Patients with obesity who contract COVID-19 develop a more severe form of illness with increased ICU admission and a high mortality rate (58% in patients with a BMI ≥40). Recent publications highlight that many also have time-sensitive comorbid conditions that are likely to cause increasing ill-health if access to bariatric surgery is delayed [1,2].

As bariatric/metabolic surgery (BMS) is the only rapidly effective treatment for severe and complex obesity, it is BOMSS’ view (expressed in a recent open letter to the Prime Minister) [3] that BMS should feature prominently in the reintroduction of NHS elective surgery. The latest NBSR and HES data reaffirms that NHS elective BMS is exceptionally safe with a 30-day mortality of 0.07%, and so there is a strong argument that patients are likely to benefit from a prompt restart of bariatric programmes.

The reintroduction of cross-specialty elective surgery must balance the benefits of treatment against any (as yet) unquantified health risk that contracting COVID-19 whilst recovering from surgery might bring. We need to know whether that risk is greater in a bariatric population and whether restarting BMS is likely to strain NHS resources in a disproportionate manner compared with other elective activity. We will only get this information once BMS has restarted and outcomes recorded on the NBSR in near-real time. BOMSS proposes a weekly NBSR report during the coming year to constantly update our knowledge of the safety of BMS in the COVID-era.

Until we have these data to guide us, there is a fear that some hospitals (influenced by the stigma that still surrounds obesity and BMS) will cite the broad recommendations issued by the Royal Colleges to unreasonably demote BMS as a low priority specialty, thereby denying patients at the greatest risk of death and severe COVID-19 access to potentially lifesaving care. BOMSS does not support such an approach and believes carefully audited bariatric programmes should be restarted at the earliest opportunity.

BOMSS believes that published recommendations for prioritisation of elective surgery are a valuable tool in assisting clinicians to prioritise patients within their own specialty, but should not be used to prioritise patients for care across different branches of surgery. This would otherwise create a highly divisive situation and be a poor use of NHS resource (with some surgeons in ‘high priority’ specialties over-worked in theatre whilst others stood idle).

In keeping with advice from the Royal Colleges of Surgeons [4], instead of adopting a blanket policy we recommend that commissioners, service managers and surgeons should seek data-driven solutions that recognise that the level of risk varies across the UK and encourage BMS
services compliant with this BOMSS position statement to recommence surgery at the start of July 2020.

The following statements set out BOMSS’ current position of the safe resumption of bariatric surgery in the UK:

1. **The Current Status of Elective Bariatric Surgery**

   - Severe and complex obesity damages the physical and psychological health of patients and if untreated can promote multi-system end-organ damage, cancer and early death.
   - Bariatric surgery in the UK is exceptionally safe and is by far the most effective treatment for severe and complex obesity. It can reverse organ damage, type 2 diabetes, sleep apnoea/obesity hypoventilation and many other co-morbid conditions associated with obesity.
   - Bariatric surgery should not be viewed as a discretionary service and most patients awaiting treatment are at risk of harm should their treatment be delayed for many months during the re-start of NHS elective work.
   - The strong evidence linking obesity with worse outcomes from COVID-19 only adds to the importance of ensuring that resumption of bariatric surgical programmes is prioritised by the NHS.
   - Self-funding patients with obesity have similar clinical needs to NHS patients and the principles governing any resumption of NHS bariatric activity should apply equally to the private sector.

2. **Prioritisation of Bariatric Patients**

   - Theatre throughput will be reduced in the COVID-era.
   - BOMSS therefore encourages bariatric MDTs to carry out an expedited review of the clinical records of all patients on their waiting list and decide which individuals could be appropriately categorised as Cat 1-4 using the bariatric prioritisation template shown in Table 1. **Table 1 is a guide and is not exhaustive, nor is it intended to be a proscriptive document.**
   - Local MDTs should prioritise admissions taking into account patient and local factors (such as the hospital’s capacity to take on higher risk patients at the current time).
   - It is the bariatric MDT that should make a clinical decision on which patients to prioritise, the reasons should be documented in MDT minutes and a member of the MDT (not a non-
clinical administrator) should contact each patient to inform them of the implications of accepting an offer of admission at the present time as part of an advanced consent process (see below).

- If patients wish to defer their surgery, they should be able to do this without risk of being removed from the surgical pathway.

3. Consent

- We recommend a policy of "COVID-enhanced" informed consent. This should occur before admission and should be performed (virtual or F2F) by the operating surgeon and not a designee.

- The following areas should be discussed and documented:
  
a) Explain the lack of information on the true risks of otherwise routine bariatric procedures during the pandemic.

b) Explain the uncertain (but likely increased) risk of nosocomial infection with SARS-CoV-2, particularly if surgery is not carried out at a ‘cold’ site.

c) Inform patients that the pandemic has changed day-to-day hospital operations in ways that have the potential to significantly alter their perioperative care and experience.

d) Discuss the possible impact of pandemic-associated healthcare resource shortages on the care of the postoperative patient.

e) Consider the value of advance directives and living wills for patients undergoing surgery during the pandemic to allow care teams to make time-sensitive medical decisions that respect the wishes and dignity of the patient.

4. Additional Measures in Preparation for Surgery

a) Screening:

The local bariatric pre-admission assessment should be modified to include a period of pre-admission self-isolation for 14 days, swab testing before admission, symptom questionnaires and temperature checks. Most hospitals already have similar local or regionally agreed procedures in place to manage patient admissions.

This advice may change in future as accurate rapid diagnostic testing becomes more widely available.

b) Advanced Consent:

See section 3 above
c) Admission should be to clinical facilities that are geographically or physically separate from COVID-19 treatment areas to minimise the risk of nosocomial infection with SARS-CoV.

d) Regular screening of staff including surgeons, particularly if they work across both acute and ‘cold’ elective surgery sites.

e) As per BOMSS previously issued Commissioning and Professional Standards Guidance, a robust critical care transfer policy should be in place to manage patients who need care escalation in the post-operative period.

f) It is BOMSS’ view based on current evidence that it is not necessary to otherwise alter the usual bariatric inpatient pathway which has proven so successful at producing exceptionally safe surgical outcomes in the UK

5. **Intra-operative Considerations**

- Laparoscopy surgery has significant advantages over open surgery in the treatment of patients with severe and complex obesity:
  - reduced LOS, thus reduced risk of nosocomial SARS-CoV-2 infection;
  - enhanced recovery with reduced risk of LRTI, ventilation and non-invasive respiratory support;
  - reduced risk of VTE;
  - reduced risk of incisional hernia
  - reduced risk of death

- BOMSS strongly recommends that bariatric surgery should be carried out laparoscopically with appropriate precautions to minimise the potential harm from aerosolisation of viral particles and patient body fluids.

- As the risk of transmission of live viral particles to staff during laparoscopic surgery remains unclear, BOMSS recommends the continued use of enhanced PPE in line with hospital policies until this level of risk is better defined and minimising the number of staff in theatre during surgery.

- BOMSS has endorsed guidance produced by the Association of Laparoscopic Surgeons of GB and Ireland [5] for safe laparoscopic practice including the use of low-pressure pneumoperitoneum (12mm Hg), smoke extraction systems, controlled and filtered release of pneumoperitoneum (particularly during specimen extraction during sleeve gastrectomy) etc.
• List planning should allow adequate time for case turnover to avoid the risk of admitting a patient and then subsequently cancelling their procedure on the day.

• BOMSS strongly recommends that reallocation of clinical staff should not impact on the provision of team members trained and experienced in the specialist management of bariatric surgery and anaesthesia.

6. Training

• BOMSS acknowledges the inevitable impact of COVID-19 on surgical training.

• Trainees should be encouraged to act as first assistant in the early phase of the reintroduction of bariatric surgery and this should be a requirement that applies equally to NHS and independent sector hospitals.

• Once the safety of bariatric surgery has been established, training should be re-instigated at the earliest opportunity and consideration given to dual surgeon operating (particularly given problems with PPE fatigue), with supervised trainees acting as one half of a two-person operating team.

7. Post-operative Care

• Bariatric patients should recover from surgery using existing enhanced recovery protocols in a COVID-free ward area

• Surgical and nursing teams should aim for an inpatient stay of 1-2 nights to minimise the risk of nosocomial infection.

• Bariatric surgery is considered to be a higher risk specialty for litigation. BOMSS strongly recommends that all patients should be swabbed for COVID-19 as the final step before discharge from hospital.

• Patients should avoid social contact for two weeks after discharge

• Multidisciplinary follow-up remains essential and protocols should not differ from pre-COVID standards of care other than
  o An increased use of remote consultation (although patients should attend in person to allow accurate recording of weight in the case of suspected post-operative nutritional compromise)
Where contractually possible, an increase in primary care delivered phlebotomy services for post-op nutritional monitoring. Consideration should also be given to self-administered blood monitoring using commercial finger prick testing kits.

8. Audit

- For the remainder of 2020, BOMSS’ position is that it is mandatory that surgical teams enter the following data into NBSR in near-real time (within max 48 hrs of surgery or discharge):
  
  a) NHS Number and details of the index procedure;
  
  b) in-patient complications;
  
  c) unplanned admission to critical care for invasive/non-invasive respiratory support, sepsis
  
  d) any other SUI

- In addition, immediate reporting of any unplanned readmission is required. The 6-week post-op follow-up appointment (remote or F2F) should also include direct questions about any readmission and details reported to NBSR (even if negative) immediately.

- NBSR will produce a weekly report of SUI and COVID-related outcomes to closely monitor the re-introduction bariatric surgery and share this with BOMSS members

- Our view is that it would be unsafe to practice without such close oversight of outcomes.
### TABLE 1
Categorisation guide for bariatric surgery

<table>
<thead>
<tr>
<th>Category</th>
<th>Maximum Waiting Time</th>
<th>Examples of bariatric surgery</th>
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| 1        | Emergency             | Suspected obstructed/strangulated internal hernia  
Acute band complication, eg acute slippage, erosion, port/band infection  
Early or late major complications related to index procedure  
Balloon intolerance |
| 2        | Up to 4 weeks         | Dysphagia/vomiting due anastomotic stenosis/refractory stomal ulcer  
Nutritional failure (once nutritionally and clinically optimised) for surgical intervention |
| 3        | Up to 3 months        | Severe Diabetes  
Poorly controlled HbA1c >8% (64mmol/mol) on 2 or more diabetic oral meds  
Insulin use  
Microalbuminuria or CKD 3-4  
NASH  
Adjuvant bariatric/metabolic surgery required to enable access to other time-sensitive treatments  
Organ transplant  
Arthroplasty (impaired mobility)  
CABG  
Significant Comorbidity  
>2 conditions (other than T2DM) increasing cardiovascular risk  
Severe Obstructive Sleep apnoea  
BMI >60  
Cardiac failure (AHA C)  
Removal of intragastric balloons that have reached their 6- or 12-month removal date |
| Not currently designated as category by RCS | 3-12 months | Moderate Diabetes  
HbA1c <8 on oral medication  
No history of cardiovascular disease  
No more than 1 other metabolic condition increasing cardiovascular risk eg hypertension  
No evidence of significant microvascular disease  
Adjuvant therapy/metabolic surgery  
Enable treatment of other less time sensitive conditions  
arthroplasty in the case of mild-moderate impairment of mobility  
Less Significant Comorbidity  
Mild-moderate obstructive sleep apnoea  
Moderate osteoarthritis  
Hypertension  
Weight-related depression  
BMI>50 |
|---|---|---|
| 4 | Up to or beyond 12 months | BMI 40-50 – no clinically apparent weight related comorbidity  
Mild physical/physiological dysfunction related to weight |

This advice is current at 28th May 2020.

It is will be kept under regular the review and updated in the light of future developments and greater understanding of the impact of COVID-19 on elective bariatric surgery.
References


