Diabetes Surgery Summit consensus lays foundation for ‘diabetes surgery'

Currently, bariatric surgery is only available as a treatment for severe obesity, defined as a BMI of at least 35, according to National Institutes of Health guidelines established in 1991. A new consensus statement on diabetes surgery acknowledges that the BMI cutoff is arbitrary and not supported by scientific evidence and recognizes the need to use more appropriate criteria for surgery in patients with diabetes.

The consensus statement, published in *Annals of Surgery*, illustrates the findings of the first international Diabetes Surgery Summit, in which an international group of more than 50 medical and scientific experts met in Rome and agreed on a set of evidence-based guidelines and definitions to guide the use and study of gastrointestinal surgery to treat type 2 diabetes.

“We have finally established safety measures to guide the development of diabetes surgery from the very onset,” Francesco Rubino, MD, director of the gastrointestinal metabolic surgery program at Weill Cornell Medical College in New York, told *Endocrine Today*.

“The importance of bariatric surgery in this population is fundamental, and there is room for better, additional treatment of these patients,” Rubino said. We felt that in order for these recommendations to be credible, they needed to come from a multidisciplinary group representing all areas of expertise, which they have.”

The recommendations summarize the mounting body of evidence showing that bariatric surgery effectively reverses type 2 diabetes in a high proportion of morbidly obese patients, even well before they have lost a significant amount of body weight.

Recommendations for diabetes surgery

Gastrointestinal surgery (ie, Roux-en-Y gastric bypass, laparoscopic adjustable gastric banding or biliopancreatic diversion) is recommended as a reasonable treatment option for patients with type 2 diabetes and BMI ≥35 who are inadequately controlled by lifestyle and medical therapy.

Surgery may also be appropriate as a non-primary alternative for patients with type 2 diabetes and mild-to-moderate obesity (BMI 30 to 35), according to the position statement. In this patient population, Roux-en-Y gastric bypass may be an appropriate surgical option.

This recommendation “goes beyond parameters established by the NIH for bariatric surgery in 1991, which reserved bariatric surgery for people with a BMI of ≥35 with an obesity-related condition or a BMI of ≥40 with or without any obesity-related condition,” according to the statement.

Moreover, the Diabetes Surgery Summit group achieved strong consensus that certain intestinal bypass procedures engage antidiabetes mechanisms beyond those related to
reduced food intake and body weight.

The consensus group also recommended:

- Novel gastrointestinal surgical techniques such as duodenal-jejunal bypass, ileal interposition, sleeve gastrectomy and endoluminal sleeves should be used only in institutional review board-approved and registered trials, despite promising results for the treatment of type 2 diabetes in early clinical studies.
- Randomized controlled trials to assess the efficacy, safety and utility of gastrointestinal surgery to treat type 2 diabetes and identification of parameters other than BMI as criteria for appropriate patient selection.
- Establishment of a multidisciplinary task force to guide the study and development of diabetes surgery is a high priority.

Two proposals did not achieve consensus:

- Laparoscopic adjustable gastric banding for the treatment of diabetes in patients with BMI <35 (only 66% of panel members endorsed its use).
- Biliopancreatic diversion for the treatment of diabetes in patients with BMI <35 (only 33% endorsed its use)

“The science of diabetes, obesity and surgery has significantly advanced since 1991, and the evidence suggests that a precise BMI cutoff of 35 is not a good predictor of whether or not surgery will induce diabetes remission or improvement,” Philip R. Schauer, MD, of the Bariatric and Metabolic Institute, Lerner College of Medicine, Cleveland Clinic, said in a press release.

Rubino added, “Once a patient has full-blown diabetes, BMI can’t accurately predict that patient’s cardiovascular risk. It simply doesn’t make sense to offer the surgical option to a patient with a BMI of 35 and deny it to one with a BMI of 34, especially if the latter patient has more severe diabetes.” – by Jennifer Southall