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Editorial comment

Comment on: Effect of the COVID-19 pandemic on bariatric surgery in North America: a retrospective analysis of 834,647 patients

This is the first large study [1] reporting on the effect of the COVID-19 pandemic on bariatric and metabolic surgery (BMS) in North America, making it highly interesting. Significant morbidity and mortality with perioperative COVID-19 [2], higher mortality with COVID-19 in those with obesity, diversion of health care resources to dealing with the pandemic, and guidelines from the International Federation for the Surgery of Obesity and Metabolic Disorders at the beginning of the pandemic to cease all elective BMS severely affected the provision of BMS worldwide. In this context, a 12.1% reduction in the volume of bariatric surgery during 2020 in North America as reported in this study [1] in comparison with 2019 seems hardly surprising. Several other studies [3] have also shown a significant reduction in volumes of bariatric surgery globally as a result of the pandemic.

It is, however, interesting that the patients who underwent BMS during the pandemic were younger and had fewer comorbidities. This suggests that fewer at-risk patients were prioritized for surgery during the pandemic, contrary to the authoritative advice published at the time [4]. Rubino et al. [4] had recommended that patients at the highest risk of death from COVID-19 should be prioritized during the pandemic. However, this study [1] and the findings of the GENEVA (Global 30-day outcomes after bariatric surgery during the COVID-19 pandemic) study [5], which reported on 30-day morbidity and mortality of BS worldwide during the pandemic, suggest that this advice was largely ignored and that surgical teams prioritized fewer at-risk patients. This may be because the frequency and outcome of perioperative COVID-19 were unknown in this group of patients when BMS resumed. This was one of the main reasons we conducted the GENEVA study. Interestingly, only 43 (.56%) patients developed symptomatic postoperative COVID-19 in the GENEVA cohort, and only 1 patient (out of 7734) died owing to postoperative COVID-19. It would have been interesting to know how many patients developed symptomatic COVID-19 (and mortality as a consequence of that) after BMS during the pandemic in North America, but this study [1] does not report those numbers.

A slight increase in the proportion of sleeve gastrectomy (SG) during the pandemic in this study [1] might

suggest a preference for a less risky procedure. It could, however, also represent the upward trajectory of SG over the past decade at the expense of Roux-en-Y gastric bypass (RYGB) in North America. It may also be because patients with fewer co-morbidities were prioritized during this period and many surgeons reserve a gastric bypass for those with a higher metabolic burden of disease.

Unsurprisingly, this study [1] found the postoperative outcomes of patients who underwent BS during the pandemic to be “similar” to the cohort before the pandemic. This is exactly what the global GENEVA study had found even though the GENEVA study did not have an built-in prepandemic cohort for a robust comparison. The GENEVA study had reported 30-day morbidity and mortality of 6.76% and .14%, respectively, in a global cohort of 7084 patients undergoing primary BS during the pandemic. The 30-day mortality of .13% reported in this study [1] bears striking resemblance to the figure of .14% observed in the GENEVA study.

Another interesting aspect of this study is a reduction in the length of stay of patients. This may be to ease the pressures on finite hospital resources and also to reduce the risk of contracting SARS CoV-2 while in the hospital. In our unit, we were able to restart bariatric services sooner by adopting a 1-night stay protocol for patients undergoing bariatric surgery.

In summary, we need to understand the effect of the pandemic on BMS for several reasons. First, there is a real concern that SARS-CoV-2 may never completely disappear. So, we need to re-examine the safety of all invasive procedures to be able to ameliorate their effect. Secondly, data on safety collected during the pandemic allow us to understand the efficacy of various preoperative strategies aimed at reducing perioperative SARS-CoV-2 infection. Finally, it allows us to estimate the activity lost as a result of the pandemic so we can plan to address it in the ensuing years [6].

Disclosures

The authors have no commercial associations that might be a conflict of interest in relation to this article.

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