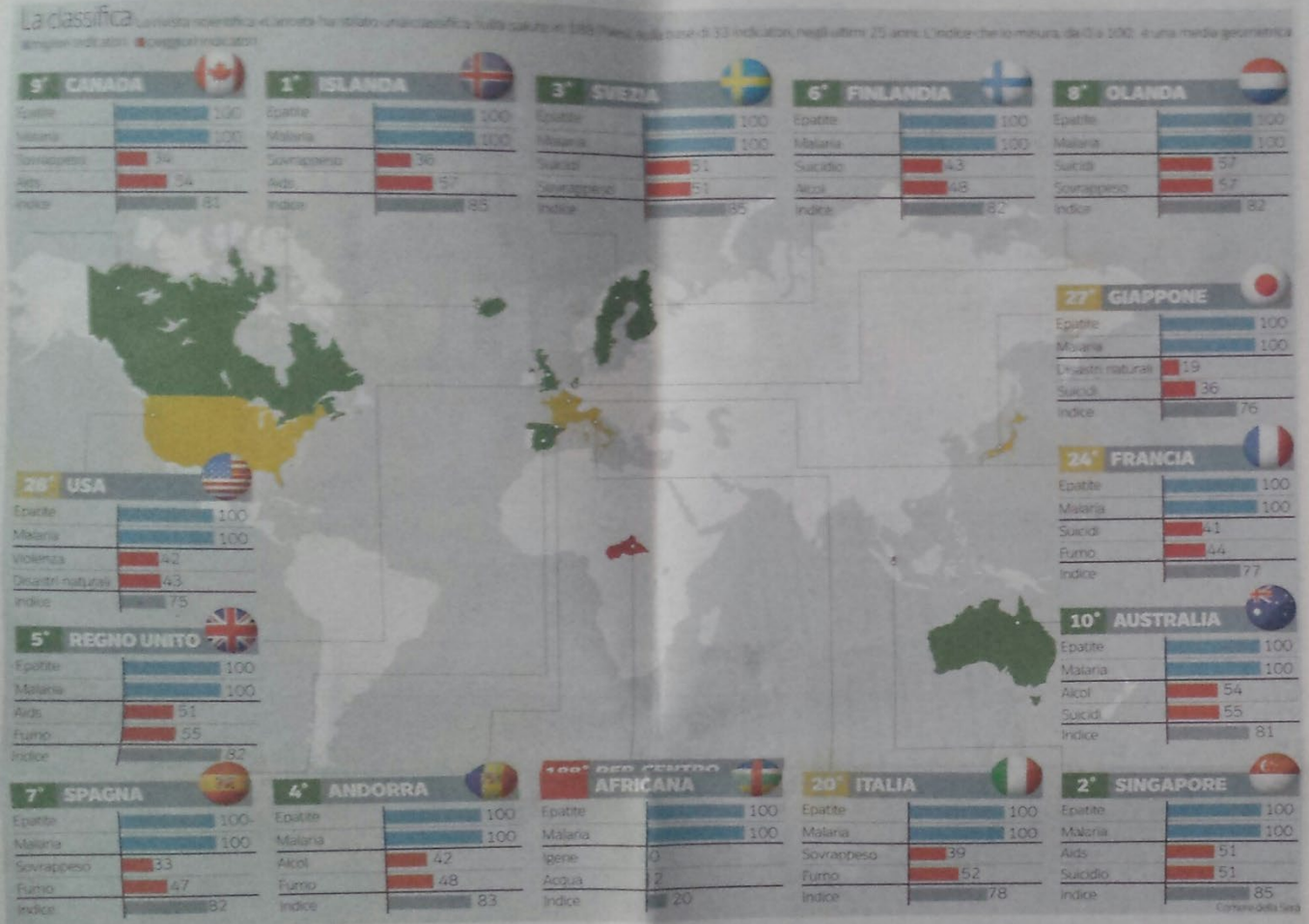
European Association for the Study of Obesity
Level 2, 8 Waldegrave Road,
Teddington, TW11 8GT, UK
Registered Charity Number 1111288

EASO
European Association for the Study of Obesity

www.easo.org
+44 (0) 20 3751 7967

2015 Milan Declaration: A Call to Action on Obesity
A Statement of the members of the European Association for the Study of Obesity to EXPO 2015

La salute del mondo



Il mega studio realizzato da settecento scienziati L'Italia è al ventesimo posto, tra i punti dolenti la qualità dell'aria e i troppi bimbi in sovrappeso

di Giuseppe Remuzzi

muoiono meno bambini e neonati sotto i

(il parametro che si considera qui è il numero di nuove infezioni ogni 1.000 persone). Siamo messi peggio di chi ci precede per numero di morti in occasione di catastrofi naturali: questa voce oltre che per noi, fra i Paesi industrializzati è negativa per solo Australia, Norvegia e Svizzera. Non andiamo troppo bene nemmeno per consumo di alcol e violenza nei confronti del partner e andiamo malissimo per incidenti stradali. L'acqua da noi è pulita ma lo è dappertutto nei paesi industrializzati, e la mortalità infantile è bassa da

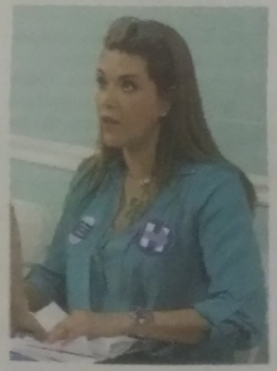
Stati Uniti

PER SAPERNE DI PIÙ
www.nytimes.com
www.cnn.com

La fobia anti grassi Trump si fa nemici gli obesi d'America

Quasi metà dell'elettorato statunitense è sovrappeso ma il repubblicano moltiplica le offese sul tema

FOTO © JOHN LOCHER/AP



EX MISS UNIVERSO

VITTORIO ZUCCONI

WASHINGTON. Ultima riserva di caccia per il "politicamente scorretto" il ciccione, nelle sue variazioni dal grassottello all'obeso, è l'ossessione di Donald Trump. Dal giorno del catastrofico dibattito televisivo contro Hillary Clinton, lui stesso non proprio dotato di fisico da modella con i suoi 120 chili di peso per 185 centimetri di altezza, sta sprofondando nell'adipe di una polemica insensata e potenzialmente micidiale.

Come tutti gli imbonitori della bancarella televisiva, anche il candidato repubblicano ha l'ingenuità di credere che l'apparenza, spesso contrabbandata come salute, condanna.

I suoi nervi non saldissimi sono saltati sulla storia di Alicia Machado, la ragazza venezuelana che fu proclamata da lui, patron del concorso di bellezza,

> I suoi nervi sono saltati sul caso della Miss Alicia Machado, da lui umiliata perché ingrassata

Miss Universo nel 1997 e poi ebbe problemi di peso «ingrassan-

sazione biasimata da Hillary. In un crescendo isterico, Trump è sprofondato in un barile di lardo aggiungendo agli insulti un «donna disgustosa» twittato ieri alle 3 del mattino da lui, insonne e inquieto.

Per la disperazione dei suoi consiglieri, l'ostinazione di Donald ha riportato alla luce la sua lunga storia di adipofobia, dai dipendenti licenziati perché sovrappeso all'insinuazione che l'hackeraggio di tanti siti americani non sia opera di gnomi al servizio di Putin, ma di un «ciccione di 200 chili seduto sul suo letto». Accusa che ha ovviamente scatenato la tempesta di

bili siano le donne a giudizi e pregiudizi sul loro corpo e quanto sia vile per un uomo giocare sulle diffuse insicurezze femminili sulla propria forma, ancora fraintesa come sostanza. Ma le donne sono la maggioranza di chi vota, sono la "constituency", la base elettorale sulla quale Clinton punta per superare il vantaggio di lui fra i maschi.

Con il 40 per cento di americane giudicate "obese" dal Centro per il Controllo delle Malattie di Atlanta (35 per cento gli uomini) e il restante 65 che segretamente si considerano "grasse" anche quando non lo sono, fare

I NUMERI

36,5 %

GLI AMERICANI ADULTI SOVRAPPESO

Lo Stato che ha il numero più alto di obesi è la Louisiana (36,2 %) quello che ha il numero più basso è il Colorado (20,2 %). Il numero di minorenni sovrappeso è del 17%


Alimentazione Naturale
Con Kiwi e Sesamo previeni il diabete
Curarsi MANGIANDO
Spazza via il colesterolo
Le arterie tornano elastiche
VERO cucina
SCIENZE
DIMAGRISCI SUBITO CON LO ZENZERO
Dimagrire
DEPURA L'INTESTINO VEDRAI CHE GRINTA
Focus
DINO SAPIENS
I manuali
Ringiovanire dopo i 40 anni

OBESITA' IN CALABRIA

Percentuale > media italiana (34.8 vs 31.2)

Percentuale età pediatrica (27.2 vs 24.2)

< Percentuale attività sportiva continuata (12 vs 18.1)

Sovrappeso e Obesità in Calabria : Progetto Passi 2010-2013

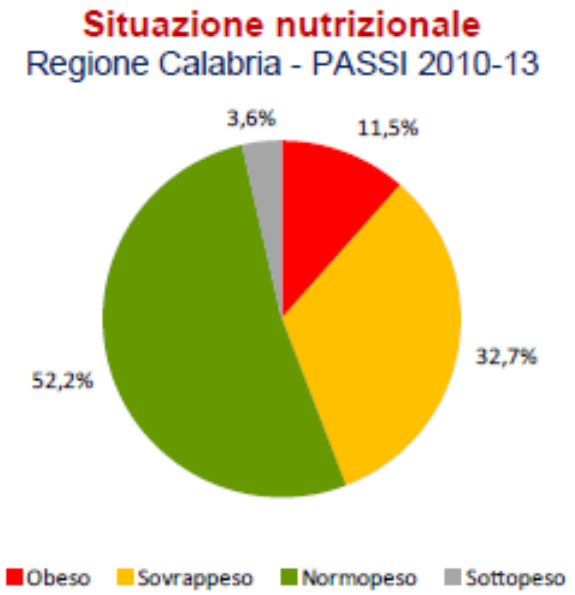
In Calabria nel periodo 2010-13, secondo i dati Passi1 (degli adulti di 18-69 anni):

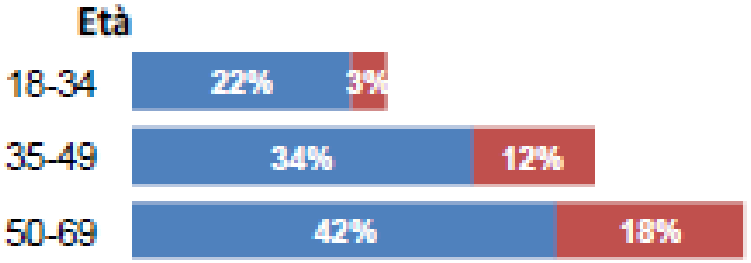
33% Sovrappeso

11,5% Obeso.

150.000 adulti obesi

435.000 sovrappeso.





I costi dell'Obesità in Calabria

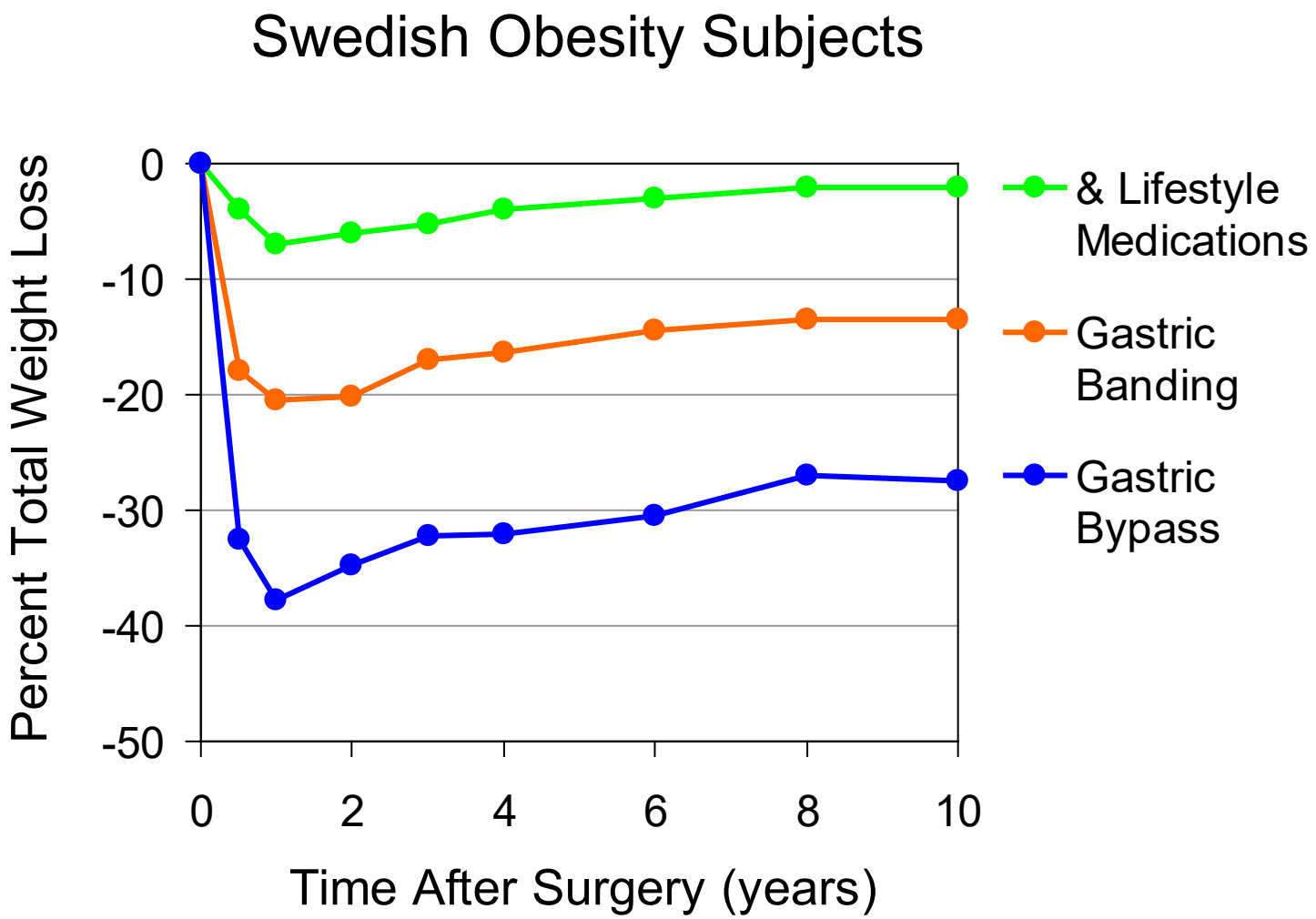
609.000.000 € ***(anno 2013)***

(Studio ***Scuola Superiore Sant'Anna di Pisa****)*

La regione Calabria quanto ha speso in Mobilità per obesità ?

PERCHE' LA CHIRURGIA ?

Surgical Weight Loss



OBESITA' e CHIRURGIA

Aumento spettanza di vita

Swedish Obese Subjects Study (SOS) : <24,6% mortalità a 10 anni

Busetto: < 60% mortalità a 5 anni

Australia: < 73% mortalità a 7 anni

Sesso - Età - BMI - EWL ?

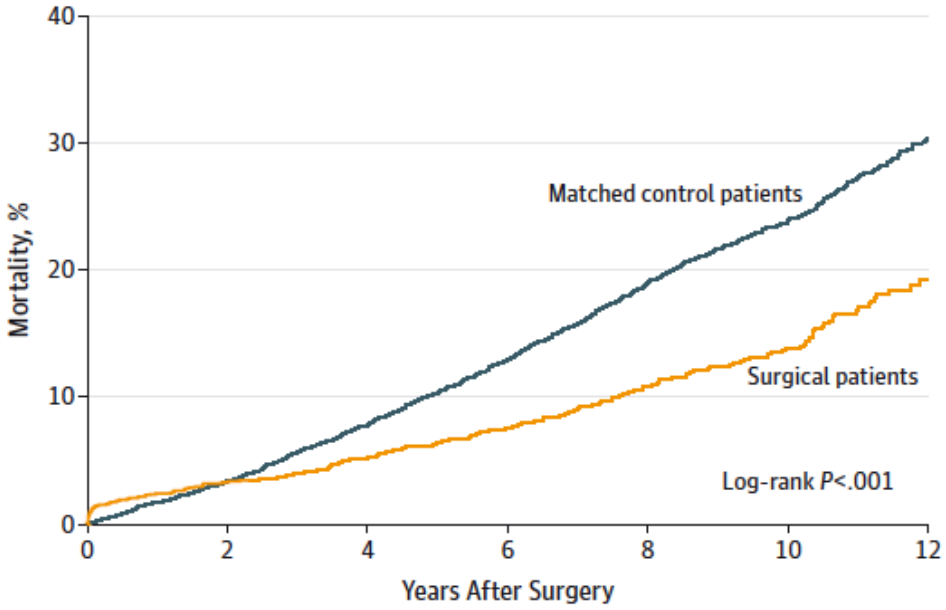
Original Investigation

Association Between Bariatric Surgery and Long-term Survival

David E. Arterburn, MD, MPH; Maren K. Olsen, PhD; Valerie A. Smith, MS; Edward H. Livingston, MD, MS; Lynn Van Scoyoc; William S. Yancy Jr, MD, MHSc; George Eid, MD; Hollis Weidenbacher, PhD; Matthew L. Maciejewski, PhD

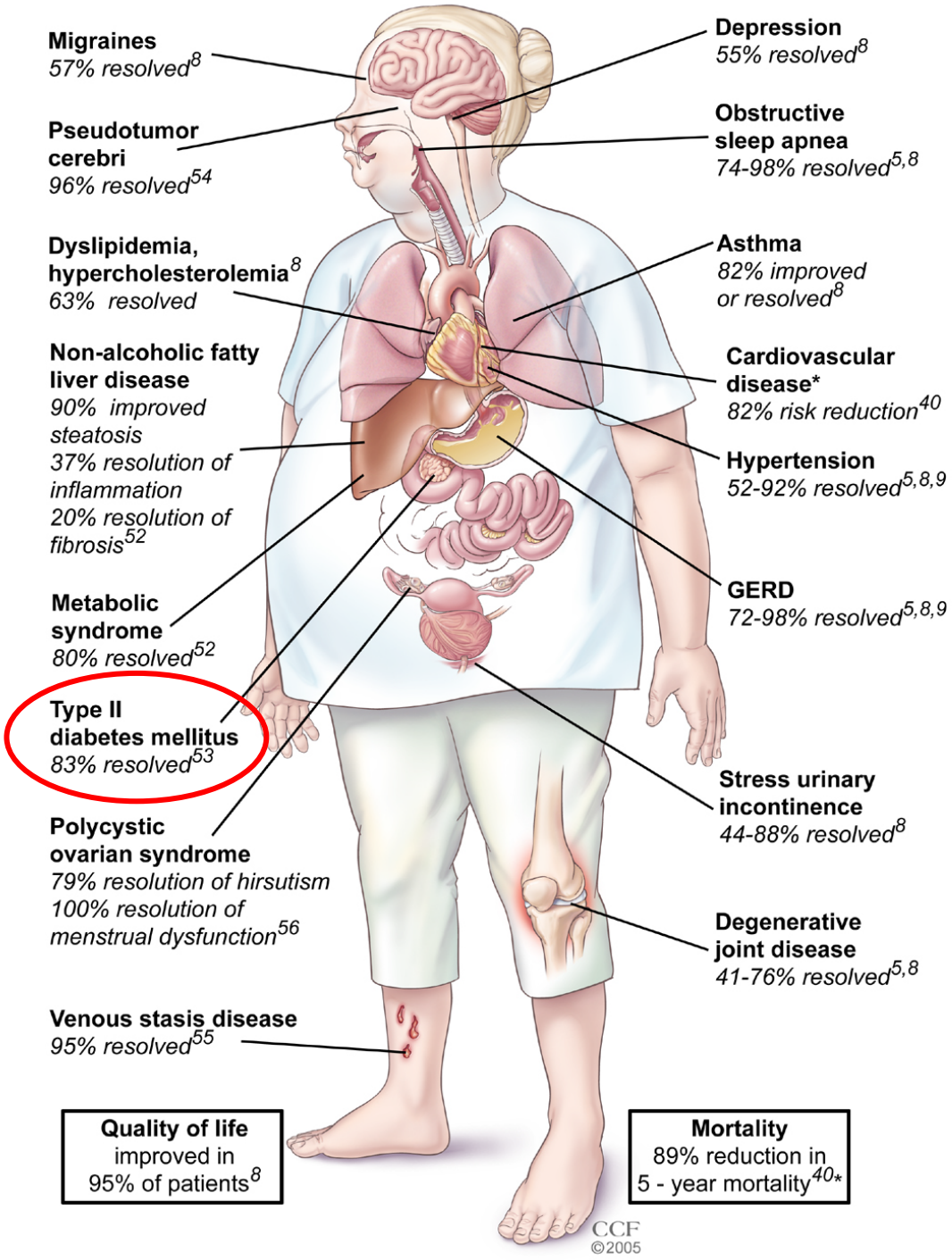
JAMA, Jan 2015

Figure. Kaplan-Meier Estimated Mortality Curves for Surgical Patients and Matched Control Patients



No. at risk							
Matched control patients	7462	7114	5306	3878	2641	1407	472
Surgical patients	2500	2416	1868	1412	1004	552	185

Chirurgia e comorbilita' obesita'- correlate



SOS, *NEJM,* 2004

***Clev Clin J Med,* 2006**

OBESITA' E CHIRURGIA

Intervento chirurgico 233.226.000 Euro

(degenza, occupazione S.O.,presidi, follow up, complicanze)

Risparmio SSN 329.433.800 Euro

(costo gestione comorbilità)

Studio Lattuada per il bendaggio in Lombardia su un periodo di 5 anni

OBESITA' E CHIRURGIA

Indicazioni all' Intervento:

BMI > 40 Kg/m2

BMI > 35 Kg/m2 in presenza di comorbilità

(diabete, ipertensione, dislipidemie, osteoartropatie)

OBESITA' E CHIRURGIA

Controindicazioni:

- assenza di un periodo di trattamento medico verificabile
- disordini psicotici, depressione severa, disturbi della personalità e del comportamento alimentare valutati da psichiatra/psicologo dedicato
- alcoolismo e tossicodipendenza
- malattie correlate a ridotta spettanza di vita
- pz inabili alla cura di sè e senza adeguato supporto familiare e sociale

Obesity Surgery Through the Years…

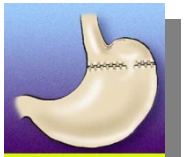


Fig. 11
Horizontal
Gastroplasty

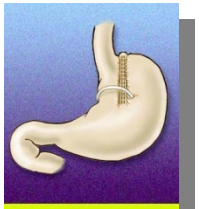


Fig. 13
Silastic Ring
Vertical Gastroplasty

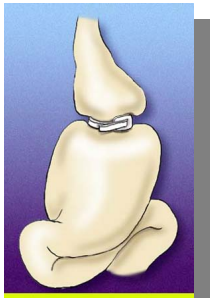


Fig. 14
Non-Adjustable
Gastric Banding

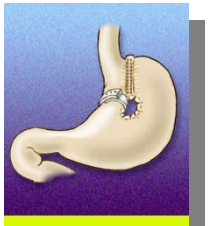


Fig. 12
Vertical Banded
Gastroplasty

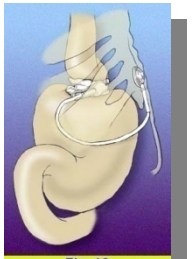


Fig. 16
Adjustable Gastric Band
Obtec AG
(Swedish)

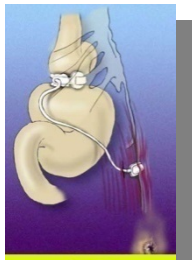


Fig. 15
Adjustable
Gastric Band
LapBand (Kuzmak)

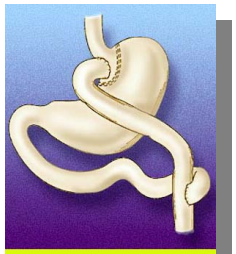


Fig. 7
Gastric Bypass with
Lesser Curve
Pouch & Roux-en-Y

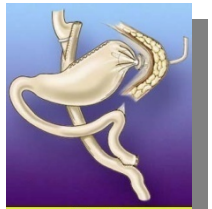


Fig. 10
Silastic Ring
Gastric Bypass OR
Vertical Banded
Gastroplasty/Gastric
Bypass (Fobi)

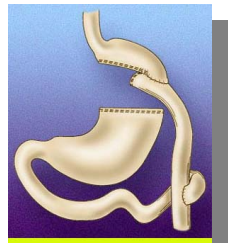


Fig. 8
Transected Roux-en-Y
Gastric Bypass

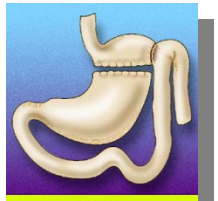


Fig. 6
Gastric Bypass
with Loop
Gastro-jejunostomy

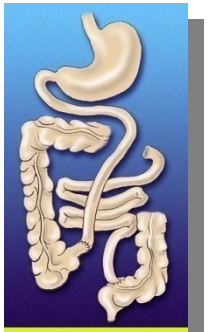


Fig. 3
Jejuno-ileal
Bypass (JIB)
End-toEnd (Scott)

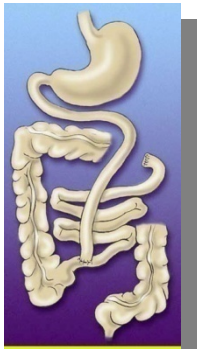


Fig. 2
Jejuno-ileal
Bypass (JIB)
End-to-Side (Payne)

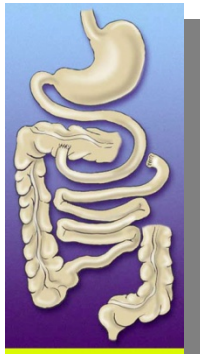


Fig. 1
Jejuno-colic
bypass

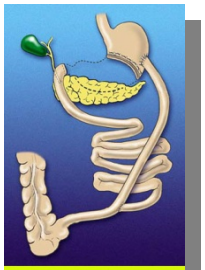


Fig. 4
Biliopancreatic
Diversion (BPD)
(Scopinaro)

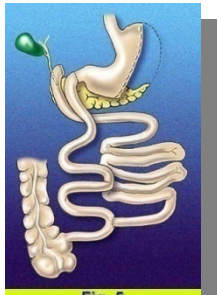


Fig. 5
Biliopancreatic
Diversion (BPD) with
Dudenal Switch
(Marceau)

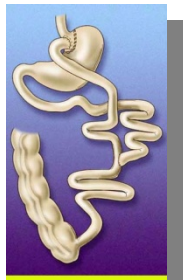
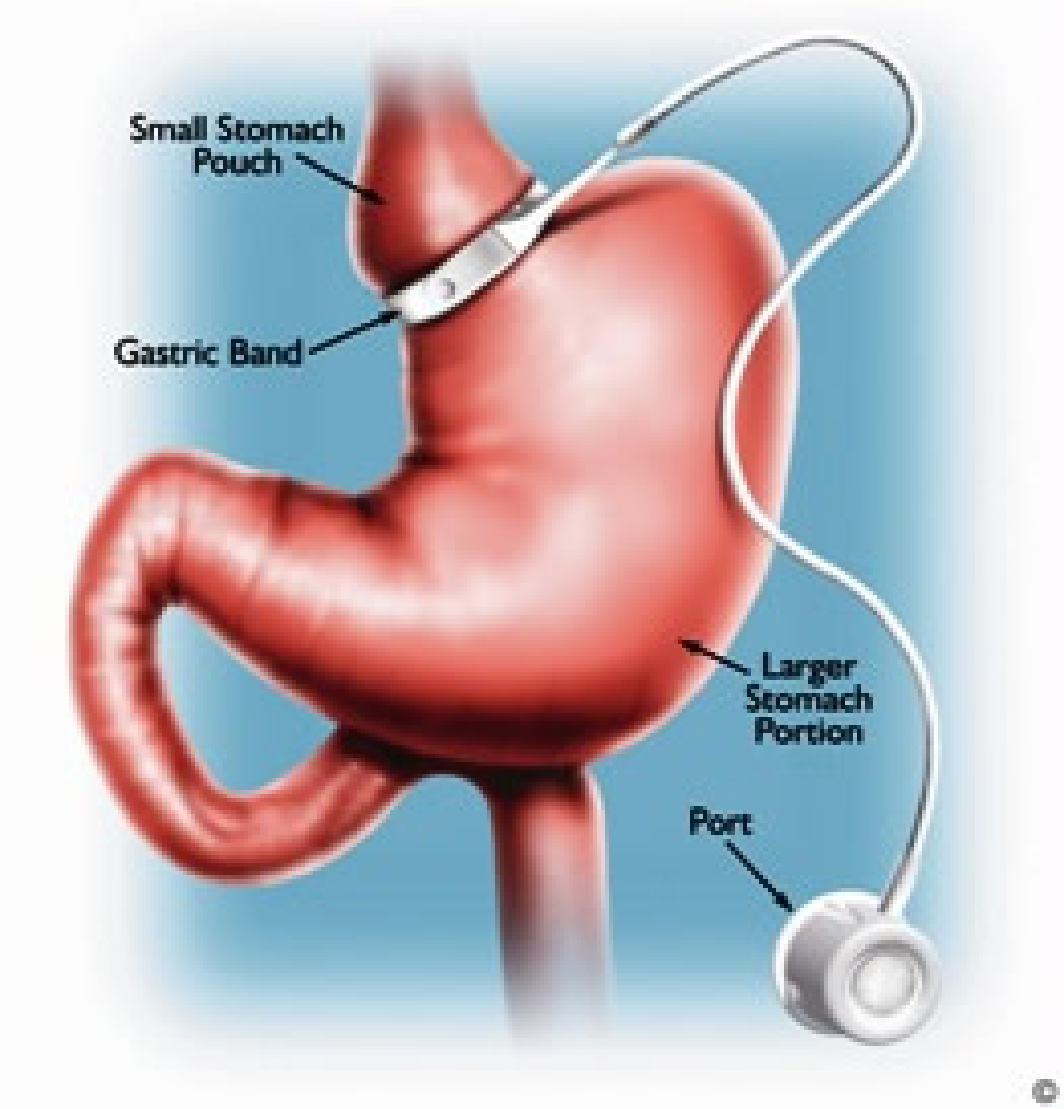


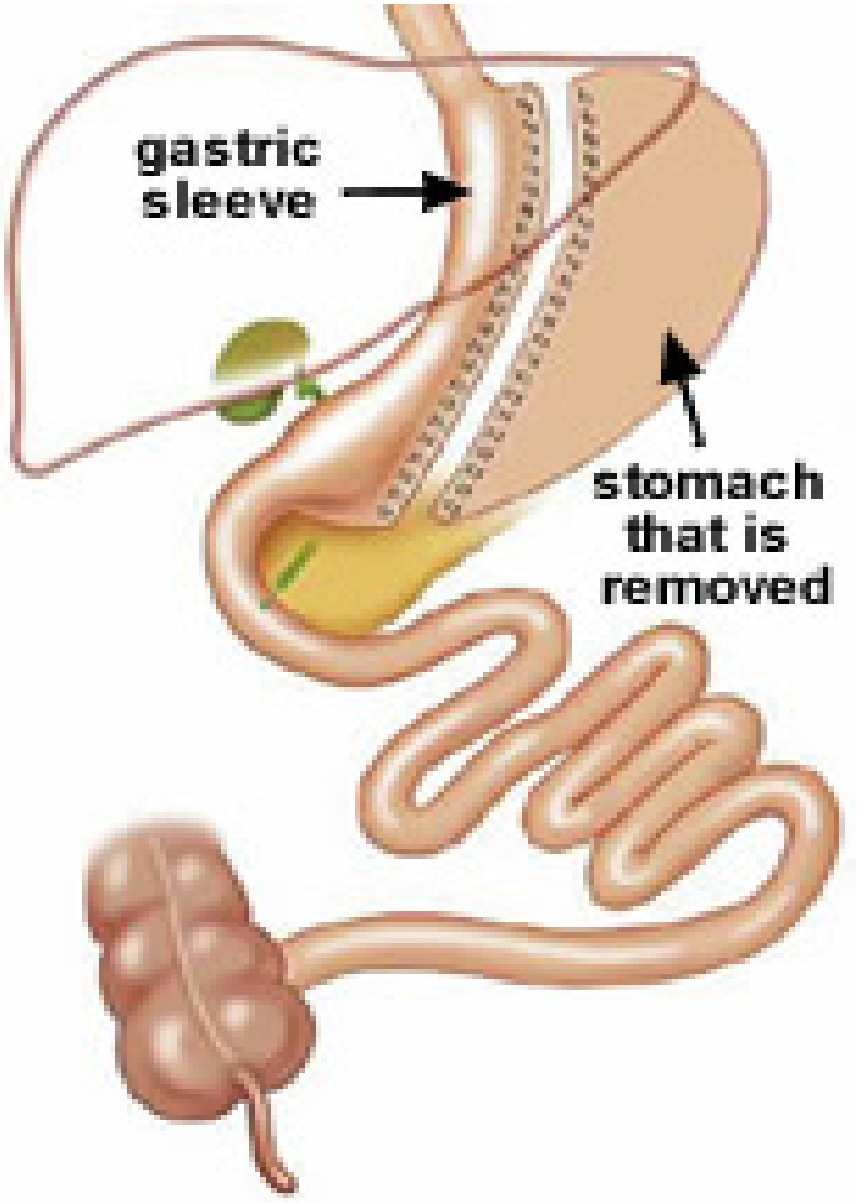
Fig. 9
Long Limb
Gastric Bypass

OBESITA' e CHIRURGIA

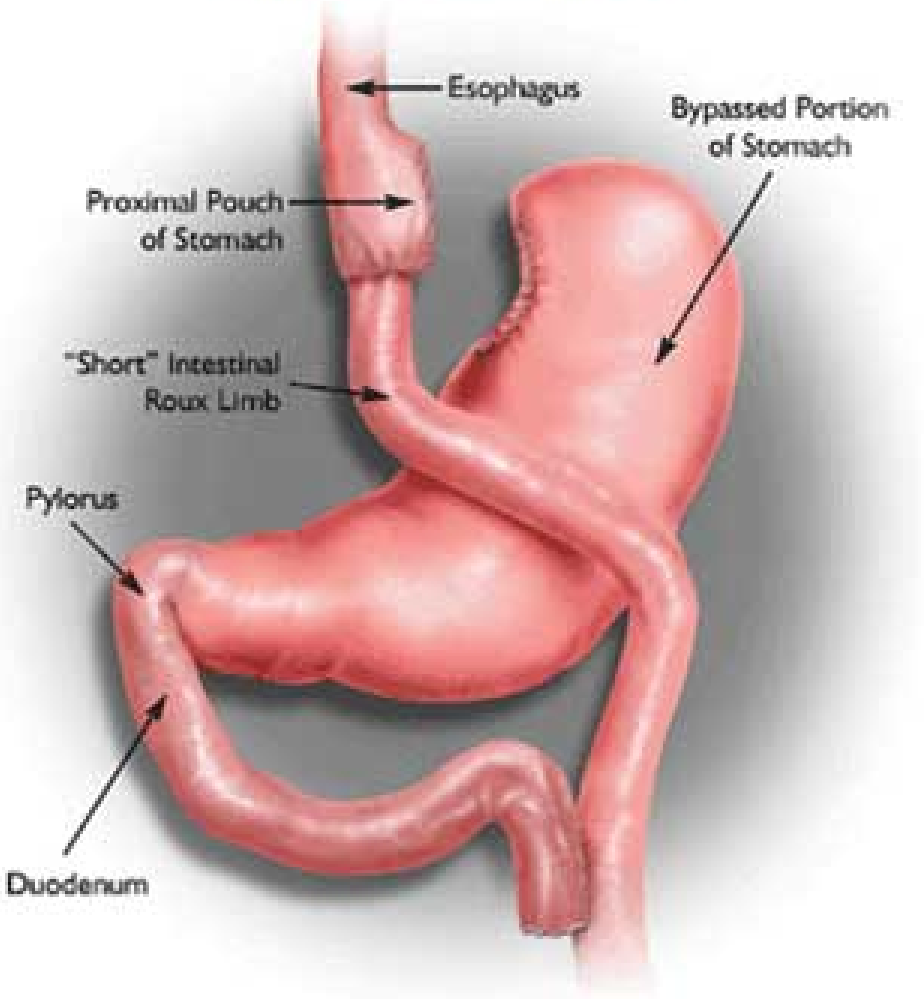
Tipi di Intervento:

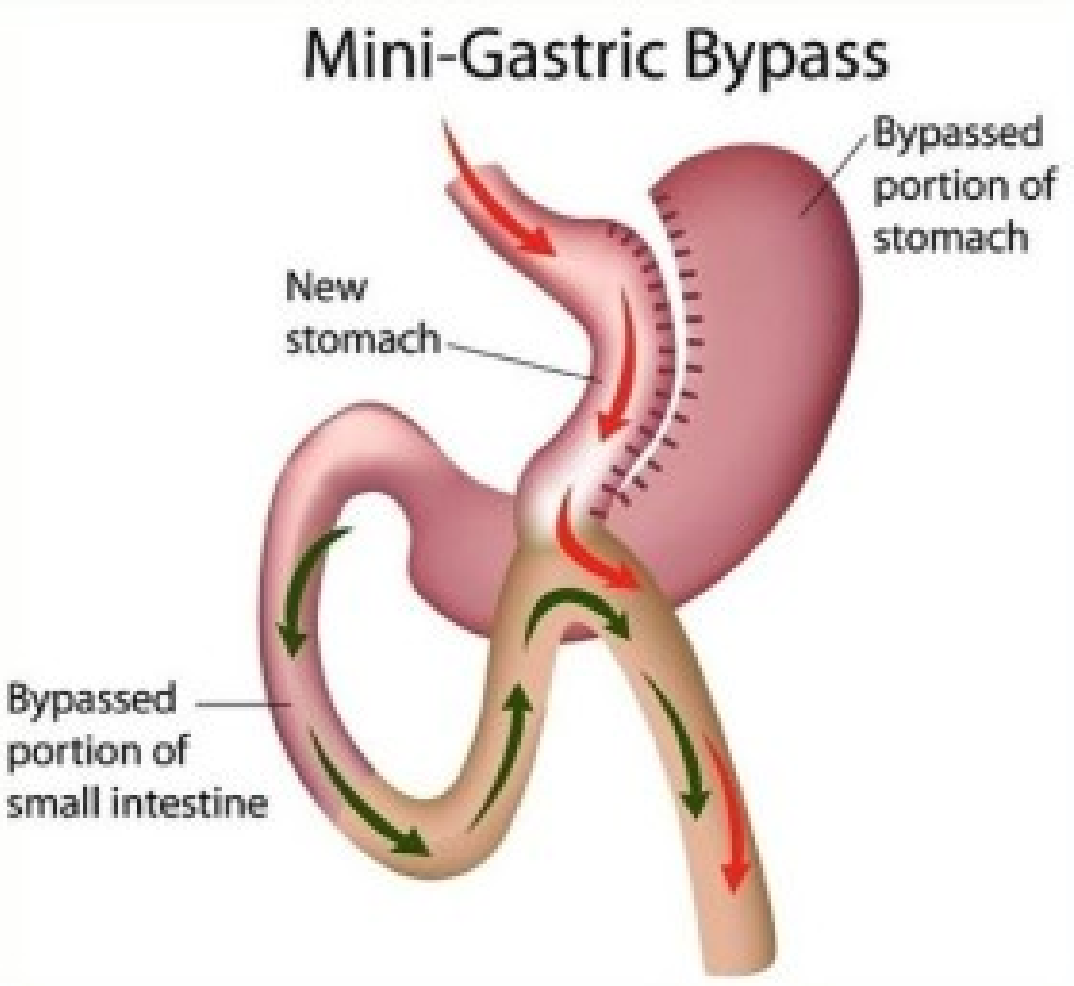
- Restrittivi
  - *Bendaggio gastrico regolabile*
  - *Sleeve Gastrectomy*
- Malassorbitivi
  - *Diversione biliopancreatica sec. Scopinaro*
- Misti
  - *By pass gastrico*
  - *Mini Bypass (OAGB)*

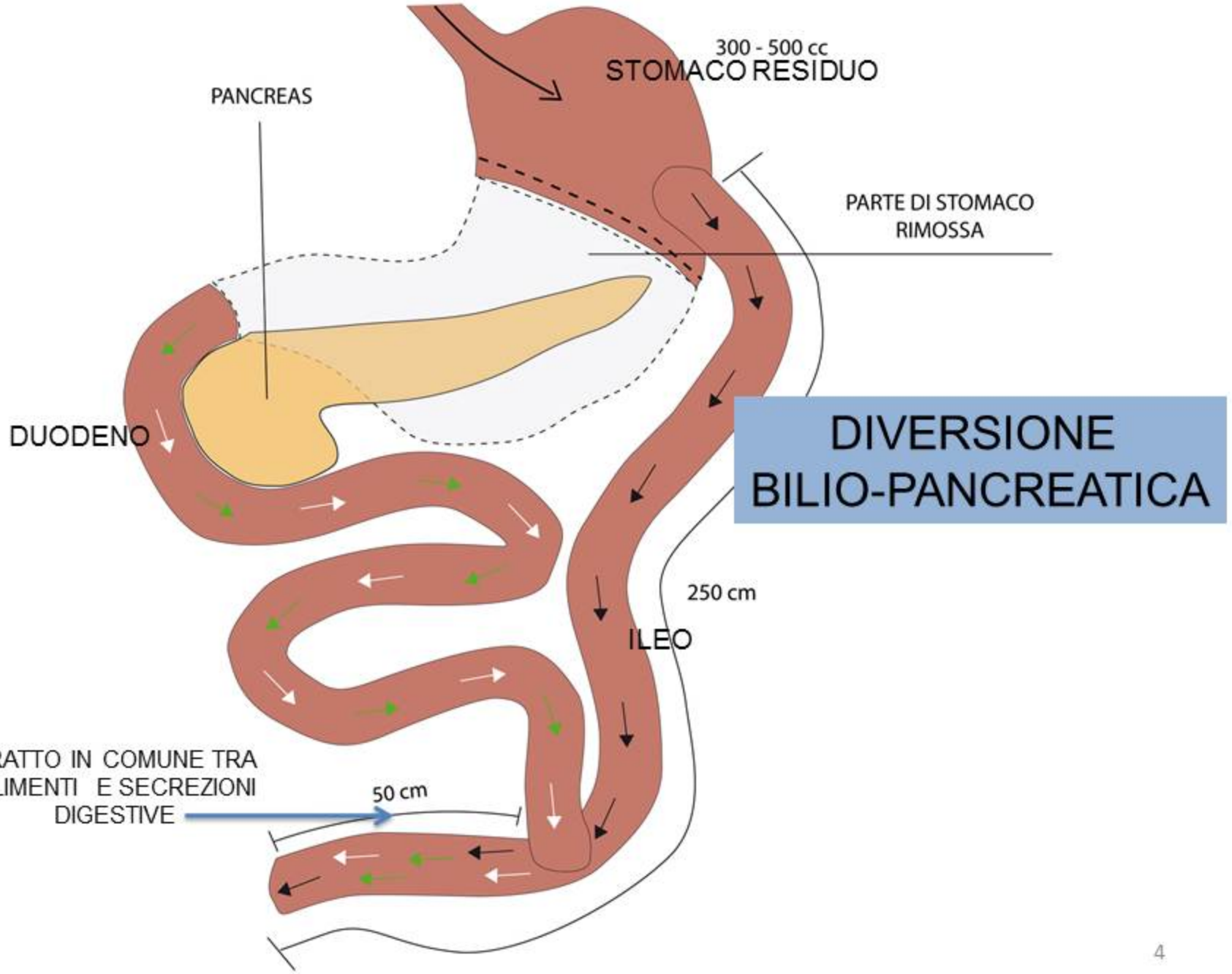

Small Stomach Pouch
Gastric Band
Larger Stomach Portion
Port


gastric
sleeve
stomach
that is
removed

Roux-en-Y Gastric Bypass



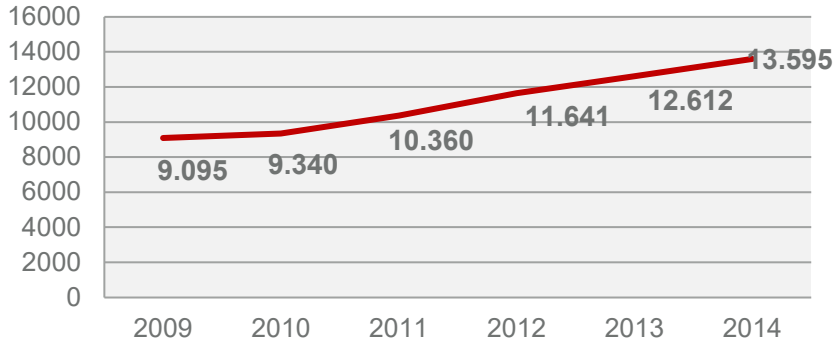

Mini-Gastric Bypass
Bypassed portion of stomach
New stomach
Bypassed portion of small intestine



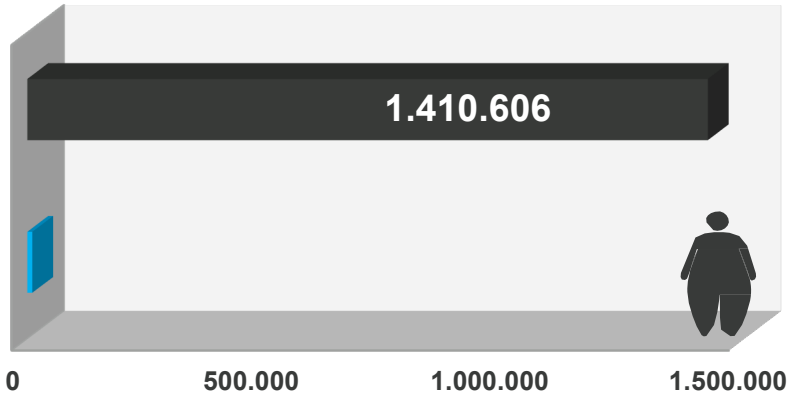
disegnato da
Marta Mugnaini

Stato dell'arte della Chirurgia Bariatrica in Italia

Numero Interventi DRG 288



Penetrazione Chirurgia Bariatrica



REGIONI	Elegibili	Trattati
LAZIO	131.021	1,1%
CAMPANIA	131.535	1,1%
VENETO	116.606	1,1%
SICILIA	122.549	0,7%
PUGLIA	109.033	0,2%
EMILIA ROMAGNA	108.288	1,1%
ABRUZZO	36.724	0,8%
LIGURIA	35.430	0,7%
TOSCANA	85.572	1,2%
UMBRIA	22.733	0,9%
LOMBARDIA	229.060	2,0%
VALLE D'AOSTA	3.393	1,6%
FRIULI VENEZIA GIULIA	28.862	0,7%
CALABRIA	46.776	0,2%
MARCHE	34.678	0,2%
MOLISE	9.154	0,3%
BASILICATA	18.706	0,4%
PIEMONTE	84.114	0,3%
TRENTINO ALTO ADIGE	18.107	0,6%
SARDEGNA	38.171	0,2%

Perception of risks of bariatric surgery

Bariatric Surgery

Elective General Surgery
Cholecystectomy, Hernia Surgery, Reflux Surgery, Colorectal (benign)

Bariatric Surgery Mortality Rate: 0.3% (55,567 patients)

	Aortic Aneurysm	CABG	Craniotomy	Esophageal Resection	Hip Replacement	Pediatric Heart Surgery
Hospitals Performing Operation	2485	1036	1600	1717	3445	458
Mortality Index (%)	3.9	3.5	10.7	9.1	0.3	5.4
Median Volume per Hospital	30	491	12	5	24	4

Source: Dimick JB, Welch HG, Birkmeyer JD. Surgical mortality as an indicator of hospital quality. JAMA 2004,292, 847-851

Safety profile and healthcare usage of Bariatric/Metabolic surgery compared to commonly elective procedures

- D.Tassinari[1], S.Panagiotopoulos[1], E.Giorgakis[1], L.Castagneto-Gissey[1], J.CasellaMariolo[1], A.Salerno[1], A.Chang[1], A.Patel[1], A.Haq[2], S.Ramar[1], G.Galata[2], K.M.Schulte[2], F.Rubino[1]
- [1]Metabolic and Bariatric Surgery, Division of Diabetes and Nutritional Sciences, James Black Centre, King's College London, Denmark Hill Campus, London, UK
- [2]Department of Surgery, King's College Hospital, Denmark Hill, London

Presented at the 3rd World Congress on Interventional Therapies for Type 2 Diabetes
London, September 29, 2015

Selection Criteria

Bariatric/metabolic surgery:

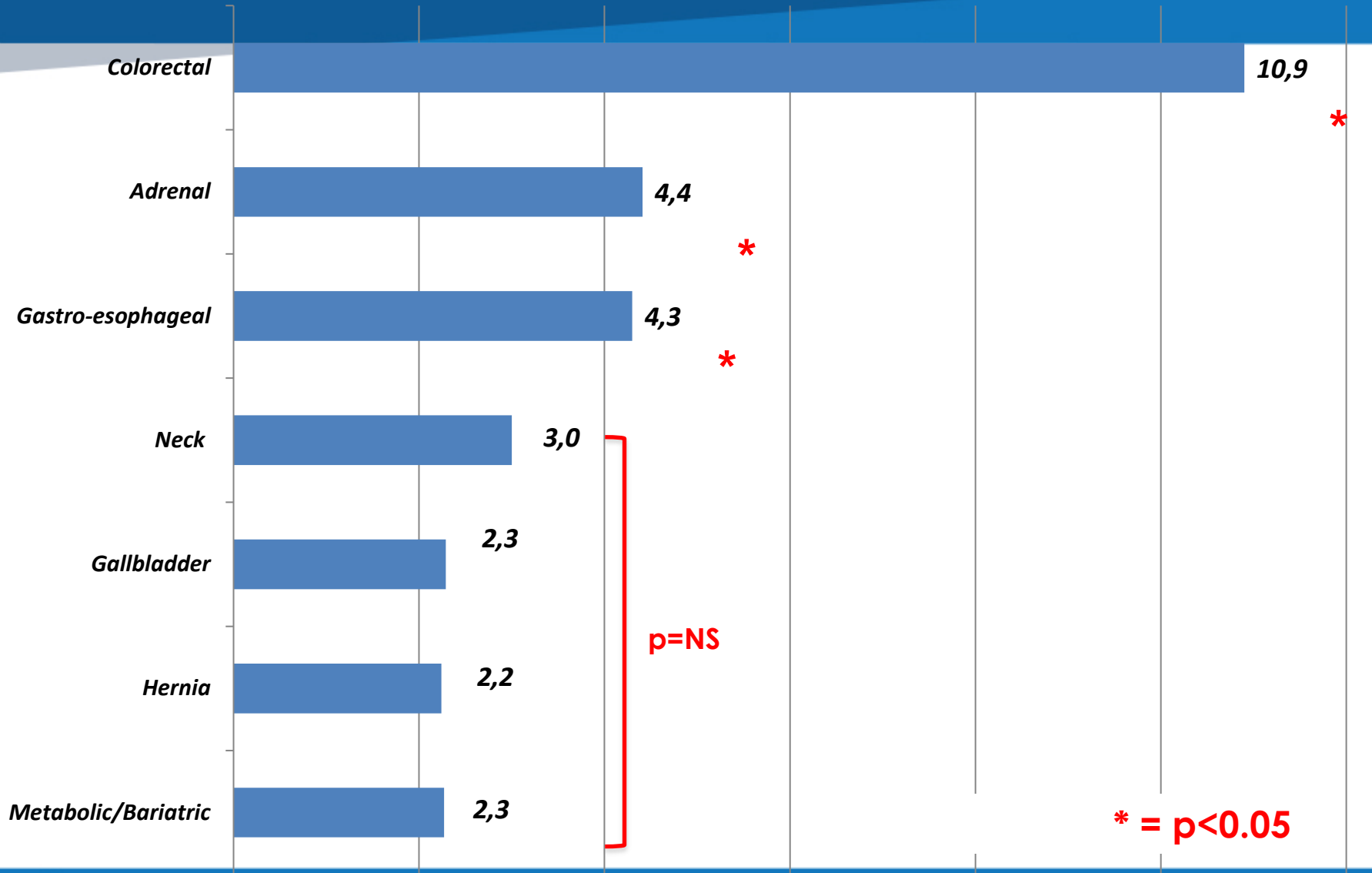
- All comers

Control groups of elective surgeries

Exclusion Criteria:

- Emergency procedures
- Cancer
- Day-surgery

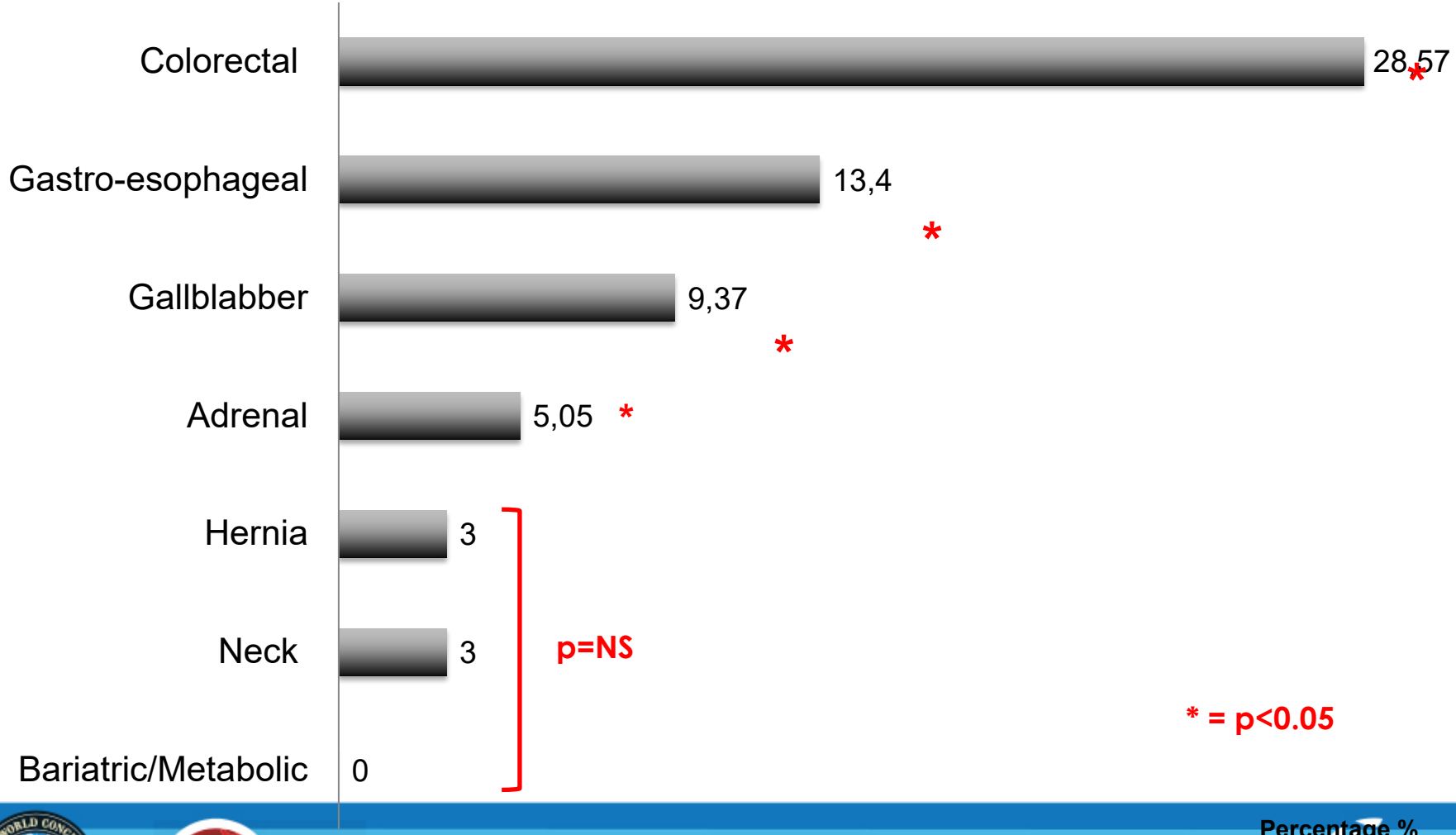
Hospital Stay [LoS] (Days)



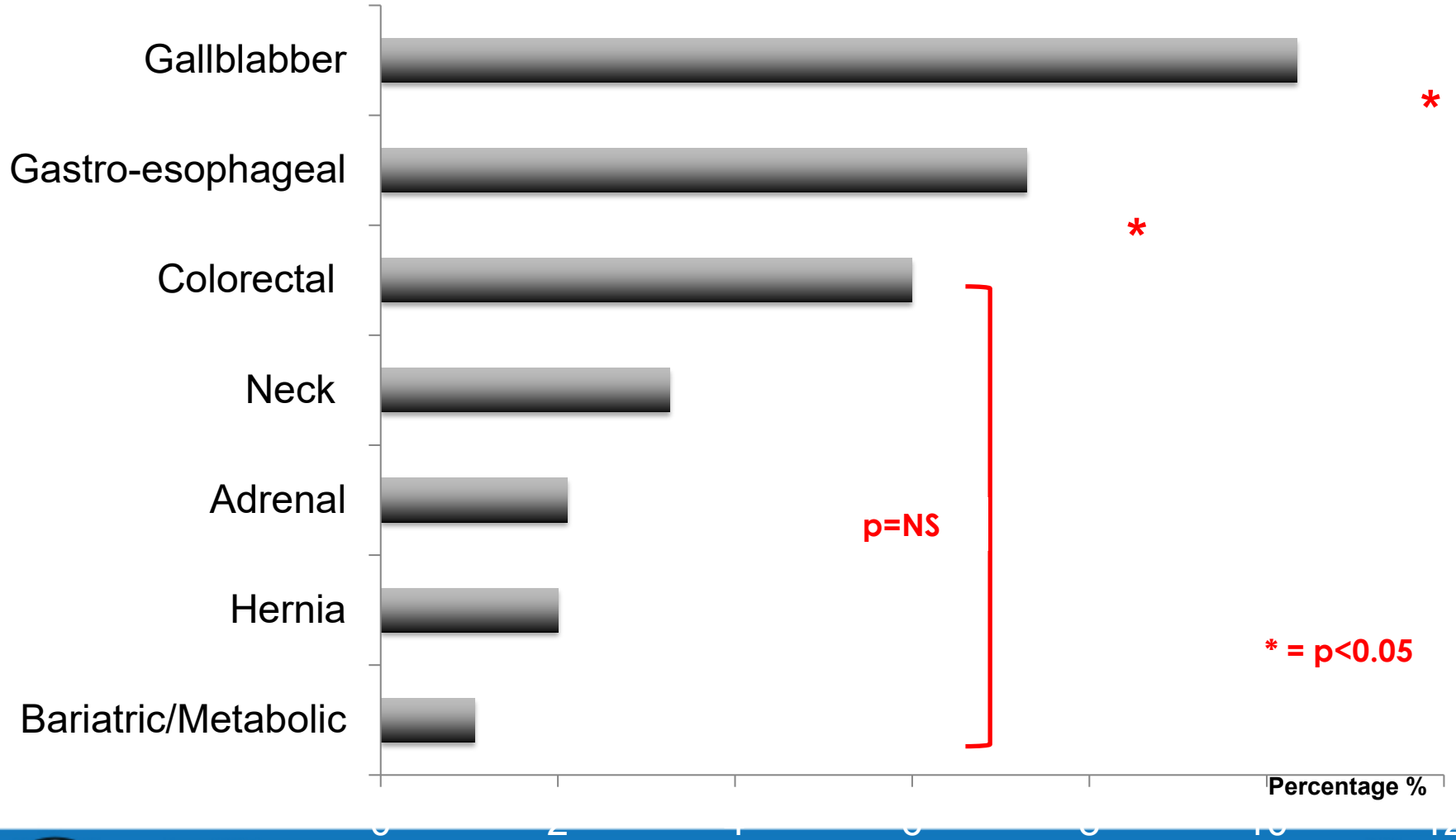
30-Day Safety Composite Score

Number of major events (major morbidity, re-admissions, and re-operations) within the first 30 days after surgery.

30-Day Safety Composite Endpoint (re-admission, re-operation and major morbidity)



3-Month Safety Composite Endpoint (re-admission, re-operation and major morbidity)




Obesità
Diabete tipo 2
Chirurgia
Metabolica

Salute, diabete: al calabrese Francesco Rubino la prima cattedra mondiale di chirurgia bariatrica e metabolica

23 gennaio 2014 - 15:47

DIABETES AND OPERATION.

A NOTE ON THE EFFECT OF GASTRO-JEJUNOSTOMY UPON A CASE OF MILD DIABETES MELLITUS WITH A LOW RENAL THRESHOLD.

BY O. LEYTON, M.D. CAMB., F.R.C.P. LOND.,
PHYSICIAN TO THE LONDON HOSPITAL.

How can we account for the apparent improvement? The glycosuria was absent after operation in spite of a diet containing a fair amount of carbohydrate. In order to determine whether the operation

THE AMELIORATION OF DIABETES MELLITUS FOLLOWING SUBTOTAL GASTRECTOMY

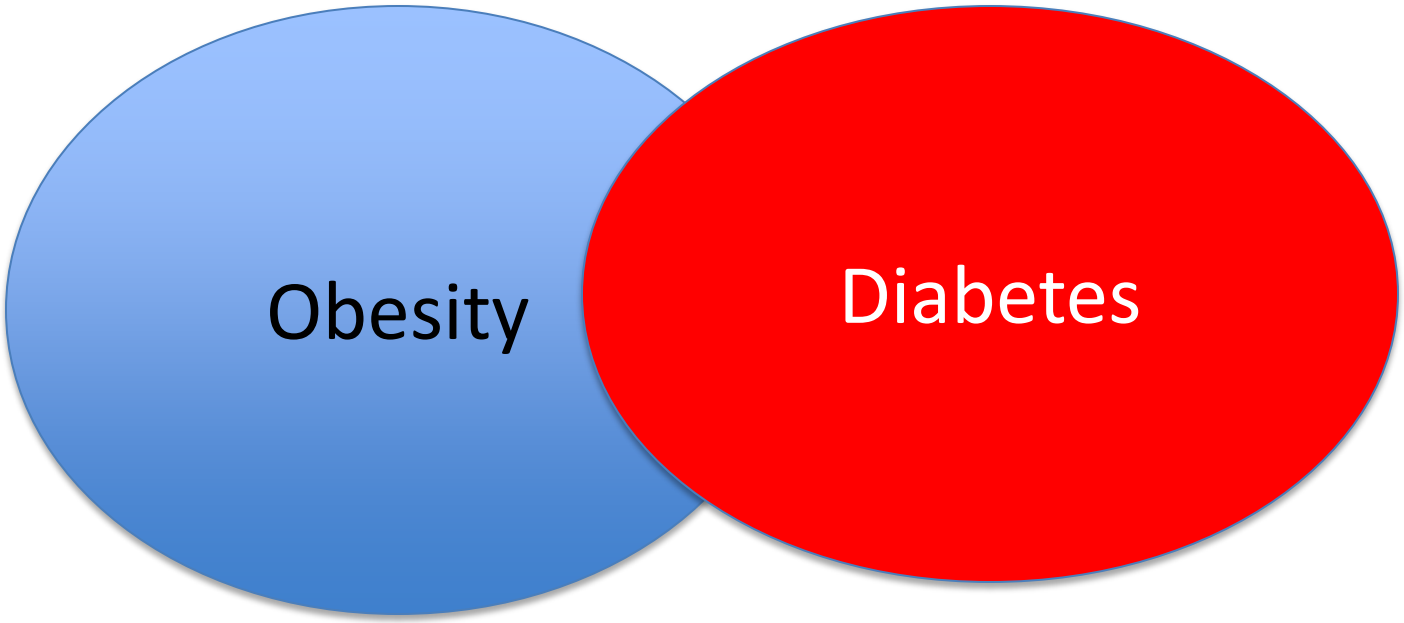
MURRY N. FRIEDMAN, M.D., F.A.C.S., ANTONIO J. SANCETTA, M.D., and GEORGE J. MAGOVERN, M.D., Brooklyn, New York

1955

IN 1923, MURLIN noted the presence of a substance in extracts of the pancreas which could raise the blood sugar. Subsequently, this hyperglycemic factor was demonstrated

and duodenum. Therefore, when subtotal gastrectomy for duodenal ulcer resulted in marked amelioration of the diabetic state in 3 patients at the Brooklyn Veterans Hospi-

The Missing Link between Obesity and Diabetes



NewScientist

This week

Could surgery spell the end of diabetes?

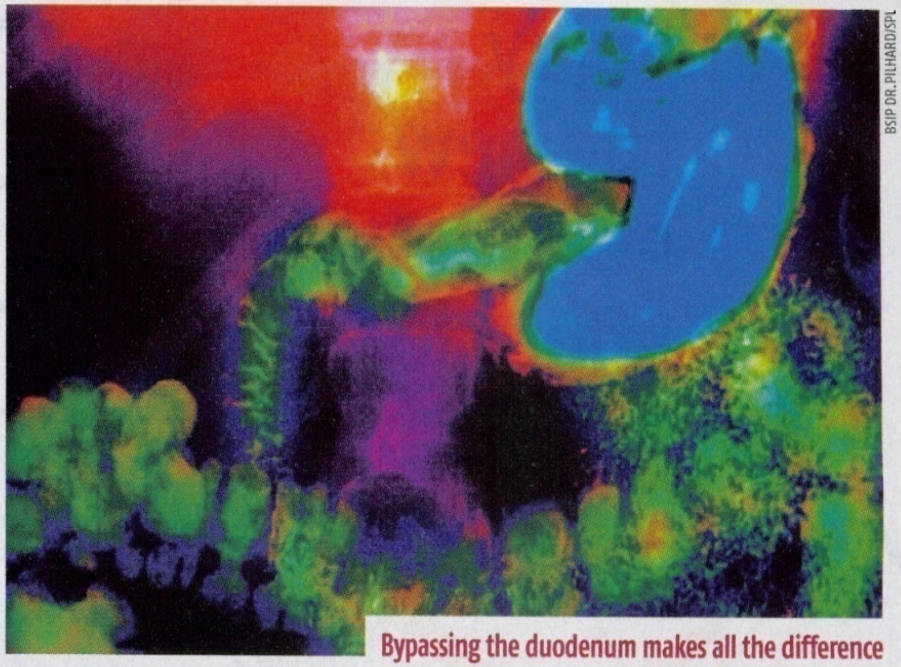
ALBERTO VASCONCELOS

ABDOMINAL surgery is a radical way of losing weight, but could it also cure type 2 diabetes?

Duodenal exclusion is a form of gastric bypass surgery in which the upper small intestine or duodenum is removed, so that the stomach feeds directly into the mid-small intestine. This reduces the amount of time the body has to absorb calories from food, meaning people lose weight.

Surgeons performing duodenal exclusions on obese cases the patients' diabetes spontaneously vanished a few weeks after surgery – too soon to be accounted for by weight loss.

Now a team of Italian, Brazilian and French doctors has performed duodenal exclusions on seven people with type 2 diabetes who were classified as normal weight to moderately obese, to see if it has a similar effect. Nine months after surgery, the first two people they operated on are both free of anti-diabetic medication. Both experienced dramatic reductions in their blood sugar and insulin



BSIP DR. PILHARD/SPL

Bypassing the duodenum makes all the difference

took place (*Surgery for Obesity and Related Diseases*, DOI: 10.1016/j.soard.2007.01.009). It is too soon to report on the other five patients.

Type 2, or adult-onset, diabetes is characterised by insulin resistance. This means the body liver and muscle cells to take up glucose from the blood – but cells no longer respond to it.

Francesco Rubino, a surgeon at the Catholic University of Rome, Italy, who was involved in the study, believes that the duodenum

DIABETOLOGIA

"Con un bypass gastrico sconfiggo il diabete"

La tecnica inventata da un italiano, reclutato dal King's College

RICCARDO LATTANZI
NEW YORK UNIVERSITY

L'aumento dei casi di obesità fa stimare che nel 2030 quasi il 10% degli adulti nel mondo sarà affetto da diabete di tipo 2 con un costo sanitario vicino ai 360 miliardi di euro. Ma ora gli studi di un medico italiano potrebbero invertire la tendenza... e senza cambiarci la dieta!

«E' una malattia conosciuta da migliaia di anni e sempre considerata cronica, progressiva e incurabile», spiega Francesco Rubino, che per primo ha intuito e dimostrato che il diabete si può sconfiggere con la chirurgia gastrointestinale. «E' accertato che almeno il 30% dei pazienti ottiene una risoluzione completa e prolungata oltre i cinque anni.» Quarantaquattrenne, dopo essersi formato alla Cattolica di Roma, ha proseguito la sua carriera all'estero e nel '99, ricercatore al Mount Sinai Medical Center di New York, ha teorizzato che la patofisiologia dell'insulinoresistenza, che è responsabile del diabete di tipo 2, fosse legata ad anomalie nei meccanismi di regolazione gastrointestinale e potesse essere curata col bisturi.

Altri medici, già negli Anni 50, avevano osservato che, modificando l'anatomia dello stomaco e dell'intestino, si poteva alterare il decorso del diabete, però si era sempre ritenuto che l'effetto fosse una conseguenza del dimagrimento dovuto all'operazione. «Entro pochi giorni e al massimo in due settimane questi pazienti non avevano più bisogno dell'insulina e i livelli di zucchero nel sangue erano tornati normali - racconta Rubino -. Un cambiamento troppo rapido per essere causato dalla perdita di peso!» Per confermare la sua ipotesi, ha quindi modificato l'operazione standard di bypass gastrico in modo da lasciare intatta la grandezza dello stomaco, ma deviandone l'uscita, che viene collegata al secondo tratto dell'intestino tenue, quello «digiuno», scavalcando la parte alta, il «duodeno». Così facendo, la quantità di cibo ingerito rimane la stessa e si poteva quindi attribuire ogni variazione della glicemia a cambiamenti ormonali. La sperimentazione sui topi gli ha dato ragione e i risultati preliminari sull'uomo sembrano confermare che la remissione del diabete non dipende dalla perdita di peso. «L'operazione fa sì che i nutrienti affluiscano al "digiuno", che percepisce una sovrabbondanza di zuccheri e di conseguenza inesca i meccanismi neuro-endocrini per stabilizzarne il metabolismo», spiega Rubino, i cui studi hanno contribuito a trasformare concettualmente la chirurgia bariatrica da terapia per la perdita di peso ad approccio contro il diabete e le malattie metaboliche.

Cervello in fuga Rubino si è specializzato negli Stati Uniti prima di approdare a Londra

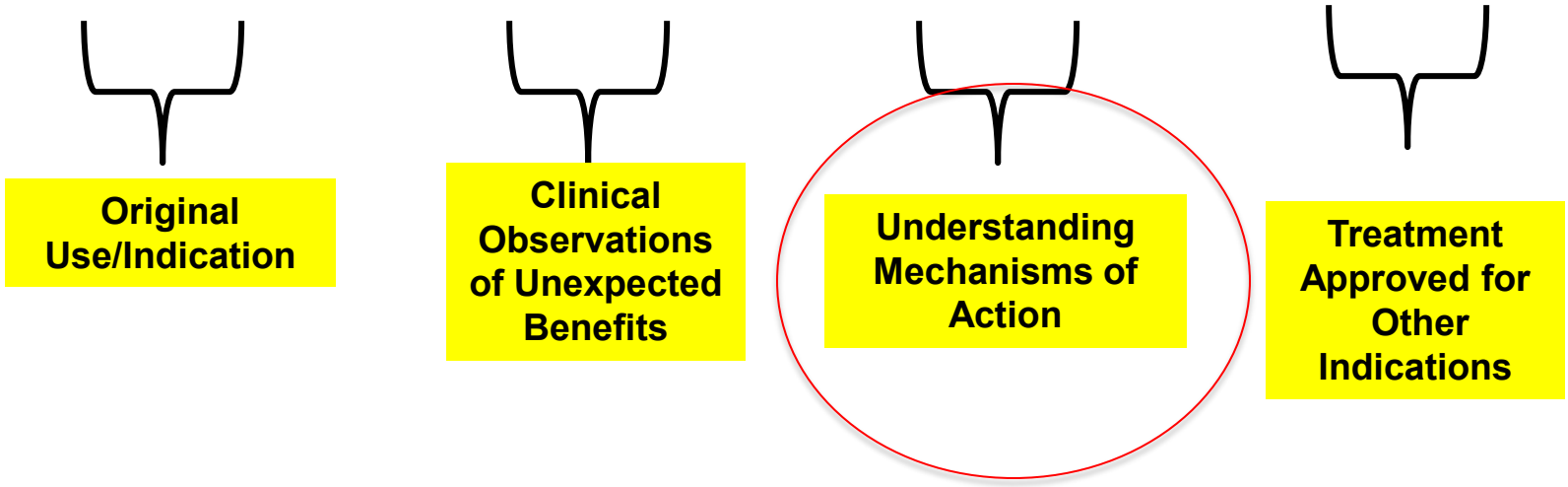
Francesco Rubino
Chirurgo

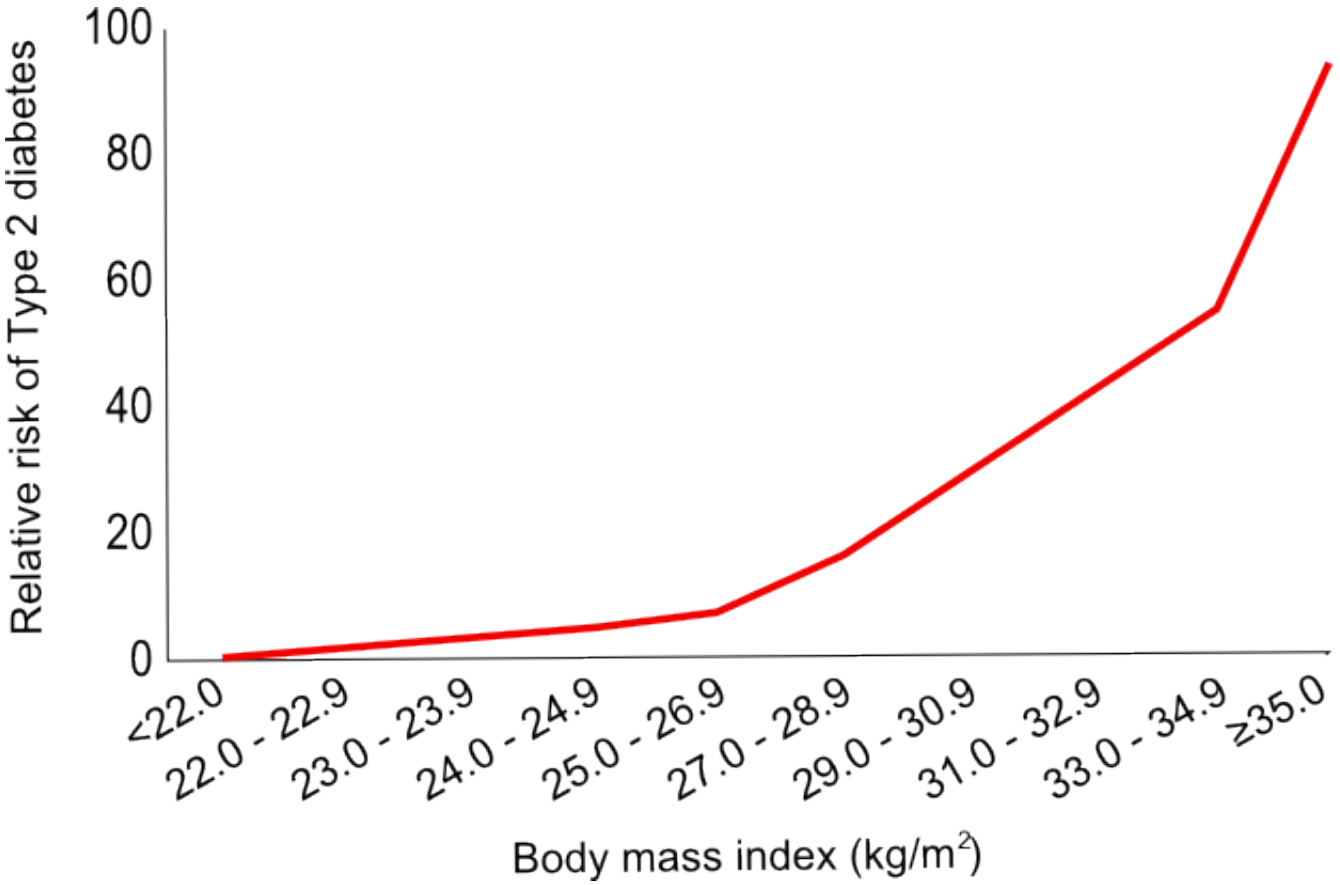
RUOLO: È PROFESSORE DI CHIRURGIA BARIATRICA E METABOLICA E DIRETTORE DELL'ISTITUTO PER LA CHIRURGIA DEL DIABETE AL KING'S COLLEGE DI LONDRA

Il termine «chirurgia metabolica» è ormai accettato dalla comunità medica ed è aumentato il numero di chi ricorre all'operazione per motivi di salute piuttosto che per problemi fisici ed estetici legati all'obesità. Ora il passo successivo sarà creare un nuovo modello sanitario mirato alla cura delle malattie metaboliche. Un obiettivo che ha convinto Rubino a trasferirsi a Londra per dirigere il nuovo istituto per la chirurgia del diabete del King's College, dove dallo scorso ottobre è titolare della prima cattedra al mondo di chirurgia bariatrica e metabolica. «Il programma clinico sarà multispecialistico, con chirurghi, endocrinologi-diabetologi, esperti di nutrizione, psicologi e personale infermieristico specializzato - aggiunge -. Il programma di ricerca si concentrerà sullo studio dei meccanismi d'azione della chirurgia metabolica per comprendere le cause, ancora sconosciute, di diabete e obesità».

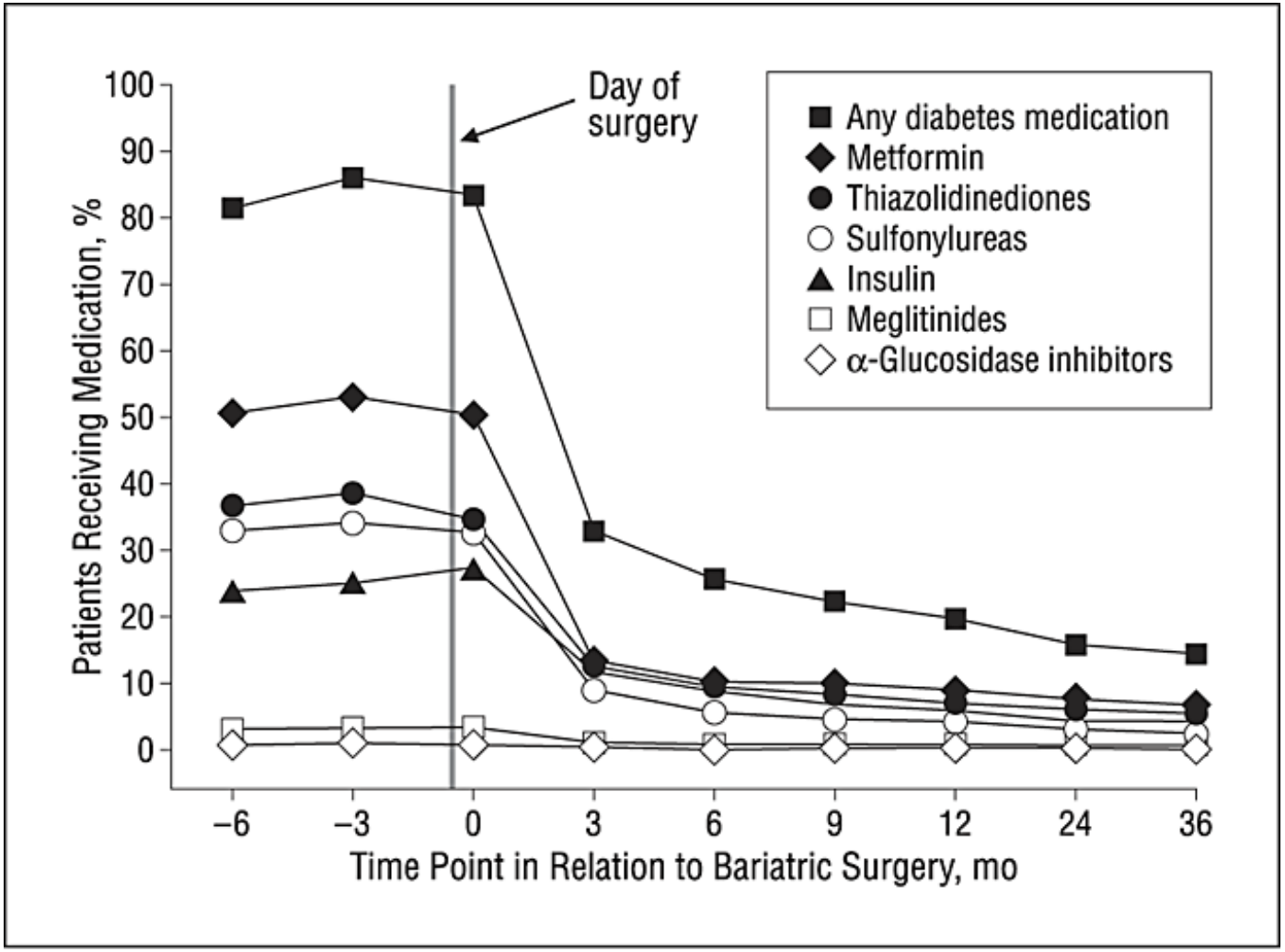
La speranza è di mettere a punto interventi più efficaci e sviluppare terapie miste farmacologico-chirurgiche in modo da aumentare la percentuale di successi e prevenire le recidive. Un po' come in oncologia si affianca la chemioterapia all'asportazione dei tumori. Rubino è però convinto che già oggi si potrebbe fare meglio, intervenendo negli stadi iniziali della malattia. «Purtroppo la selezione dei candidati è ancorata a criteri stabiliti 20 anni fa per la cura dell'obesità e non del diabete e, quindi, molte assicurazioni sanitarie ne limitano l'utilizzo a pazienti severamente obesi». Per supportare le sue convinzioni Rubino ha iniziato uno studio sull'efficacia della chirurgia metabolica per pazienti diabetici con indice di massa corporea basso, tra 27 e 34, cioè in sovrappeso o affetti da obesità lieve. Le operazioni di bypass gastrico sono pagate da Covidien Plc, azienda che si occupa di strumenti chirurgici, e l'obiettivo è reclutare almeno 50 pazienti e seguirne il decorso per cinque anni. «Sarà un'occasione per identificare sottotipi del diabete che non rispondono alla chirurgia, ma anche per studiare il contributo dei meccanismi gastrointestinali nella genesi della malattia e capire se possono essere utilizzati come bersagli di nuovi farmaci».

Il King's College vanta già Premi 12 Nobel e chissà che non abbiano visto giusto anche stavolta.


Original Use/Indication
Clinical Observations of Unexpected Benefits
Understanding Mechanisms of Action
Treatment Approved for Other Indications


Relative risk of Type 2 diabetes
100
80
60
40
20
0
<22.0
22.0 - 22.9
23.0 - 23.9
24.0 - 24.9
25.0 - 26.9
27.0 - 28.9
29.0 - 30.9
31.0 - 32.9
33.0 - 34.9
≥35.0
Body mass index (kg/m2)

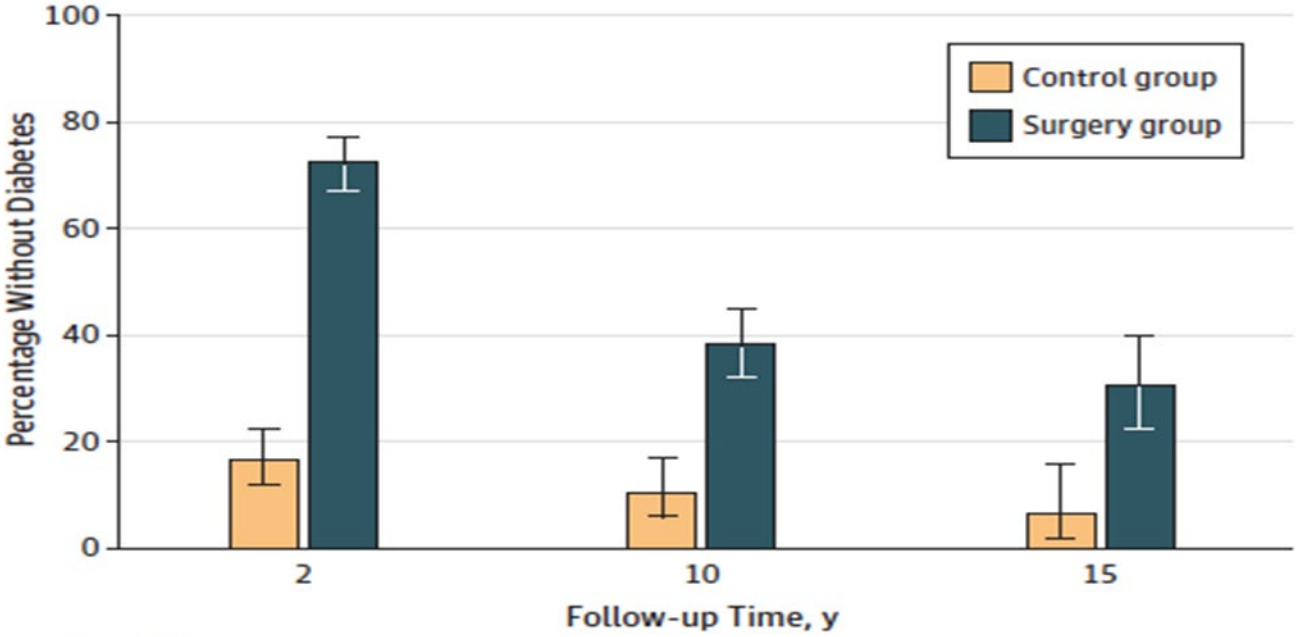
Use of diabetes medication before and after bariatric surgery



Makary, M. A. et al. Arch Surg 2010;145:726-731.

ARCHIVES OF SURGERY

Figure 1. Prevalence of Diabetes Remission in the Bariatric Surgery and Control Groups

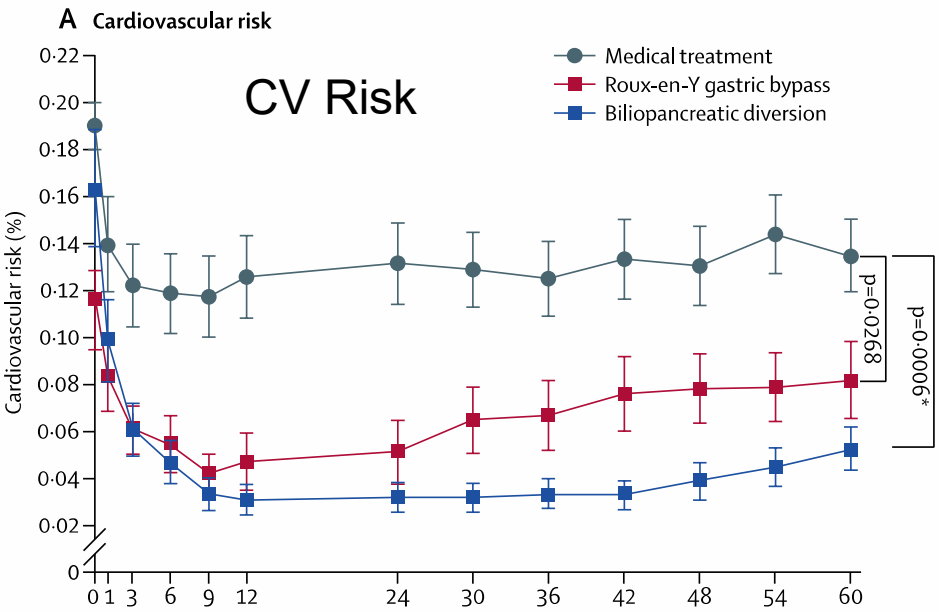


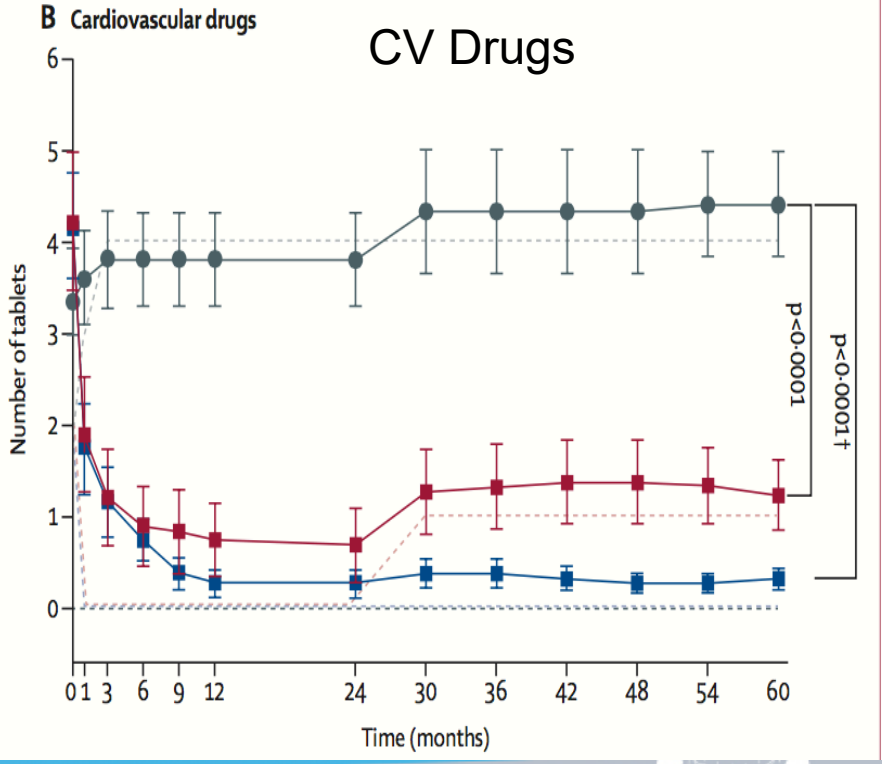
Total participants			
Control	207	135	62
Surgery	303	236	115
Odds ratio (95% CI)	13.3 (8.5-20.7)	5.3 (2.9-9.8)	6.3 (2.1-18.9)

5-Yr Outcomes of Surgical vs Medical Treatment of T2DM:

Open-label, Randomized Clinical Trial

Reduction of CVR and CV Medications After Surgery

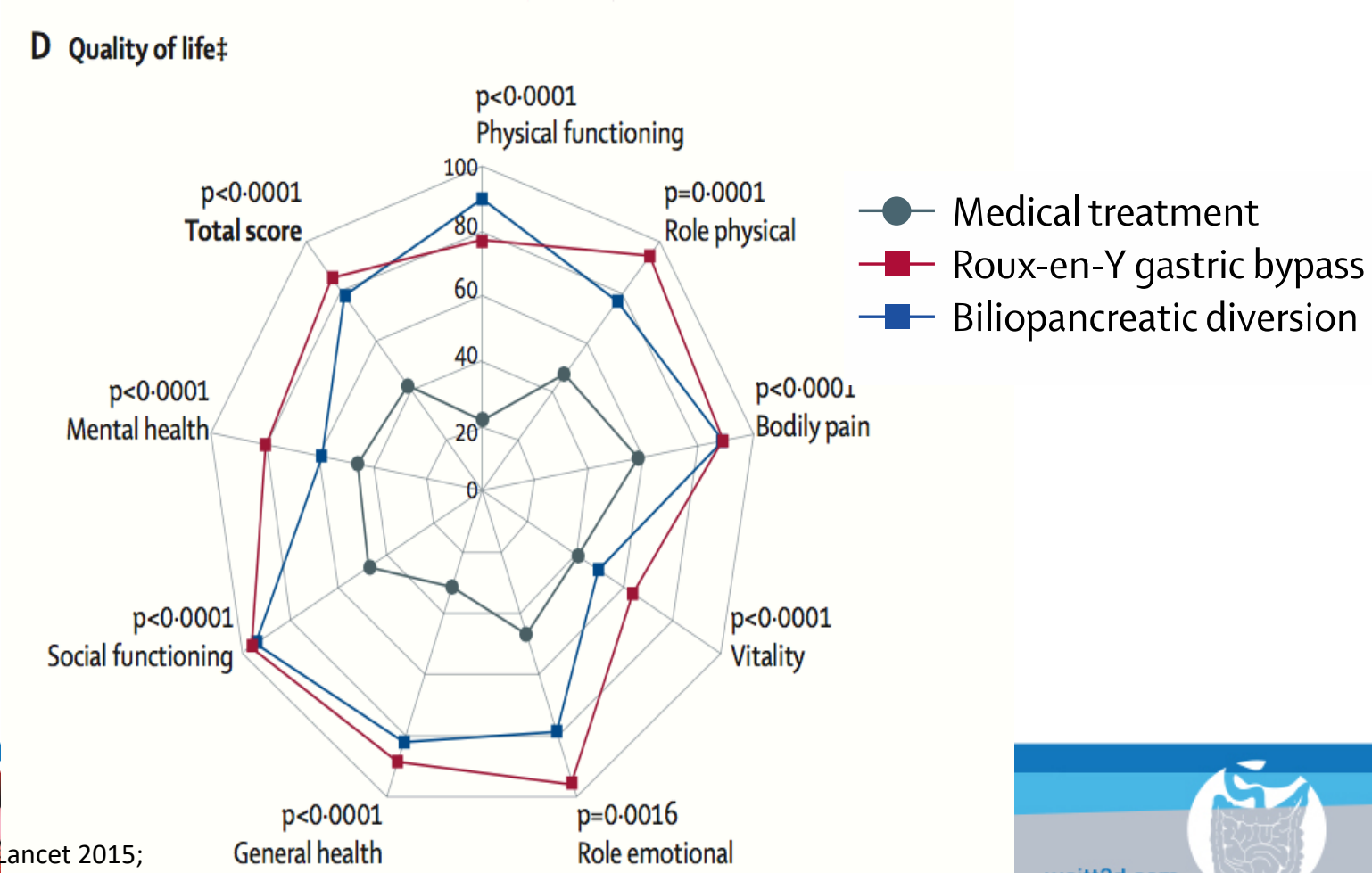




G. Mingrone….F. Rubino. Lancet 2015; 386:964-73

5-Yr Outcomes of Surgical vs Medical Treatment of T2DM: An Open-label, Randomized Clinical Trial

Surgery associated with Improved QoL



G. Mingrone…F. Rubino. Lancet 2015; 386:964-73

GI Mechanisms of Metabolic Regulation

Gut Hormones

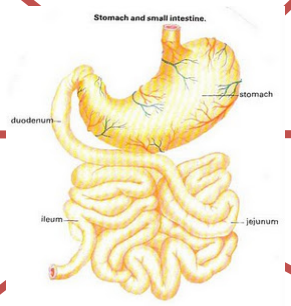
Insulin secretion
Insulin sensitivity
Beta-cell function
Beta-cell proliferation
Appetite/hunger
Energy expenditure

Bile Acids

Insulin sensitivity
Energy expenditure
Gut hormone secretion
Microbiota composition

Nutrient Sensing

Hepatic glucose production
Appetite/satiety



Glucose Transporters

Glucose metabolism

Gut Microbiota

Insulin sensitivity
Inflammation
Energy Expenditure

Intestinal Glucose Metabolism

Whole body glucose disposal
Energy expenditure

Francesco Rubino and Stephanie A. Amiel

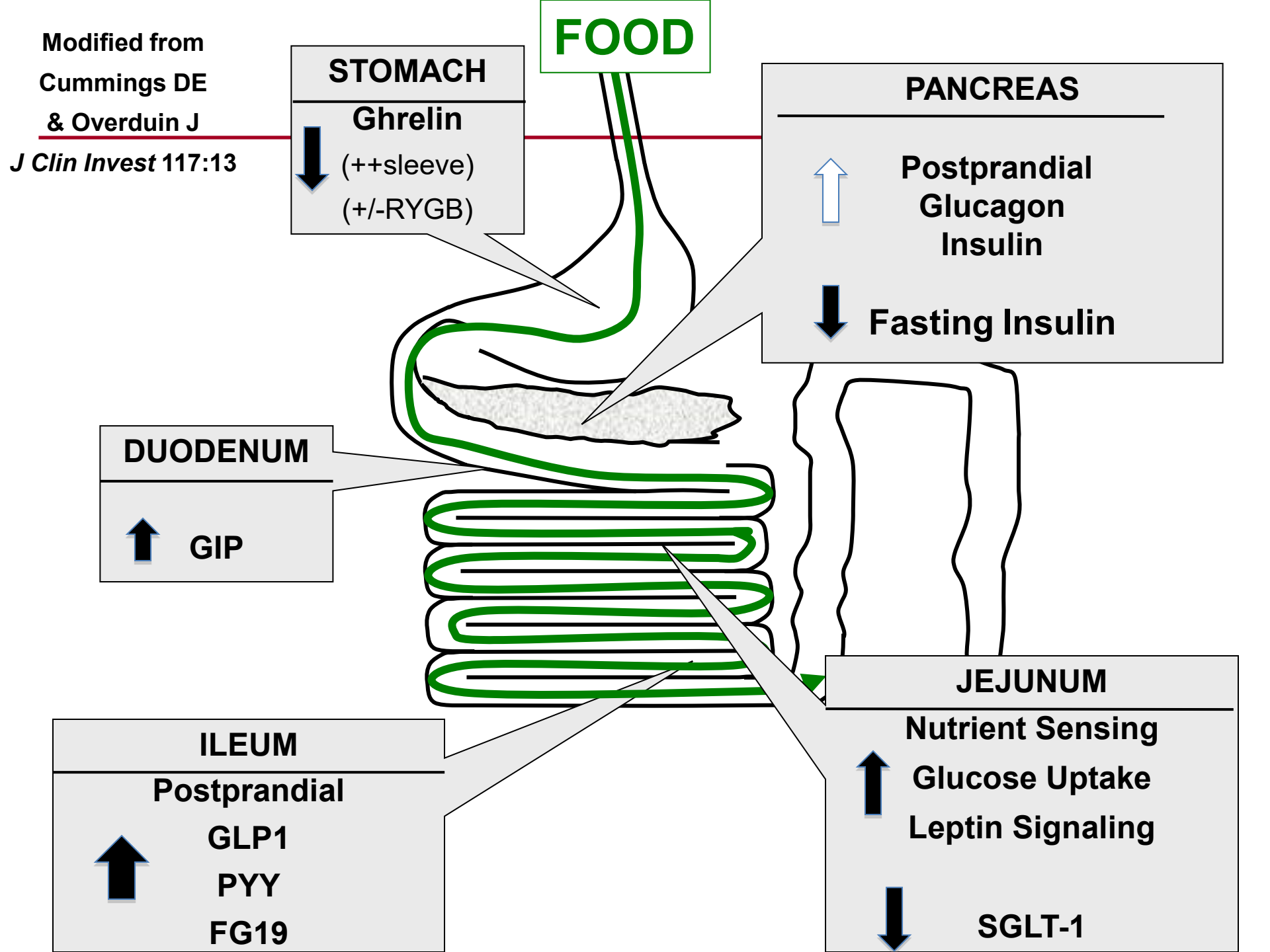
Is the Gut the "Sweet Spot" for the Treatment of Diabetes?

Diabetes 2014;63:1–4 | DOI: 10.2337/db14-0402

Oskar Minkowski possessed a rare combination of talents: He was an internist with the intuition of a scientist and the dexterity of a surgeon. One day in 1889, he and his

In particular, Roux-en-Y gastric bypass (RYGB) restores first-phase insulin response (10) and results in hypersecretion of C-peptide and insulin following nutrient in-

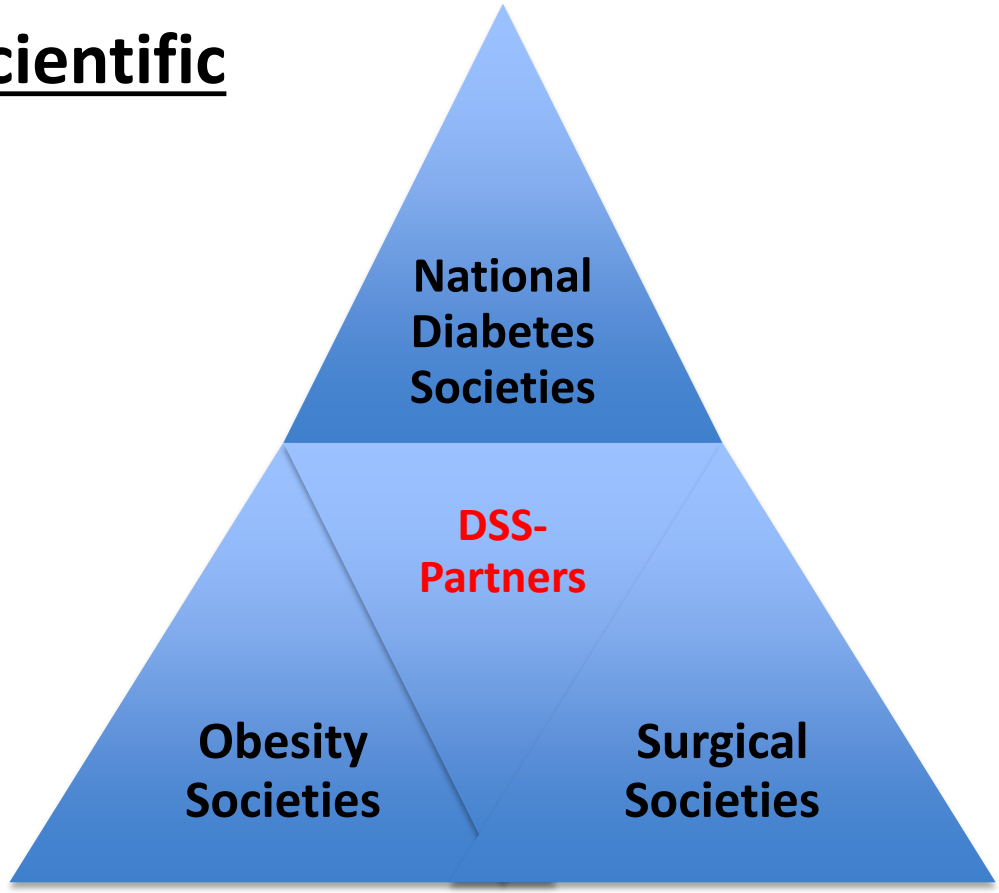
Diabetes, July 2014


Modified from
Cummings DE
& Overduin J
J Clin Invest 117:13
FOOD
STOMACH
Ghrelin
(++sleeve)
(+/-RYGB)
PANCREAS
Postprandial
Glucagon
Insulin
Fasting Insulin
DUODENUM
GIP
JEJUNUM
Nutrient Sensing
Glucose Uptake
Leptin Signaling
SGLT-1
ILEUM
Postprandial
GLP1
PYY
FG19

A new landscape of Diabetes Care

Broad Endorsement of DSS-II Guidelines

45 worldwide scientific societies!



American Diabetes Association.

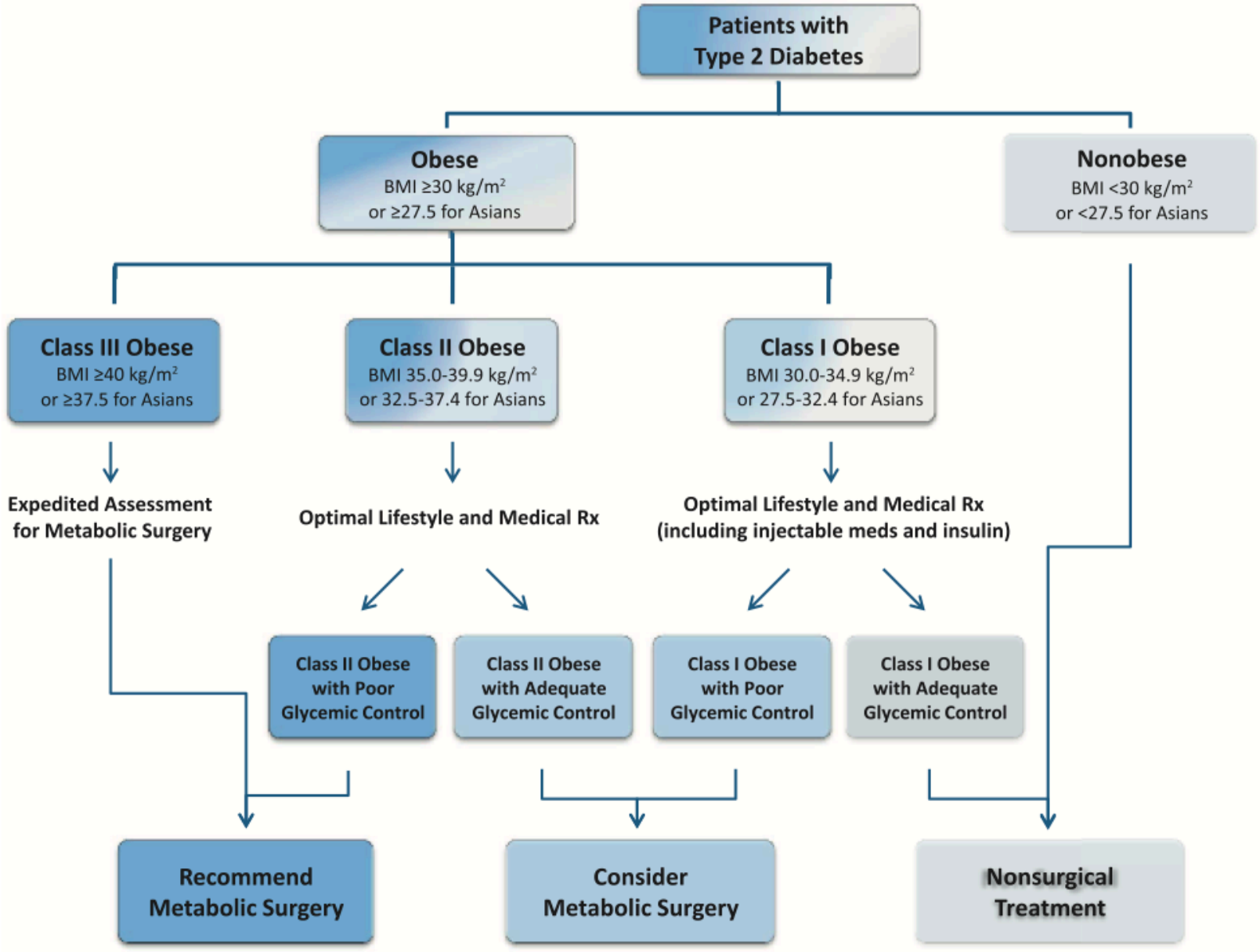
EASD
European Association for the Study of Diabetes

AVAILABLE ACCESSIBLE AND AFFORDABLE
Diabetes India
Flame of Hope

CDS
CHINESE DIABETES SOCIETY
中华医学会糖尿病学分会

International Diabetes Federation

DIABETES UK
CARE. CONNECT. CAMPAIGN.


Patients with Type 2 Diabetes
Obese
BMI ≥30 kg/m²
or ≥27.5 for Asians
Nonobese
BMI <30 kg/m²
or <27.5 for Asians
Class III Obese
BMI ≥40 kg/m²
or ≥37.5 for Asians
Class II Obese
BMI 35.0-39.9 kg/m²
or 32.5-37.4 for Asians
Class I Obese
BMI 30.0-34.9 kg/m²
or 27.5-32.4 for Asians
Expedited Assessment for Metabolic Surgery
Optimal Lifestyle and Medical Rx
Optimal Lifestyle and Medical Rx (including injectable meds and insulin)
Class II Obese with Poor Glycemic Control
Class II Obese with Adequate Glycemic Control
Class I Obese with Poor Glycemic Control
Class I Obese with Adequate Glycemic Control
Recommend Metabolic Surgery
Consider Metabolic Surgery
Nonsurgical Treatment

DSS-II

Conclusions:

Although additional studies are needed to further demonstrate long-term benefits, there is sufficient clinical and mechanistic evidence to support inclusion of metabolic surgery among anti-diabetes interventions for people with T2DM and even just mild obesity.

Healthcare regulators should introduce appropriate reimbursement policies.

nature

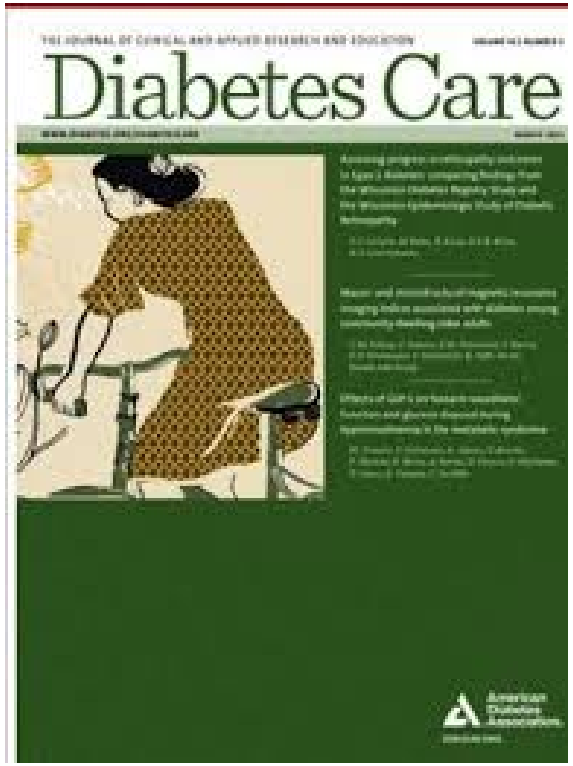
UIG/GETTY

Surgery can be an effective treatment for type 2 diabetes.

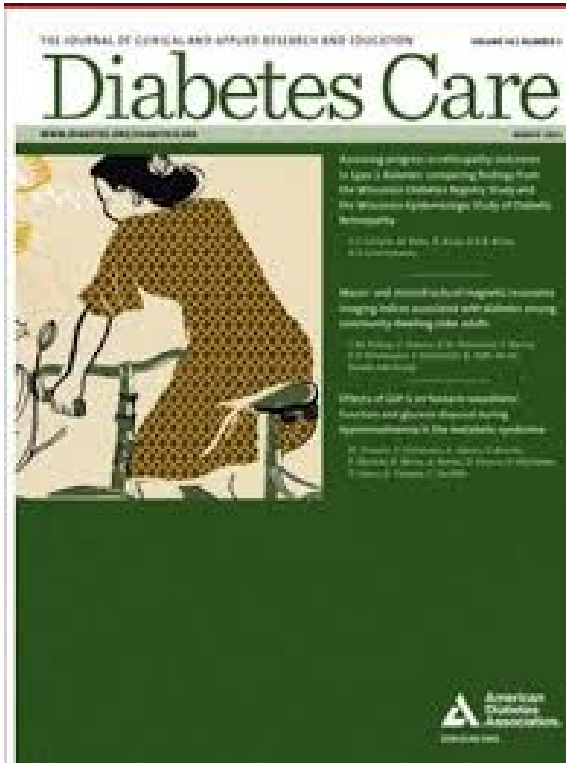
Time to think differently about diabetes

New guidelines for the surgical treatment of type 2 diabetes bolster hopes of finding a cure, writes **Francesco Rubino**, but long-standing preconceptions must be put aside.

June 2016: DSS-Guidelines



Special Issue on Metabolic Surgery



American Diabetes Association. Diabetes Care

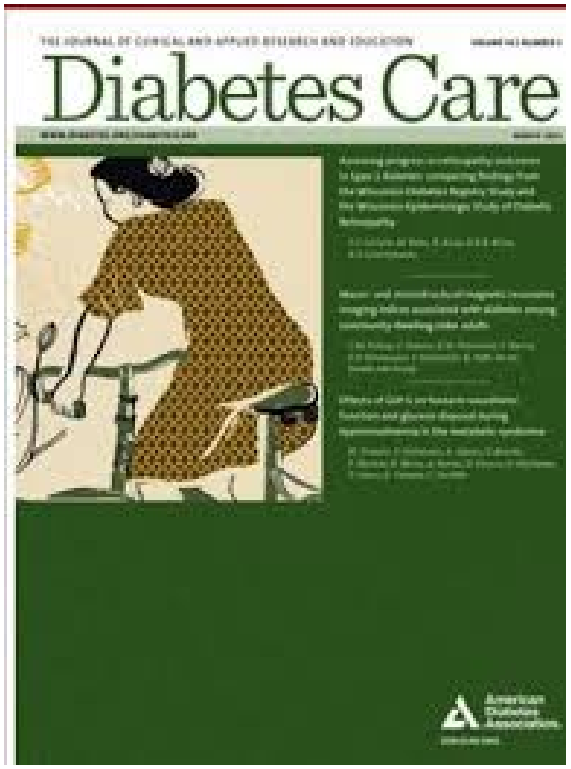
Metabolic Surgery for Type 2 Diabetes: Changing the Landscape of Diabetes Care

William T. Cefalu[1]↟, Francesco Rubino[2] **and** David E. Cummings[3]

Author Affiliations

Corresponding author: William T. Cefalu, cefaluwt@pbrc.edu.

Diabetes Care 2016 Jun; 39(6): 857-860.
https://doi.org/10.2337/dc16-0686



American Diabetes Association. Diabetes Care

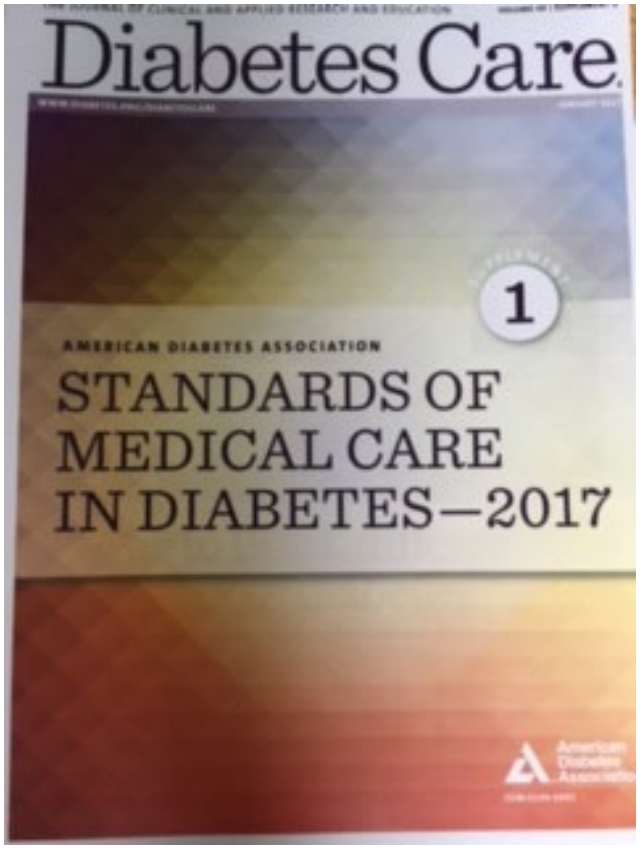
Check for updates

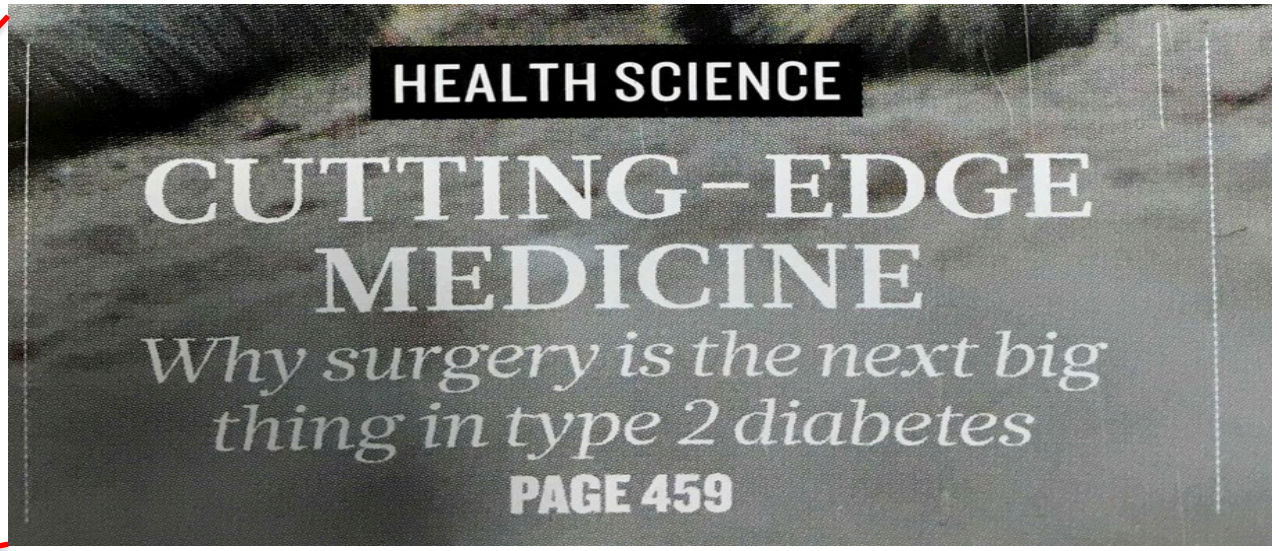
Metabolic Surgery in the Treatment Algorithm for Type 2 Diabetes: A Joint Statement by International Diabetes Organizations

Francesco Rubino[1]⇑, David M. Nathan[2], Robert H. Eckel[3], Philip R. Schauer[4], K. George M.M. Alberti[5], Paul Z. Zimmet[6], Stefano Del Prato[7], Linong Ji[8], Shaukat M. Sadikot[9], William H. Herman[10], Stephanie A. Amiel[1], Lee M. Kaplan[2], Gaspar Taroncher-Oldenburg[11] **and** David E. Cummings[12]⇑ **on behalf of the Delegates of the 2nd Diabetes Surgery Summit***

January 2017:

The American Diabetes Association (ADA) introduces surgery in the ***Standards of Medical Care*** for Diabetes





NewScientist

"One of the most significant changes in treating diabetes since the discovery of insulin in 1921"

American Diabetes Association. Diabetes Care

"Metabolic Surgery for Type 2 Diabetes: The Changing Landscape of Diabetes Care"

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Bariatric Surgery vs. Conventional Medical Therapy for Type 2 Diabetes

Geltrude Mingrone, M.D., Simona Panunzi, Ph.D., Andrea De Gaetano, M.D., Ph.D., Caterina Guidone, M.D., Amerigo Iaconelli, M.D., Laura Leccesi, M.D., Giuseppe Nanni, M.D., Alfons Pomp, M.D., Marco Castagneto, M.D., Giovanni Ghirlanda, M.D., and Francesco Rubino, M.D.

Bariatric–metabolic surgery versus conventional medical treatment in obese patients with type 2 diabetes: 5 year follow-up of an open-label, single-centre, randomised controlled trial

Geltrude Mingrone, Simona Panunzi, Andrea De Gaetano, Caterina Guidone, Amerigo Iaconelli, Giuseppe Nanni, Marco Castagneto, Stefan Bornstein, Francesco Rubino

Lancet 2015; 386: 964–73

THE TIMES

Scalpel, Please

Gastric surgery can achieve extraordinary results for diabetes sufferers

alth secretary would lightly spend £600 million on 100,000 operations if he did not think were essential. That is why the diabetes rch community has assembled every possible nent in favour of gastric surgery as a nent for the condition. The arguments are elling and Jeremy Hunt and NHS regulators d pay attention to them.

tric surgery is traditionally seen as a last for the morbidly obese. The latest science tes that it may in fact be the closest thing ave to a cure for diabetes, which afflicts illion people in Britain and consumes 12 per f global healthcare spending.

betes is the pandemic of the modern age. is a direct correlation between rising GDP he incidence of obesity-linked type 2 diabehere are also serious barriers to the adoption rasive surgery as a way of containing it, ling the high cost per patient and the widely iew that the first line of defence should be a to healthier lifestyles by people seen to have ht the illness on themselves. Economics as s science suggest otherwise. Gastric bands and bypasses on a mass scale may be the best investment on offer to a cash-strapped NHS.

Research released yesterday based on 11 clinical trials finds that surgery can attack the causes of diabetes, not just its symptoms — and can do so more effectively than drugs, diet or exercise. In one study by Newcastle University the blood-sugar levels of 18 patients returned to normal after gastric bypass surgery. In another published last year half the subjects were, effectively, free of diabetes five years after a similar procedure. Meanwhile, fewer than half of sufferers who rely on conventional treatments significantly lower their risk of complications, which include stroke, kidney failure, blindness and heart disease.

How surgery can achieve such dramatic results is not yet clear. Some experiments suggest that it boosts natural insulin production by altering the secretion of hormones in the gut. Others point to fat loss in the pancreas itself, allowing formerly obese patients to resume virtually normal blood-sugar management. However, the potential for surgery to reverse the effects of diabetes rather than merely treat them is clear. The conclusion that surgery should be considered a mainstream response is unavoidable.

In Britain the first step towards this would be for the National Institute for Health and Care Excellence (Nice) to approve surgery not just for extreme obesity but specifically for advanced type 2 diabetes. About a million patients would be eligible. Of these 100,000 would be highly likely to benefit. At present, their treatment costs the NHS about £3,000 per patient a year. At an average cost per operation of £6,000 the health service could expect to earn that back in subsequent savings within two years.

Some worry that the easy availability of surgery would signal to diabetes sufferers that better diets and less sedentary lifestyles were no longer paramount. This advice has not stopped the global incidence of diabetes quadrupling since 1980. Moreover, surveys show that the rapid results achieved through surgery often encourage patients where willpower alone has let them down. In straitened times, with an ageing population and spiralling diabetes-related costs, Nice and the NHS need to think outside the box and embrace the band.

“The conclusion that Surgery should be considered a mainstream response is unavoidable”

OBESITA’

Approccio multidisciplinare (OBESITY UNIT)

- Endocrinologo/ Internista
- Nutrizionista
- Psichiatra/Psicologo
- Endoscopista
- Anestesista
- Chirurgo
- Radiologo

Endocrinologa: ***R. Talarico***

Medico Nutrizionista : ***A. Curti,***

Psicoterapeuta: ***G. Marchese***

Gastroenterologo: ***M. Verta***

Anestesisti: ***A. Silvagni, L. Brunelli***

Radiologi: ***M. Florio, A. Zanolini***

Chirurghi***: N. Urso, C. Chiodo, D. Chiappetta***

Bariatric and Methabolic Team Annunziata Hospital - Cosenza

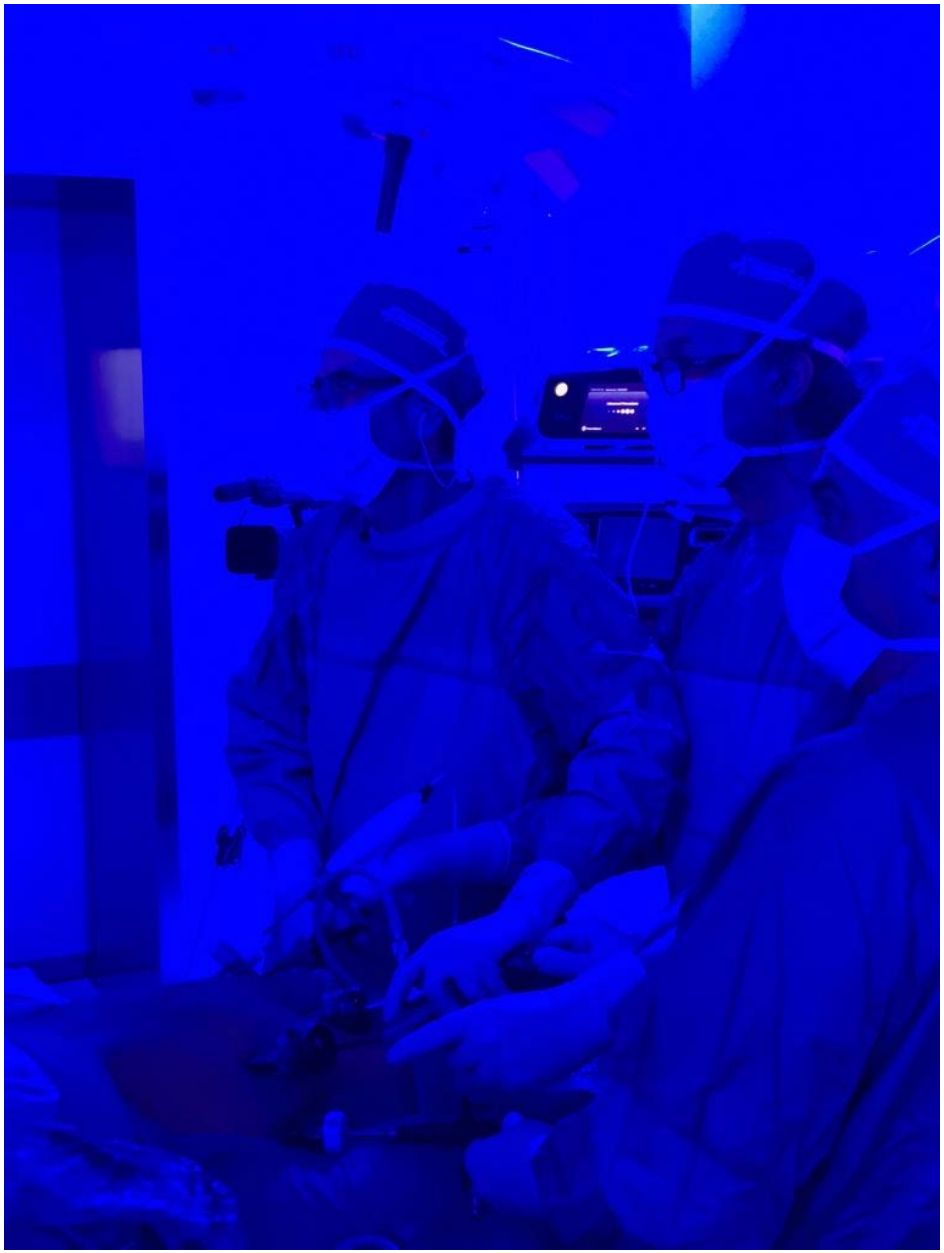
….e i pazienti ?


18


85%
13:44


PORTATA 225 KG.
CAPIENZA 3 PERSONE
ATTENZIONE
DAL 27 DICEMBRE
AL 6 GENNAIO
CAPIENZA 2 PERSONE
E.N.P.I.
ENTE NAZIONALE PER LA PREVENZIONE DEGLI INFORTUNI
SEDE IN ROMA
ASCENSORE
CAT. A
IMPIANTO N°
MATR.
PORTATA: PERSONE N°
KG.
E' VIETATO

Grazie !!!



Grazie !!!


MEZZO METRO
Kinder
Cioccolato


3
4s
OTIS Genesis
480 kg
6 PERS
CE 0051
54KJ0351
2016


Schindler
4
Schindler
1275 kg
17 Pers.
10447002 / 2009

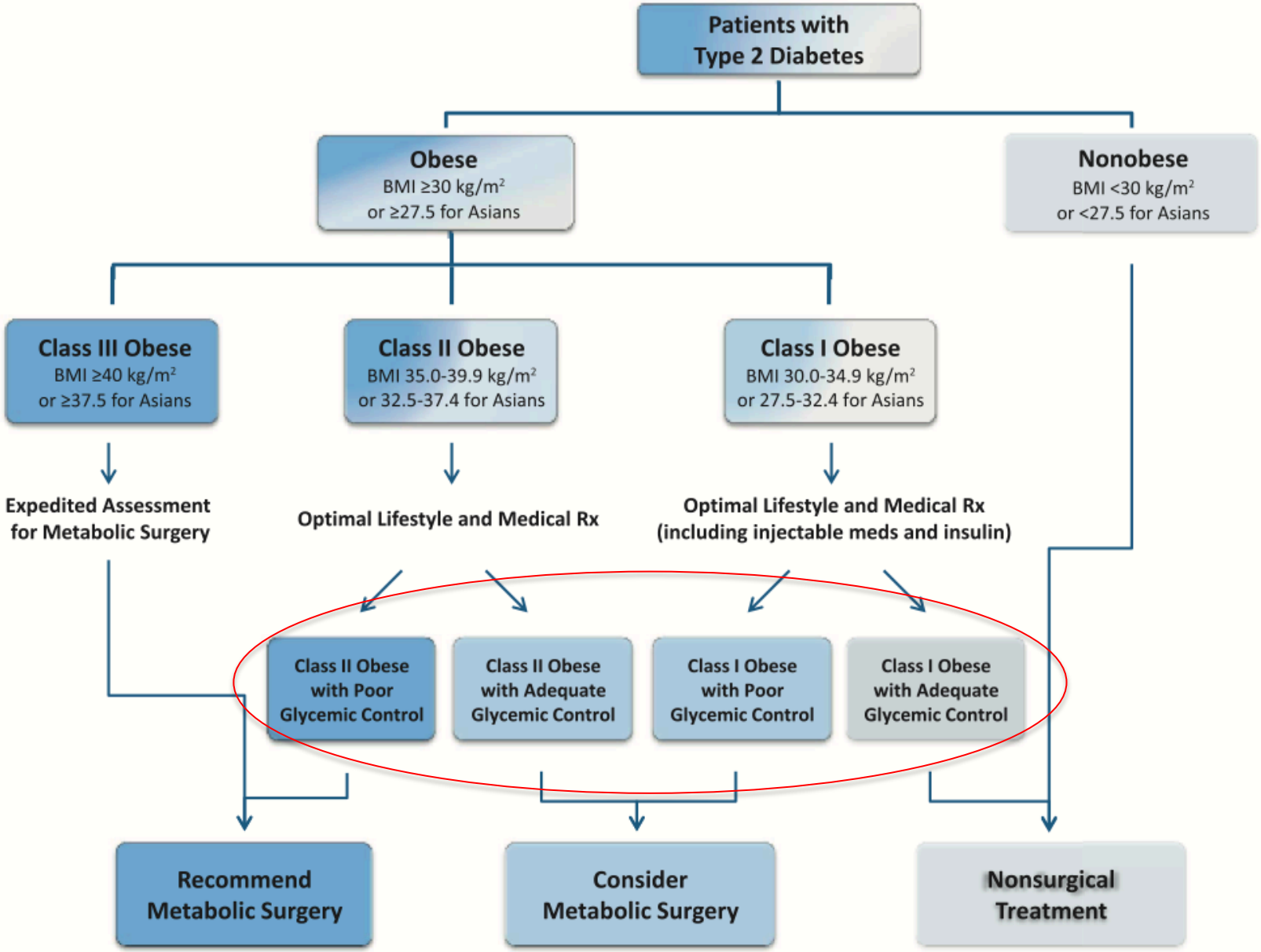
BARIATRIC SURGERY: THE SOLUTION FOR TYPE 2 DIABETES?

Prof. Francesco Rubino, M.D.

Chair, Bariatric and Metabolic Surgery

King's College London

King's College Hospital


Patients with Type 2 Diabetes
Obese
BMI ≥30 kg/m²
or ≥27.5 for Asians
Nonobese
BMI <30 kg/m²
or <27.5 for Asians
Class III Obese
BMI ≥40 kg/m²
or ≥37.5 for Asians
Class II Obese
BMI 35.0-39.9 kg/m²
or 32.5-37.4 for Asians
Class I Obese
BMI 30.0-34.9 kg/m²
or 27.5-32.4 for Asians
Expedited Assessment for Metabolic Surgery
Optimal Lifestyle and Medical Rx
Optimal Lifestyle and Medical Rx (including injectable meds and insulin)
Class II Obese with Poor Glycemic Control
Class II Obese with Adequate Glycemic Control
Class I Obese with Poor Glycemic Control
Class I Obese with Adequate Glycemic Control
Recommend Metabolic Surgery
Consider Metabolic Surgery
Nonsurgical Treatment

American Diabetes Association. Diabetes Care

Diabetes Care: "Taking It to the Limit One More Time"

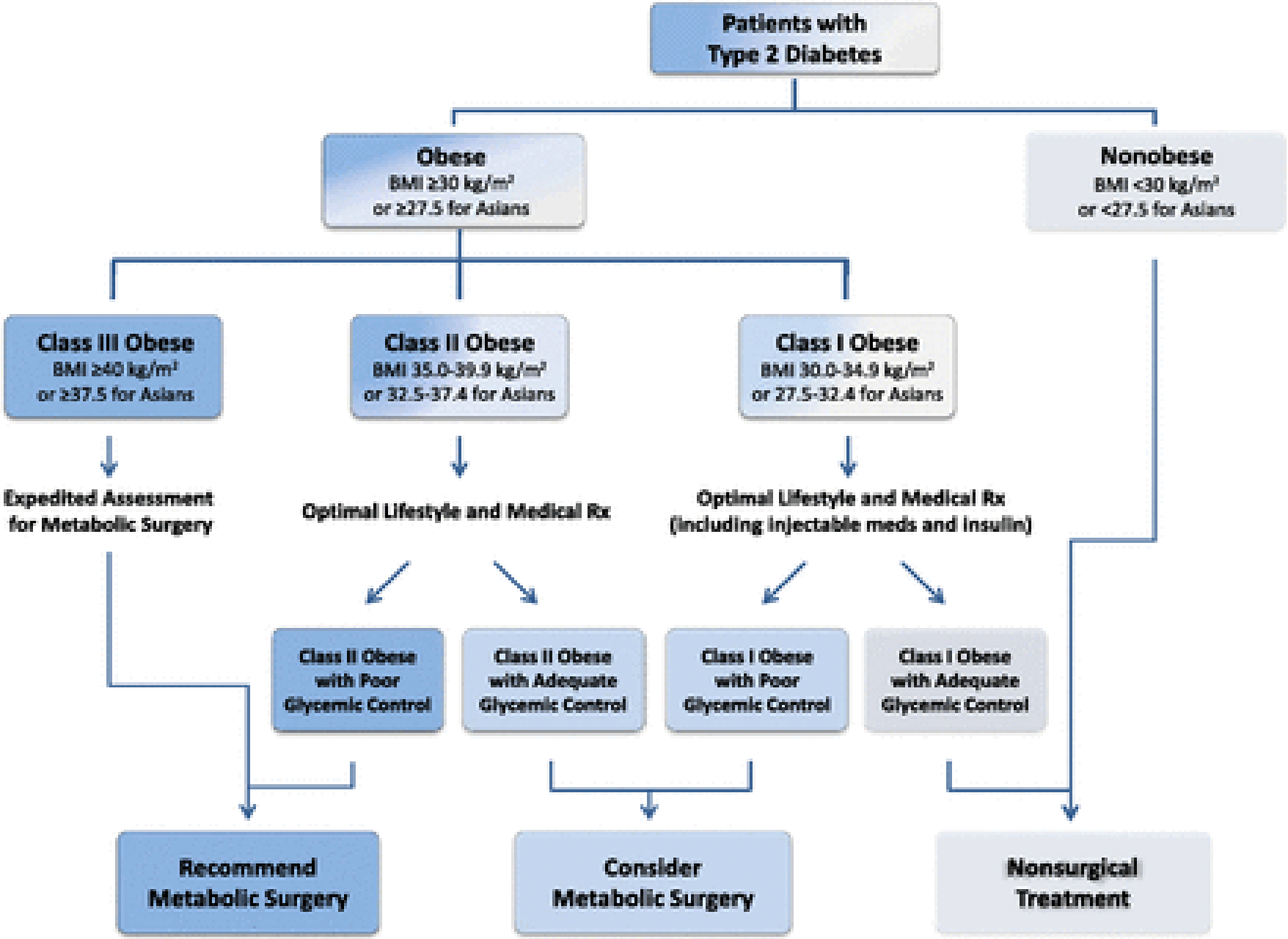
William T. Cefalu[1], Andrew J.M. Boulton[2], William V. Tamborlane[3], Robert G. Moses[4], Derek LeRoith[5], Eddie L. Greene[6], Frank B. Hu[7], George Bakris[8], Judith Wylie-Rosett[9], Julio Rosenstock[10], Steven E. Kahn[11], Katie Weinger[12], Lawrence Blonde[13], Mary de Groot[14], Stephen Rich[15], David D'Alessio[16], Lyn Reynolds[17] **and** Matthew C. Riddle[18]

Author Affiliations

Corresponding author: William T. Cefalu, cefaluwt@pbrc.edu.

Diabetes Care 2017 Jan; 40(1): 3-6.
https://doi.org/10.2337/dc16-2326

diabetes (3). Another "first" was presented in the June issue, which featured 12 articles supporting bariatric/metabolic surgery as a new treatment option in the management of type 2 diabetes (4). The centerpiece of this collection was a contribution from Rubino et al. (5), writing on behalf of 48 voting delegates from the 2nd Diabetes Surgery Summit (DSS-II). This international consensus conference, organized in collaboration with major diabetes organizations, proposed new evidence-based guidelines for surgical treatment of type 2 diabetes, the first in over 20 years of experience. The report summarized a large body of evidence demonstrating that several gastrointestinal operations, originally designed to promote weight loss, improved glucose homeostasis more effectively than any current pharmaceutical or behavioral approach and led to sustained improvement of glycemic control in many patients with type 2 diabetes (5). *Diabetes Care* was honored to be the journal chosen to disseminate these important and new treatment guidelines, which promise to help medical providers and patients alike in assessing treatment options!


Patients with Type 2 Diabetes
Obese
BMI ≥30 kg/m²
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BMI <30 kg/m²
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Optimal Lifestyle and Medical Rx (including injectable meds and insulin)
Class II Obese with Poor Glycemic Control
Class II Obese with Adequate Glycemic Control
Class I Obese with Poor Glycemic Control
Class I Obese with Adequate Glycemic Control
Recommend Metabolic Surgery
Consider Metabolic Surgery
Nonsurgical Treatment

Original Use/Indication

Clinical Observations Additional/Unexpected Benefits

New Understanding Mechanisms of Action

Treatment Approved for Other Indications

The case of Laron-type dwarfism

- *Laron syndrome is characterized by a mutation at the GH receptor; Subjects with LS lack IGF-1*
- ***Characteristic visceral obesity***
- *99 Villagers with Laron-type dwarfism studies for 24 years*
  - ***Diabetes and cancer free***
  - ***Normal relatives had same prevalence of diabetes and cancer compared to village population***

OBESITA' e CHIRURGIA

- mortalità *0.17 complessiva*

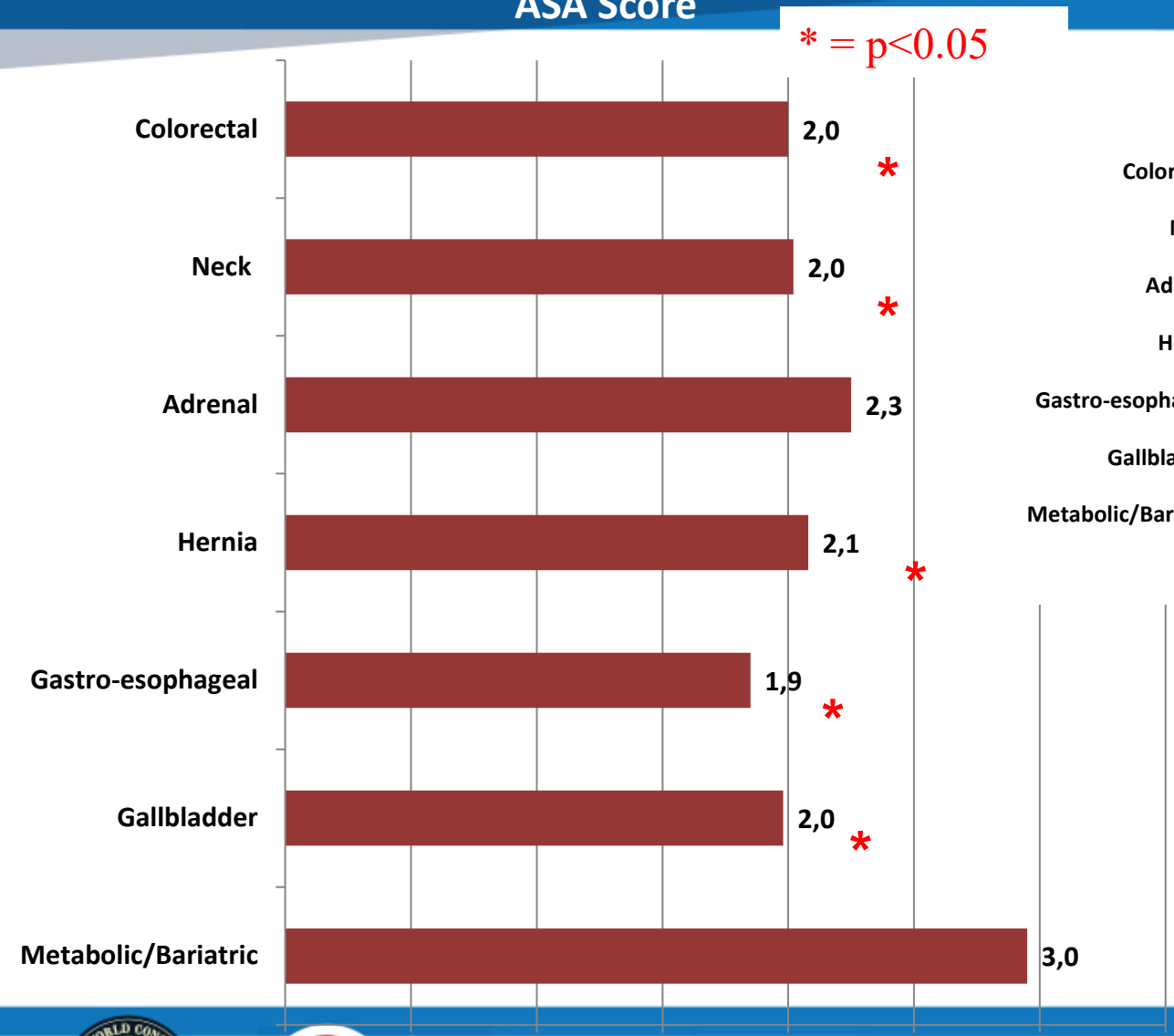
  0.10% Bendaggi
  0.15 Sleeve
  0.54 Bypass
  0.80 Diversione

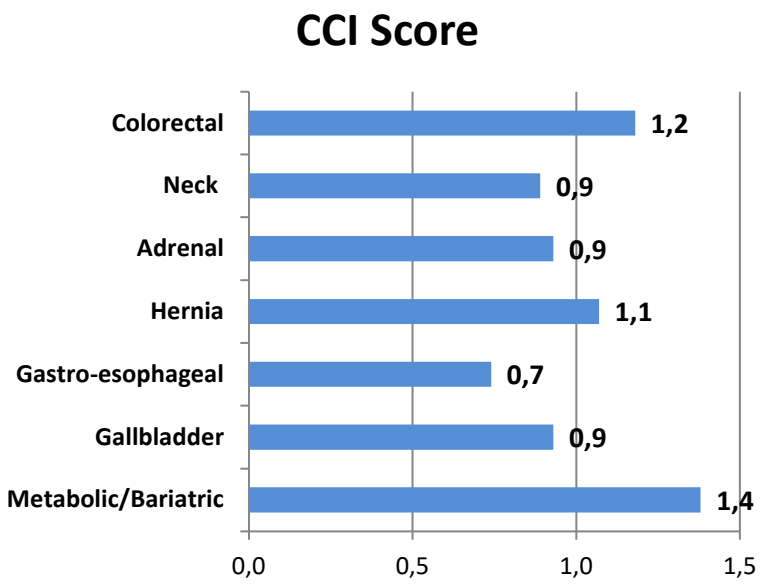
- EWL *45% Bendaggi*
  54 Sleeve
  58 Bypass
  66 Diversione

- complicanze *1.9% Bendaggi*
  8.3 Sleeve
  12.4 Diversione
  14.2 Bypass

- diabete *Sleeve 26.5-75%*
  Bypass 42-93%

Baseline Surgical Risk





Biological Effects of RYGB are the Opposite of those from Restriction of Food Intake by Dieting

	Diet	RYGB
Energy expenditure	↓	↑
Appetite	↑	↓
Hunger	↑	↓
Satiety	↓	↑
Reward-based eating	↑	↓
Stress response	↑	↓
Gut peptides		
Ghrelin	↑	↓
GLP-1, PYY, CCK, amylin	↓	↑

Courtesy of Dr LM Kaplan

OBESITA' e CHIRURGIA

Skill Factor (> 80 procedure/anno)

- *Degenza* *3.8* *vs* *5.1 %*
- *Complicanze* *10.2* *vs* *14.5 %*
- *Mortalità* *0.3* *vs* *1.2 %*

Misperception

National Health Care Budgets

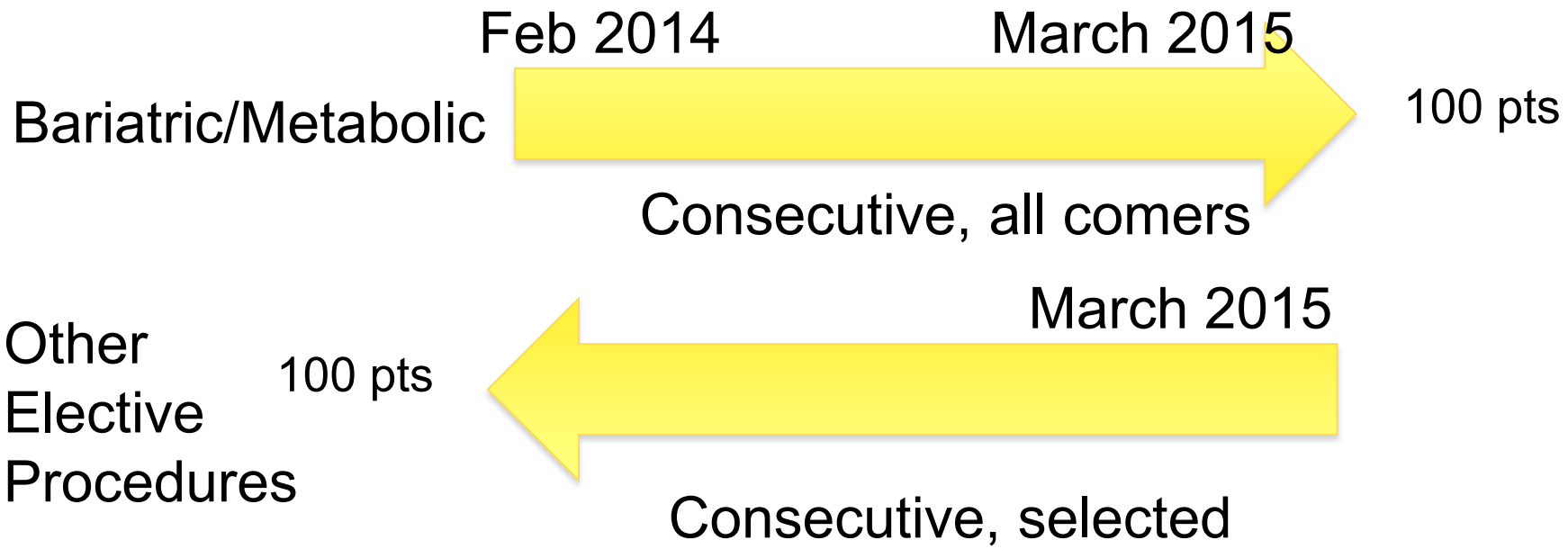
Diabetes

Obesity

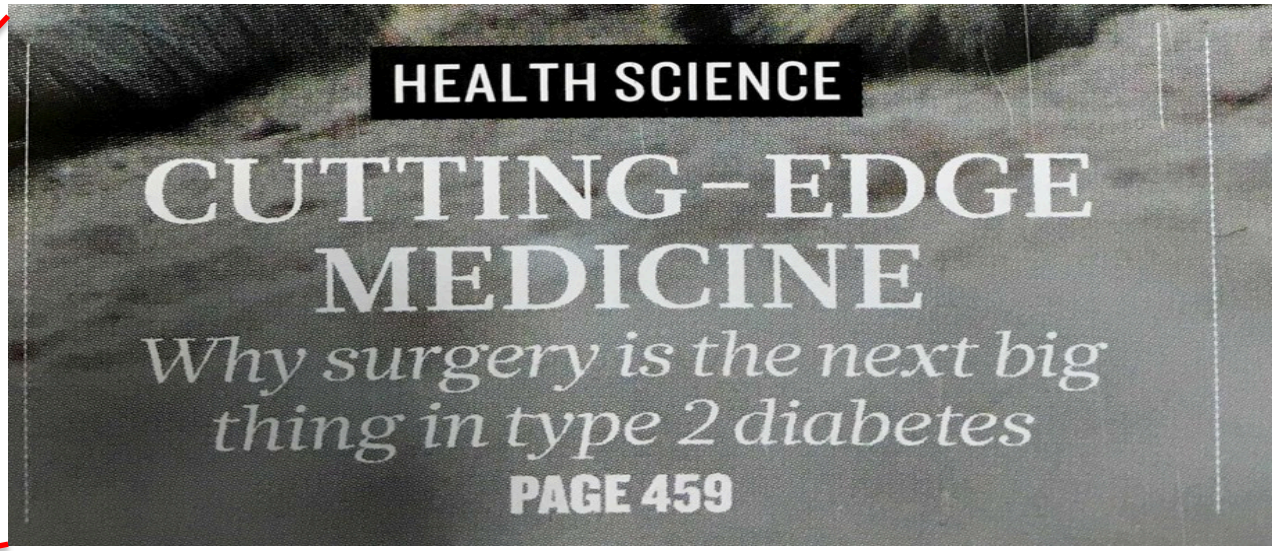
Bariatric Surgery

Surgery

Methods



Seniority of surgeons: Consultant level, specialized



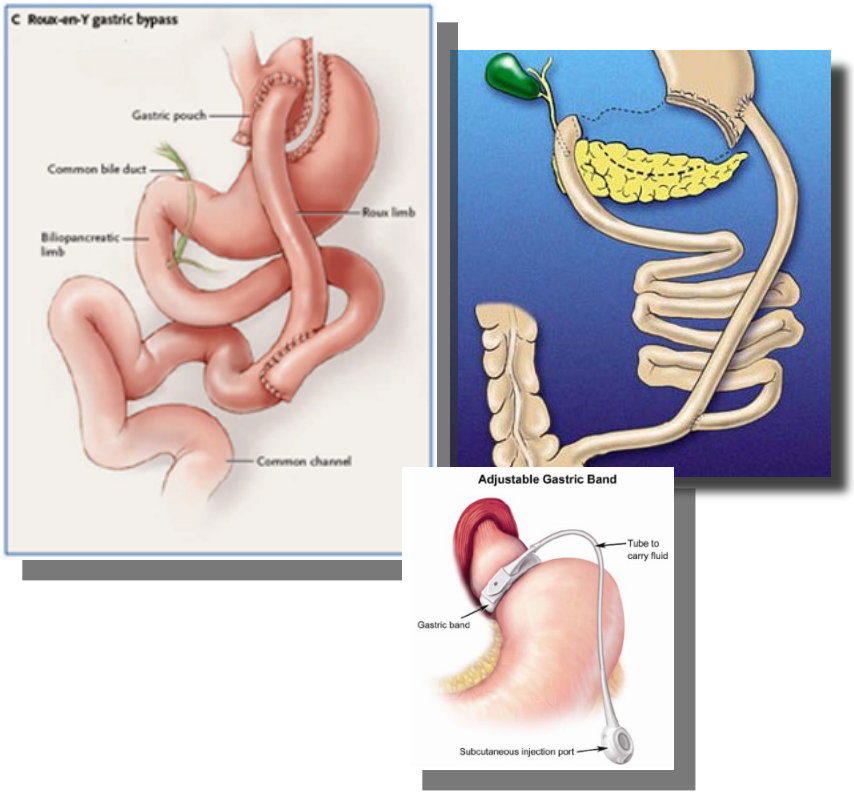
NewScientist

"One of the most significant changes in treating diabetes since the discovery of insulin in 1921"

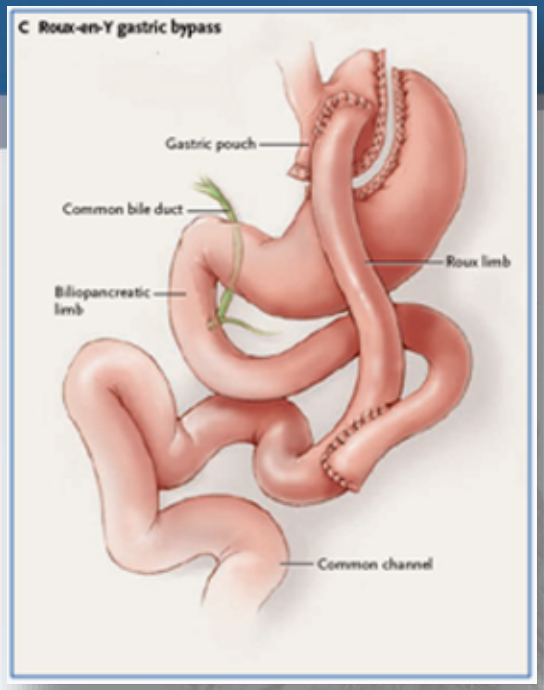
American Diabetes Association. Diabetes Care

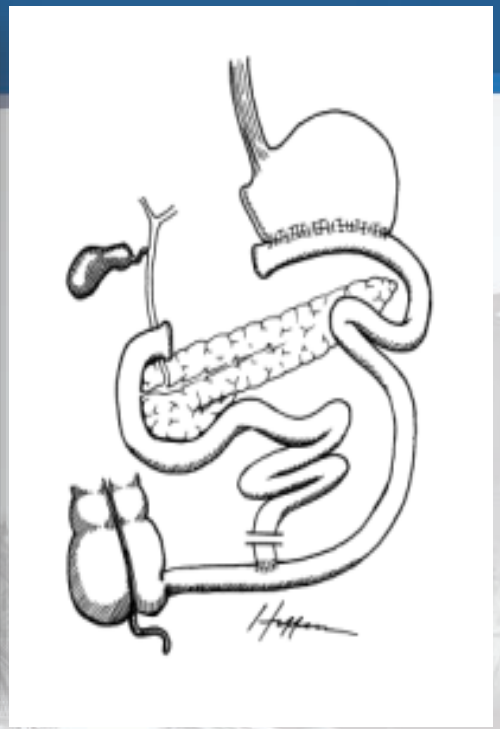
"Metabolic Surgery for Type 2 Diabetes: The Changing Landscape of Diabetes Care"

Reports of Diabetes Remission after Bariatric Surgery Procedures



- Jejuno-ileal bypass
  - Ahmad et al; Diabetes Care 1978
  - Ackerman NB. Surg Gynecol Obstet. 1981
- Verical banded gastroplasty
  - Neve HJ et al; Obesity Surg 1993
- Biliopancreatic diversion
  - Scopinaro et al; WJS 1998
- Gastric Bypass
  - Printen et al; Am Surg 1979
  - Pories et al; Ann Surg. 1987
  - Pories et al; Ann Surg 1992



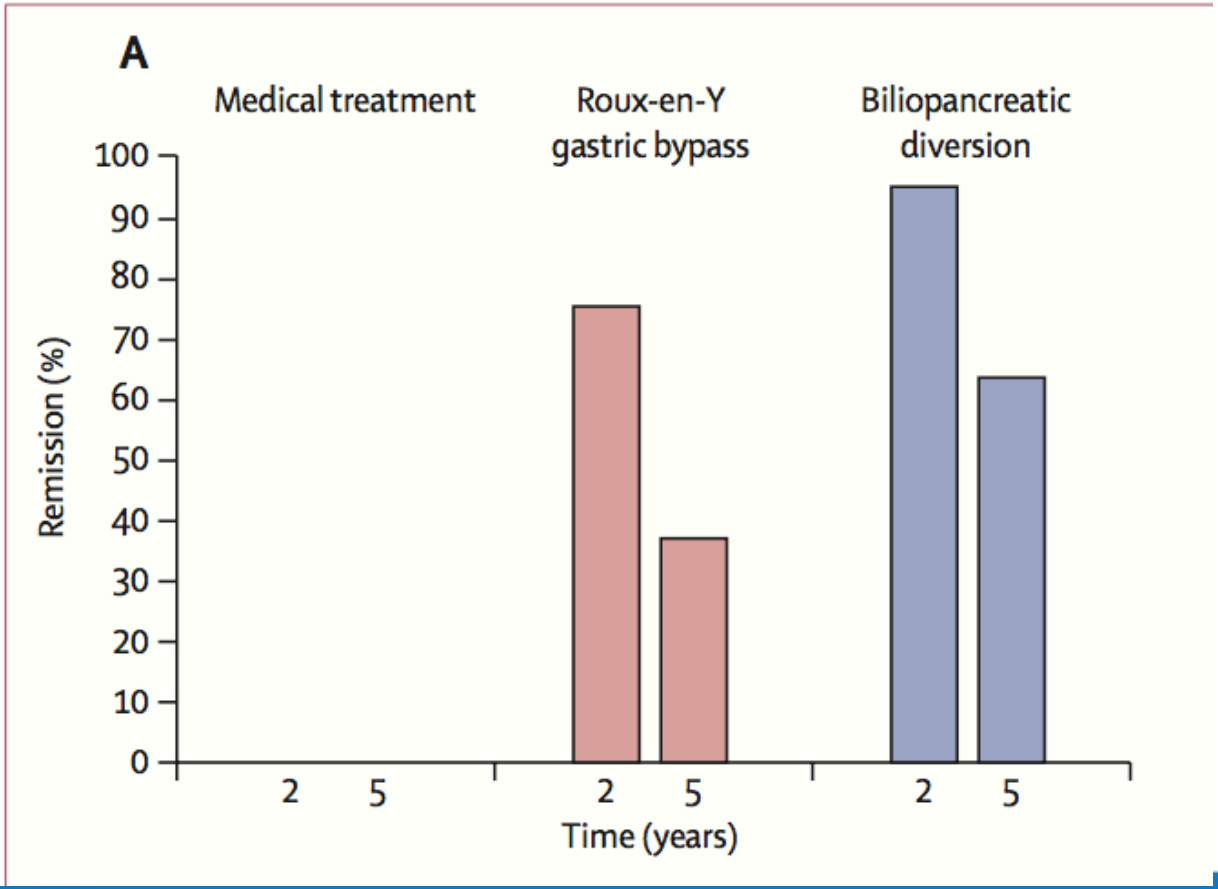


RY-Gastric Bypass

Biliopancreatic Diversion
BPD-

GI Surgery vs Medical Therapy

5-Yr Outcomes of Surgical vs Medical Treatment of T2DM: An Open-label, Randomized Clinical Trial



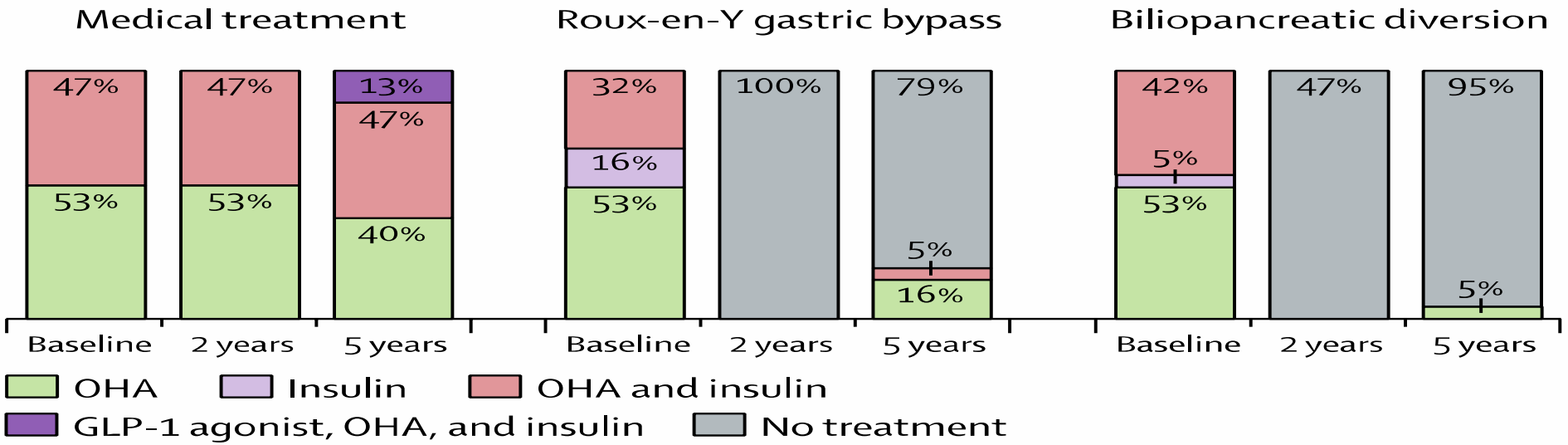
Durable Remission of Hyperglycemia

G. Mingrone….F. Rubino. Lancet 2015; 386:964-73

5-Yr Outcomes of Surgical vs Medical Treatment of T2DM: An Open-label, Randomized Clinical Trial

HbA_{1c} (%)	MT	RYGB	BPD	P value
Baseline	8·5 (1·3)	8·7 (1·4)	8·9 (1·8)	0·66
5 years	6·9 (0·6)	6·7 (0·5)	6·4 (0·4)	0·0280

Diabetes medications



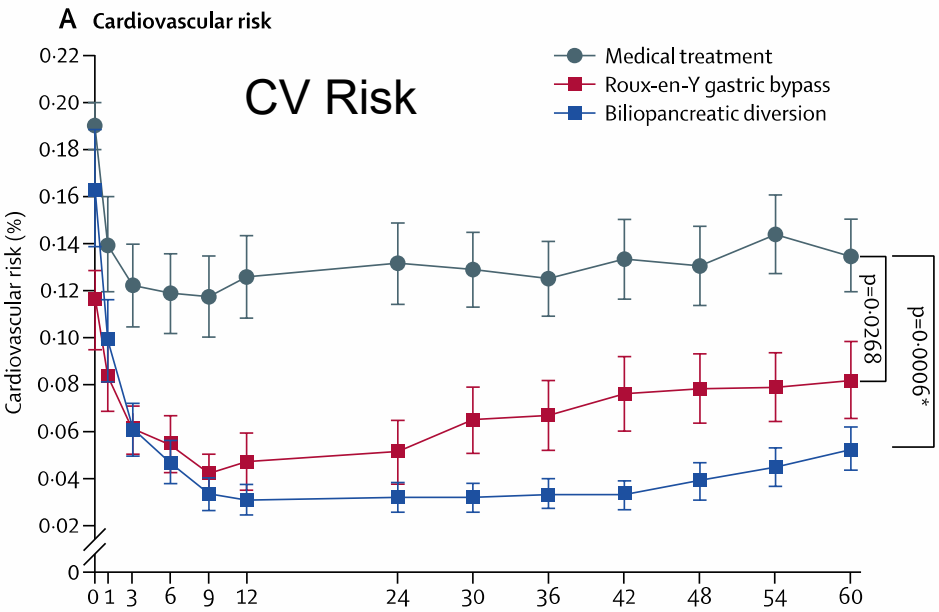
Number of OHA tablets

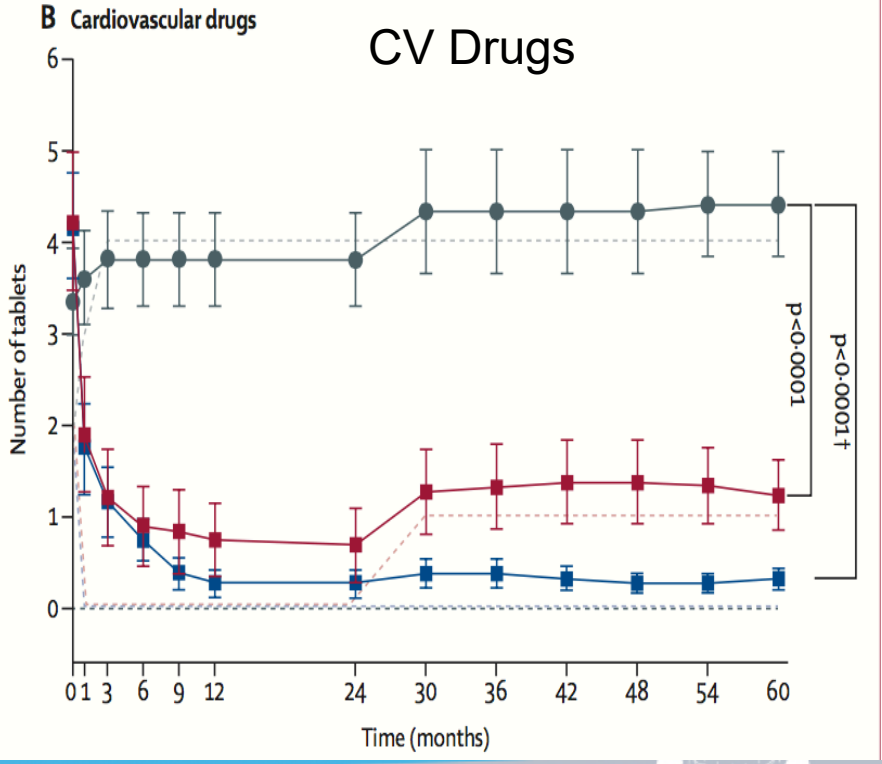
	Medical treatment	Roux-en-Y gastric bypass	Biliopancreatic diversion
Baseline	3 (0)	2·53 (1·12)	2·84 (0·69)
2 years	3 (0)	0 (0)	0 (0)
5 years	3 (0)	0·32 (0·67)	0·11 (0·46)

5-Yr Outcomes of Surgical vs Medical Treatment of T2DM:

Open-label, Randomized Clinical Trial

Reduction of CVR and CV Medications After Surgery

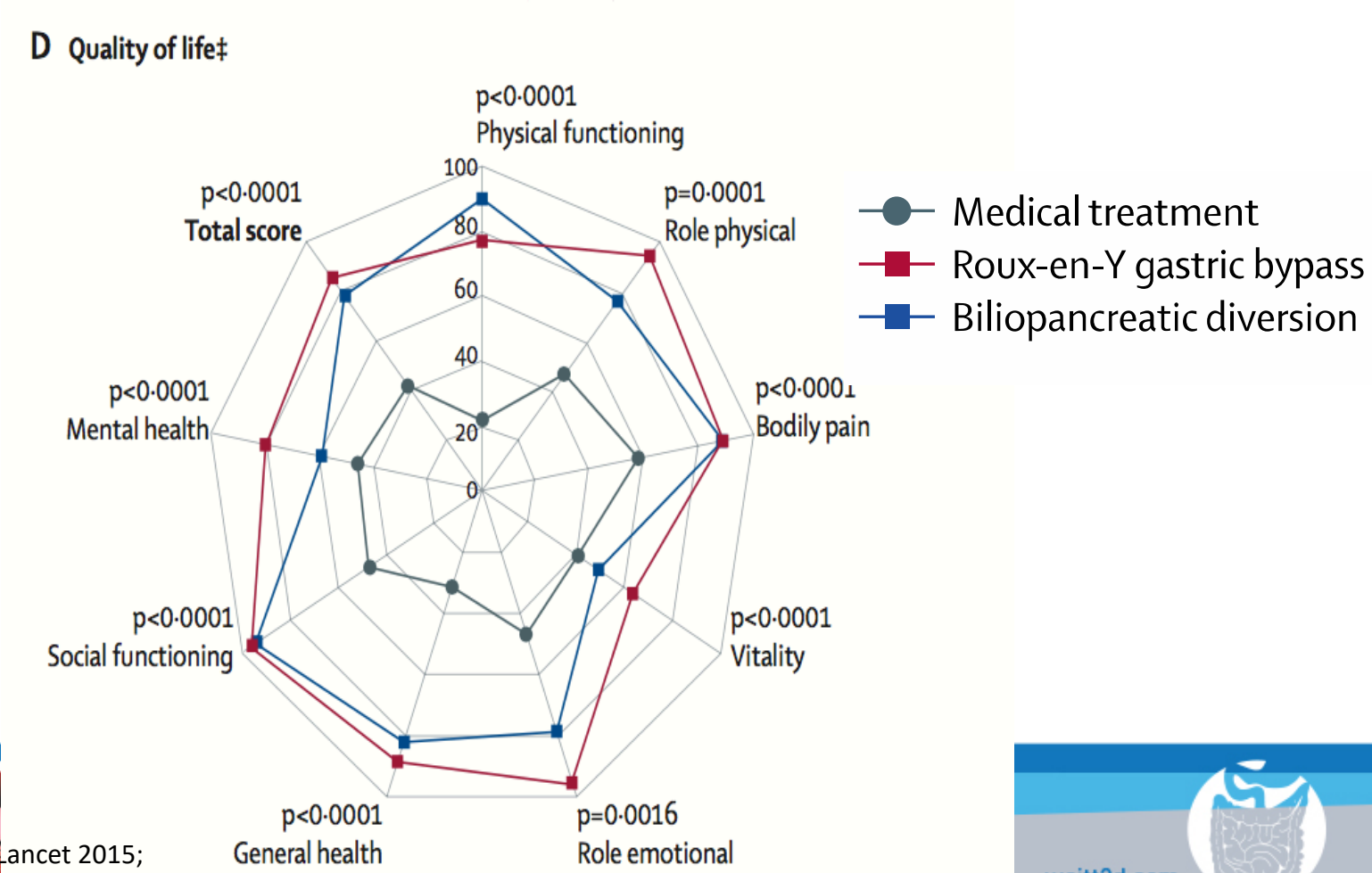




G. Mingrone….F. Rubino. Lancet 2015; 386:964-73

5-Yr Outcomes of Surgical vs Medical Treatment of T2DM: An Open-label, Randomized Clinical Trial

Surgery associated with Improved QoL



G. Mingrone…F. Rubino. Lancet 2015; 386:964-73

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

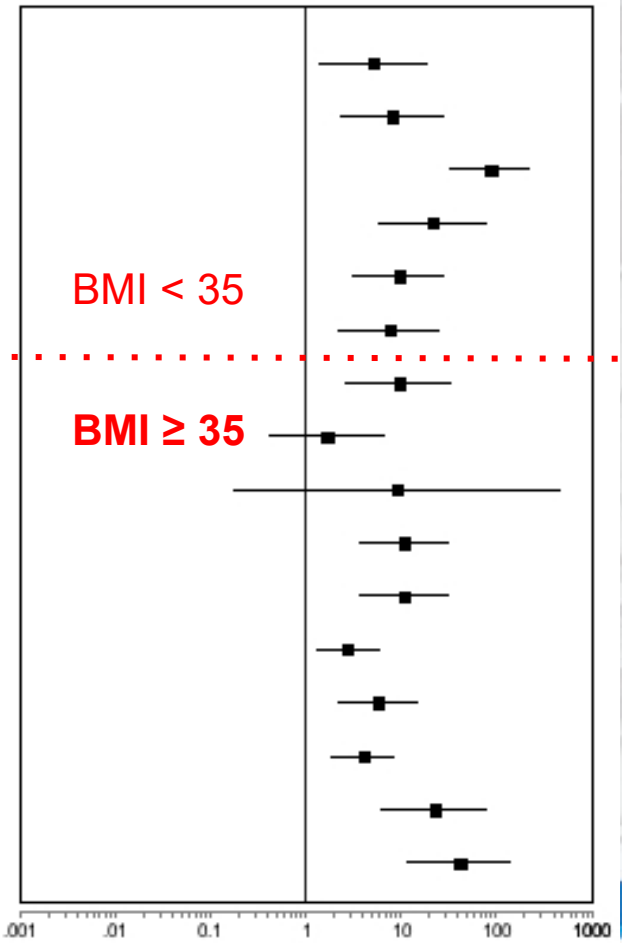
Bariatric Surgery versus Intensive Medical Therapy for Diabetes — 3-Year Outcomes

Philip R. Schauer, M.D., Deepak L. Bhatt, M.D., M.P.H., John P. Kirwan, Ph.D., Kathy Wolski, M.P.H., Stacy A. Brethauer, M.D., Sankar D. Navaneethan, M.D., M.P.H., Ali Aminian, M.D., Claire E. Pothier, M.P.H., Esther S.H. Kim, M.D., M.P.H., Steven E. Nissen, M.D., and Sangeeta R. Kashyap, M.D., for the STAMPEDE Investigators*

March, 2014

Odds of Diabetes Remission or Glycemic Control in Surgical *vs.* Non-Surgical Intervention *RCTs*

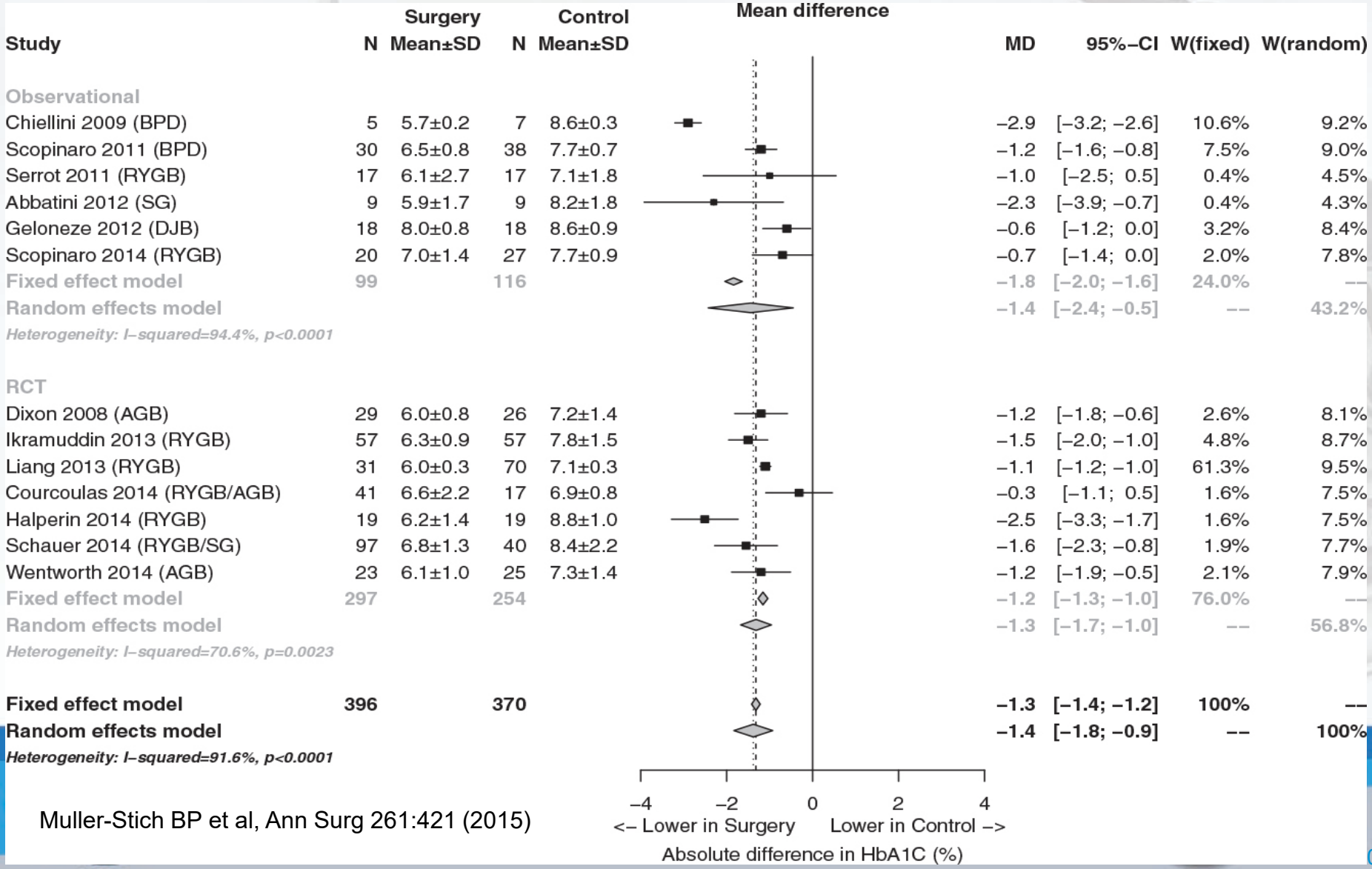
Study	*Surgery*	*Control*	*95%–CI*
Wentworth 2014 (AGB) GC	21 [23]	15 [25]	[1.41; 18.71]
Wentworth 2014 (AGB)	12 [23]	2 [25]	[2.37; 27.84]
Liang 2013 (RYGB)	28 [31]	0 [70]	[33.89; 222.08]
Parikh 2015 (RYGB/LAGB/SG)	13 [20]	0 [24]	[5.85; 76.51]
Ikramuddin 2015 (RYGB)	15 [60]	0 [59]	[3.23; 27.9]
Courcoulas 2014 (RYGB/AGB)	18 [41]	0 [17]	[2.24; 25.21]
Halperin 2014 (RYGB) GC	15 [19]	4 [19]	[2.72; 33.44]
Ding 2015 (LAGB) GC	6 [18]	5 [22]	[0.42; 6.66]
Ding 2015 (LAGB)	1 [18]	0 [22]	[0.18; 474.36]
Dixon 2008 (AGB) GC	25 [29]	6 [26]	[3.71; 30.47]
Dixon 2008 (AGB)	22 [29]	4 [26]	[3.79; 30.96]
Schauer 2014 (RYGB/SG) GC	63 [97]	16 [40]	[1.31; 5.8]
Schauer 2014 (RYGB/SG)	27 [97]	0 [40]	[2.28; 14.42]
Sjöström 2015 (AGB/VBG/RYGB)	35 [115]	4 [62]	[1.91; 8.42]
Mingrone 2012 (RYGB)	15 [20]	0 [20]	[6.4; 80.17]
Mingrone 2012 (BPD)	19 [20]	0 [20]	[12.05; 139.75]



Taroncher-Oldenburg G, et al (unpublished)

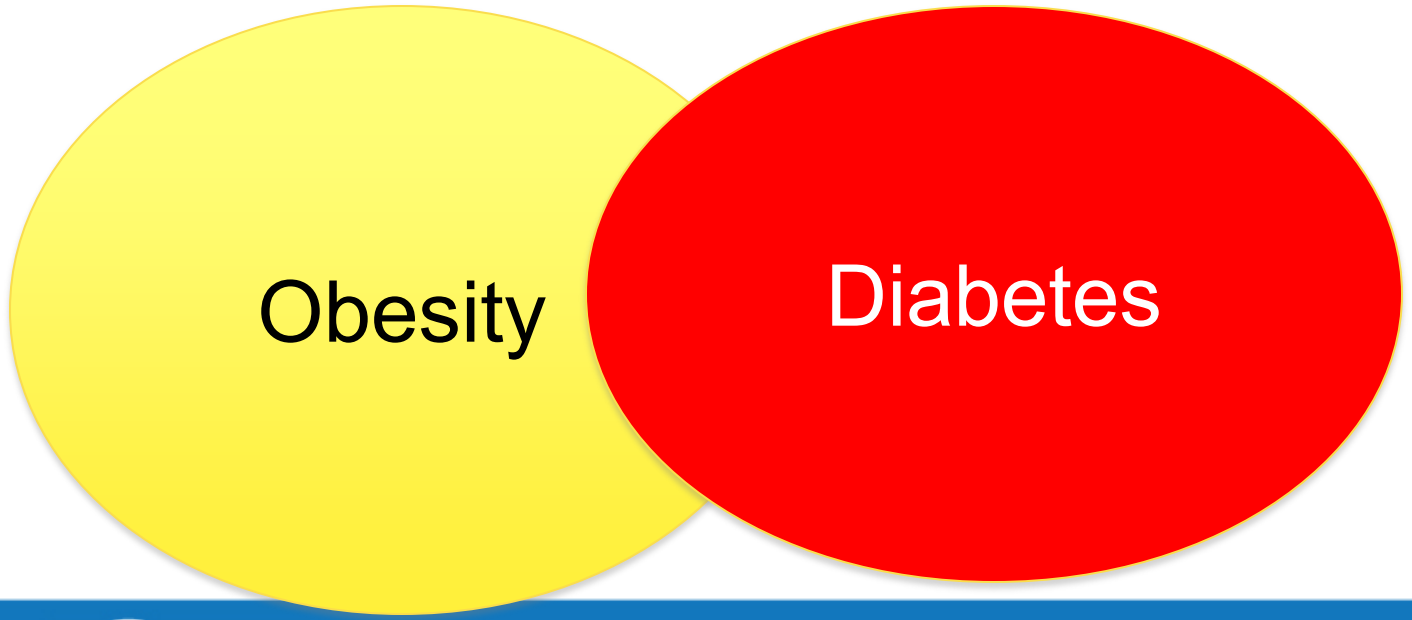
Meta-Analysis of Surgical vs. Medical Treatments for T2DM in BMI <35

HbA1c



Muller-Stich BP et al, Ann Surg 261:421 (2015)

Bariatric Surgery
vs
Diabetes Surgery



“Diabetes Surgery”: A Controversial Name

Endocrinologists:

- Concerns about giving surgeons “a license” to operate on any patient at any BMI

Surgeons:

- Concerns that diabetes surgery may distract attention from the treatment of obesity
- “Bariatric surgery” now well known among physicians and public at large

“Bariatric Surgery for Diabetes”

“Bariatric Surgery for Diabetes”…
…a square peg in a round hole”

Selection Criteria

DISEASE-SPECIFIC CRITERIA

Obesity

BMI (?)

Diabetes

HbA1c? CVR?
Responsiveness to medical treatment?

Post-operative Follow-Up

DISEASE-SPECIFIC CRITERIA

Obesity

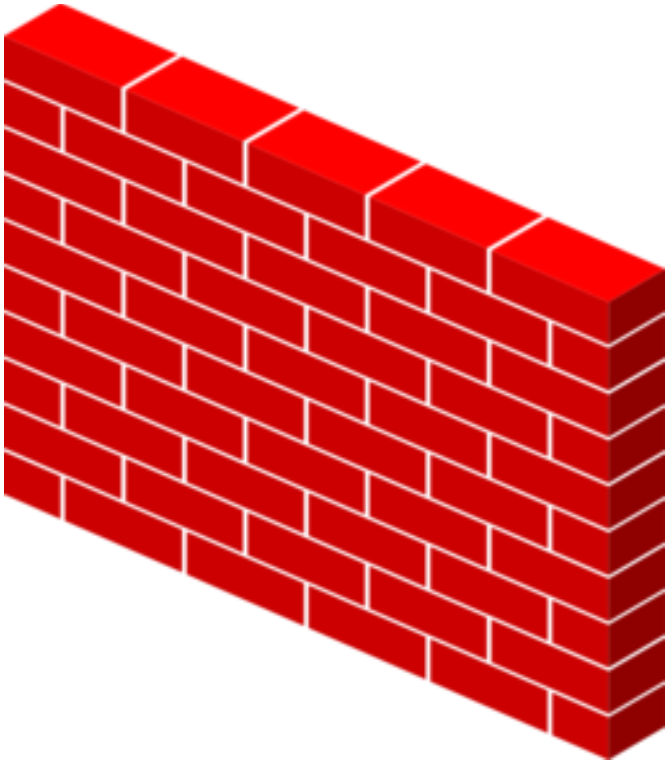
Weight Reduction
Diet, exercise

Diabetes

Diabetes Control,
CVD Risk reduction
Adjuvant medical Tx?

OBESITY BIAS > MISPERCEPTIONS and “BARIATRIC SURGERY

Access to Care



Perception of risks of bariatric surgery

Bariatric Surgery

Elective General Surgery
Cholecystectomy, Hernia Surgery, Reflux Surgery, Colorectal (benign)

SAFETY PROFILE AND HEALTHCARE USAGE OF BARIATRIC-METABOLIC SURGERY COMPARED TO COMMON

D.Tassinari[1], S.Panagiotopoulos[1], E.Giorgakis[1], L.Castagneto-Gissey[1], J.CasellaMariolo[1], A.Salerno[1], A.Chang[1], A.Patel[1], A.Haq[2], S.Ramar[1], G.Galata[2], K.M.Schulte[2], F.Rubino[1]

[1]Metabolic and Bariatric Surgery, Division of Diabetes and Nutritional Sciences, James Black Centre, King's College London, Denmark Hill Campus, London, UK

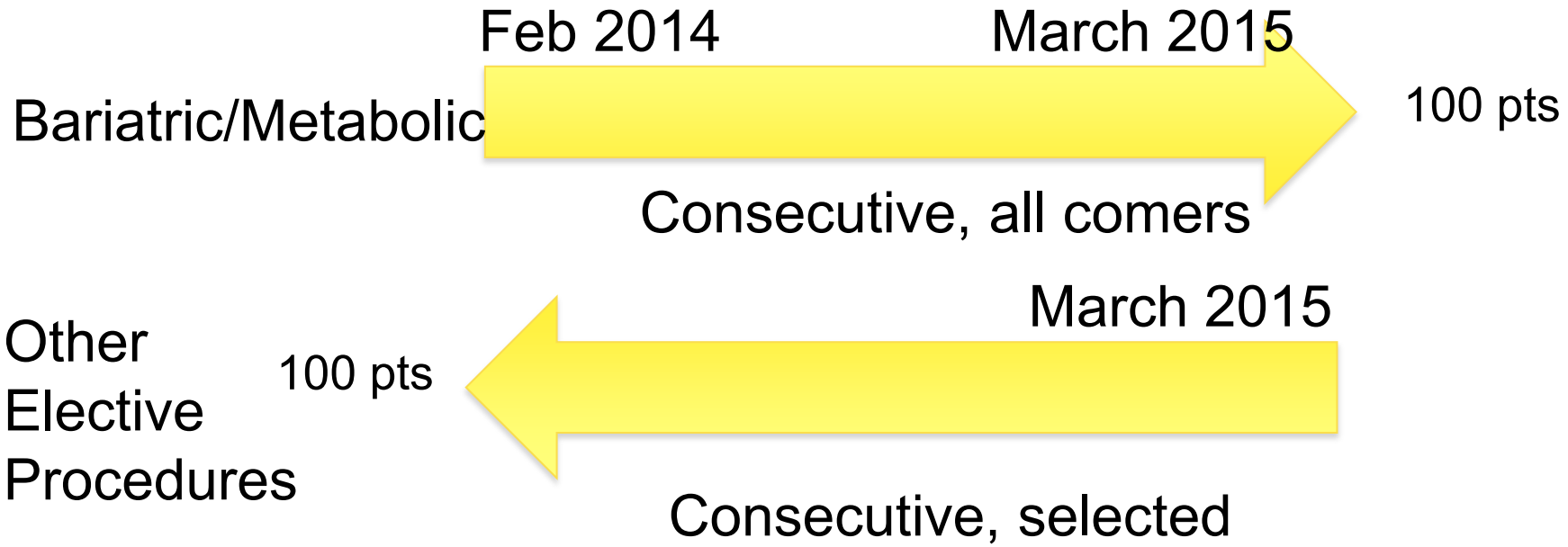
[2]Department of Surgery, King's College Hospital, Denmark Hill, London

Presented at the 3rd World Congress on Interventional Therapies for Type 2 Diabetes
London, September 29, 2015

Study Aim

To compare peri-operative safety and healthcare usage after bariatric surgery and other commonly performed elective procedures

Methods



Seniority of surgeons: Consultant level, specialized

Selection Criteria

Bariatric/metabolic surgery:

- All comers

Control groups of elective surgeries

Exclusion Criteria:

- Emergency procedures
- Cancer
- Day-surgery

Morbidity classification

Major morbidity:

-Any complications requiring surgical, endoscopic or radiological intervention

-Pulmonary embolism

-Bleeding requiring transfusion of ≥ 2 units of blood

-Life-threatening complication requiring IC/ICU-management

- Single or multiple organ dysfunction

Minor morbidity:

- Any complications not included in the major list

- Flum DR, Belle SH, King WC, et al. Perioperative safety in the longitudinal assessment of bariatric surgery. N Engl J Med 2009;361:445–454.
- Bariatric, Metabolic, and Diabetes Surgery What's in a Name? Rubino R, Shukla A, Pomp, Moreira M, et al. Ann Surg 2014;259:117–122

The Clavien-Dindo Classification of Surgical Complications

Grade I:

Any deviation from the normal postoperative course without the need for pharmacological treatment or surgical, endoscopic and radiological interventions. Allowed therapeutic regimens are: drugs as antiemetics, antipyretics, analgetics, diuretics and electrolytes and physiotherapy. This grade also includes wound infections opened at the bedside.

Grade II:

Any deviation from the normal postoperative course requiring pharmacological treatment with drugs other than such allowed for grade I complications.
Blood transfusions and total parenteral nutrition are also included

Grade III:

Any deviation from the normal postoperative course requiring surgical, endoscopic or radiological intervention:
A: intervention not under general anesthesia
B: intervention under general anesthesia

Grade IV:

Life-threatening complication requiring IC/ICU-management:
A: single organ dysfunction (including dialysis)
B: multi organ dysfunction

Grade V:

Death of a patient

Suffix 'd':

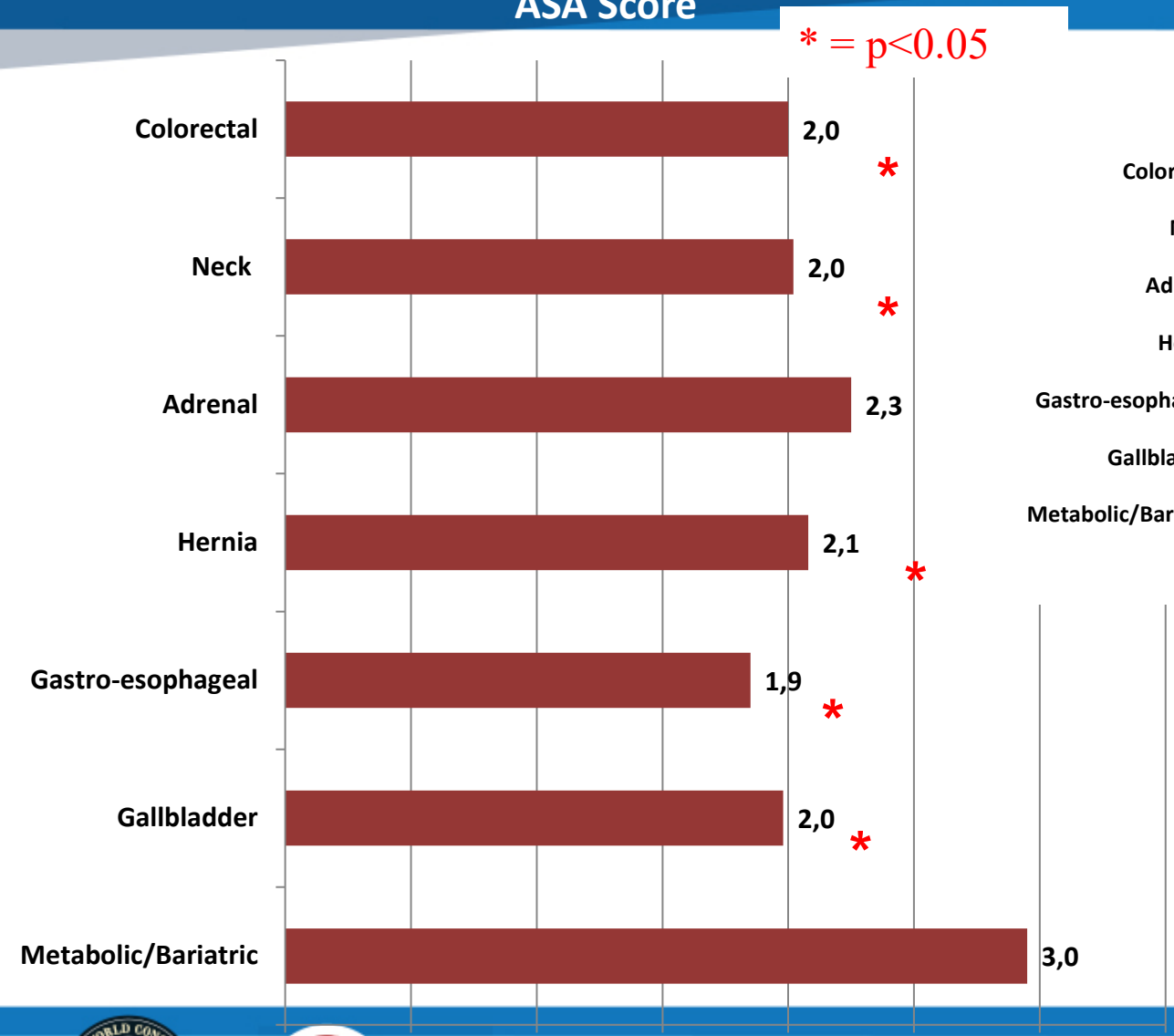
If the patients suffers from a complication at the time of discharge, the suffix "d" (for 'disability') is added to the respective grade of complication. This label indicates the need for a follow-up to fully evaluate the complication.

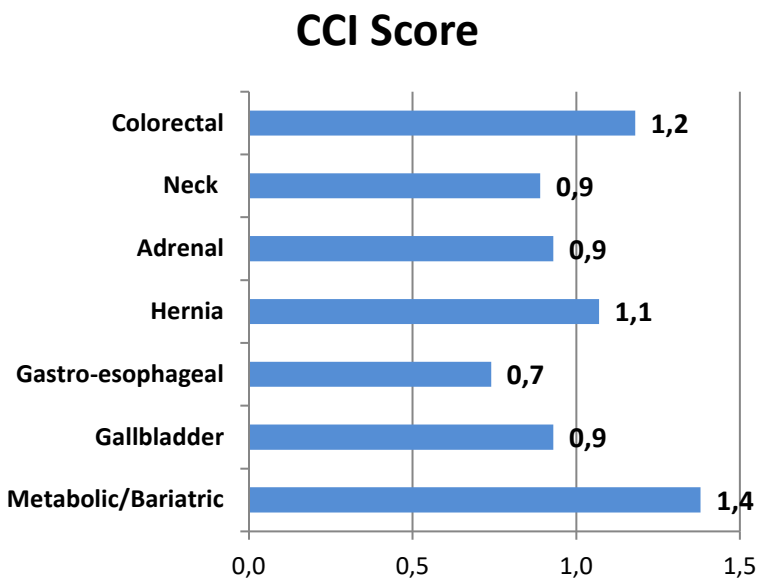
❖ Dindo D., Demartines N., Clavien P.A.; Ann Surg. 2004; 244: 931-937

Results

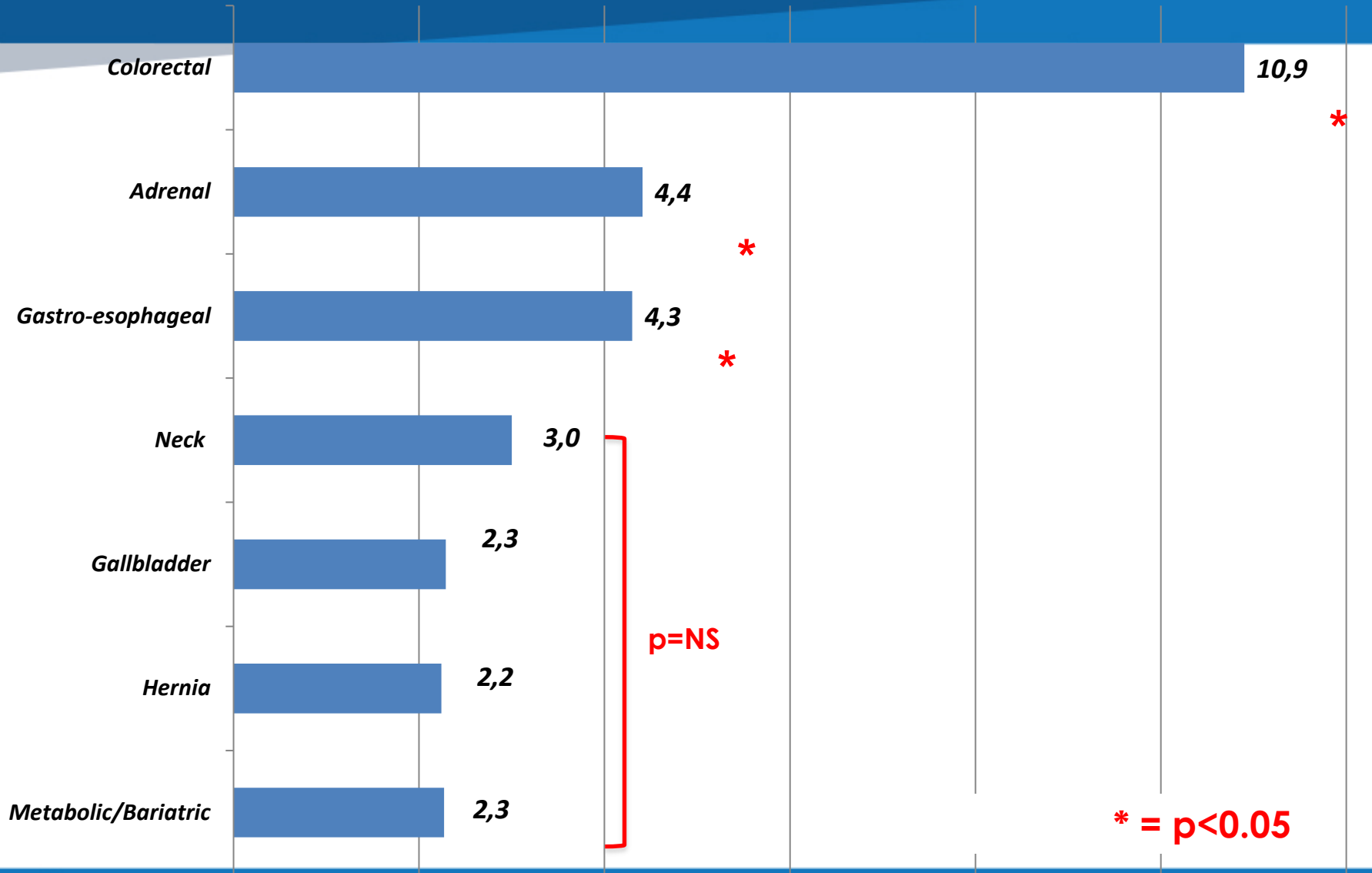
- A total of 700 patients were included in this study
- Follow up data: 100% inpatient; 98% at 1 month and 96% at 3 month postop.
- There was no mortality in any group

Baseline Surgical Risk





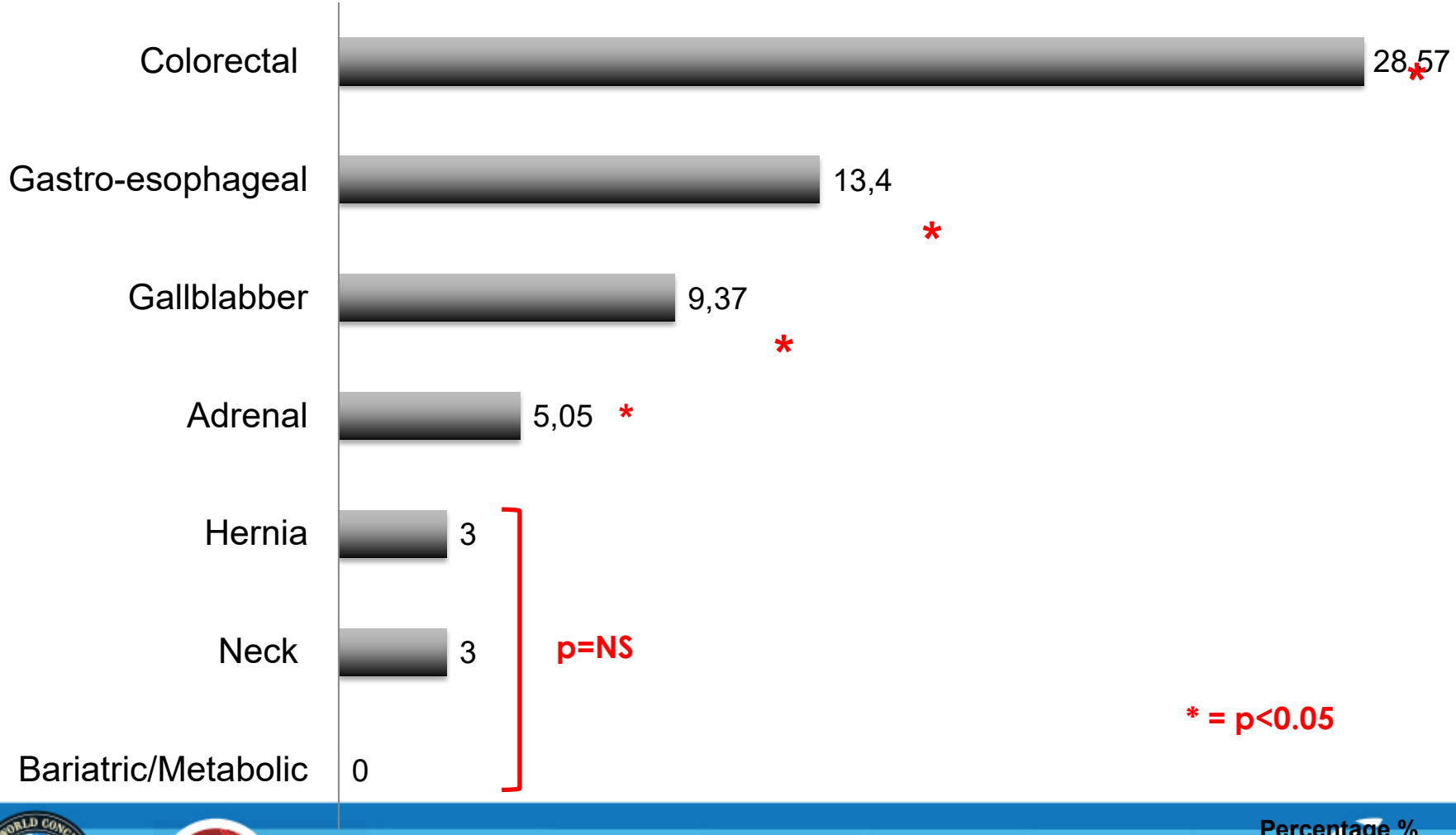
Hospital Stay [LoS] (Days)



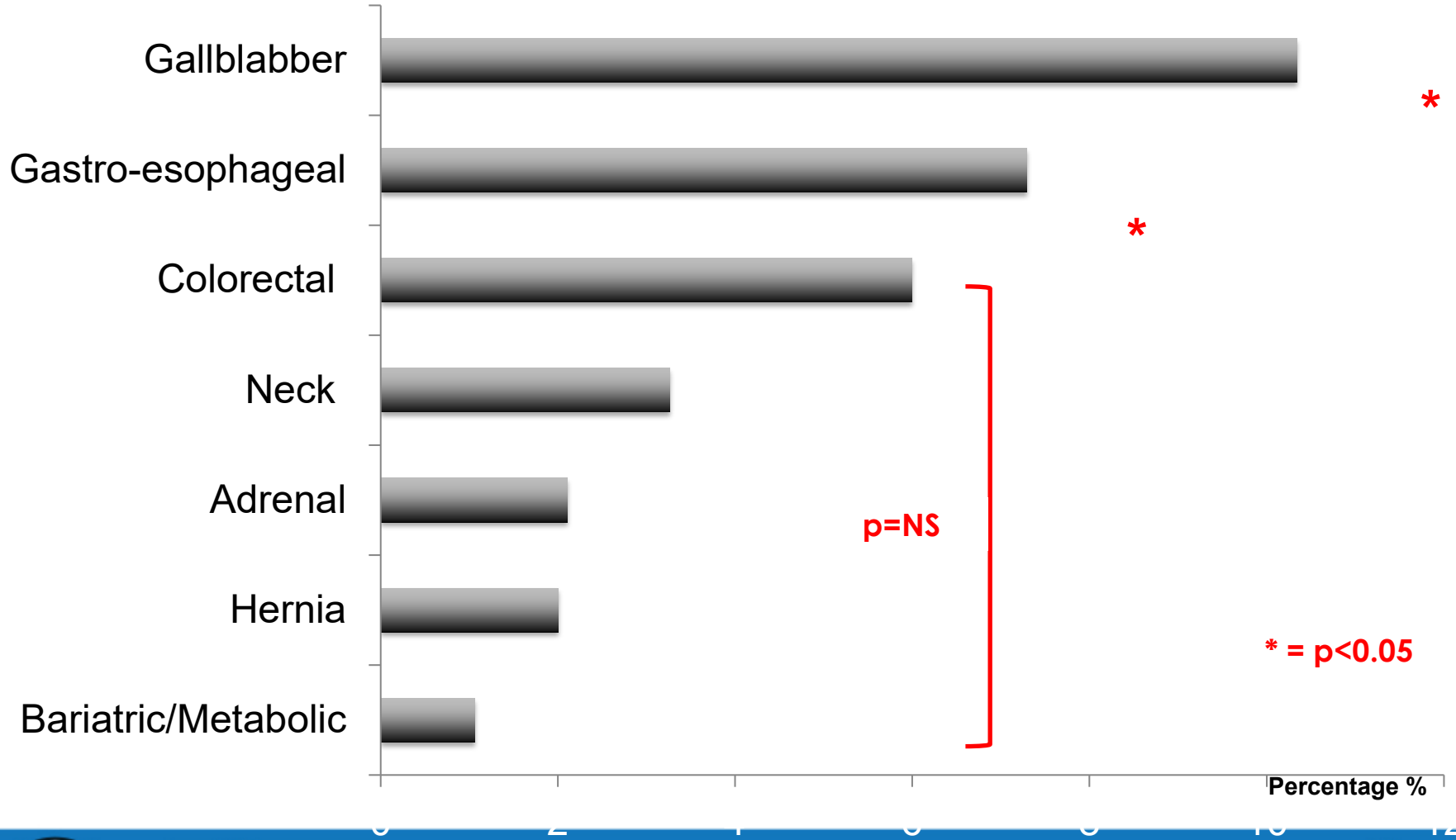
30-Day Safety Composite Score

Number of major events (major morbidity, re-admissions, and re-operations) within the first 30 days after surgery.

30-Day Safety Composite Endpoint (re-admission, re-operation and major morbidity)



3-Month Safety Composite Endpoint (re-admission, re-operation and major morbidity)



Costs of bariatric surgery

SUNDAY EXPRESS

INCLUDING 6 MAGAZINE, REVIEW, PROPERTY, FINANCE AND SPORT — FEBRUARY 13, 2011 — www.sundayexpress.co.uk — £1.35

Valentine's Day Giveaway

FREE LOVE HEARTS

LOVE HEARTS

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PAGE 32

PLUS!

FREE ALAN TITCHMARSH SEEDS IN OUR BUMPER BEDDING COLLECTION

£40

PAGE 32

OBESE WILL BANKRUPT NHS

EXCLUSIVE

By Lucy Johnston HEALTH EDITOR

BRITAIN'S growing obesity problem is on the verge of bankrupting the NHS, a shock new report reveals.

The study, which shows British people are the fattest in Europe, predicts that by 2030 obesity will cost the health service £50 billion, equivalent to about 11 per cent of the budget.

Professor Philip James, founder of the International Obesity Task Force, who compiled the report, said: "If levels of obesity rise in line with Government predictions the NHS will no longer be able to afford to treat all of its patients." Steve Somers, who performed

TURN TO PAGE 4

The King's smooch

WHO GAVE COLIN A VALENTINE'S SMACKER? PAGE 5

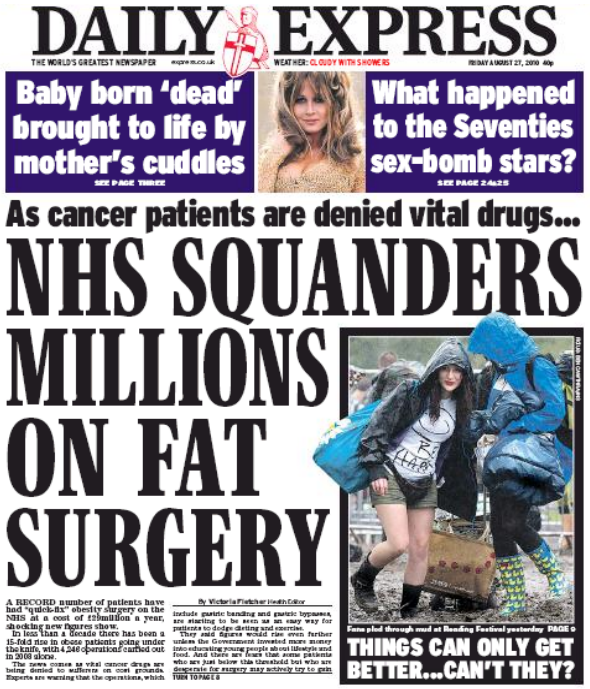
Queen is asked: 'May we dig up Henry VIII?'

EXCLUSIVE

By Josephine Forster

HENRY VIII could be exhumed if the Queen gives permission for an investigation into a disease that may have driven him to behead two of his six wives. American researchers are seeking the go-ahead to dig up the 16th-century monarch in a bid to find out if his ferocious temper was caused by a genetic disorder. Scientists say DNA samples could prove that he suffered from a disease which causes severe mental illness. It may also have prevented him fathering a male heir.

FULL STORY: PAGE 25



DAILY EXPRESS

THE WORLD'S GREATEST NEWSPAPER — express.co.uk — WEATHER: CLOUDY WITH SHOWERS — FRIDAY AUGUST 27, 2010 40p

Baby born 'dead' brought to life by mother's cuddles

SEE PAGE THREE

What happened to the Seventies sex-bomb stars?

SEE PAGE 24&25

As cancer patients are denied vital drugs...

NHS SQUANDERS MILLIONS ON FAT SURGERY

By Victoria Fletcher Health Editor

A RECORD number of patients have had "quick-fix" obesity surgery on the NHS at a cost of £89million a year, shocking new figures show.

In less than a decade there has been a 15-fold rise in obese patients going under the knife, with 4,246 operations carried out in 2008 alone.

The news comes as vital cancer drugs are being denied to sufferers on cost grounds. Experts are warning that the operations, which include gastric banding and gastric bypasses, are starting to be seen as an easy way for patients to dodge dieting and exercise.

They said figures would rise even further unless the Government invested more money into educating young people about lifestyle and food. And there are fears that some patients who are just below the threshold but who are desperate for surgery may actively try to gain

TURN TO PAGE 8

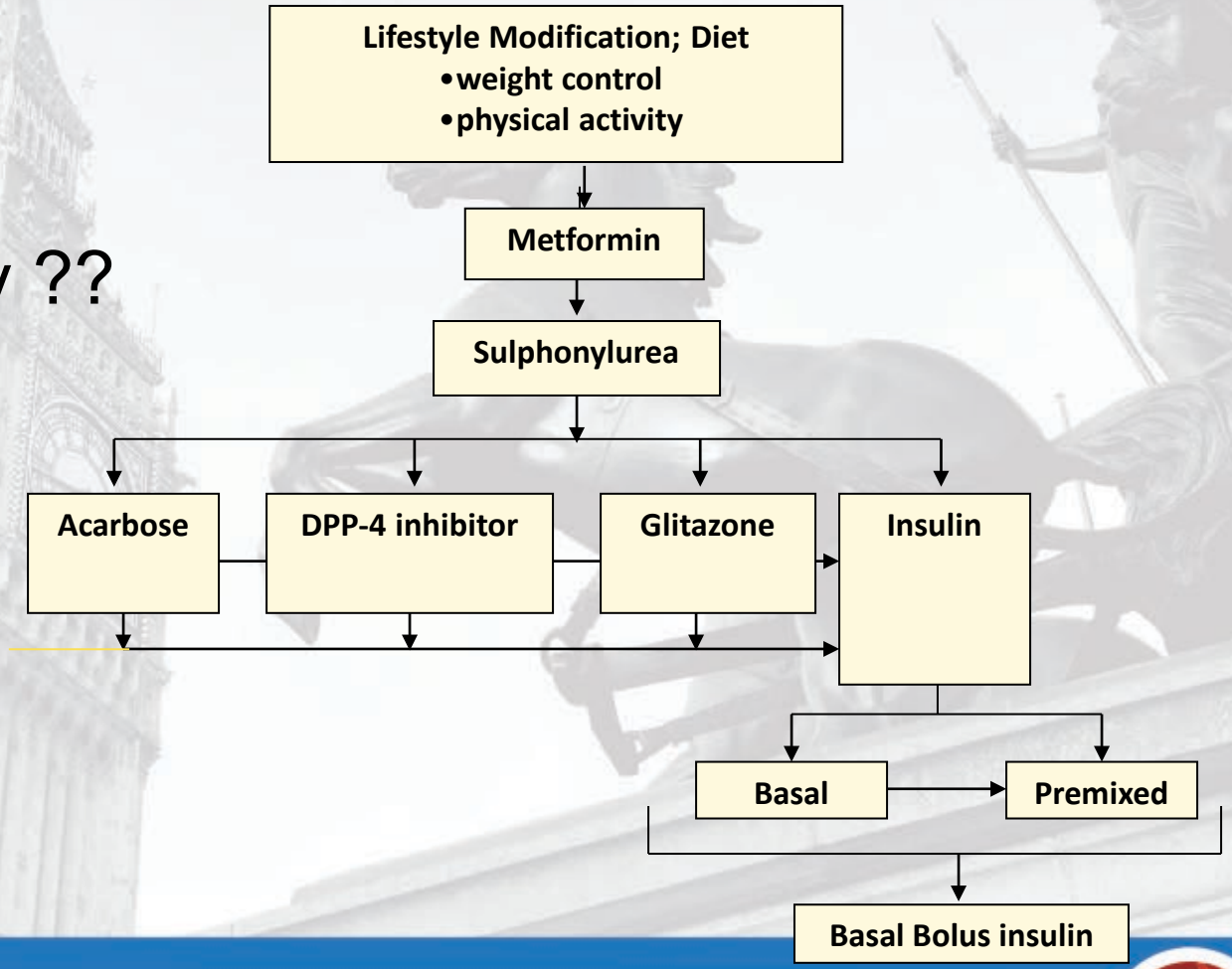
Fans plod through mud at Reading Festival yesterday PAGE 9

THINGS CAN ONLY GET BETTER...CAN'T THEY?

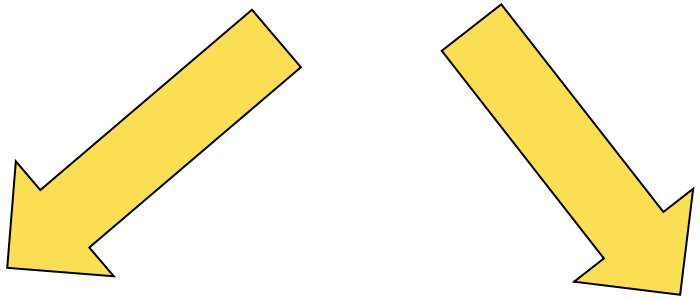
Target Population

Management Algorithm for Type 2 Diabetes

Surgery ??



NICE



Obesity Guidelines 2014	Diabetes Guidelines 2015
Bariatric/Metabolic Surgery for pts with T2DM and BMI >30	**No mention of Surgery for diabetes treatment at any level of BMI**

2nd Diabetes Surgery Summit

American Diabetes Association.

EASD
European Association for the Study of Diabetes

Available Accessible and Affordable
Diabetes India
Flame of Hope

DSS-II

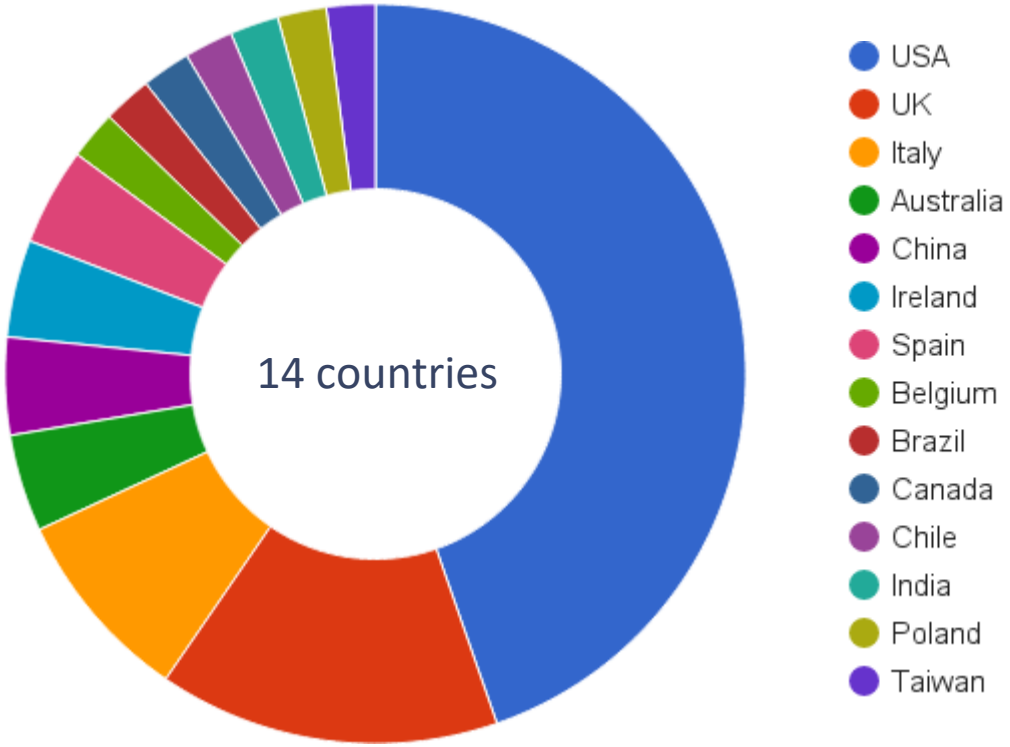
CDS
CHINESE DIABETES SOCIETY
中华医学会糖尿病学分会

International Diabetes Federation

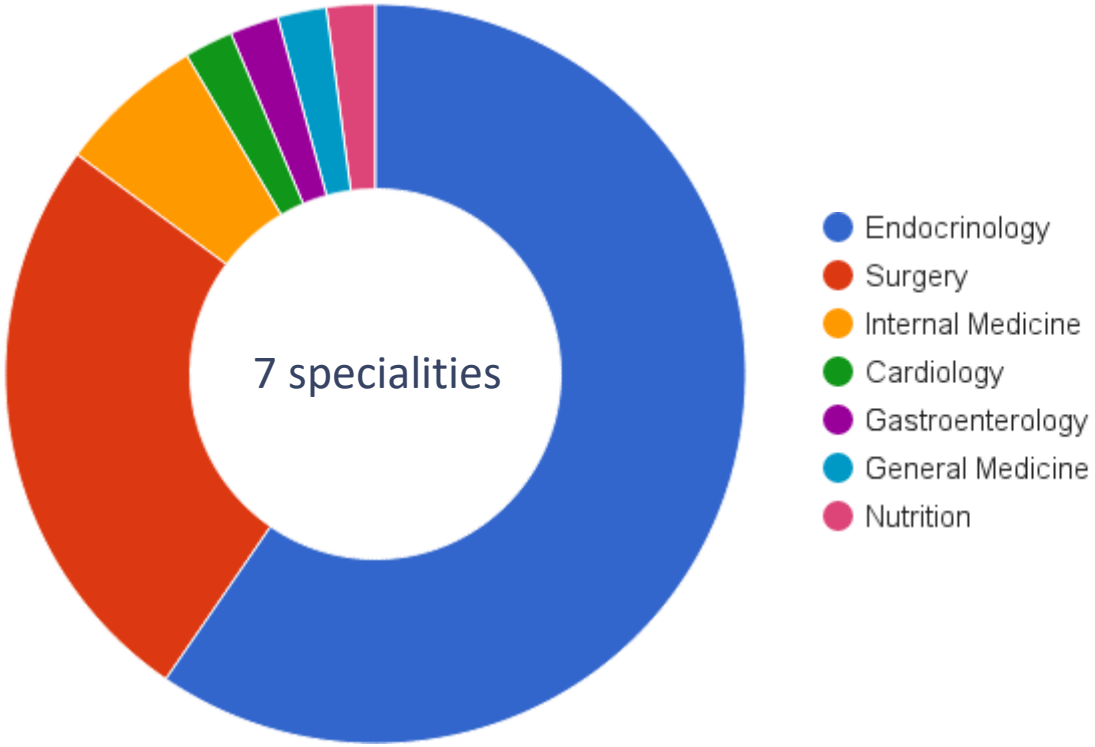
DIABETES UK
CARE. CONNECT. CAMPAIGN.

DSS-II Voting Delegates

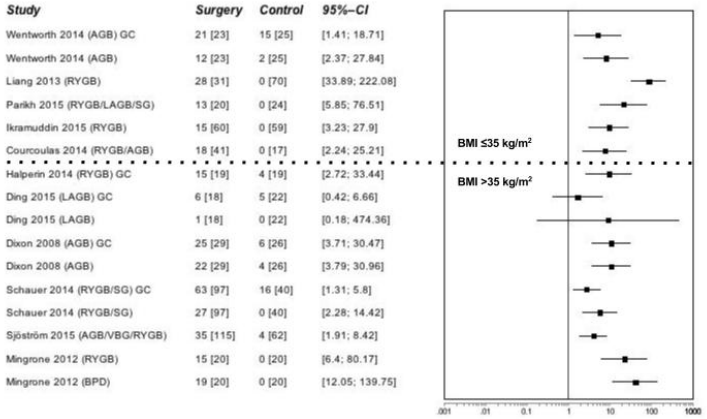
Geographic diversity

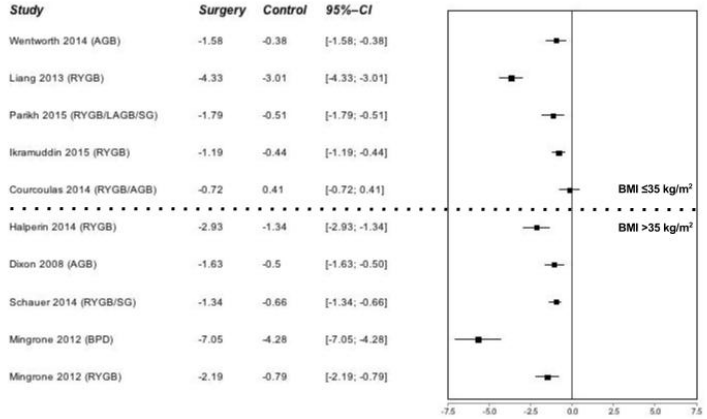


Clinical diversity



Evidence gathering and analysis





Randomized controlled trials

Study	Design, sample size, follow-up	Criteria of T2DM Remission	Outcome							
				RYGB		Medical				
				Baseline	12 months	Baseline	12 months			
Cummings et al. 2015	RYGB vs. Medical 43 patients FUP: 12 months multi-centre	HbA1c ≤ 6.0% no medication	N	23	15	20	17			+ sample size calculation + method of randomization reported + blinding + definition of outcome parameters + standardized treatment + intention to treat analysis + standardized FUP + reasons to FUP reported
			BMI (kg/m²)	38.3 ± 3.7	28.4 ± 3.1	37.1 ± 3.5	34.7 ± 2.8			
			HbA1c (%)	7.7 ± 1.0	6.4 ± 1.6	7.3 ± 0.9	6.9 ± 1.3			
			Remission (%)	-	60 (9/15)	-	5.9 (1/17)			
			Glycemic control (%)	-	-	-	-			
			Hypertension (%)	-	-	-	-			
			Hyperlipidemia (%)	-	-	-	-			
Courcoulas et al. 2015	RYGB/LAGB vs. Medical 69 patients FUP: 36 months single-centre	HbA1c ≤ 6.5 % and FPG < 126 mg/dl no medication		RYGB		LAGB		Medical		
				Baseline	36 months	Baseline	36 months	Baseline	36 months	
			N	24	18	22	20	23	14	+ sample size calculation + method of randomization reported - no blinding + definition of outcome parameters + standardized treatment + intention-to-treat-analysis + standardized FUP + reasons for loss to FUP reported
			BMI (kg/m²)	35.5 ± 2.6	27.0 ± 0.7	35.5 ± 3.4	30.4 ± 0.7	35.7 ± 3.3	334.0 ± 0.8	
			HbA1c (%)	8.7 ± 2.2	7.1 ± 0.4	7.9 ± 2.2	7.1 ± 0.32	7.0 ± 0.8	7.2 ± 0.4	
			Remission (%)	-	40 (8/18)	-	29 (6/19)	-	0 (0/14)	
			Glycemic control (%)	-	n/a	-	n/a	-	n/a	
			Hypertension (%)	50 (12/24)	n/a	59 (13/22)	n/a	70 (16/23)	n/a	
			Hyperlipidemia (%)	58 (14/24)	n/a	72 (16/22)	n/a	65 (15/23)	n/a	
Mingrone et al. 2015	RYGB/BPD vs. Medical 60 patients FUP: 60 months single-centre	HbA1c ≤ 6.5% and FPG < 100 mg/dl no medication		RYGB		BPD		Medical		
				Baseline	60 months	Baseline	60 months	Baseline	60 months	
			N	20	19	20	19	20	15	+ sample size calculation + method of randomization reported - no blinding + definition of outcome parameters + standardized treatment + intention to treat analysis + standardized FUP + reasons to FUP reported
			BMI (kg/m²)	44.85 ± 5.16	31.3 ± 2.5	45.14 ± 7.78	30.3 ± 4.0	45.62 ± 6.24	42..1 ± 5.8	
			HbA1c (%)	8.56 ± 1.4	6.7 ± 0.5	8.88 ± 1.71	6.4 ± 0.4	8.51 ± 1.24	6.9 ± 0.6	
			Remission (%)	-	37 (7/19)	-	63 (12/19	-	0 (0/15)	
			Glycemic control (%)	-	n/a	-	n/a	-	n/a	
			Hypertension (%)	n/a	n/a	n/a	n/a	n/a	n/a	
			Hyperlipidemia (%)	n/a	n/a	n/a	n/a	n/a	n/a	

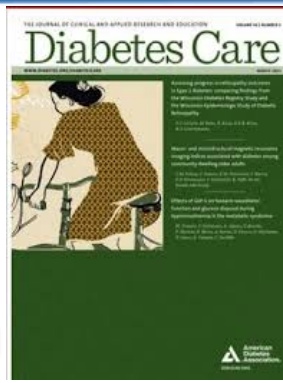
The DSS-II Delphi process

- 36 initial questions
- Several statement categories:
  - *General framework*
  - *Definition of Diabetes Surgery (DS)*
  - *Definition of DS success*
  - *Patient selection criteria*
  - *The case for DS at BMIs < 35*
  - *Preoperative considerations*
  - *Postoperative considerations*
- 47 faculty involved
- 3 iterations
- Over 80% consensus achieved

3rd World Congress: presentation and discussion of draft recommendations

DSS-II: Face to Face Meeting

DSS-II: Consensus Conference



Review and Appraisal of Evidence

Delphi phase (3 rounds)

Discussion of draft recommend /guidelines and public input

Sept 30 Morning sessions

Face to Face Meeting (Sept 30- closed session)

Review by Partner organizations and endorsing societies

DSS-II

Given its role in the regulation of glucose levels in homeostasis and in disease, the GI tract constitutes a clinically and biologically meaningful target for anti-diabetes interventions.

Results

- A total of 700 patients were included in this study
- Follow up data: 100% inpatient; 98% at 1 month and 96% at 3 month postop.
- There was no mortality in any group

ASSIMEFAC

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SERVIZIO SANITARIO REGIONALE

AZIENDA OSPEDALIERA DI COSENZA

OBESITÁ E CHIRURGIA: ISTRUZIONI PER L'USO

19 MAGGIO 2018

VILLA FABIANO – RENDE COSENZA

RESPONSABILE SCIENTIFICO: **DR. CARLO CHIODO**

PROGRAMMA

Ore 8,30 Registrazione dei partecipanti
Ore 9,00 Introduzione dei Lavori – **C. Chiodo**
SALUTO DELLE AUTORITÀ

PRIMA SESSIONE: *Approccio metodologico al paziente Obeso*

Ore 9,20 Prevenzione e Stili di vita nel paziente Obeso: esiste un ruolo per il Medico di Base? – **P. Guglielmelli**
Ore 9,40 L'importanza della Multidisciplinarietà nella cura delle patologie complesse: La presa in carico e la creazione del PDTA – **M. Loizzo**
Ore 10,00 Patologie Endocrine ed Obesità: lo screening endocrinologico propedeutico alla Chirurgia – **R. Talarico**
Ore 10,20 La gestione del paziente in un reparto di Chirurgia Bariatrica: Nursing pre e post operatorio – **B. Baffa Scirocco- S. De Rose**
Discussione
Ore 11.00 Coffè break

SECONDA SESSIONE: *La gestione pluri-specialistica del paziente Obeso*

Ore 11,20 I disturbi del comportamento alimentare (DCA): la percezione della propria immagine corporea – **A. Funaro**
Ore 11,40 Chirurgia Metabolica e Riabilitazione Nutrizionale – **A. Curti**
Ore 12,00 Diagnostica strumentale nel paziente Obeso – **M. Florio**
Ore 12,20 Il Management anestesiologico del paziente Obeso – **P. Brunelli**
Ore 12,40 Procedure endoscopiche nel paziente Obeso: il ruolo del gastroenterologo nel trattamento di prima istanza e nelle complicanze della chirurgia – **M. Verta**
Discussione
Ore 13.30 Light Lunch

TERZA SESSIONE: *Il Trattamento Chirurgico delle Malattie Metaboliche*

Ore 14,30 L'arrivo del paziente Obeso in Sala Operatoria: preparazione e svolgimento di un intervento di Chirurgia Bariatrica – **C. Murano - I. Crocco**
Ore 14,50 La Chirurgia dell'Obesità: varianti Tecniche e Risultati – **A. Urso**
Ore 15,10 La Rinascita dei pazienti Obesi dopo Chirurgia: esperienze a confronto – **R. Chiarello**
Discussione
Ore 16,30 Valutazione dell'Apprendimento e Questionario ECM
Ore 17.30 Conclusione dei Lavori

INFORMAZIONI GENERALI

SEDE DEL CONVEGNO: Villa Fabiano Palace Hotel,
Via Cristoforo Colombo, 70 - 87036 Rende Cosenza

DESTINATARI: Medico Chirurgo, Infermiere, Psicologo, Biologo e Farmacista

ISCRIZIONE: L'iscrizione è gratuita, posti disponibili 100.
Iscrizioni esclusivamente on-line con modulo unico collegandosi sul sito:
www.assimefac.it

Le iscrizioni potranno essere effettuate dal 5 al 30 Aprile 2018
L'iscrizione da diritto a: Partecipazione ai lavori, kit congressuale, attestato di partecipazione e certificato ecm (agli aventi diritto).

SEGRETERIA ORGANIZZATIVA

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Ref. Elena Staglianò Cell. 320 7541106
Sede legale: Via Gradoni Ospedale Civile 11 - 88100 Catanzaro
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IN FASE DI ACCREDITAMENTO

TERAPIA CHIRURGICA DELL' OBESITA'

Dr. Ninni Urso
UOSD Chirurgia Bariatrica

AO Annunziata Cosenza

LA TERAPIA CHIRURGICA NELL'OBESITA' GRAVE DELL' ADULTO

Dr. Ninni Urso

Direttore UOSD Chirurgia Bariatrica

AO Annunziata – COSENZA

Il sottoscritto

ai sensi dell'art. 76 comma 4 dell'Accordo Stato-Regioni del 2 febbraio 2017 e in accordo con il Codice Etico della Xenia S.a.s.

dichiara

per l'evento in oggetto l'esistenza negli ultimi due anni di rapporti di natura finanziaria e lavorativa con le seguenti imprese commerciali operanti in ambito sanitario

LA TERAPIA CHIRURGICA NELL'OBESITA' GRAVE DELL' ADULTO

Dr. Ninni Urso

Direttore UOSD Chirurgia Bariatrica

AO Annunziata - COSENZA

LA TERAPIA CHIRURGICA NELL'OBESITA' GRAVE DELL' ADULTO

Dr. Ninni Urso

Direttore UOSD Chirurgia Bariatrica

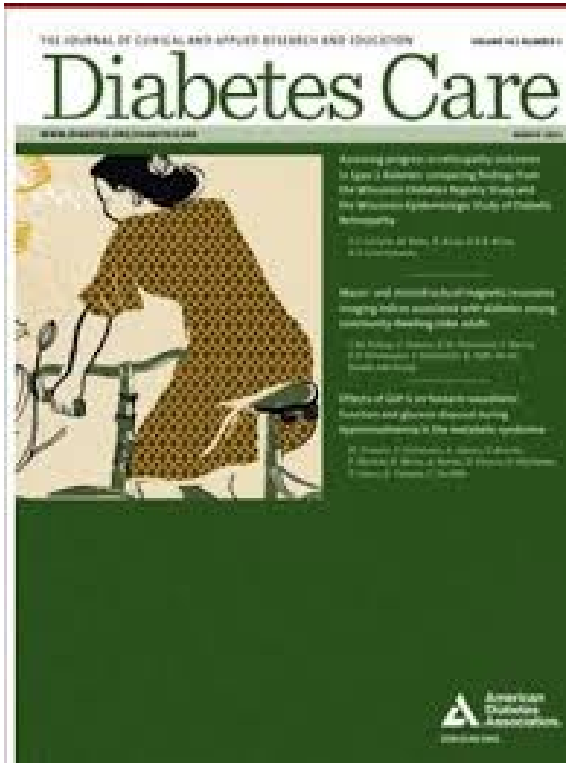
AO Annunziata - COSENZA

LA CHIRURGIA METABOLICA

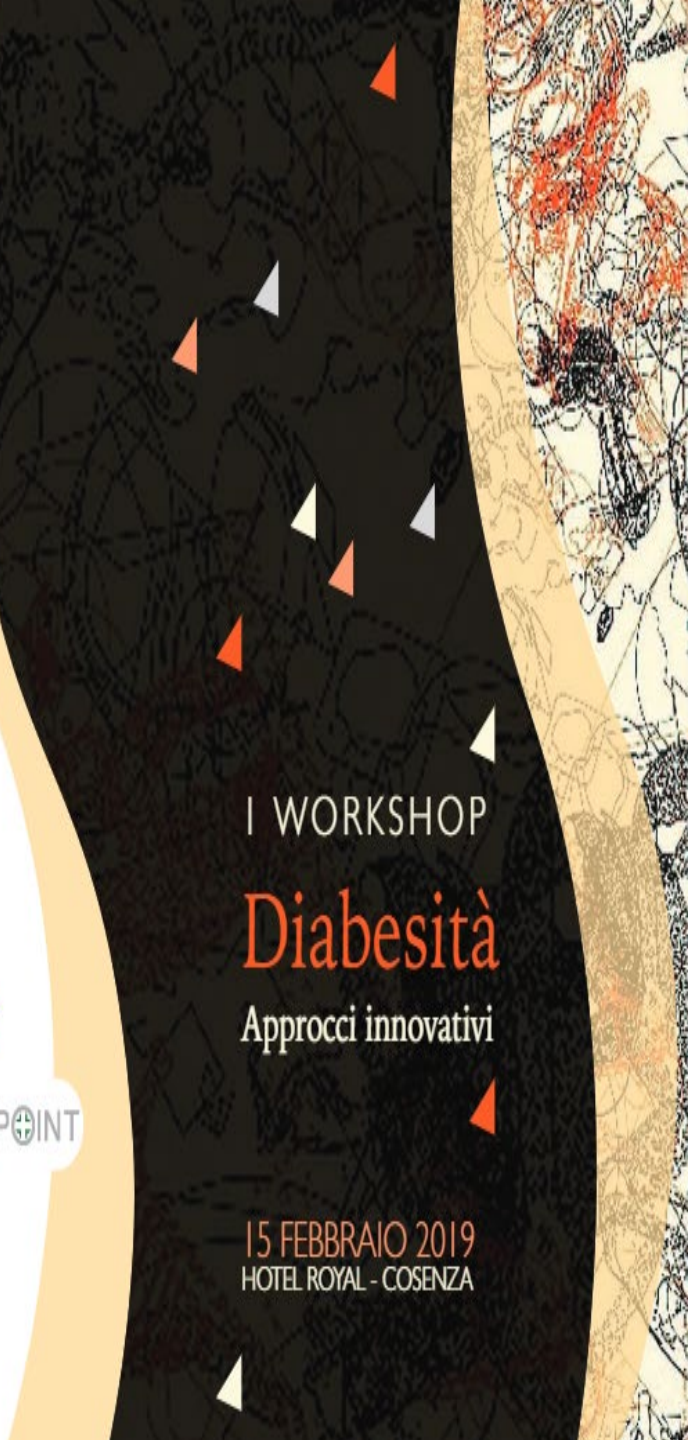
Dr. Ninni Urso

Resp UOSD Chirurgia Bariatrica e Metabolica

AO Annunziata Cosenza


Diabetes Care


nature
medicine
Angiogenesis inhibition comes undone
Targeting CCR2 for osteoporosis
The curious case of clioquinol



CHIRURGIA BARIATRICA O METABOLICA ?

Dr. Ninni Urso

Resp. UOSD Chirurgia Bariatrica
AO Annunziata Cosenza

Morbidity classification

Major morbidity:

-Any complications requiring surgical, endoscopic or radiological intervention

-Pulmonary embolism

-Bleeding requiring transfusion of ≥ 2 units of blood

-Life-threatening complication requiring IC/ICU-management

- Single or multiple organ dysfunction

Minor morbidity:

- Any complications not included in the major list

- Flum DR, Belle SH, King WC, et al. Perioperative safety in the longitudinal assessment of bariatric surgery. N Engl J Med 2009;361:445–454.
- Bariatric, Metabolic, and Diabetes Surgery What's in a Name? Rubino R, Shukla A, Pomp, Moreira M, et al. Ann Surg 2014;259:117–122

Baseline Surgical Risk