Bariatric Surgery (for Nebraska Only)

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Instructions for Use

Table of Contents **Page**

Related Policies

- Minimally Invasive Procedures for Gastric and Esophageal Diseases
- Obstructive and Central Sleep Apnea Treatment (for Nebraska Only)
- Robotic-Assisted Surgery Policy

Application

This Medical Policy only applies to the State of Nebraska.

Coverage Rationale

State-Specific Criteria

For medical necessity clinical coverage criteria, refer to the Nebraska Medical Assistance Program Services, Chapter 18, Physicians' Services.

Note: According to the Nebraska Administrative Code (NAC), bariatric procedures must be performed at a Bariatric Surgery Center of Excellence.

Additional Non State-Specific Criteria

The following bariatric surgical procedures are proven and medically necessary for treating obesity:

- Adjustable gastric banding (using open or laparoscopic approaches) for individuals ≥ 18 years of age; refer to the U.S. Food and Drug Administration (FDA) section for additional information
- Sleeve gastrectomy (vertical sleeve gastrectomy)
- Vertical banded gastroplasty

In adults, bariatric surgery using one of the procedures identified above for treating obesity is proven and medically necessary when all of the following criteria are met:

- **One** of the following:
  - Class III obesity; **or**
  - Class II obesity in the presence of one or more of the following co-morbidities:
    - Type 2 diabetes; **or**

        - Cardiovascular disease [e.g., history of stroke and/or myocardial infarction, poorly controlled hypertension (systolic blood pressure-greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite pharmacotherapy)]; **or**
        - History of coronary artery disease with a surgical intervention such as coronary artery bypass or percutaneous transluminal coronary angioplasty; **or**
        - History of cardiomyopathy; **or**
        - Obstructive Sleep Apnea (OSA) confirmed on polysomnography with an AHI or RDI of ≥ 30

    and
- The individual must also meet the following criteria:
    - Both of the following:
        - Completion of a preoperative evaluation that includes a detailed weight history along with dietary and physical activity patterns; **and**
        - Psychosocial-behavioral evaluation by an individual who is professionally recognized as part of a behavioral health discipline to provide screening and identification of risk factors or potential postoperative challenges that may contribute to a poor postoperative outcome

        or
    - Participation in a Multidisciplinary surgical preparatory regimen

In Adolescents, the bariatric surgical procedures identified above are proven and medically necessary for treating obesity when all of the following criteria are met:
- **One** of the following:
    - Class III obesity; **or**
    - Class II obesity in the presence of one or more of the following co-morbidities:
        - Type 2 diabetes; **or**
        - Poorly controlled hypertension (systolic blood pressure-greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite pharmacotherapy); **or**
        - Obstructive Sleep Apnea confirmed on polysomnography with an AHI or RDI of ≥ 30

    and
- The individual must also receive an evaluation at, or in consultation with, a multidisciplinary center focused on the surgical treatment of severe childhood obesity. This may include adolescent centers that have received accreditation by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) or can demonstrate similar programmatic components.

Revisional Bariatric Surgery using one of the procedures identified above is proven and medically necessary when due to a technical failure or major complication from the initial procedure; potential failure/complications include but are not limited to the following:
- Bowel perforation (including adjustable gastric band erosion)
- Adjustable gastric band migration (slippage) that cannot be corrected with manipulation or adjustment (records must demonstrate that manipulation or adjustment to correct band slippage has been attempted)
- Leak
- Obstruction (confirmed by imaging studies)
- Staple-line failure
- Mechanical adjustable gastric band failure
- Uncontrollable reflux related to sleeve gastrectomy when all the following criteria are met:
    - Maximum nonpharmacological medical management failure (e.g., positional, dietary modification and behavioral changes); **and**
    - Maximum pharmacological medical management failure (e.g., at least one month of double dose PPI, H2 blocker, and/or sucralfate); **and**
    - Severe esophagitis (class C or D) confirmed by endoscopy despite maximum medical management

Removal of adjustable gastric band and all related components which does not result in a revisional surgery is proven and medically necessary.

The following procedures are unproven and not medically necessary for treating obesity due to insufficient evidence of efficacy:

- Revisional Bariatric Surgery for any other indication than those listed above
- Bariatric surgery as the primary treatment for any condition other than obesity
- Bariatric interventions for the treatment of obesity including but not limited to:
  - Bariatric artery embolization (BAE)
  - Gastric electrical stimulation with an implantable gastric stimulator (IGS)
  - Intragastric balloon
  - Laparoscopic greater curvature plication, also known as total gastric vertical plication
  - Mini-gastric bypass (MGB)/Laparoscopic mini-gastric bypass (LMGBP)
  - Single-Anastomosis Duodenal Switch [also known as duodenal switch with single anastomosis, or stomach intestinal pylorus sparing surgery (SIPS)]
  - Stomach aspiration therapy (AspireAssist®)
  - Transoral endoscopic surgery [includes TransPyloric Shuttle® (TPS®) Device, endoscopic sleeve gastroplasty]
  - Vagus nerve blocking (VBLOC®)

Gastrointestinal liners (EndoBarrier®) are investigational, unproven and not medically necessary for treating obesity due to lack of U.S. Food and Drug Administration (FDA) approval, and insufficient evidence of efficacy.

Definitions

Adolescent: Individuals 12-21 years of age [Hardin and Hackell (American Academy of Pediatrics), 2017]. For the purposes of this policy, adults are considered ≥ 18 years of age.

Body Mass Index (BMI): A person's weight in kilograms divided by the square of height in meters. BMI can be used as a screening tool but is not diagnostic of the body fatness or health of an individual [Centers for Disease Control and Prevention (CDC), 2017].

The National Heart, Lung and Blood Institute's (NHLBI) Practical Guide Identification, Evaluation and Treatment of Overweight and Obesity in Adults classifies the ranges of BMI in adults as follows:
- < 18.5 - Underweight
- 18.5 to 24.9 kg/m^2 – Normal Weight
- 25-29.9 kg/m^2 – Overweight
- 30-34.9 kg/m^2 – Obesity Class I
- 35-39.9 kg/m^2 – Obesity Class II
- ≥ 40 kg/m^2 – Obesity Class III

The American Society of Metabolic and Bariatric Surgeons (ASMBS; Pratt et al., 2018), classifies severe obesity in adolescents as follows:
- Class II Obesity – 120% of the 95th percentile height, or an absolute BMI of 35-39.9 kg/m^2, whichever is lower*
- Class III Obesity – 140% of the 95th percentile height, or an absolute BMI of ≥ 40 kg/m^2, whichever is lower

*Also as defined by the American Heart Association (Kelly et al., 2013).

Los Angles (LA) Classification of Oesophagitis:
Grade A: One (or more) mucosal break no longer than 5 mm that does not extend between the tops of two mucosal folds
Grade B: One (or more) mucosal break more than 5 mm long that does not extend between the tops of two mucosal folds
Grade C: One (or more) mucosal break that is continuous between the tops of two or more mucosal folds but which involve less than 75% of the circumference
Grade D: One (or more) mucosal break which involves at least 75% of the esophageal circumference
(Lundell, et al. 1999)

Multidisciplinary: Bariatric center or regimen combining or involving several academic disciplines or professional specializations in an approach to create a well-trained, safe and effective environment for the complex bariatric patient. Building the multidisciplinary team includes staff such as the bariatric surgeon, obesity medicine specialist, registered dietician,

specialized nursing, behavioral health specialist, exercise specialist and support groups [American Society for Metabolic and Bariatric Surgery (ASMBS) textbook of bariatric surgery].

Obstructive Sleep Apnea (OSA): The American Academy of Sleep Medicine (AASM) defines OSA as a sleep related breathing disorder that involves a decrease or complete halt in airflow despite an ongoing effort to breathe. OSA severity is defined as:

- Mild for AHI or RDI ≥ 5 and < 15
- Moderate for AHI or RDI ≥ 15 and ≤ 30
- Severe for AHI or RDI > 30/hr

For additional information, refer to the Medical Policy titled Obstructive and Central Sleep Apnea Treatment.

Revisional Bariatric Surgery:

- Conversion – A second bariatric procedure that changes the bariatric approach from one procedure to a different type of procedure [e.g., sleeve gastrectomy or adjustable gastric band converted to Roux-en-Y (RYGB)]. Note: This is not to the same as an intraoperative conversion (e.g., converting from laparoscopic approach to an open procedure).
- Corrective – A procedure that corrects or modifies anatomy of a previous bariatric procedure to achieve the original desired outcome or correct a complication. These procedures also address device manipulation (e.g., gastric pouch resizing, re-sleeve gastrectomy, limb length adjustments in RYGB and gastric band replacement).
- Reversal – A procedure that restores original anatomy.

(Mirkin, et al. 2021)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Coding Clarification: Utilize CPT code 43775 to report laparoscopic sleeve gastrectomy rather than the unlisted CPT code 43659.

CPT Code	Description
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43659	Unlisted laparoscopy procedure, stomach
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only

CPT Code	Description
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
43999	Unlisted procedure, stomach
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
64999	Unlisted procedure, nervous system

Description of Services

Obesity

Obesity is defined clinically using the Body Mass Index (BMI). Obesity is a significant health concern due to its high prevalence and associated health risks.

Health consequences associated with obesity include hypertension, Type II diabetes, hyperlipidemia, atherosclerosis, heart disease, stroke, diseases of the gallbladder, liver disease, osteoarthritis, Obstructive Sleep Apnea and other respiratory problems. In addition, certain cancers are more prevalent in obese individuals, including endometrial, ovarian, breast, prostate, colon cancer, renal cell carcinoma, and non-Hodgkin's lymphoma.

The U.S. Preventive Services Task Force (USPSTF) recommends screening all adults for obesity. Clinicians should offer or refer patients with a BMI of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions (USPSTF, 2012).

The National Health and Nutrition Examination Survey (NHANES) report explains the creation of the 2017–March 2020 pre-pandemic data files provide recommendations for and limitations of the files' use and presents prevalence estimates for

selected health outcomes based on the files. The report indicates the prevalence of obesity was 41.9% in adults and 19.7% in children. This information was part of the last NHANES data collected before widespread transmission of COVID-19.

The National Heart, Lung, and Blood Institute (NHLBI) Obesity Expert Panel (2013) estimates that 8.1% of women, and 4.4% of men in the U.S. population has a BMI over 40. The NHLBI clarified that the term Class III or Extreme Obesity has replaced the term "morbid obesity." The American Society for Metabolic and Bariatric Surgery [American Society of Metabolic and Bariatric Surgery (ASMBS)] (English et al., 2016) estimates there were over 216,000 bariatric surgery procedures in 2016.

Bariatric Surgery in the Adolescent Population

For adolescents, physical development and maturation may be determined utilizing the gender specific growth chart and BMI chart developed by the CDC, National Center for Health Statistics (2017).

First-Line Treatments for Obesity

First-line treatments for obesity include dietary therapy, physical activity, behavior modification, and medication management; all of which have often been unsuccessful in long-term weight management for obese individuals (Lannoo and Dillemans, 2014).

Bariatric Surgical Procedures

The goal of surgical treatment for obesity is to induce significant weight loss and, thereby, reduce the incidence or progression of obesity-related comorbidities, as well as to improve quality of life. The purpose of performing bariatric surgery in adolescent patients is to reduce the lifelong impact of severe obesity.

Surgical treatment of obesity offers two main weight-loss approaches: restrictive and malabsorptive. Restrictive methods are intended to cause weight loss by restricting the amount of food that can be consumed by reducing the size of the stomach. Malabsorptive methods are intended to cause weight loss by limiting the amount of food that is absorbed from the intestines into the body. A procedure can have restrictive features, malabsorptive features, or both. The surgical approach can be open or laparoscopic. The clinical decision on which surgical procedure to use is made based on a medical assessment of the patient's unique situation.

Laparoscopic Adjustable Gastric Banding (LAGB)

The laparoscopic adjustable gastric banding procedure involves placing an inflatable silicone band around the upper portion of the stomach. The silicone band contains a saline reservoir that can be filled or emptied under fluoroscopic guidance to change the caliber of the gastric opening.

Vertical Sleeve Gastrectomy (VSG)

VSG can be performed as part of a two-staged approach to surgical weight loss or as a stand-alone procedure. A VSG involves the removal of 60-75% of the stomach, leaving a narrow gastric "tube" or "sleeve." This small remaining "tube" cannot hold as much food and produces less of the appetite-regulating hormone ghrelin, lessening a patient's desire to eat. VSG is not a purely malabsorptive procedure, so there is no requirement for lifetime nutritional supplementation (California Technology Assessment Forum, 2015).

Vertical Banded Gastroplasty (VBG)

VBG restricts the size of the stomach using a stapling technique; there is no rearrangement of the intestinal anatomy. VBG has been abandoned by many due to a high failure rate, a high incidence of long-term complications, and the newer adjustable gastric band (AGB) and sleeve gastrectomy (van Wezenbeek et al., 2015). David et al. (2015) estimated the failure rate to be approximately 50% based on results from long-term studies.

Robotic-Assisted Surgery

Robotic surgery provides surgeons with three-dimensional vision, increased dexterity and precision by downscaling surgeon's movements enabling a fine tissue dissection and filtering out physiological tremor. It overcomes the restraint of torque on ports from thick abdominal wall and minimizes port site trauma by remote center technology (Bindal et al., 2015).

Transoral Endoscopic Surgery

Transoral endoscopic surgery is an option being explored for bariatric surgery. Natural orifice transluminal endoscopic surgery (NOTES) is performed via a natural orifice (e.g., mouth, vagina, etc.), and in some cases eliminates the need for abdominal incisions. This form of surgery is being investigated as an alternative to conventional surgery.

Transoral restorative obesity surgery (ROSE) is another endoscopic procedure. The endoscope with four channels is inserted into the esophagus and then the stomach. Specialized instruments are placed through the channels to create multiple folds around the existing stoma to reduce the diameter.

The Transpyloric Shuttle® (TPS®) device is a non-balloon, space occupying device with a 12-month treatment duration that is proposed as a new endoscopic bariatric therapy. The TPS device is comprised of a spherical silicone bulb connected to a smaller cylindrical silicone bulb by a flexible tether; it is delivered to and removed from the stomach using transluminal endoscopic procedures in the outpatient setting (Marinos, 2014;). The device was granted FDA premarket approval on April 16, 2019 and was approved for up to 12 months weight loss therapy in patients with a BMI of 35.0 kg/m^2 to 40.0 kg/m^2 or a BMI of 30.0 kg/m^2 to 34.9 kg/m^2 with 1 or more obesity-related comorbid condition. The device is intended to be used in conjunction with a diet and behavior modification program (ECRI, 2019).

Endoscopic Sleeve Gastroplasty (ESG) is a minimally invasive technique through the mouth that uses an endoscopic suturing device (e.g., OverStitch) to reduce gastric capacity by sealing off most of the stomach, forcing ingested food through an open tube of stomach tissue that connects the esophagus to the small intestine. ESG is similar to a laparoscopic sleeve gastrectomy in which the stomach is manipulated to create a tube-shape, however no stomach tissue is removed.

Implantable Gastric Stimulator (IGS)

IGS is a small, battery-powered device similar to a cardiac pacemaker, in a small pocket, created beneath the skin of the abdomen using laparoscopy. The IGS is programmed externally using a controller that sends radiofrequency signals to the device. Although the exact mechanism of action is not yet understood, gastric stimulation is thought to target ghrelin, an appetite-related peptide hormone (Gallas and Fetissov, 2011).

Vagus Nerve Blocking Neurostimulation Therapy (VBLOC)

VBLOC uses an implanted subcutaneous neurostimulator to deliver electrical pulses to the vagus nerve, which may suppress appetite (ECRI, 2016).

VBLOC therapy (such as via the Maestro® System; Enteromedics, Inc.) is designed to target the multiple digestive functions under control of the vagus nerves and to affect the perception of hunger and fullness.

Intragastric Balloon (IGB)

IGBs are acid-resistant balloons that are inserted into the stomach and expanded with saline or air. These space-occupying devices promote weight loss by creating a feeling of fullness, which can lead to reduced consumption of food. The devices are intended as an adjunct to diet, exercise, and behavioral counseling for the treatment of obesity (Hayes, 2021). Available clinical data and manufacturer recommendations indicate 6 months to be the current standard duration of therapy from insertion to removal (ASMBS, 2016).

Laparoscopic Greater Curvature Plication (LGCP) [also known as Total Gastric Vertical Plication (TGVP)]

LGCP is a restrictive procedure that involves folding and suturing the stomach onto itself to decrease the size of the stomach and requires no resection, bypass, or implantable device. This procedure is a modification of the gastric sleeve which requires surgical resection of stomach.

Stomach Aspiration Therapy

Stomach aspiration therapy, such as with the AspireAssist®, uses a surgically placed tube (endoluminal device) designed to aspirate a portion of the stomach contents after every meal (Hayes, 2021). The AspireAssist is intended for long-term use in conjunction with lifestyle therapy (to help patients develop healthier eating habits and reduce caloric intake) and continuous

medical monitoring. Patients must be monitored regularly for weight loss progress, stoma site heath, and metabolic and electrolyte balance.

Bariatric Artery Embolization (BAE)

BAE is a minimally invasive procedure which is the percutaneous, catheter-directed, trans-arterial embolization of the left gastric artery (LGA). The procedure is performed by an interventional radiologist and targets the fundus that produces the majority of the hunger-controlling hormone ghrelin. Beads placed inside the vessels purportedly help decrease blood flow and limit the secretion of ghrelin to minimize feelings of hunger to initiate weight loss.

Gastrointestinal Liners

Gastrointestinal liners, such as the EndoBarrier™ system, utilize an endoscopically implanted sleeve into the stomach to reduce the stomach size. The sleeve is then removed after weight loss has been achieved. The EndoBarrier is not approved for use by the U.S. Food and Drug Administration (FDA) in the United States; it is limited by federal law to investigational use only.

Revisional Surgery

The indications for revisional bariatric surgery vary greatly depending on the index procedure performed and the nature of the complication. Some complications may be encountered during the acute postoperative recovery period (leaks, abscesses, fistulae, etc.). Prior to revisional surgery, patients should undergo a thorough multidisciplinary assessment and consideration of their individual risks and benefits from revisional surgery (Brethauer et al., 2014). It is important to determine if the poor response to primary bariatric surgery is due to anatomic causes that led to inadequate weight loss or weight regain or to the patient's postoperative behavior, such as not following the prescribed diet and lifestyle changes (e.g., consuming large portions, high-calorie foods, and/or snacks between meals; not exercising). Uncontrollable reflux may be a complication experienced by some patients; first-line therapy for patients who experience GERD after bariatric surgery includes dietary and lifestyle modification, alcohol and smoking cessation, followed by acid-reducing medications (King et al. 2021).

The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) is a national accreditation standard for bariatric surgery centers. In 2012, the American College of Surgeons (ACS) and the American Society for Metabolic and Bariatric Surgery (ASMBS) combined their individual accreditation programs into a single unified program. MBSAQIP works to advance safe, high-quality care for bariatric surgical patients through the accreditation of bariatric surgical centers. A bariatric surgical center achieves accreditation following a rigorous review process during which it proves that it can maintain certain physical resources, human resources, and standards of practice. All accredited centers report their outcomes to the MBSAQIP database (MBSAQIP, 2019).

Clinical Evidence

The criteria for patient selection for bariatric surgery are relatively uniform among clinical studies published in the peer-reviewed literature and broadly correspond to criteria recommended by the American Association of Clinical Endocrinologists (AACE), the Obesity Society, and American Society for Metabolic & Bariatric Surgery (ASMB) (Mechanick et al., 2019):

- Patients with a BMI ≥ 40 kg/m^2 (Obesity Class III) with or without coexisting medical problems and for whom bariatric surgery would not be associated with excessive risk.
- Patients with a BMI ≥ 35 kg/m^2 (Obesity Class II) and one or more severe obesity-related co-morbidities.
- Demonstration that a multidisciplinary approach with dietary, other lifestyle modifications (such as exercise and behavioral modification), and pharmacological therapy, if appropriate, have been unsuccessful.

Refer to the Clinical Practice Guidelines section of the policy for additional information.

Khalaj et al. (2020) conducted a cohort study comparing gastric bypass (GB) to sleeve gastrectomy (SG) and the effectiveness and safety of these two procedures. The authors evaluated 2,202 patients that underwent laparoscopic SG and 1,085 patients who underwent laparoscopic GB. The SG procedure was performed over a 36-F bougie and reinforced with an omental pouch; the GB procedure was performed as either RYGB or one anastomosis (OAGB). Evaluation of weight loss included body mass index change, percent of total weight loss, and percentage of excess weight loss. Type 2 diabetes mellitus (T2DM), hypertension (HTN), and dyslipidemia, as obesity-associated comorbidities were assessed in all patients. There were no major complications identified which was recognized by a return to the operating room, prolonged hospital stays beyond 7 days, or

the need for re-admission. Quality of life (QoL) was assessed using the Iranian version of the Short-Form Health Survey which measured physical, social, and mental aspects of health. Patient follow up for both types of procedures occurred at 6, 12, and 24 months after surgery. The authors found no significant differences between the two surgical groups; patients that underwent SG had a lower FPG and HbA1C when compared to the GB group. BMI was not significantly different between the two groups. Excess weight loss (EWL)% was 61.9 ±15.7, 74.8 ±19.1, and 75.0 ±21.9 in the SG group and 62.7 ±15.3, 77.5 ±18.4, and 80.1 ±20.8 in the GB group at 6-, 12-, and 24-month follow-ups, respectively. All patient comorbidities and QoL improved. The authors concluded that bariatric surgery is effective and safe for treatment of obesity; while both procedures are effective for weight loss, remission of obesity-associated comorbidities, and QoL, SG is associated with fewer complications and nutritional deficiencies.

O'Brien et al. (2019) performed a systematic review and meta-analysis on 33 reports containing ten or more years of follow-up for patients that underwent bariatric surgery. The authors evaluated the long-term effectiveness of Roux-en-Y gastric bypass (RYGB), laparoscopic adjustable gastric banding (LAGB), or BPD/DS. Results for gastric bypass surgery showed a weighted mean % EWL of 56.7% at 10 or more years with a mean of 55.4% EWL. Eleven reports addressing BPD/DS showed a mean of 74.1% EWL and two reports for sleeve gastrectomy showed a mean of 57.0% EWL. A longitudinal cohort study for the patients receiving LAGB showed patient weight loss reached a peak at the 2-year follow-up and remained relatively stable through the next 18 years with a mean weight loss of 24.8 kg representing 47.2 %EWL. The authors concluded that RYGB, LAGB and BPD/DS lead to substantial weight loss which continued for at least 10 years. Due to patient education and lap band design changes, revisional surgery has decreased significantly over the past eleven years. The findings are limited by lack of direct comparison between techniques and lack of comparison groups not undergoing surgical treatments.

Zhao and Jiao (2019) conducted a systematic review to determine whether LRYGB and LSG are equivalent for mid- and long-term weight loss, resolution of comorbidities and adverse events (AEs). Eleven RCTs were included in the meta-analysis and the authors found no significant difference in excess weight loss between LRYGB and LSG nor any significant difference for T2D improvement. This analysis did identify more postoperative early complications for LRYGB, but no difference between the two procedures in later postoperative period. Future studies should focus on the comparison of complication and comorbidities. Limitations included the variation in sample size among the included studies which may have created a bias, variation of patient age and preoperative BMIs which may have led to heterogeneity, and failure of subgroup analysis for reoperation rate. Additional studies are needed to determine the relative long-term efficacy of different bariatric surgeries.

Salminen et al. (2018) reported 5-year outcomes from the SLEEVEPASS multicenter, open-label, randomized clinical equivalence trial. The purpose of the trial was to determine whether laparoscopic sleeve gastrectomy (LSG) (n = 121) and laparoscopic Roux-en-Y gastric bypass (n = 119) are equivalent for weight loss at 5 years in patients with morbid obesity. Among 240 patients randomized [mean age, 48 (SD, 9) years; mean baseline body mass index, 45.9, (SD, 6.0); 69.6% women], 80.4% completed the 5-year follow-up. Based on the results, the authors concluded that the use of laparoscopic sleeve gastrectomy compared with use of laparoscopic Roux-en-Y gastric bypass did not meet criteria for equivalence in terms of percentage excess weight loss at 5 years. Although gastric bypass compared with sleeve gastrectomy was associated with greater percentage excess weight loss at 5 years, the difference was not statistically significant, based on the prespecified equivalence margins. Limitations included a small number of bariatric procedures performed along with technical complications which may have resulted in a higher reoperation rate accompanied by 20% of patients lost to follow-up.

Chaar et al. (2018) reported 30-day outcomes of SG versus RYGB based on the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program database in a large retrospective cohort study. The authors' evaluation showed that the incidence of postoperative complications in the first 30 days after surgery is low for both RYGB and SG. However, SG seems to have a better safety profile in the first 30 days postoperatively compared with RYGB. These findings should be considered in the preoperative evaluation and counseling of bariatric patients. Long-term follow-up is needed to compare safety and efficacy of SG versus RYGB.

Jambhekar et al. (2018) evaluated demographic and socioeconomic factors in the United States that are predictors of long-term weight loss after LSG in a cohort study. Prospectively collected data on 713 consecutive primary LSG operations was included in this study. Multiple regression analyses were done to determine if gender, race, or socioeconomic factors such as insurance and employment status correlated with postoperative weight loss. The presence of chronic comorbidities affecting quality of life such as T2D and obstructive sleep apnea (OSA) were also recorded and analyzed. All studied groups had similar preoperative body mass index (BMI) (mean 46 kg/m^2). Race was not significantly associated with weight loss at any postoperative interval. Male gender was associated with increased weight loss through the first three months (48.2 ±12.5 lbs. vs. 40.5 ±11 lbs.; p =

0.0001). Patients with T2D had significantly less weight loss at the 6 through 18-month intervals (50.4 ±17.9 lbs. vs. 59.6 ±15.6 lbs. at six months; p = 0.00032; 53.3 ±25.4lbs vs. 80.5 ±31.3lbs at 18 months; p = 0.008). Patients with OSA had significantly less weight loss at the two-year interval (57.5 ±29.2 lbs.) vs. those without OSA (69.6 ±23.5 lbs.; p = 0.047). Finally, those patients who were students had the greatest weight loss at two years postoperatively with the least weight loss seen in retired patients followed by those on disability (108.0 ±21.5 lbs. vs. 26.0 lbs. vs. 46.0 ±19.7 lbs.; p = 0.04). Further studies are needed to evaluate whether demographic differences impact long term weight loss. Limitations included loss to follow-up, identification and testing of only selected predictive factors, thus underrepresenting other socioeconomic factors, and conflicting results were identified between the model variables.

Shoar and Saber (2017) conducted a systematic review and meta-analysis to compare long-term and midterm outcomes of LSG versus laparoscopic RYGB (LRYGB). Fourteen studies comprising 5,264 patients were eligible. Follow-up ranged from 36 months to 75.8 ±8.4 months. The pooled result for weight loss outcomes did not show any significant difference in midterm weight loss [standardized mean difference = -0.03; 95% confidence interval (CI), -0.38-.33; p = .88] but a significant difference in the long-term weight loss outcome favoring LRYGB (standardized mean difference = .17; 95% CI, .05-.28; p = .005). The pooled results demonstrated no significant difference for resolution of T2D, hypertension, hyperlipidemia, and hypertriglyceridemia. Despite the insignificant difference between LRYGB and LSG in midterm weight loss, LRYGB produced better weight loss in the long-term. There was no significant difference between the 2 procedures for co-morbidity resolution. A major limitation of this study was the inclusion of short-term studies in the pooled analysis of midterm studies but claimed to be a long-term meta-analysis.

Lager et al. (2017) retrospectively studied 30-day postoperative complications as well as changes in weight, blood pressure, cholesterol, hemoglobin, hemoglobin A1C, and creatinine from baseline to 2, 6, 12, and 24 months postoperatively in 383 patients undergoing RYGB and 336 patients undergoing SG. Follow-up rates were 706/719 at 2 months, 566/719 at 6 months, 519/719 at 12 months, and 382/719 at 24 months. Baseline characteristics were similar in both groups except for higher weight and BMI in the SG group. The RYGB group experienced greater total body weight loss at 6, 12, and 24 months (41.9 vs. 34.6 kg at 24 months, p < 0.0001). Excess weight loss was 69.7 and 51.7% following RYGB and SG respectively at 24 months (p < 0.0001). Blood pressure improved significantly in both groups. Surgical complication rates were greater after RYGB (10.1 vs. 3.5%, p = 0.0007) with no significant difference in life-threatening or potentially life-threatening complications. Weight loss was greater following RYGB compared to SG at 2 years. The authors recommend that surgical intervention be tailored to surgical risk, comorbidities, and desired weight loss. Limitations included retrospective design which may have impacted patient selection and other biases, incomplete biochemical data as some patients did not return to clinic for routine blood draws and performed at specific institution.

Schauer et al. (2017) reported 5-year outcomes from the STAMPEDE clinical trial which included 150 patients who had T2D and a BMI of 27 to 43 and were randomly assigned to receive intensive medical therapy alone or intensive medical therapy plus RYGB or SG. The primary outcome was a glycated hemoglobin level of 6.0% or less with or without the use of diabetes medications. Among the 134 participants (90%) who completed 5 years of follow-up, a glycated hemoglobin level of 6.0% or less at 5 years was achieved in 2 of 38 patients (5%) in the medical-therapy group, as compared with 14 of 49 patients (29%) in the RYGB group (p = 0.01) and 11 of 47 patients (23%) in the SG group (p = 0.03). Changes from baseline observed in the RYGB and SG groups were deemed as superior by the authors as compared to the changes seen in the medical-therapy group with respect to body weight (-23%, -19%, and -5% in the RYGB, SG, and medical-therapy groups, respectively), triglyceride level (-40%, -29%, and -8%), high-density lipoprotein cholesterol level (32%, 30%, and 7%), use of insulin (-35%, -34%, and -13%), and quality-of-life measures (general health score increases of 17, 16, and 0.3; scores on the RAND 36-Item Health Survey ranged from 0 to 100, with higher scores indicating better health) (p < 0.05 for all comparisons). No major late surgical complications were reported except for one reoperation. The authors concluded that five-year outcome data showed that, among patients with T2D and a BMI of 27 to 43, bariatric surgery plus intensive medical therapy was more effective than intensive medical therapy alone in decreasing, or in some cases resolving, hyperglycemia.

Kang and Le (2017) conducted a systematic review and meta-analysis to determine the effectiveness of bariatric surgical procedures. Eleven randomized controlled trials (RCTs) that met the criteria were included in the review. Of 9 trials (n = 765), the differences in mean BMI reduction were -0.76 (95% CI: -3.1 to 1.6) for RYGB versus SG, -5.8 (95% CI: -9.2 to -2.4) for RYGB versus LAGB, and -5.0 (95% CI: -9.0 to -1.0) for SG versus LAGB. Eight RCTs (n = 656) reported percentage excess weight-loss (%EWL), the mean differences between RYGB and SG, RYGB and LAGB, and SG and LAGB were 3.8% (95% CI: -8.5% to 13.8%), -22.2% (95% CI: -34.7% to -6.5%), and -26.0% (95% CI: -40.6% to -6.4%), respectively. The meta-analysis indicated low heterogeneity between studies, and the node splitting analysis showed that the studies were consistent between direct and

indirect comparisons (p > .05). The authors concluded that the RYGB and SG were similar in weight-loss effect, and both were superior to LAGB. Other factors such as complications and patient preference should be considered during surgical consultations.

In a systematic analysis, Osland et al. (2017a) evaluated the postoperative impact on T2D resolution following laparoscopic vertical sleeve gastrectomy (LVSG) and LRYGB. Seven RCTs involving a total of 732 patients (LVSG n = 365, LRYGB n = 367) met inclusion criteria. Significant diabetes resolution or improvement was reported with both procedures across all time points. Similarly, measures of glycemic control (HbA1C and fasting blood glucose levels) improved with both procedures, with earlier improvements noted in LRYGB that stabilized and did not differ from LVSG at 12 months postoperatively. Early improvements in measures of insulin resistance in both procedures were also noted in the studies that investigated this. The authors suggest that both procedures are effective in resolving or improving preoperative T2Din obese patients during the reported 3- to 5-year follow-up periods. However, further studies are required before longer-term outcomes can be elucidated. Areas identified that need to be addressed for future studies on this topic include longer follow-up periods, standardized definitions and time point for reporting.

Osland et al. (2017b) conducted a systematic review of non-diabetic comorbid disease status following LRYGB and LVSG. Six RCTs involving a total of 695 patients (LVSG n = 347, LRYGB n = 348) reported on the resolution or improvement of comorbid disease following LVSG and LRYGB procedures. The authors concluded that this systematic review of RCTs suggests that both LVSG and LRYGB are effective in resolving or improving preoperative nondiabetic comorbid diseases in obese patients. While results are not conclusive, in the authors' opinion, LRYGB may provide superior results compared to LVSG in mediating the remission and/or improvement in some conditions such as dyslipidemia and arthritis.

Polega et al. (2017) conducted a matched cohort study of laparoscopic BPD/DS and SG to compare 30-day outcomes. Of the 741 patients who underwent BPD/DS or SG, 2 cohorts of 167 patients each were matched for age, sex, and BMI. Length of stay (LOS) was longer in the BPD/DS cohort (2.5 ±.9 days versus 2.1 ±.7 days, p < .001). There were no significant differences between the groups in relation to 30-day postoperative rates of leak (0.3% versus 0.6%, p > 0.99), bleed (0% versus 0.3%, p > 0.99), reoperation (1.2% versus .6%, p > .99), or readmission (3% versus 1.2%, p = .45). There were no mortalities. After matching for age, sex, and BMI, the authors found no significant differences between BPD/DS and SG with regard to 30-day postoperative rates of leak, bleed, reoperation, readmission, or mortality.

Maciejewski et al. (2016) examined 10-year weight changes in a large, multisite, clinical cohort of veterans who underwent RYGB compared with nonsurgical matches and the 4-year weight change in veterans who underwent RYGB, adjustable gastric banding (AGB), or SG. The 1,787 patients undergoing RYGB had a mean (SD) age of 52.1 (8.5) years and 5,305 nonsurgical matches had a mean (SD) age of 52.2 (8.4) years. Patients undergoing RYGB and nonsurgical matches had a mean body mass index of 47.7 and 47.1, respectively, and were predominantly male [1,306 (73.1%) and 3,911 (73.7%), respectively]. Patients undergoing RYGB lost 21% (95% CI, 11%-31%) more of their baseline weight at 10 years than nonsurgical matches. A total of 405 of 564 patients undergoing RYGB (71.8%) had more than 20% estimated weight loss, and 224 of 564 (39.7%) had more than 30% estimated weight loss at 10 years compared with 134 of 1,247 (10.8%) and 48 of 1247 (3.9%), respectively, of nonsurgical matches. Only 19 of 564 patients undergoing RYGB (3.4%) regained weight back to within an estimated 5% of their baseline weight by 10 years. At 4 years, patients undergoing RYGB lost 27.5% (95% CI, 23.8%-31.2%) of their baseline weight, patients undergoing AGB lost 10.6% (95% CI, 0.6%-20.6%), and patients undergoing SG lost 17.8% (95% CI, 9.7%-25.9%). Patients undergoing RYGB lost 16.9% (95% CI, 6.2%-27.6%) more of their baseline weight than patients undergoing AGB and 9.7% (95% CI, 0.8%-18.6%) more than patients undergoing SG. The authors concluded that surgical patients lost substantially more weight than nonsurgical matches and sustained most of this weight loss in the long term. RYGB induced significantly greater weight loss among veterans than SG or AGB at 4 years. Limitations included lack of randomization, lack of specificity in disease severity, bias due to loss of follow-up and lack of systematic weight data collection.

In a systematic review and meta-analysis, Osland et al. (2016) evaluated the early postoperative complication rate (i.e. within 30-days) in 6 RCTs involving a total of 695 patients (LVSG n = 347, LRYGB n = 348). A statistically significant reduction in relative odds of early major complications favoring the LVSG procedure was noted (p = 0.05). Five RCTs representing 633 patients (LVSG n = 317, LRYGB n = 316) reported early minor complications. A non-statically significant reduction in relative odds of 29% favoring the LVSG procedure was observed for early minor complications (p = 0.4). However, other outcomes directly related to complications which included reoperation rates, readmission rate, and 30-day mortality rate showed comparable effect size for both surgical procedures. The authors concluded that this meta-analysis and systematic review of RCTs suggests

that fewer early major and minor complications are associated with LVSG compared with LRYGB procedure. However, this does not translate into higher readmission rate, reoperation rate, or 30-day mortality for either procedure.

Xie et al. (2016) prospectively evaluated Apnea-Hypopnea Index (AHI) and Functional Outcomes of Sleep Questionnaires Scores (FOSQ) pre- and post-operatively in patients undergoing bariatric surgery. A total of 167 subjects were studied. The median age was 46 (14-75) years and BMI 49 (36-69) kg/m^2. Ninety-two (55.0%) patients were diagnosed with OSA preoperatively. Fifty (54.0%) required positive airway pressure (PAP) therapy. The mean reduction in BMI post bariatric surgery was 12.2 ±4.52 kg/m^2 at 6.56 ±2.70 months. Eighty (87.9%) reported improved sleep quality reflected in improved scores in all domains of the FOSQ ($p < 0.001$, paired t-test). Improvement in FOSQ scores remained significant ($p < 0.05$) in those with and without OSA. Thirty-nine (90.7%) patients discontinued PAP due to resolution of daytime sleepiness. In conclusion, the authors identified that weight loss following bariatric surgery has a positive impact on sleep in patients with and without OSAS. The findings are however limited by lack of comparison group without bariatric surgery.

Giordano (2015) conducted retrospective comparative study of consecutive super-obese patients. Patients either underwent RYGB (n = 102) or LAGB (n = 79). Early complications and weight loss outcomes were comparable between the two groups in the short term. However, weight loss and excess weight loss percent at 6 and 12 months of follow-up was significantly higher in patients who underwent RYGB than LAGB.

Arterburn et al. (2015) evaluated the association between bariatric surgery and long-term survival in a retrospective cohort study of obese patients treated at the Veterans Administration (VA) health system. A cohort of surgical patients [n = 2,500; mean age, 52 years; mean body mass index (BMI) of 47], undergoing any bariatric surgery procedure, were compared with control patients (n = 7,462). At the end of 14 years, there were a total of 263 deaths in the surgical cohort group (n = 2,500) and 1,277 deaths in the matched controls (n = 7,462). Based on Kaplan-Meier estimates, mortality rates were 2.4% at 1 year, 6.4% at 5 years, and 13.8% at 10 years for surgical cohort patients. In the matched controls, mortality rates were 1.7% at 1 year, 10.4% at 5 years, and 23.9% at 10 years. Bariatric surgery was associated with reduced mortality compared controls after 1 to 5 years [hazard ratio (HR), 0.45; 95% CI, 0.36 to 0.56] and after 5 years (HR, 0.47; 95% CI, 0.39 to 0.58). Across different subgroups based on diabetes diagnosis, sex, and period of surgery, there were no significant differences between surgery and survival at the mid- and long-term evaluations. Limitations include lack of randomization and retrospective design, lack of disease specificity due to inaccurate identification of comorbid conditions with ICD-9 classification, and a small number of cases missing preoperative BMI data which may have affected the results.

Magallares et al. (2015) conducted a meta-analysis of 21 studies evaluating the mental and physical health-related quality of life (HR-QOL) measures with the Short Form-36 (SF-36) before and after bariatric surgery. Study authors reported that obese patients scored less in the mental health component of SF-36 prior to bariatric surgery (n = 2,680) compared with after surgery (n = 2,251). Similar results were observed in the physical health component of SF-36. Study authors concluded that obese patients experienced strong improvement in mental and physical QOL measures following surgery. The findings are limited by lack of comparison group.

A retrospective cohort study was conducted by Yska et al. (2015) within the Clinical Practice Research Datalink involving 2,978 patients with a record of bariatric surgery, with a BMI of > 35. They identified 569 patients with T2D and matched them to 1,881 patients with T2D without bariatric surgery. Data on the use of medication and laboratory results were evaluated. Among patients undergoing bariatric surgery, the authors found a prevalence of 19.1% for T2D. Per 1,000 person-years, 94.5 T2D remissions were found in patients who underwent bariatric surgery compared with 4.9 remissions in matched control patients. Patients with T2D who underwent bariatric surgery had an 18-fold increased chance for remission [adjusted relative rate (RR), 17.8; 95% CI, 11.2-28.4] compared with matched control patients. The authors conclude that bariatric surgery strongly increases the chance for remission of T2D with gastric bypass and sleeve gastrectomy having a greater effect than gastric banding. Limitations included discrepancy between the patient's actual use of medication and what was recorded along with incomplete recording of clinical and laboratory testing.

A 2014 Cochrane Systematic Review of RCTs by Colquitt et al. found that surgery results in greater improvement in weight loss outcomes and weight associated comorbidities compared with non-surgical interventions, regardless of the type of procedures used. They noted the overall quality of evidence in this analysis to be moderate. When compared with each other, certain procedures resulted in greater weight loss and improvements in comorbidities than others. Outcomes were similar between RYGB and SG, and both of these procedures had better outcomes than AGB. However, in one RCT, the LRGYB procedure resulted in greater duration of hospitalization in two RCTs (4/3.1 versus 2/1.5 days) and a greater number of late major

complications (26.1% versus 11.6%). For people with very high BMI, biliopancreatic diversion with duodenal switch resulted in greater weight loss than RYGB. Duodenojejunal bypass with sleeve gastrectomy and LRYGB had similar outcomes; however, this was based on one small trial. Isolated SG led to better weight-loss outcomes than AGB after three years follow-up. This was based on one trial only. Weight-related outcomes were similar between laparoscopic gastric imbrication and LSG in one trial. Across all studies adverse event rates and reoperation rates were generally poorly reported. The authors also found that most trials followed participants for only one or two years, therefore the long-term effects of surgery remain unclear. In addition, open RYGB, LRYGB and LSG led to losses of weight and/or BMI but there was no consistent picture as to which procedure was better or worse in the seven included trials.

In a systematic review and meta-analysis, Chang et al. (2014) examined the effectiveness and risks of bariatric surgery using up-to-date, comprehensive data and appropriate meta-analytic techniques. A total of 164 studies were included (37 randomized clinical trials and 127 observational studies). Analyses included 161,756 patients with a mean age of 44.56 years and body mass index of 45.62. In randomized clinical trials, the mortality rate within 30 days was 0.08% (95% CI, 0.01%-0.24%); the mortality rate after 30 days was 0.31% (95% CI, 0.01%-0.75%). BMI loss at 5 years post-surgery was 12 to 17. The complication rate was 17% (95% CI, 11%-23%), and the reoperation rate was 7% (95% CI, 3%-12%). Based on this review, the authors found that gastric bypass was more effective in weight loss but associated with more complications, AGB had lower mortality and complication rates (yet, the reoperation rate was higher and weight loss was less substantial than gastric bypass), SG appeared to be more effective in weight loss than AGB and comparable with gastric bypass. The authors concluded that bariatric surgery provides substantial and sustained effects on weight loss and ameliorates obesity-attributable comorbidities in the majority of bariatric patients, although risks of complication, reoperation, and death exist. Death rates were lower than those reported in previous meta-analyses.

A randomized, nonblinded, single-center trial, Schauer et al. (2012) evaluated the efficacy of intensive medical therapy alone versus medical therapy plus RYGB or SG in 150 obese patients with uncontrolled T2D. The mean age of the patients was 49 ±8 years, and 66% were women. The average glycated hemoglobin level was 9.2 ±1.5%. The primary end point was the proportion of patients with a glycated hemoglobin level of 6.0% or less 12 months after treatment. In obese patients with uncontrolled T2D, 12 months of medical therapy plus bariatric surgery achieved glycemic control in significantly more patients than medical therapy alone. The authors conclude that further studies will be necessary to assess the durability of these results.

Christou et al. (2004) performed a matched cohort study of 1,035 patients who had bariatric surgery with 5,746 obese patients who did not have surgery. Subjects with medical conditions other than morbid obesity were not included. The participants were followed for 5 years. The mortality rate in the treatment group was 0.68% compared with 6.17% of the controls which results in a reduction in the relative risk of death by 89%. Furthermore, patients who underwent bariatric surgery had significant risk reductions for developing cardiovascular, cancer, endocrine, infectious, psychiatric, and mental disorders compared with controls, with the exception of hematologic (no difference) and digestive diseases (increased rates in the bariatric cohort). The authors concluded that bariatric surgery not only decreased risk factors, but also decreased overall mortality.

Laparoscopic Adjustable Gastric Banding (LAGB)

In a longitudinal case series, Mistry et al. (2018) reported changes in glycemic control, blood pressure and lipids 5 years following LAGB combined with medical care in patients with T2D. A total of 200 patients [age 47 ±9.7 years; body mass index (BMI) 52.8 ±9.2 kg m^{-2}; glycosylated hemoglobin (HbA1c) 7.9 ±1.9% (62.8 mmol mol^{-1}); women, n = 123 (61.5%); insulin treatment, n = 71 (35.5%)] were included. The mean follow-up was 62.0 ±13.0 months (range 18-84 months). There were significant reductions in body weight [-24.4 ±12.3% (38 ±22.7 kg)], HbA1c (-1.4 ±2.0%), systolic blood pressure (BP) (-11.7 ±23.5 mmHg), total cholesterol and triglyceride levels. The proportion of patients requiring insulin reduced from 36.2% to 12.3%. The overall band complication rate was 21% (21 patients). The authors concluded that LAGB, when combined with multidisciplinary medical care, significantly improved metabolic outcomes in patients with T2D independent of diabetes duration, and baseline BMI over 5 years. Diabetes duration and baseline BMI did not predict changes in glycemic control, BP or lipids following LAGB. The findings are limited by lack of comparison group.

Froylich et al. (2018) conducted a retrospective case series of LAGB in 74 patients. The mean age at LAGB placement was 50.5 ±9.6 years, and the mean BMI was 45.5 ±4.8 kg/m^2. Preoperative comorbidities were diabetes mellitus (13.5%), hypertension (32%), hyperlipidemia (12.1%), obstructive sleep apnea (5.4%), joints disease (10.8%), mood disorders (5.4%), and gastro-esophageal reflux disease (GERD) symptoms (8.1%). The mean follow-up was 162.96 ±13.9 months; 44 patients (59.4%) had their band removed, and 22 (30%) had another bariatric surgery. The follow-up BMI was 35.7 ±6.9 ($p < 0.001$), and the % TWL was 21.0 ±0.13. There was no improvement in any of the comorbidities. GERD symptoms worsened at long-term follow-up ($p <$

0.001). Undergoing another bariatric procedure was associated with a higher weight loss (OR 12.8; CI 95% 1.62-23.9; p = 0.02). LAGB required removal in the majority of patients and showed poor resolution of comorbidities with worsening of GERD-related symptoms. In the authors' opinion, patients who go on to have another bariatric procedure have more durable weight loss outcomes.

In a retrospective case series, Khoraki et al. (2018) reported long-term outcomes from a cohort of 208 patients who underwent LAGB. Complete follow-up was available for 90% at one year (186/207), 80% at five years (136/171), and 71% at ten years (10/14). Percentage of EWL at one, five, and ten years was 29.9, 30, and 16.9, respectively. LAGB failure occurred in 118 (57%) and 48 patients (23.1%) required a reoperation. Higher baseline BMI was the only independently associated factor (OR 1.1; 95%CI 1.0-1.1; p = 0.016).

Giet et al. (2018) conducted a retrospective study of 2,246 patients who underwent LAGB. Patients were followed for a minimum of 2 years, and up to 9 years post-procedure. Operative mortality was zero and there were no in-hospital re-operations. Mean preoperative weight and BMI were 111.2 ±22.1 kg and 39.9 ±6.7 kg/m^2 respectively. Mean excess % BMI loss at 1-, 2-, 5- and 8-years of follow-up was 43.1 ±25.4, 47.9 ±31.9, 52.4 ±41.7 and 57.1% ±28.6 respectively. There was no significant difference in mean excess % BMI loss between those < 50 or ≥ 50 years old (p value = 0.23) or between patients with an initial BMI of < or ≥ 50 g/m^2 (p value = 0.65). Complications over nine years occurred in 130 (5.8%) patients and included: 39 (1.7%) slippage or pouch dilatation, 2 (0.04%) erosions and 76 (3.4%) complications related to the access port or LAGB tubing. The overall re-operation rate for LAGB complications was 4.2% over 9 years with a LAGB explanation rate of 1.5%. Thirty-nine LAGBs were converted to a sleeve or gastric bypass procedure, 11 of these due to complications.

Vinzens et al. (2017) evaluated the long-term results of 405 patients (age 41 ±10 years), with a BMI of 44.3 ±6 kg/m^2, who were treated with LAGB. Mean follow-up was 13 ±3 years, with a follow-up rate of 85% (range 8-18 years), corresponding to 343 patients. One hundred patients exceeded 15-year follow-up. In 216 patients (63%), sleeve gastrectomy, gastric bypass, or biliopancreatic diversion with duodenal switch was performed as revisional surgery. Twenty-seven patients (8%) refused revisional surgery after band removal. Finally, 100 patients (29%) still had the band in place at the final follow-up, with a mean BMI of 35 ±7 kg/m^2, corresponding to an excess BMI loss of 48 ±27%. According to the Bariatric Analysis and Reporting Outcome System (BAROS), the failure rate was 25%, and 50% had what was considered to be a good to excellent outcome. The authors concluded that more than 10 years after LAGB, 71% of patients lost their bands and only 15% of the 343 followed patients with the band in place had a good to excellent result. The findings are limited by lack of comparison group.

Angrisani et al. (2013) retrospectively evaluated the efficacy and safety of LAGB in moderately obese subjects with or without obesity-related co-morbidities. Thirty-four patients with BMI between 30 and 35 kg/m^2 and mean percentage excess weight 48.7 ±9%) who underwent LAGB were included. Good response was defined as BMI < 30 kg/m^2 or percentage estimated weight loss > 50. Poor response was defined as BMI > 30 kg/m^2 or percentage estimated weight loss less than 50 after a minimum of 1 year. Mean weight, BMI and percentage estimated weight loss were recorded at 1, 3, 5 and 7 years and were 77.4 ±7.6, 69.9 ±10.8, 70.9 ±9.3 and 73.3 ±12.0 kg; 28.8 ±2.9, 26.4 ±3.2, 26.5 ±3.4 and 27.4 ±5.0 kg/m^2; and 36 ±23, 46.1 ±33.8, 58.6 ±31.5 and 45 ±57, respectively (p < 0.01). Co-morbidities were diagnosed in 17/34 (50%) patients at baseline and underwent remission or improvement in all cases after 1 year. The authors concluded that LAGB is a safe and effective procedure in patients with a BMI < 35 kg/m^2. Small sample size and lack of comparison group were limitations to this study.

Dixon et al. (2008) conducted an unblinded randomized controlled trial (RCT) to determine if surgically induced weight loss results in better glycemic control and less need for diabetes medications than conventional approaches to weight loss and diabetes control. A total of 60 patients were randomized into the 2 groups; 30 receiving surgical treatment and 30 receiving conventional treatment. Remission of type 2 diabetes, at 2-year follow-up, was reduced 73% in the surgical group and 13% in the conventional therapy group.

Sleeve Gastrectomy (Vertical Gastrectomy)

Clapp et al. (2018) conducted a meta-analysis to evaluate long-term (7 or more years) outcomes of LSG. Nine studies met the inclusion criteria, with a total of 2,280 patients included initially. Only 652 patients had completed ≥ 7 years of follow-up. At ≥ 7 years, the long-term weight recidivism rate was estimated to be 27.8% (I^2 = .60%; 95% CI: 22.8%-32.7%) with a range of 14% to 37%. The overall revision rate was estimated to be 19.9% (I^2 = 93.8%; 95% CI: 11.3%-28.5%). This was broken down into 13.1% (I^2 = 93.8%; 95% CI: 5.6%-20.6%) due to weight regain (5 studies) and 2.9% (I^2 = 60.8%; 95% CI: 1%-4.9%) due to gastroesophageal reflux disease (5 studies). Based on available data up to the beginning of 2017, in the authors' opinion

bariatric surgeons should be aware of the long-term outcomes of the sleeve gastrectomy, especially regarding revisions and weight regain.

Noel et al. (2017) conducted a retrospective analysis of a prospective cohort of 168 patients who underwent laparoscopic sleeve gastrectomy (LSG) to present the 8-year outcome concerning weight loss, modification of co-morbidities, and occurrence of revisional surgery. Follow-up was available for 116 patients (69%). Of the remainder, 23 patients underwent revisional surgery and 29 were lost to follow-up. For the entire cohort, the mean EWL was 76% (0-149) at 5 years and 67% (4-135) at 8 years, respectively. Of the 116 patients with 8 years of follow-up, 82 patients had > 50% EWL at 8 years (70.7%). Percentages of co-morbidities resolved were hypertension, 59.4%; type 2 diabetes, 43.4%; and obstructive sleep apnea, 72.4%. Twenty-three patients had revisional surgery for weight regain (n = 14) or for severe reflux (n = 9) at a mean period of 50 months (9-96). Twelve patients underwent repeat LSG, 6 patients underwent conversion to a bypass, and 5 patients to duodenal switch (1 single anastomosis duodenoileostomy). A total of 31% of patients reported GERD symptoms at 8 years. The findings are limited by lack of comparison group.

Felsenreich et al. (2017) evaluated long-term outcomes and complications following SG. 53 patients did not have symptomatic reflux or hiatal hernia preoperatively and of the 43 patients available for follow-up, six patients (14.0%) were converted to RYGB due to intractable reflux over a period of 130 months. Ten out of the remaining non-converted patients (n = 26) also suffered from symptomatic reflux. Gastroscopies revealed de novo hiatal hernias in 45% of the patients and Barrett's metaplasia in 15%. SG patients suffering from symptomatic reflux scored significantly higher in the RSI ($p = 0.04$) and significantly lower in the GIQLI ($p = 0.02$) questionnaire. This study shows a high incidence of Barrett's esophagus and hiatal hernias at more than 10 years after SG. Its results therefore suggest maintaining pre-existing large hiatal hernia, GERD, and Barrett's esophagus as relative contraindications to SG. The limitations of this study include its small sample size as well as the fact that it was based on early experience with SG-make drawing any general conclusions about this procedure inconclusive.

Fløl o et al. (2017) presented 5-year outcomes after VSG, including complications and revisions, weight change, obesity-related diseases and health-related quality of life (HRQOL). Of 168 operated patients (mean age, 40.3 ±10.5 years; 71% females), 92% completed 2-year and 82% 5-year follow-up. Re-intervention for complications occurred in four patients, whereas revision surgery was performed in six patients for weight regain and in one patient for GERD. BMI decreased from 46.2 ±6.4 kg/m^2 at baseline to 30.5 ±5.8 kg/m^2 at 2 years and 32.9 ±6.1 kg/m^2 at 5 years. Remission of T2DM and hypertension occurred in 79 and 62% at 2 years, and 63 and 60% at 5 years, respectively. The percentage of patients treated for GERD increased from 12% preoperatively to 29% at 2 years and 35% at 5 years. Preventing weight regain and GERD are important considerations with this procedure. The findings are limited by lack of comparison group.

Nocca et al. (2017) reported 5-year outcomes from a cohort of 1,050 patients who underwent SG (mean preoperative BMI was 44.58 kg/m^2) either as the primary or revisional surgical procedure. The overall preoperative rate was 6.8%, and the most common late complication was GERD (39.1%). After 3, 4 and 5 years of LSG, the average of %EBL was, respectively, 75.95% (±29.16) (382 patients), 73.23% (±31.08) (222 patients) and 69.26% (±30.86) (144 patients). The success rate at 5 years was 65.97% (95 patients). The improvement or remission of comorbidities was found, respectively, in 88.4 and 57.2% of diabetic patients; 76.9 and 19.2% for hypertensive patients and 98 and 85% for patients with sleep apnea syndrome. The authors conclude that five-year results are very convincing for SG, although GERD is the main long-term complication. The findings are limited by lack of comparison group.

El Chaar et al. (2017) evaluated the incidence, indications, and outcomes of revisional surgery following LSG in adult patients. Of the 630 LSGs performed, 481 patients were included in the analysis (mean age and BMI = 46.2 and 44.3, respectively; 79.5% female; 82.3% white). A total of 12/481 patients underwent conversion to a different bariatric procedure due to inadequate weight loss, GERD, or both. The 6/12 patients with GERD-related symptoms and failed medical management underwent conversion to RYBG following preoperative wireless Bravo pH monitoring (Given Imaging) to confirm the diagnosis objectively. The other 6/12 patients with inadequate weight loss received either RYBG or BPD/DS based on personal choice. Overall, 9/12 patients underwent conversion to RYBG, and 3/12 underwent conversion to BPD/DS. Median time from the initial surgery to conversion was 27 months (range 17-41). Median operating room time was 168 min (range 130-268). Median length of stay was 48 h (range 24-72). The follow-up rate at 3 months was 100% (12/12 patients). The authors conclude that conversion to RYBG or BPD/DS may be done safely and effectively in patients present following LSG with refractory GERD or inadequate weight loss. Longer term outcomes are needed. The findings are limited by lack of comparison group.

Brethauer et al. (2009) performed a systematic review (n = 36 studies) of the evidence on SG. Studies included a single nonrandomized matched cohort analysis, RCTs (n = 2 studies) and uncontrolled case series (n = 33 studies). The mean BMI in all 36 studies was 51.2 kg/m^2. The mean baseline BMI was 46.9 kg/m^2 for the high-risk patients (range 49.1-69.0) and 60.4 kg/m^2 for the primary SG patients (range 37.2-54.5). The follow-up period ranged from 3–60 months. The mean %EWL after SG reported in 24 studies was 33–85%, with an overall mean %EWL of 55.4%. The mean postoperative BMI was reported in 26 studies and decreased from a baseline mean of 51.2 kg/m^2 to 37.1 kg/m^2 postoperatively. Improvement or remission of T2D was found in more than 70% of patients. Significant improvements were also seen in hypertension and hyperlipidemia, as well as in sleep apnea and joint pain. The major postoperative complication rate ranged from 0%-23.8%.

Vertical Banded Gastroplasty (VBG)

van Wezenbeek et al. (2015) retrospectively evaluated a total of 392 patients (80% female) with a BMI of 44 ±5 kg/m^2 who underwent primary VBG. Mean follow-up after VBG was 66 ±50 months and showed a mean EWL of 53 ±27% and comorbidity reduction of 54%. One hundred fifty-two patients (39%) out of 227 patients (58%) with long-term complaints underwent revisional surgery. Main reasons for revision were weight regain and vomiting/food intolerance. Analysis before revision showed an outlet dilatation (17%), pouch dilatation (16%), and outlet stenosis (10%). After revision, an additional EWL of 23% and 33% further reduction in comorbidities was seen. They concluded that primary VBG has an acceptable EWL of 53% and 55% of comorbidities were improved however, the high complication rate, often necessitating revision, underlines the limits of this procedure.

A Cochrane Database Systematic Review by Colquitt et al. (2009) found that while complication rates for VBG are relatively rare, revision rates requiring further surgical intervention are approximately 30%. Complication rates for VBG were not included in their updated 2014 Cochrane Database Systematic Review.

Revision Surgery

Chierici et al. (2022) conducted a systematic review and meta-analysis to identify which revisional bariatric surgery performs best after a failed primary restrictive surgery. A literature search was conducted using Embase, PubMed, Cochrane Library, and Scopus databases which returned 39 retrospective and prospective comparative studies. Inclusion criteria included patients undergoing revisional bariatric surgery after a failed primary restrictive surgery of LAGB, VBG, or SG. The authors confirmed SG continues to have a low rate of immediate postoperative complications. The authors found duodenal switch (DS) and biliopancreatic diversion (BPD) were superior when it came to %EWL and %TWL, but not free from the risk of weight regain. Secondary SG ensures the lowest rate of early and late complications when compared to single-anastomosis duodenoileal bypass (SADI) and one-anastomosis gastric bypass (OAGB) but it also provides the worst benefits for either 1 and 3 years %EWL and %TWL thus should not be considered when planning revisional surgery unless there are exceptional circumstances that warrants its use. RYGB is the most frequently performed revisional surgery following a primary bariatric procedure, however this approach has not always been justified in terms of weight loss when compared to SG. In addition, RYGB is more frequently associated with early and late complications when compared to SG, OAGB, and SADI. Finally, the authors found the most balanced procedures were OAGB and SADI; these two procedures were determined to have 21.16% and 14.66% more EWL, respectively, after 3 years.

Limitations included retrospective design, surgical intervention allocation bias, heterogeneity and lack of evaluation of important outcomes like GERD or malabsorption which could affect the patient's quality of life.

Koh et al. (2020) performed at systematic review and meta-analysis to examine the impact revisional bariatric surgery has on obesity related metabolic outcomes. The analysis included review of 33 articles which contained 1,593 patients. The outcomes examined included improvement of diabetes, hypertension (HTN), hyperlipidemia, and OSA. The surgeries used for revision included SG, RYGB, pouch revision, duodenal switch, and mini-gastric bypass. The authors found 92% of the patients improved their diabetes, 81% achieved improvement in HTN and 86% had improvement of OSA. The authors concluded revisional bariatric surgery improved patient outcomes and should be considered in patients with persistent metabolic disease after primary bariatric surgery. Limitations included lack of randomized control trials, lack of long-term outcomes, and significant heterogeneity.

Janik et al. (2019) assessed the safety of revisional surgery to LSG compared to LRYGB after failed LAGB. Converted LSG cases were matched (1:1) with converted LRYGB patients by age (±year), body mass index (±kg/m), sex, and comorbidities including diabetes, hypertension, hyperlipidemia, venous stasis, and sleep apnea. A total of 2,708 patients (1,354 matched

pairs) were included in the study. The mean operative time in conv-LRYGB was significantly longer in comparison to conv-LSG patients (151 ±58 vs. 113 ±45 minutes, p < 0.001). No mortality was observed in either group. Patients after conv-LRYGB had a clinically increased anastomotic leakage rate (2.07% vs. 1.18%, p = 0.070) and significantly increased bleed rate (2.66% vs. 0.44%, p < 0.001). Thirty-day readmission rate was significantly higher in conv-LRYGB patients (7.46% vs. 3.69%, p < 0.001), as was 30-day reoperation rate (3.25% vs. 1.26%, p < 0.001). The length of hospital stay was longer in conv-LRYGB. The authors concluded that a single-stage conversion of failed LAGB leads to greater morbidity and higher complication rates when converted to LRYGB versus LSG in the first 30 days postoperatively. These differences are particularly notable with regard to bleed events, 30-day reoperation, 30-day readmission, operative time, and hospital stay.

Qiu et al. (2018) reviewed prospectively collected data on revisional bariatric procedures. Patients (n = 84) included in this review underwent surgery for weight regain (WR) or, underwent surgery to address refractory complications (RC) related to their primary bariatric procedure. Demographics, indications, and outcomes of each group were compared using Fisher's exact test, Mann-Whitney rank sums, and chi-square tests. WR patients were divided based on their primary index procedure. Forty-three patients (53.6%) underwent surgery for WR and 41 (46.4%) for RC. The variety and distribution of primary bariatric procedures were gastric band (40%), gastric bypass (35.4%), SG (22%), and VBG (3.7%). The indications for revisional surgery due to RC included gastroesophageal reflux disease, internal hernia, gastro-gastric fistula, marginal ulcer, excess weight loss, and pain. Overall complication rate was 14.3% (three early, nine late); there was one leak. Five patients required a reoperation (5.9%; two early, three late). Excess weight loss varied from 31.5-79.1% 12 months after revision. The authors concluded that revisional bariatric surgery can be performed with low complication rates and with acceptable 12-month weight loss, though not with the same safety as primary procedures.

Dardamanis et al. (2018) conducted a retrospective comparative study of primary versus revisional LRYGB for insufficient weight loss after VBG or adjustable gastric banding. Three hundred forty-two LRYGB operations were performed, 245 were primary, and 97 revisional. Median follow-up was 30 months (range 0-108 months). Mean BMI (kg/m^2) before bypass was 45.2 for primary LRYGB (pLRYGB) and 41.1 for revisional laparoscopic RYGB (rLRYGB). Median operative time and length of stay were longer for rLRYGB 157.5 versus 235 min (p < 0.001) and 6 versus 6.5 days (p = 0.05). Conversion to laparotomy was performed in eight patients, 0.4% of primary and 7.2% of revisional. Morbidity rate was 6.5% in pLRYGB versus 10% in rLRYGB (NS). There was one death in the primary group. Percentage of excess BMI loss was significantly lower in the revisional group at 12, 18, and 24 months of follow-up. The authors concluded that revisional and primary gastric bypass have no statistical differences in terms of morbidity. The % of excess BMI loss is lower after revisional gastric bypass during the first 2 years of follow-up. The trend of weight loss or weight regain was similar in both groups.

Altieri et al. (2018) reported the rate of revisions or conversions (RC) in patients who originally underwent RYGB, LSG, or LAGB. Patients were followed for at least 4 years. There were 40,994 bariatric procedures with 16,444 LAGB, 22,769 RYGB, and 1,781 LSG. Rate of RC was 26.0% for LAGB, 9.8% for SG, and 4.9% for RYGB. Multiple RCs were more common for LAGB (5.7% for LAGB, 0.5% for RYGB, and 0.2% for LSG). Band revision/replacements required further procedures compared with patients who underwent conversion to RYGB/SG (939 compared with 48 procedures). The majority of RCs were not performed at the initial institution (68.2% of LAGB patients, 75.9% for RYGB, 63.7% of SG). Risk factors for multiple procedures included surgery type, as LAGB was more likely to have multiple RCs. The authors concluded that reoperation was common for LAGB, but less common for RYGB (4.9%) and SG (9.8%). The RC rate is almost twice after SG than after RYGB. LAGB had the highest rate (5.7%) of multiple reoperations. Conversion was the procedure of choice after a failed LAGB.

Wijngaarden et al. (2017) identified that non-responders of LAGB showed inferior weight loss results after revisional LRYGB compared with responders of LAGB, and primary LRYGB at all moments of follow-up (12, 24, 36 months). This is based on an observational study of 96 non-responders, and 120 responders. In addition, the failure rate was significantly higher after revisional LRYGB compared with primary LRYGB (10.9% no responders, 8.5% responders, and 2.5% primary, p = 0.001).

In a retrospective review of primary LRYGB (pLRYGB) versus revisional LRYGB (rLRYGB) after failed LSG, Malinka et al. (2017) evaluated 3-year outcomes. There were no significant differences in patient demographics or median BMI (kg/m^2) for pLRYGB or rLRYGB (42.8 ±12.1 vs. 42.3 ±11.5, respectively; p = 0.748). Coexisting comorbidities were rated similarly in both groups. At 3 years, the percentage of excess weight loss (74.4 ±23.3 vs. 52.0 ±26, respectively; p = 0.007) was higher for pLRYGB than rLRYGB, while similar improvements of coexisting comorbidities could be observed. The authors concluded that rLRYGB is a feasible and practical surgical approach that allows effective weight loss at 3 years of follow-up and alleviates refractory reflux symptoms. Although weight loss is lower compared to pLRYGB, resolution or improvement of coexisting comorbidities appears similar. According to the authors, rLRYGB appears to be a reliable procedure to address failure after LSG.

Pinto-Bastos et al. (2017) conducted a systematic review of preoperative surgery following the failure of primary bariatric surgery. The etiology of reasons for undergoing a second surgery includes medical (e.g., fistula, ulcer disease) and behavioral aspects. Eating and lifestyle behaviors, difficulty in embracing the required lifestyle changes, and reappearance of depressive and anxious symptoms have been associated with failure of weight loss or weight regain after primary surgeries. The authors recommend that particular attention be paid to surgical candidates with a history of difficulties in engaging in healthy eating patterns.

In a retrospective review, Fulton et al. (2017) evaluated outcomes of revisional bariatric surgery in 2,769 patients. The mean preoperative BMI was 44.7 ±9.5 in revision patients compared with 45.7 ±7.6 in primary bariatric surgery patients. Most revision patients had a prior VBG (48%) or a LAGB (24%). Bands were removed in 36% of all LAGB patients presenting to clinic. Of the 134 procedures performed in the revision clinic, 83 were bariatric weight loss surgeries, and 51 were band removals. Revision clinic patients experienced a significant decrease in BMI (from 44.7 ±9.5 to 33.8 ±7.5, $p < 0.001$); their BMI at 12-month follow-up was similar to that of primary clinic patients (34.5 ±7.0, $p = 0.7$). The authors identified that complications were significantly more frequent in revision patients than primary patients (41% v. 15%, $p < 0.001$).

Sharples et al. (2017) conducted a systematic review and meta-analysis of outcomes after revisional bariatric surgery. 2,617 patients in 36 studies underwent either adjustable gastric band to Roux-en-Y gastric bypass (B-RYGB) or band to sleeve gastrectomy (B-SG). There was no difference between the B-RYGB and B-SG groups in morbidity, leak rate or return to surgery. %EWL following the revisional procedure for all patients combined at 6, 12 and 24 months was 44.5, 55.7 and 59.7%, respectively. There was no statistical difference in %EWL between B-RYGB and B-SG at any time point. The rates of remission of diabetes, hypertension and obstructive sleep apnea were 46.5, 35.9 and 80.8%, respectively. Available observational evidence does suggest that revisional bariatric surgery is associated with outcomes similar to those experienced after primary surgery. Further, high-quality research, particularly RCTs, is required to assess long-term weight loss, comorbidity and quality of life outcomes.

Tran et al., (2016) conducted a systematic review of 24 studies and 866 patients to evaluate outcomes and complications of different surgical methods of revision that were done after failed primary RYGB. All patients in the studies reported significant early initial weight loss after revisional surgery. However, of the five surgical revision options considered, biliopancreatic diversion/duodenal switch, distal RYGB, and gastric banding resulted in sustained weight loss, with what is considered by the authors as an acceptable complication rate.

Quezada et al. (2016) conducted a retrospective analysis of SG conversion to RYGB (n = 50) due to the observation of increased complications of SG as the number of procedures increase. Revisions were done due to weight regain, GERD, or gastric stenosis. At follow-up (over a 3-year period), the authors reported median excess weight loss was 60.7 lbs., all gastric stenosis symptoms had resolved, and over 90% of GERD patients reported either a resolution or improvement in symptoms. Despite their findings, long term follow-up on this patient population is needed.

Buttelmann et al. (2015) compared outcomes for patients undergoing diet/exercise intervention with patients undergoing surgical intervention through restorative obesity surgery-endolumenal (ROSE), band over bypass, and endoscopic gastro gastric fistula closure. A retrospective analysis of 60 patients was performed on those who underwent gastric bypass and failed to lose weight. Records were reevaluated at 3, 6, and 12 months after intervention for primary outcomes of, weight loss and comorbidity resolution. The authors concluded ROSE, band over bypass, and endoscopic fistula closure results in greater weight loss and trend toward greater comorbidity resolution compared with diet and exercise. This study is limited by small sample size, lack of randomization, and short-term follow-up.

David et al. (2015) reported their experience in laparoscopic conversion of failed VGB to RYGB or BPD (n = 39), noting that the reoperation rate for VGB in long-term studies is approximately 50%. Most (89%) of the conversions were completed laparoscopically. The mean operative time was 195 and 200 min for RYGB and BPD, respectively. There was no mortality. Complications occurred in 11 patients (28%), 5 in RYGB (19%) and 6 in BPD (42%). At the 3-year follow-up, the mean body mass index decreased from 47 ±8 kg/m^2 to 26 ±4 kg/m^2 for BPD, and from 43 kg/m^2 to 34 kg/m^2 ($p = 0.05$) for RYGB. Weight (kg) decreased from 110 to 84 and to 92, and from 123 to 81 and 68, at 1 and 3 years for RYGB and BPD, respectively. The weight loss for RYGB and BPD was equal at 1 year but tended to be better for BPD at 3 years postoperatively. Laparoscopic conversion of failed VBG to RYGB or BPD was feasible, but it was followed by prohibitively high complication rates in BPD patients. The authors concluded that the risk: benefit ratio of these procedures in this series is questionable.

Brethauer et al. (2014) was part of a task force that reviewed current evidence which identified procedure-specific indications and outcomes for re-operative procedures. 175 articles were included in the systematic review and analysis and the majority of the published studies were single center retrospective reviews. The evidence supporting re-operative surgery for acute and chronic complications is described along with additional guiding principles. GERD was identified as a long-term complication that may occur following a sleeve gastroplasty. The authors indicate treatment begins with medical management and behavioral modifications; if medical control of GERD fails, surgical revision may be required.

Pediatric and Adolescent Bariatric Surgery

Hoeltzel et al. (2021) evaluated adolescent bariatric surgeries from the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) database from 2015 to 2018. Participants included patients 19 years old and younger with a BMI ≥ 30 kg/m^2 and underwent laparoscopic RYGB or SG. Primary outcomes included mortality and overall complications; secondary outcomes included rates of readmission and reoperation. A total of 5,068 individuals met inclusion criteria for the study with 78.5% being females and 70.4% being white. Patients between the ages of 10 to 14 years comprised 1.5% of participants, 15 to 17 years 18.5%, and 18 to 19 years 79.9%. The mean BMI was 47.3 kg/m^2 and the most prevalent comorbidities were HTN, OSA, GERD, and diabetes. The 30-day analysis following surgery demonstrated intraoperative or postop complications in only 1.2% of patients and the death of two patients which was likely due to internal hernia. The authors concluded that bariatric surgery for adolescents was a safe and effective procedure with low complication rate and a recommendation of future robust studies to evaluate the long-term outcomes in this age group of patients.

Alqahtani et al. (2021) analyzed the long-term results and adverse events associated with LSG in children and adolescents with severe obesity. 2,504 children and adolescents that underwent LSG between 2008 and 2021, were enrolled in the program. Weight loss was reported in terms of mean weight change, percentage of weight lost, %EWL, change in BMI, and BMI for age percentile along with assessment of comorbidity conditions. The mean standard deviation (SD) %EWL for one to three years was 82.3%, for 4 to 6 years was 76.3% and 7 to 10 years was 71.1%; 10-year results demonstrated that 30% of total weight was lost permanently. Prior to surgery 263 patients were diagnosed with T2D, 227 with dyslipidemia, and 377 had hypertension. After more than 7 years of follow-up, complete remission was observed in 188 patients for T2D, 130 patients for dyslipidemia, and 219 patients for HTN. Only 1% of the patients were readmitted within the first 90 days after the operation; two patients had a staple line leak and 22 were readmitted with nausea and vomiting. The data showed no significant change in growth velocity, including among participants younger than age 14 years. The authors concluded long-term follow-up after LSG in children and adolescents demonstrates positive weight loss and comorbidity resolution. The findings are however limited by lack of comparison group.

Lainas et al. (2020) conducted a study to assess whether bariatric surgery was successful for adolescents under the age of 18. The authors evaluated 84 adolescent patients (57 females, 27 males) that underwent LSG. Surgical postop care included blood work and diet restrictions with a discharge when oral diet was well tolerated. Patients follow-up included 4 outpatient visits the first year then annually; complete metabolic screening was done at 3 months, again at one year and annually thereafter. The quality of life was evaluated prior to surgery using the French version of the Short Form 36 questionnaire which assessed general health, physical function, social function, emotional and mental status, and bodily pain. The scoring ranged from 0-100 with higher scores indicating better wellbeing. All patients were contacted one-year post-surgery to answer the same questions. Comorbidities assessed included HTN, T2D, OSA, dyslipidemia, arthralgia, and GERD. According to the authors, the study showed LSG is a safe and effective procedure for patients under the age of 18, resulting in significant weight loss, comorbidity remission, and improvement in quality of life. In addition it was felt that adherence to the medical team was an essential component for successful treatment in this group of patients. Limitations included small sample size, retrospective design, substantial loss to follow-up thus affecting long-term outcomes and lack of comparison group.

A Hayes (2019, updated 2022) comparativeness effective review for bariatric surgeries for treatment of obesity in adolescents analyzed nineteen studies which compared AGB, VSG and RYGB. The authors concluded that while the body of evidence is moderate in size with a low quality overall, these surgical procedures are superior to medical management for promoting weight loss and improving obesity-related comorbidities in adolescents. AGB was inferior to the others, but all three types are associated with low to moderate risk of postop complications and show similar efficacy.

Inge et al. (2018) compared glycemic control in cohorts of severely obese adolescents with T2D undergoing medical and surgical interventions. Participants in the Teen-LABS group (n = 242) underwent a primary bariatric procedure, while those in the Youth TODAY consortia (n = 699) were randomized to receive medication alone, or an intensive lifestyle intervention. After selection of 30 participants from Teen-LABS with diabetes [mean (SD) age at baseline, 16.9 (1.3) years; 21 (70%) female; 18

(66%) white], 63 matched controls from TODAY were selected [mean (SD) age at baseline, 15.3 (1.3) years; 28 (44%) female; 45 (71%) white] and the two groups were compared. During 2 years, mean hemoglobin A1c concentration decreased from 6.8% (95% CI, 6.4%-7.3%) to 5.5% (95% CI, 4.7% -6.3%) in Teen-LABS and increased from 6.4% (95% CI, 6.1%-6.7%) to 7.8% (95% CI, 7.2%-8.3%) in TODAY. Compared with baseline, the BMI decreased by 29% (95% CI, 24%-34%) in Teen-LABS and increased by 3.7% (95% CI, 0.8%-6.7%) in TODAY. Twenty-three percent of Teen-LABS participants required a subsequent operation during the 2-year follow-up. Compared with medical therapy, surgical treatment of severely obese adolescents with type 2 diabetes was associated with better glycemic control, reduced weight, and improvement of other comorbidities. According to the authors, these data support the need for a well-designed, prospective controlled study to define the role of surgery for adolescents with T2D, including health and surgical outcomes.

In a retrospective review of 79 adolescents who underwent LSG, Elhag et al. (2018) assessed preoperative levels and postoperative changes in 4 anthropometric, 15 nutritional and 10 cardiometabolic parameters. At a mean of 24.2 months post-LSG, significantly reduced mean weight and BMI by 51.82 ±28.1 kg and 17 ±6.24 kg/m^2, respectively were observed. The highest prevalence of post-LSG deficiencies pertained to vitamin D, albumin, and ferritin (89.3, 38, and 33.3%, respectively). Low hemoglobin levels (29.3%) were reported only in females. Trace elements were not deficient. Significant reductions in percentage of adolescents with elevated low-density lipoprotein (from 66.1 to 38.9%), alanine aminotransferase (from 45.3 to 10.9%), and aspartate aminotransferase (from 24.1 to 8.6%) levels were reported. Finally, 100% remission of prediabetes cases, and 80% remission of T2D cases were observed. The slight worsening of preexisting nutritional deficiencies warrants careful preoperative surveillance and appropriate postoperative nutritional supplementation.

Benedix et al. (2017) compared the perioperative course, weight loss and resolution of comorbidities after primary LSG for morbid obesity between adolescents (n = 362) and adults (n = 15,428). Pre-procedure BMI was similar between these populations, but the adult cohort had a higher incidence of co-morbidities. Late adolescents experienced the highest weight loss; resolution rate of comorbidities was lower in adults. Resolution rate of hypertension was significantly higher in adolescents. In the authors' opinion, the results at 12 and 24 months demonstrate that LSG is a safe therapeutic option that can be performed in adolescents without mortality.

Manco et al. (2017) evaluated the benefit of sleeve gastrectomy in ninety-three obese (BMI ≥ 35 kg/m^2) adolescents with nonalcoholic steatohepatitis (NAFLD) and hepatic fibrosis. Obese adolescents (13-17 years of age) with biopsy proven NAFLD underwent LSG (n = 20), lifestyle intervention plus intragastric weight loss devices (IGWLD) (n = 20), or lifestyle intervention only (n = 13). One year after treatment, patients who underwent LSG lost 21.5% of their baseline body weight, whereas patients who underwent IGWLD lost 3.4%, and patients who underwent nonsurgical weight loss (NSWL) increase 1.7%. In patients who underwent LSG, NASH reverted completely in all patients and hepatic fibrosis stage 2 disappeared in 18 patients (90%). After IGWLD, NASH reverted in 6 patients (24%) and fibrosis in 7 (37%). Patients who received the NSWL intervention did not improve significantly. Hypertension resolved in all patients who underwent LSG with preoperative hypertension (12/12) versus 50% (4/8) of the patients who underwent IGWLD (p = .02). The cohort-specific changes in impaired glucose metabolism were similar: 100% (9/9) of affected patients who underwent LSG versus 50% (1/2) of patients who underwent IGWLD (p = 0.02). LSG was also more affective in resolving dyslipidemia [55% (7/12) vs. 26% (10/19); p = 0.05) and sleep apnea [78% (2/9) vs. 30% (11/20); p = .001]. Based on these findings, the authors determined that LSG was more effective than lifestyle intervention, even when combined with intragastric devices, for reducing NASH and liver fibrosis in obese adolescents after 1 year of treatment.

In a systematic review and meta-analysis, Qi et al. (2017) evaluated the effects of bariatric surgery on glycemic and lipid metabolism, surgical complications and quality of life in adolescents with obesity. A total of 49 studies with 3,007 patients were included. RYGB (n = 1,216), LAGB (n = 1,028), and LSG (n = 665) were the most common bariatric surgeries performed. At the longest follow-up (range, 12-120 months), bariatric surgery led to an overall 16.43 kg/m^2 [95% confidence interval (CI): 14.84-18.01] and 31% (95% CI: 28%-34%) reduction in BMI. There were significant improvements in glycemic and lipid profiles including glycosylated hemoglobin A1C, fasting blood insulin, fasting blood glucose, total cholesterol, triglyceride, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol, postoperatively at 12 months. The remission rate of dyslipidemia was 55% (95% CI: 34%-76%), 70% (95% CI: 55%-82%), and 95% (95% CI: 80%-100%) at 1, 3, and > 5 years after surgery. RYGB produced better improvements than other surgical procedures. The authors concluded that bariatric surgery in adolescents may achieve significant weight loss, and glycemic and lipid control.

The Teen-Longitudinal Assessment of Bariatric Surgery (LABS) Study was a prospective, multicenter, observational study, which enrolled 242 adolescents (≤ 19 years of age) who were undergoing bariatric surgery from March 2007 through February

2012, at 5 U.S. adolescent bariatric surgery centers. The patients underwent RYGB (n = 161), SG (n = 67), or LAGB (n = 14). Ryder et al. (2016) evaluated 2-year outcomes to determine the impact of bariatric surgery on functional mobility and musculoskeletal pain. Participants completed a 400 m walk test prior to bariatric surgery (n = 206) and at 6 months (n = 195), 12 months (n = 176), and 24 months (n = 149) after surgery. Time to completion, resting heart rate (HR), immediate posttest HR, and HR difference (resting HR minus posttest HR) were measured and musculoskeletal pain concerns, during and after the test, were documented. Data were adjusted for age, sex, race/ethnicity, baseline BMI, and surgical center (posttest HR and HR difference were further adjusted for changes in time to completion). Compared with the baseline, the post-surgery data showed an improvement in all measurements at all times measured. The authors conclude that bariatric surgery in adolescents with extreme obesity is associated with significant improvement in functional mobility and in the reduction of walking-related musculoskeletal pain up to 2 years after surgery. Findings are however limited by lack of comparison group.

Inge et al. (2016) reported 3-year outcomes from the TEEN-LABS study of adolescents (n = 242) undergoing RYGB (161 participants) or SG. Changes in body weight, coexisting conditions, cardiometabolic risk factors, and weight-related quality of life and postoperative complications were evaluated. The mean weight had decreased by 27% [95% confidence interval (CI), 25 to 29] in the total cohort, by 28% (95% CI, 25 to 30) among participants who underwent gastric bypass, and by 26% (95% CI, 22 to 30) among those who underwent sleeve gastrectomy. By 3 years after the procedure, remission of T2D occurred in 95% (95% CI, 85 to 100) of participants who had had the condition at baseline, remission of abnormal kidney function occurred in 86% (95% CI, 72 to 100), remission of prediabetes in 76% (95% CI, 56 to 97), remission of elevated blood pressure in 74% (95% CI, 64 to 84), and remission of dyslipidemia in 66% (95% CI, 57 to 74). Weight-related quality of life also improved significantly. However, at 3 years after the bariatric procedure, hypoferritinemia was found in 57% (95% CI, 50 to 65) of the participants, and 13% (95% CI, 9 to 18) of the participants had undergone one or more additional intraabdominal procedures. The authors found significant improvements in weight, cardiometabolic health, and weight-related quality of life at 3 years after the procedure. Risks associated with surgery included specific micronutrient deficiencies and the need for additional abdominal procedures. Findings are however limited by lack of comparison group.

In a prospective study, Hervieux et al. (2016) compared 2-year results between adolescent patients and young adult controls that underwent LAGB. Follow-up programs were similar, weight loss and comorbid disease were analyzed. During this period, insulin resistance and dyslipidemia decreased similarly in both groups, although there was no difference between overall weight loss and BMI. The authors' overall assessment is that provided there is careful selection of patients and a supportive multidisciplinary team, satisfying results can be obtained after LAGB in adolescents, comparable to those obtained in young adults at 2-year follow-up.

Serrano et al. (2016) evaluated patients ≤ 21 years old to determine the safety and efficacy of bariatric surgery in this population. The primary end point was EWL. Secondary end points included surgical morbidity, improvement in obesity-related metabolic parameters, and subjective obesity-related symptoms at 1 year. Fifty-four patients were identified who had a LRYGB or LSG. Fourteen patients were male (25.9%). Thirty-seven patients (68.5%) underwent LRYGB, and 17 patients (31.5%) underwent LSG. Median follow-up was 13.3 months. The baseline BMI was 51.7 kg/m^2 for the LRYGB group and 51.0 kg/m^2 for the LSG group. EWL was 35.2, 47.6, 62.4, 58.1, and 61.8% for the LRYGB group; 29.7, 44.7, 57.4, 60.3, and 59.0% for the LSG group at 3, 6, 12, 24, and 36 months, respectively. Complications included 1 anastomotic bleed, 1 postoperative stricture, and 1 patient who developed vitamin deficiency that manifested as a peripheral neuropathy in the LRYGB group. LRYGB was more successful than LSG in improving lipid panel parameters and HbA1c at 1 year, and it also seemed to offer better subjective improvement in obesity-related symptoms. Overall, they observed that LRYGB and LSG seem to confer comparable weight loss benefit in patients ≤ 21 years old with acceptable surgical morbidity.

In a systematic review and meta-analysis, Paulus et al. (2015) evaluated the efficacy, safety, and psychosocial health benefits of various bariatric surgical techniques (RYGB, LAGB, LSG) as a treatment for morbid obesity in adolescents. A total of 37 peer-reviewed articles were included, although the studies were mainly observational and varied in quality. Authors of 9 studies were contacted for additional information. All three procedures lead to significant weight loss in morbidly obese adolescents, and weight loss is most pronounced after RYGB. For LSG studies, long-term follow-up were not yet available. While adverse events were relatively mild and long-term complication rates were acceptable, they were more frequent and more serious after RYGB than after LAGB. In the currently available follow-up after LSG, the rate of adverse events appeared to be similar to that after LAGB. Although a healthy nutritional status in adolescents is important to prevent developmental and growth deficiencies, standard postoperative vitamin supplementation regimens and the occurrence of deficiencies were not reported in most studies (not at all in LSG studies). However, more and more severe deficiencies occurred after RYGB than after LAGB. Reduction of comorbidity, which is pivotal for health gain, was impressive in all techniques, and QOL consistently showed

improvement, although follow-up up to 24 months may not be enough to capture negative long-term effects in life after bariatric surgery. A limitation of this review is the lack of high-quality, prospective randomized controlled trials, which increases the risk of bias and therefore introduces heterogeneity.

Zitsman et al. (2015) studied a population of morbidly obese teenagers (n = 137) who underwent LAGB to evaluate its safety and effectiveness. The mean weight gain between enrollment and LAGB was 4.7 kg. Mean preoperative weight, body BMI, and excess BMI were 136.1 kg, 48.3 kg/m^2, and 23.6 kg/m^2, respectively. Mean BMI at 6, 12, 18, 24, and 36 months was 43.8, 41.6, 41.5, 40.5, and 39.3. Excess BMI loss was 28.4%, 35.9%, and 41.1% at 1, 2, and 3 years postop. Co-morbid conditions improved or resolved with weight loss after LAGB. Thirty patients (22%) underwent one or more additional operations for complications. Twenty-seven patients (20%) converted to other weight loss procedures or had their bands removed. The authors concluded that morbidly obese adolescents can lose weight successfully and experience health improvement following LAGB, but the role of LAGB in the younger population requires long-term evaluation.

O'Brien et al. (2010) conducted a prospective, randomized controlled study of 42 adolescents to compare the outcomes of gastric banding (n = 24) with an optimal lifestyle program (n = 18) for adolescent obesity. Patients in the gastric banding group had an estimated weight loss of 78.8% compared to 13.2% in the optimal lifestyle program. BMI scores decreased from 42.3 to 29.6 in the gastric banding group compared with 40.4 to 39.1 in the optimal lifestyle program group. Prior to the study, 9 gastric banding patients and 10 lifestyle patients had metabolic syndrome. At 24-month follow-up, none of the patients in the gastric banding group had the metabolic syndrome compared with 4 in the lifestyle group. Eight reoperations were required in 7 patients due to proximal pouch dilatation or tubing injury during follow-up. The authors concluded that use of gastric banding compared with lifestyle intervention resulted in a greater percentage of excess weight loss. Study limitations include small number of study participants as well as a third of the gastric banding patients required surgical revision due to complications.

Bariatric Artery Embolization (BAE)

There is insufficient evidence for bariatric artery embolization and its outcomes for weight loss; additional robust RCTs are warranted for safety and efficacy along with long-term follow up.

Reddy et al. (2020) conducted a single-center, sham controlled, masked RCT to evaluate the efficacy of transcatheter bariatric embolization (TBE) for weight reduction in obesity. Participants were randomized to either sham procedure (n = 20) or TBE targeting the left gastric artery using embolic beads (n = 20). The primary efficacy endpoint was the difference in TBWL between the two groups at 6 months. All patients entered a lifestyle counseling program and follow-up was completed by physicians that were masked to allocated therapy. At 6 months, the TBWL for TBE in the intention to treat (ITT) population was 7.4 kg compared to 3.0 kg for sham procedure. The change in BMI at 6 months for ITT was -2.6 in TBE versus -1.1 in sham. The TBE ITT population did maintain the weight loss at 12 months. Patients with in the sham group were unblinded at 6 months and permitted to crossover to TBE and then only initial group was followed for 12 months. Limitations included small sample size, single center, no control group after 6 months, and possibility that the efficacy of TBE was related to subject participation in weight management counseling as it is unknown if TBE alone would have an impact on obesity without lifestyle counseling. Additionally, four subjects withdrew consent after randomization and another three prior to the 6-month visit. Furthermore, the clinical significance of the effect, its long-term sustainability, and safety are unclear.

Hafezi-Nejad et al. (2019) conducted a systematic review and meta-analysis of case series investigating the safety and efficacy of left gastric artery (LGA) embolization as a bariatric procedure. Meta-regression was performed to assess associations of age, sex, body mass index, and ghrelin and leptin levels with weight change after LGA embolization were selected. Six case series published between January 2014 and April 2019, comprising 47 patients investigating the safety and/or efficacy of LGA embolization for weight loss were included in the meta-analysis. The results showed a mean weight loss of 8.68 kg (19.14 lbs.) after 12 months of follow-up, approximately 8% of baseline total body weight which is superior to weight loss from diet and exercise, and comparable to other more invasive interventions. Transient superficial mucosal ulcers were common after LGA embolization, and one case of major complications (severe pancreatitis, splenic infarct and gastric perforation) was identified. There were considerable variations in patient age, sex distribution, and baseline characteristics among the studies. Significant variation was observed in the duration of follow-up, which ranged from 3 months to 20–24 months. Limitations of this study include variations in the indications for LGA embolization, study designs, embolization techniques, follow-up plans, dietary assessments, patient comorbidities, and availability of control subjects, the authors concluded that LGA embolization is an investigative method and not yet proven to be effective management for obesity. Larger studies are needed to expand these findings and determine other correlates of weight loss after LGA embolization.

Weiss et al. (2019) evaluated the safety and efficacy of bariatric artery embolization up to twelve months following surgery in 20 severely obese patients [five of which are identified below in the Weiss et al. (2017) case series]. The primary endpoint was weight loss with additional end points assessed. Bariatric embolization was performed successfully in all participants. Participants experienced mean excess weight loss of 8.2% at one month, 11.5% at 3 months, 12.8% at six months and 11.5% at twelve months. The mean total weight loss was 7.6 kg at twelve months. As a result of loss to follow-up, 18 participants remained at three months, 16 at six months, and 15 at twelve months. No major adverse events (AE) were identified and only eleven minor AE occurred in eight participants. The authors found bariatric embolization is well tolerated and promotes clinically relevant weight loss in adults with severe obesity. Limitations included lack of comparison group, small sample size, insufficient data due to lack of continuous follow up for several participants, required weight management compliance before the embolization procedure on the first five participants only and a large portion of participants were African American thus overrepresenting that population.

The BEAT Obesity Trial [included in Hafezi-Nejad (2019) study above], a U.S. Food and Drug Administration (FDA)-approved prospective investigational device exemption study, is being conducted to evaluate the feasibility, safety, and short-term efficacy of bariatric artery embolization (BAE) (Weiss et al., 2017). In the initial phase of the study, 5 severely obese patients (four women, one man) who were 31-49 years of age and who had a mean body mass index of 43.8 kg/m^2 ±2.9 with no clinically significant comorbidities were enrolled in this study and received BAE. There were no major adverse events (AEs), 2 minor AEs healed prior to the time of the 3-month endoscopy. Mean change in serum ghrelin was 8.7% ±34.7 and -17.5% ±29 at 1 month and 3 months, respectively. Mean changes in serum glucagon-like peptide 1 and peptide YY were 106.6% ±208.5 and 17.8% ±54.8 at 1 month. There was a trend toward improvement in QOL parameters. Hunger/appetite scores decreased in the first 2 weeks after the procedure and then rose without reaching preprocedural levels. The authors concluded that in this initial phase of the study, BAE is feasible and appears to be well tolerated in severely obese patients. In this small patient cohort, it appears to induce appetite suppression and may induce weight loss. Further expansion of this study will provide more insight into the long-term safety and efficacy of bariatric embolization. The findings are limited by lack of comparison group.

In a small case series (n = 5), Bai et al. (2018) investigated the safety and 9-month effectiveness of transcatheter LGA embolization [for treating patients with obesity mean BMI 38.1 kg/m^2 ±3.8 (range, 32.9-42.4 kg/m^2)]. Average body weight loss at 3, 6, and 9 months was 8.28 ±7.3 kg (p = 0.074), 10.42 ±8.21 kg (p = 0.047), and 12.9 ±14.66 kg (p = 0.121), respectively. The level of serum ghrelin decreased by 40.83% (p = 0.009), 31.94% (p = 0.107), and 24.82% (p = 0.151) at 3, 6, and 9 months after LGA embolization, respectively. In the authors' opinion, this study with 9-month data in 5 patients indicates that bariatric embolization of the LGA is safe and may be a promising strategy to suppress the production of ghrelin and results in weight loss and abdominal fat reduction. Randomized controlled trials with larger patient populations and longer-term outcomes are needed to further evaluate BAE in the treatment of obesity.

In the GET LEAN trial, Syed et al. (2016) reported 6-month safety and efficacy results from a pilot study of LGA embolization for the treatment of morbid obesity in 4 patients with a mean BMI of 42.4 kg/m^2 (range, 40.2-44.9 kg/m^2). Three minor complications (superficial gastric ulcerations healed by 30 d) occurred that did not require hospitalization. There were no serious AE. Average body weight change at 6 months was -20.3 lbs. (n = 4; range, -6 to -38 lbs.), or -8.5% (range, -2.2% to -19.1%). Average EBW loss at 6 months was -17.2% (range, -4.2% to -38.5%). Patient 4, who had diabetes, showed an improvement in hemoglobin A1c level (7.4% to 6.3%) at 6 months. QOL measures showed a general trend toward improvement, with the average physical component score improving by 9.5 points (range, 3.2-17.2) and mental component score improving by 9.6 points (range, 0.2-19.3) at 6 months. The authors conclude that these preliminary data support LGA embolization as a potentially safe procedure that warrants further investigation for weight loss in morbidly obese patients. Study limitations include small patient sample and lack of comparison group.

Gastric Electrical Stimulator (GES)

While gastric electrical stimulation may provide benefit for obesity, additional well designed RCTs with long-term follow-up are warranted to demonstrate safety and efficacy.

In this 2020 first-in-human (early feasibility) multicenter, phase 1, open prospective cohort study, (Paulus et al., 2020) the authors assessed the safety of the Exilis™ gastric electrical stimulation. They also sought to investigate whether the settings can be adjusted for comfortable chronic use in Class II or III obese patients. Meal intake and gastric emptying and motility were also evaluated. In this study, 20 obese patients were implanted with the Exilis system and amplitude was individually set during 4 amplitude titration visits. Subjects underwent two blinded baseline test days (GES ON vs. OFF), after which long-term, monthly follow-up continued for up to 52 weeks. The results suggested that this device is safe and caused no patient discomfort. At

baseline food intake and satiety were not significantly different when the device was on or off, and significant weight loss occurred at week 26, with EWL of 14% at 52 weeks. The authors conclude that the data were comparable with studies of subjects on diet and/or exercise alone, but disappointing when compared to minimally invasive procedures, such as gastric banding or endoscopic gastroplication. Furthermore, the authors did not observe changes in plasma glucose and insulin levels which other bariatric procedures are known to improve. The authors concluded that considerably more basic research is required before clinical use. Limitations included small sample size, lack of control group, and lack of long-term outcomes.

In a in a 12-month prospective multicenter study, Morales-Conde et al. (2018) monitored all participants (n = 47) up to 24 months after laparoscopic implantation of a closed-loop GES system (CLGES). Weight loss, safety, quality of life (QOL), and cardiac risk factors were analyzed. Weight regain was limited in the 35 (74%) participants remaining enrolled at 24 months. Mean %TBWL changed by only 1.5% between 12 and 24 months, reported at 14.8% (95% CI 12.3 to 17.3) and 13.3% (95% CI 10.7 to 15.8), respectively. The only serious device-/procedure-related AEs were two elective system replacements due to lead failure in the first 12 months, while improvements in QOL and cardiovascular risk factors were stable thru 24 months. The authors conclude that during the 24-month follow-up, CLGES was shown to limit weight regain with strong safety outcomes, including no serious AEs in the second year. They hypothesize that CLGES and objective sensor-based behavior data combined to produce behavior change, and in their opinion supports GES as a safe obesity treatment with potential for long-term health benefits. Larger well-designed randomized controlled trials are needed to further evaluate the safety and efficacy of GES therapy in the treatment of obesity.

In a post-implant analysis, Alarcón Del Agua I, et al. (2017) evaluated possible preoperative predictors for obtaining clinically meaningful weight loss with GES. Ninety-seven obese participants in a prospective multicenter study conducted in nine European centers were implanted laparoscopically with the abiliti® CLGES system. The mean 12-month %EWL with CLGES was 35.1 ±9.7%, with a success rate of 52% and a failure rate of 19%. Significant predictors of success were BMI < 40 kg/m^2 and age ≥ 50 years, increasing probability of success by 22 and 29%, respectively. A low F1-cognitive-restraint score was a significant predictor of failure (p = 0.004). The best predictive model for success included F1-cognitive-restraint, F2-disinhibition, BMI < 40, and age ≥ 50 (p = 0.002). The authors concluded that age, preoperative BMI, and F1-cognitive-restraint and F2-disinhibition scores from a preoperative questionnaire are predictive of weight loss outcomes with closed-loop GES and may be used for patient selection.

In a systematic review, Cha et al. (2014) evaluated the current state regarding implantable gastric stimulators. Thirty-one studies consisting of a total of 33 different trials were included in the systematic review for data analysis. Weight loss was achieved in most studies, especially during the first 12 months, but only very few studies had a follow-up period longer than 1 year. Among those that had a longer follow-up period, many were from the Transcend® (Implantable Gastric Stimulation) device group and maintained significant weight loss. Other significant results included changes in appetite/satiety, gastric emptying rate, blood pressure and neurohormone levels or biochemical markers such as ghrelin or HbA1c respectively. The authors conclude that although gastric electrical stimulation holds great promise, stronger evidence is required through more studies with a standardized way of carrying out trials and reporting outcomes, to determine the long-term effect of gastric electrical stimulation on obesity.

The Screened Health Assessment and Pacer Evaluation (SHAPE) trial by Shikora et al. (2009) compared gastric stimulation therapy to a standard diet and behavioral therapy regimen in a group of obese patients. The difference in EWL between the control group and the treatment group was not found to be statistically significant at 12 months of follow-up. These results suggest that this technology is not effective in achieving significant weight loss in severely obese individuals.

Intragastric Balloon (IGB)

There is mixed evidence regarding the long-term efficacy and safety for intragastric balloons and their use with obesity; additional well designed RCTs and long-term data are warranted.

Based on a clinical evidence assessment by ECRI (2022), the evidence for the Spatz3® IGB is inconclusive. Assessment of two RCTs, three nonrandomized comparison studies, two case series, and two chart reviews assessing weight loss and adverse events for Spatz3® in adults with obesity revealed short-term clinically significant weight loss but whether these results were long-term remains to be seen. Limitations included small sample sizes, retrospective design of studies, lack of randomization, masking and controls along with single-center focus. Large robust studies with long-term results are warranted and several ongoing clinical trials may address this in the future.

Zou et al. (2021) performed a systematic review and meta-analysis to evaluate the efficacy of the intragastric balloon (IGB) as an obesity management tool for metabolic dysfunction-associated fatty liver disease (MAFLD). Thirteen observational studies and one RCT met the inclusion criteria (624 participants in total). The results showed that over time, IGB therapy significantly improved the serum markers homeostasis model assessment of insulin resistance (HOMA-IR), alanine aminotransferase (ALT), aspartate aminotransferase (AST), and gamma-glutamyl transpeptidase (GGT) levels from baseline to follow-up. The authors concluded that IGB has the potential to become a multidisciplinary management tool of MAFLD, however IGB is a temporary measure, and if the patient cannot maintain an active lifestyle after the first balloon is removed, relapse of MAFLD is expected. Limitations include lack of comparison group; further RCTs are needed.

Hayes (2018, updated 2022) low-quality evidence suggests that IGB have mixed results with regard to weight loss over the short term when used as an adjunct to diet and exercise. These devices are consistently associated with high AE and all studies analyzed lacked long term follow up on maintaining weight loss and safety concerns.

An 2021 ECRI clinical evidence assessment on the Orbera® Intragastric Balloon System concluded that the evidence is inconclusive with mixed results, and shows the use of Orbera results in short-term, clinically significant weight loss in most patients; however, most patients regain weight, and by 1 year, the sustained weight loss has unclear clinical significance. Additional randomized studies are needed to determine whether Orbera use can reduce bariatric surgery risks for patients who are not surgery candidates and/or use the device to lose weight to become eligible for surgery. Additional studies that directly compare Orbera with other IGBs would also be useful.

In a multicenter, open-label industry-sponsored RCT, Abu Dayyeh et al. (2021, included in ECRI 2022 report above) investigated the safety and efficacy of the Spatz IGB in adults with obesity. 288 patients were randomly assigned to receive either the IGB plus dietary and exercise counselling or dietary and exercise counselling alone for 32 weeks. Inclusion criteria were patients aged 22-65 years, BMI of 30 kg/m^2 or greater for past two years, history of unsuccessful non-surgical weight loss methods and willingness to participate in the required dietary restrictions. The IGB was implanted via esophagogastroduodenoscopy (EGD) under conscious or monitored anesthesia sedation; depending on the patient's height an initial volume of 400 ml, 450 ml, 500 ml or 550 ml was utilized. During the 32 weeks, all patients followed a 1,000–1,200 kcal/day diet and exercise plan. After 32 weeks, the IGB was removed and patients were followed for another 24 weeks. Primary outcomes consisted of %TBWL and clinical responder rate, which was achieved by a decrease of at least 5% total bodyweight loss at 32 weeks. Mean %TBWL at 32 weeks was 15·0% (95% CI 13·9-16·1) in the IGB group versus 3·3% (2·0-4·6) in the control group ($p < 0·0001$). The authors found the adjustable IGB combined with lifestyle modification enabled significant weight loss over a period of 6 months with an observed acceptable safety profile. Limitations included no masking or sham intervention, and an approximately 20% loss to follow-up at 32 weeks. Future studies should assess the long-term safety of the device.

ECRI (2020) Health Technology Assessment focused on the safety and efficacy of the Elipse™ and Obalon®, two ingestible IGBs. The evidence was inconclusive citing RCTs would be beneficial to determine whether any differences exist in weight loss and serious AE risks. Available clinical guideline recommendations on IGB are mixed and none pertain to ingestible IGB. Thus, major evidence gaps remain and additional comparative studies of ingestible and conventional IGB are needed.

Jung et al. (2020) conducted a systematic review and meta-analysis of 22 studies with 2,141 patients to comprehensively evaluate the efficacy of different endoscopic bariatric procedures compared to lifestyle modification in the treatment of morbid obesity. Intragastric balloon, duodenal-jejunal bypass liner (DJBL), aspiration therapy, primary obesity surgery endoluminal (POSE) procedure, and botulinum toxin injection to the stomach were included and the meta-analysis determined the percentage of weight loss (%weight loss) and percentage of excess weight loss (%EWL). While the Obalon Balloon system was shown to have efficacy for both %weight loss and %EWL, its efficacy was not proven due to the small number of studies and comparatively low effect size. In addition, the findings are limited by lack of long-term efficacy and safety quality data.

Moore et al. (2019, included in the ECRI report above) performed a retrospective analysis of patients that underwent the Obalon Balloon System (OBS), a swallowable, gas-filled intragastric balloon system for weight loss. A web-based registry was accessed for the data on 1,343 patients with a starting BMI ≥ 25 kg/m^2. Nonserious and serious adverse events were reported in 14.2% and 0.15% of patients, respectively. Weight loss in the indicated use (BMI 30-40 kg/m^2) was 9.7 ±6.1 kg and 10.0 ±6.1% TBWL. Weight loss in other BMI categories was 8.2 ±5.6 kg or 10.3 ±7.0% total body weight loss for BMI 25 to 29.9 kg/m^2; and 11.6 ±7.8 kg or percent total body weight loss 9.3 ±6.0 for BMI > 40 kg/m^2. The authors concluded that the OBS safe and effective at stimulating weight loss and provides practitioners with another tool to treat obese patients who have failed other weight loss programs. Limitations included lack of comparison group, the possible bias of a manufacturer-sponsored study, variation with

loss and behavior modification data collection, and lack of data collection for co-morbidities and metabolic data resulting in inability of data analysis for these areas.

In a multicenter randomized controlled trial, Courcoulas et al. (2017, included in Hayes 2021 report above) included obese (BMI 30-40 kg/m^2) patients who underwent lifestyle interventions for 12 months. Patients were randomized to receive an IGB for the first 6 months (n = 137) or to lifestyle intervention alone (n = 136). Data from 44 run-in patients were also included in the safety analyses. The investigators found that IGB patients had a mean %EWL of 26.5% at 9 months; this was not statistically significantly greater than the 25% EWL threshold (p = 0.32). The mean differences in %EWL were significantly greater among IGB patients than control group patients. At 9 months, the adjusted mean difference was 16.2% in favor of IGB (p < 0.001); and the difference at 12 months was 13.8% (p < 0.001). Nearly half of IGB patients (45.6%) achieved at least 15% EWL more than the mean %EWL in control patients (p < 0.001). Total body WL was also significantly greater among IGB patients at both 9 and 12 months (both p ≤ 0.001). The authors concluded that although intragastric balloon achieved greater short-term weight loss at 3- and 6-months post balloon removal than lifestyle intervention alone, adverse gastrointestinal events were common. Additional RCTs with longer follow-up periods are needed to further evaluate IGBs in this patient population.

Coffin et al. (2017, included in the Hayes 2021 report above) published findings from their multicenter randomized controlled trial, in which they compared 6 months of IGB or standard medical care (low-calorie diet, with bimonthly dietician evaluations) as bridge therapies to laparoscopic gastric bypass in super-obese patients (> 45 kg/m^2). The surgery was performed at 6 months, shortly after removal of the IGB, and assessments were undertaken through 12 months. While the BMIs between groups were comparable at baseline, IGBs significantly reduced BMI by 6 months compared with standard care, with median BMI of 47.9 kg/m^2 for IGB patients and 50.7 kg/m^2 for control patients (p < 0.001). However, while the implanted IGB was effective on the short term, having the IGB before surgery did not impact postsurgical outcomes after 12 months (approximately 6 months post-surgery), the groups' BMIs were not significantly different at this time point (median BMI:IGB, 38.1 kg/m^2 versus standard care, 37.6 kg/m^2; p = 0.56). The authors concluded that IGB insertion before LGBP induced weight loss but did not improve the perioperative outcomes or affect postoperative weight loss. Limitations of the study included short duration of the IGB intervention, poor recruitment rate, a higher-than-expected use of ICU facilities, and the poor weight loss in the IGB group.

Nunes et al. (2017) conducted a retrospective review of 2002 patients who underwent an IGB procedure to determine its effectiveness with different degrees of obesity. A total of 946 patients were lost to follow-up. Overall, 40 (3.78%) had device removal due to intolerance, and 1,016 patients completed the 6-month treatment. The mean weight loss was 18.9%, excess weight loss 60.1% and a BMI reduction of 6.76 points. Six months after removal of the balloon 842 patients had continued follow-up (82.8%). At this time, weight loss was 19.84%, excess weight loss was 59.49%, and BMI reduction of 7.06 points. In all groups there was statistical difference between the times T0 and T1 and between T1 and T2 (p < 0.001). There was no statistical difference between T2 and T3, in any group. The authors concluded that IGB provided sustained weight loss in patients who remained in dietary follow-up for 1 year. The study is limited by lack of comparison group and high lost-to-follow up rate. Longer term outcomes with well-designed randomized clinical controlled trials are needed to further evaluate the IGB.

Saber et al. (2017) conducted a systematic review and meta-analysis to evaluate the efficacy and safety of intragastric balloon (IGB) treatment. A total of 20 RCTs involving 1,195 participants were identified. Weight loss results before and after 3 months were analyzed separately. The weight loss results of patients with and without IGB treatment were compared. A significant effect size was calculated that favored fluid filled IGBs over air-filled IGBs. Flatulence, abdominal fullness, abdominal pain, abdominal discomfort, and gastric ulcer were significantly more prevalent among IGB patients than among non-IGB control patients. No mortality was reported from IGB treatment. In the authors' opinion, IGB treatment, in addition to lifestyle modification, is an effective short-term modality for weight loss. However, there is not sufficient evidence confirming its safety or long-term efficacy.

The REDUCE pivotal trial (Ponce et al., 2015, included in the Hayes 2021 report above) was a prospective, randomized controlled pivotal trial of a dual intragastric balloon to evaluate the safety and effectiveness of a dual balloon system plus diet and exercise in the treatment of obesity compared to diet and exercise alone. Participants (n = 326) with body mass index (BMI) 30-40 kg/m^2 were randomized to endoscopic dual balloon system (DBS) treatment plus diet and exercise (DUO, n = 187) or sham endoscopy plus diet and exercise alone (DIET, n = 139). Co-primary endpoints were a between-group comparison of %EWL and DUO subject responder rate, both at 24 weeks. Thereafter DUO patients had the DBS retrieved followed by 24 additional weeks of counseling; DIET patients were offered DBS treatment. Mean BMI was 35.4. Both primary endpoints were met. DUO weight loss was over twice that of DIET. DUO patients had significantly greater %EWL at 24 weeks (25.1% intent-to-treat (ITT), 27.9% completed cases (CC, n = 167) compared with DIET patients (11.3% ITT, p = .004, 12.3% CC, n = 126). DUO

patients significantly exceeded a 35% response rate (49.1% ITT, p < .001, 54.5% CC) for weight loss dichotomized at 25% EWL. Accommodative symptoms abated rapidly with support and medication. Balloon deflation occurred in 6% without migrations. Early retrieval for non-ulcer intolerance occurred in 9%. Gastric ulcers were observed; a minor device change led to significantly reduced ulcer size and frequency (10%). The authors concluded that the dual balloon system was significantly more effective than diet and exercise in causing weight loss with a low adverse event profile. Additional RCT with longer follow-up are needed.

Laparoscopic Greater Curvature Plication (LGCP)

While laparoscopic greater curvature plication may appear to be safe for weight loss, additional robust RCTs with comparison groups and long-term data are needed.

Doležalova-Kormanova et al. (2017) reported outcomes in a cohort of LGCP patients at 5-year follow-up. Patients with complete weight data through 5-year follow-up was 86.9%, (212/244). The ANOVA database indicated a significant BMI reduction out to 2 years ($p < 0.001$), a plateau at 3 and 4 years, and a moderate but significant BMI increase at 5 years ($p < 0.01$). Excess BMI loss at 1, 2, 3, 4, and 5 years was as follows: 50.7 ±9.1%, 61.5 ±8.1%, 60.2 ±7.0%, 58.5 ±7.0%, and 56.8 ±6.3%. At 5 years, 79.2% (168/212) of patients were successful; 20.8% (44/212) experienced a suboptimal weight outcome; mean weight regain, 9.2%. Cluster analysis identified four distinct LGCP patient profiles. Diabetes improvement rate was 65.5%. There were 12 reoperations (4.9%): 4 emergency (1.6%) and 8 (3.3%) elective. There was no mortality. The authors concluded that based on their original cohort and a 56.8% Excess BMI loss and low rate of complications, LGCP proved to be safe and effective. The findings are limited by lack of comparison group. Additional long-term outcomes are needed to evaluate LGCP in comparison to other bariatric procedures.

In an 18-month prospective, observational, open-label study, Bužga et al. (2017) reported outcomes of 127 patients; 84 underwent LSG and 43, LGCP. LSG and LGCP were then compared during long-term follow-ups in terms of glycemic control, hormone and lipid secretion, and changes in body composition. Significant weight-loss and an improved body composition resulted from either procedure vs. baseline (i.e., pre-surgery), with levels of fasting glucose and glycated hemoglobin also showing statistically significant reductions (at 3 and 18 months for either surgery). Intergroup comparisons for glycemic parameters yielded no statistically significant differences. However, a dramatic reduction in ghrelin was detected following LSG, falling from pre-surgery levels of 140.7 to 69.6 ng/L by 6 months ($p < 0.001$). Subsequently, ghrelin levels increased, reaching 107.8 ng/L by month 12. Conversely, after LGCP, a statistically significant increase in ghrelin was seen, rising from 130.0 ng/L before surgery to 169.0 ng/L by month 12, followed by a slow decline. The authors concluded that although the data showed good metabolic outcomes following LGCP, this method was less effective than LSG, possibly due to its preservation of the entire stomach, including secretory regions.

Grubnik et al. (2016) compared two-year outcomes in a European prospective randomized controlled trial comparing LGCP versus LSG. A total of 54 patients with morbid obesity were allocated either to LGCP group (n = 25) or LSG group (n = 27). Main exclusion criteria were: ASA > III, age > 75 and BMI > 65 kg/m^2. There were 40 women and 12 men, and the mean age was 42.6 ±6.8 years (range 35-62). Data on the operation time, complications, hospital stay, BMI loss, %EWL, loss of appetite and improvement in comorbidities were collected during the follow-up examinations. One year after surgery, the mean %EWL was 59.5 ±15.4% in LSG group and 45.8 ±17% in LGCP group ($p > 0.05$). After 2 years, mean %EWL was 78.9 ±20% in the LSG group and 42.4 ±18% in the LGCP group ($p < 0.01$). After 3 years, mean %EWL was 72.8 ±22 in the LSG group and only 20.5 ±23.9 in the LGCP group ($p < 0.01$). Loss of feeling of hunger after 2 years was 25% in LGCP group and 76.9% in the LSG group ($p < 0.05$). The comorbidities including diabetes, sleep apnea and hypertension were markedly improved in both groups after surgery. The authors concluded that the short-term outcomes demonstrated equal effectiveness of the both procedures, but 2-year follow-up showed that LGCP is not as effective as LSG as a restrictive procedure for weight loss.

Tang et al. (2015) conducted a meta-analysis to compare LGCP with LSG in terms of efficacy and safety. Eligible studies included one randomized controlled trial and three non-randomized controlled trials involving 299 patients. The meta-analysis demonstrated a significantly greater %EWL after LSG than LGCP at the follow-up time points of 3 months ($z = 2.26$, $p = 0.02$), 6 months ($z = 4.49$, $p < 0.00001$), and 12 months ($z = 6.99$, $p < 0.00001$). The difference in the resolution of diabetes mellitus between these two approaches did not reach statistical significance ($p = 0.66$). According to the pooled data, LGCP was associated with more adverse events than was LSG ($p = 0.01$). The operation time ($p = 0.54$) and postoperative hospital stay ($p = 0.44$) were comparable between the two groups. LGCP is inferior to LSG not only in terms of providing effective weight loss but also in terms of safety.

Stomach Aspiration Therapy

Currently there is insufficient evidence regarding the safety and efficacy of stomach aspiration therefore additional robust RCTs with comparison groups are needed along with long-term results.

A 2021 ECRI clinical evidence assessment on AspireAssist Gastric Aspiration Port (Aspire Bariatrics, Inc.) noted that evidence is somewhat favorable for AspireAssist when adding to lifestyle modification. It was noted to improve weight loss at 1 year which was maintained at up to 4 years, however, these findings are based on low-quality evidence from 2 systematic reviews and 1 single-arm extension of an RCT. It is unknown if AspireAssist therapy contributes to abnormal eating behaviors as only one single-arm extension of RCT reported too few events. Evidence limitations included risk of bias in most studies included in the systematic reviews due to small study size, lack of control group, or both. Additional larger RCTs are needed to confirm findings, especially in the long term, as well as to compare AspireAssist with other minimally invasive treatments.

Jirapinyo et al. (2020) conducted a systematic review and meta-analysis of 5 studies with a total of 590 patients to assess the outcomes of aspiration therapy (AT) (AspireAssist®) on obesity related comorbidities at one year follow up. Comorbidities included hypertension, hyperlipidemia, T2D, and NAFLD. Secondary outcomes were the amount of weight loss up to four years post operatively, and pooled serious adverse events (SAEs). The results showed after one year hypertension, hyperlipidemia, HbA1C, and NAFLD significantly improved. Weight loss at one year was 17% TWL (296 patients), 2 years 18.3% (174 patients) , 3 years 18.6% (88 patients), and 4 years 18.6% (27 patients). The pooled SAEs rate was 4.1% and included buried bumper, peritonitis severe abdominal pain, abdominal pain secondary to pre-pylric ulcer and device malfunction requiring A tube replacement. Two studies reported a rate of persistent fistula following A-tube removal. The authors concluded that at 1 year AT resulted in significant improvement in metabolic function parameters and 4 years, patients maintained their significant weight loss of 18.6% of their baseline weight, meeting the definition of successful weight loss maintenance, and may improve access to treatment in obese patients with concomitant comorbidities. The authors acknowledge the limitations of this study. The number of studies is small (to account for this, conference abstracts that met the a priori inclusion criteria were included in the analysis), and most of them were retrospective and observational in nature. Larger, high-quality studies with longer follow-up are required to validate these findings.

Jung et al. (2020) conducted a systematic review and meta-analysis of 22 studies with 2,141 patients to comprehensively evaluate the efficacy of different endoscopic bariatric procedures compared to lifestyle modification in the treatment of morbid obesity. Intragastric balloon, duodenal-jejunal bypass liner (DJBL), aspiration therapy, primary obesity surgery endoluminal (POSE) procedure, and botulinum toxin injection to the stomach were included and the meta-analysis determined the percentage of weight loss (%weight loss) and percentage of excess weight loss (%EWL). While the authors found the aspiration therapy demonstrated effectiveness for weight reduction when compared to lifestyle modification, the findings are limited by lack of long-term efficacy and safety quality data.

In the post study of the PATHWAY Trial, Thompson et al. (2019) provide 4-year outcomes of the AT patients from the initial trial (refer to Thompson 2017 below). 58 participants were enrolled in the follow up study; of these 55 had achieved at least 10% TWL at the end of the first year. Of the 58 patients who enrolled in the follow-up study, 15, 21, and 7 patients elected to have the A tube removed between years 1 and 2, 2 and 3, and 3 and 4, respectively, thus withdrawing from the study but no loss to follow-up. The 43 patients who withdrew from the study between years 2 and 4, 25 (58.1%) achieved at least 10% TWL. The mean %EWL of AT participants at years 1, 2, 3, and 4 was 37.1 ±27.6 (n/N = 81/110), 40.8 ±25.3 (n/N = 42/55), 44.7 ±29.7 (n/N = 22/55), and 50.8 ±31.9 (n = 15/55), respectively. The clinical success rate for patients participating in the follow-up study was 40/58 (69%) at 4 years from A-tube placement. The authors concluded the AT is a safe and effective intervention for people with class II and III obesity and can achieve weight loss along with improvement of quality of life. Limitations of this study are the relatively small number of participants by the fourth year, participant commitment and the absence of weight loss data after A-tube removal. Additionally, the findings are limited by the design that only allowed continued follow-up of participants maintained at least 10% TWL from baseline at each year end and lack of comparison group for the long-term.

In a post-market study, Nyström et al. (2018) evaluated the long-term safety and efficacy of aspiration therapy in 5 European clinics using the AspireAssist. A total of 201 participants (mean BMI 43.6 ±7.2 kg/m^2) participated. Mean %TWL at 1, 2, 3, and 4 years, respectively, was 18.2% ±9.4% (n/N = 155/173), 19.8% ±11.3% (n/N = 82/114), 21.3% ±9.6% (n/N = 24/43), and 19.2% ±13.1% (n/N = 12/30), where n is the number of measured participants and N is the number of participants in the absence of withdrawals or lost to follow-up. Clinically significant reductions in HbA1C, triglycerides, and blood pressure were observed. For participants with diabetes, HbA1C decreased by 1% ($p < 0.0001$) from 7.8% at baseline to 6.8% at 1 year. The only serious complications were buried bumpers, experienced by seven participants and resolved by removal/replacement of the A-Tube,

and a single case of peritonitis, resolved with a 2-day course of intravenous antibiotics. The findings are limited by lack of comparison group and large lost-to-follow-up that could have introduced biases in the findings. Although the authors concluded that AT is a safe, effective, and durable weight loss therapy in people with classes II and III obesity, RCTs comparing AT to other bariatric procedures are needed to validate these findings.

In the pivotal PATHWAY study, Thompson et al. (2017) conducted a 52-week randomized controlled trial at 10 institutions across the United States. 207 participants with a BMI of 35.0–55.0 kg/m^2 were randomly assigned in a 2:1 ratio to treatment with AspireAssist plus Lifestyle Counseling (n = 137; mean BMI was 42.2 ±5.1 kg/m^2) or Lifestyle Counseling alone (n = 70; mean BMI was 40.9 ±3.9 kg/m^2). The co-primary end points were mean %EWL and the proportion of participants who achieved at least a 25% EWL. At 52 weeks, participants in the AspireAssist group, on a modified intent-to-treat basis, had lost a mean (±s.d.) of 31.5 ±26.7% of their excess body weight (12.1 ±9.6% total body weight), whereas those in the Lifestyle Counseling group had lost a mean of 9.8 ±15.5% of their excess body weight (3.5 ±6.0% total body weight) ($p < 0.001$). A total of 58.6% of participants in the AspireAssist group and 15.3% of participants in the Lifestyle Counseling group lost at least 25% of their excess body weight ($p < 0.001$). The most frequently reported adverse events were abdominal pain and discomfort in the perioperative period and peristomal granulation tissue and peristomal irritation. A total of 46 subjects were available for the extended follow-up study. Outcomes of the post-approval study may provide more solid evidence regarding the longer-term efficacy of the AspireAssist. The findings are limited by the small effect size and lack of long-term comparative outcomes.

Norén and Forssel (2016) reported 1 and 2-year outcomes from their prospective observational study of 25 obese subjects to evaluate weight reduction and safety of AT with AspireAssist™. Twenty of the original 25 subjects completed the initial 1-year treatment. These 20 subjects lost mean 54% of their excess weight. At 2 years, 15 subjects had lost mean 61% of their excess weight. This weight loss surpassed our expectation and is nearly at the level of gastric bypass procedure and other major abdominal surgery for obesity. The subjects reported improved quality of life during treatment. There was neither mortality nor any event more severe than grade III-a according to Clavien-Dindo grading system. Limitation of this study is the combination of AT and cognitive behavioral therapy (CBT) without any control group. Long term patency is still unknown.

Forssell and Norén (2015) conducted an observational study of 25 obese patients (BMI 39.8 ±0.9 kg/m^2) who after following a very low-calorie diet for 4 weeks had the AspireAssist gastrostomy tube placed. A low-profile valve was installed 14 days later, and aspiration of gastric contents was performed approximately 20 minutes after meals three times per day. Cognitive behavioral therapy was also started. At 6 months, mean weight lost was 16.5 ±7.8 kg in the 22 subjects who completed 26 weeks of therapy ($p = 0.001$). The mean percentage excess weight lost was 40.8 ±19.8% ($p = 0.001$). Two subjects were hospitalized for complications: one subject for pain after gastrostomy tube placement, which was treated with analgesics, and another because of an aseptic intra-abdominal fluid collection 1 day after gastrostomy tube placement. No clinically significant changes in serum potassium or other electrolytes occurred. The authors concluded that the results suggest the potential of the AspireAssist as an attractive therapeutic device for obese patients. Further research with randomized controlled trials is needed to validate these findings.

Sullivan et al. (2013) conducted a pilot study of 18 obese subjects who were randomly assigned (2:1) to groups that underwent AT for 1 year plus lifestyle therapy (n = 11; mean body mass index, 42.6 ±1.4 kg/m^2) or lifestyle therapy only (n = 7; mean body mass index, 43.4 ±2.0 kg/m^2). Lifestyle intervention comprised a 15-session diet and behavioral education program. Ten of the 11 subjects who underwent aspiration therapy and 4 of the 7 subjects who underwent lifestyle therapy completed the first year of the study. After 1 year, subjects in the aspiration therapy group lost 18.6% ±2.3% of their body weight (49.0% ±7.7% of EWL) and those in the lifestyle therapy group lost 5.9% ±5.0% (14.9% ±12.2% of EWL) ($p < 0.04$). Seven of the 10 subjects in the aspiration therapy group completed an additional year of therapy and maintained a 20.1% ±3.5% body weight loss (54.6% ±12.0% of EWL). The authors reported that there were no adverse effects of aspiration therapy on eating behavior (including binge eating) and no evidence of compensation for aspirated calories with increased food intake. The small sample size does not allow a conclusion to be made as to whether the outcomes can be generalized to a larger population. Lack of long-term follow-up data and differential lost-to-follow-up rates are other study limitations.

Transoral Endoscopic Surgery [including Transpyloric Shuttle® (TPS) Device]

The evidence for transoral endoscopic surgery for bariatric surgery is limited; additional studies including RCTs, long-term data including the safety and efficacy of the procedure are warranted.

Jung et al. (2020) conducted a systematic review and meta- analysis of 22 studies with 2,141 patients to comprehensively evaluate the efficacy of different endoscopic bariatric procedures compared to lifestyle modification in the treatment of morbid

obesity. Intragastric balloon, duodenal-jejunal bypass liner (DJBL), AT, primary obesity surgery endoluminal (POSE) procedure, and botulinum toxin injection to the stomach were included and the meta-analysis determined the percentage of weight loss (%weight loss) and %EWL. The results showed most endoscopic procedures showed efficacy in terms of %weight loss: AT 10.4%, fluid-filled balloon 5.3%, POSE 4.9%, DJBL 4.5%. The gas-filled balloon and botulinum toxin injection did not show a significant difference in %weight loss or %EWL compared with the control. The authors concluded that all bariatric endoscopic procedures, with the exception of a gas filled balloon and botulinum toxin injection show superior short-term efficacy compared with lifestyle modification. The findings are however limited by lack of long-term efficacy and safety quality data.

In a brief from ECRI (2019), the evidence for the Transpyloric Shuttle® (TPS) device is inconclusive. The evidence is limited indicating longer-term follow-up data is warranted. The RCT reviewed appeared to have a low risk of bias but results from a single trial were not conclusive and need independent confirmation in another controlled trial. The case series had a very high risk of bias due to small sample size, lack of a control group and randomization, and blinding. Both the RCT and case series report relatively short follow-up.

In a prospective, multicenter, single-arm, feasibility trial, Sandler et al. (2018) evaluate 32 obese subjects with a trans-oral endoscopic gastrointestinal bypass device. The device is a cuff attached to the distal esophagus by transmural anchors and connected to a 120-cm sleeve diverting undigested nutrients to the jejunum. Baseline data collected included bodyweight, vital signs, AEs, medications, HbA1c, fasting glucose, and lipids in addition to follow-up visits. The device status was endoscopically assessed every 6 months. At 12 months, the 32 subjects had lost an average of 44.8% of excess body weight, 17.6% of total body weight, 20.8 kg, and 7.5 BMI points. The authors concluded this study demonstrated the feasibility, safety, and efficacy of a fully trans-oral gastrointestinal bypass implant and that this endoscopic device may provide a valuable addition to the available treatment for the management of morbid obesity. However this study is limited by lack of comparison group, small sample size and short-term follow-up.

The ASGE Bariatric Endoscopy Task Force and the ASGE Technology Committee reviewed endoscopic bariatric therapies (EBT) and summarized that EBTs hold the promise of providing the next major breakthrough in the management of obesity. They commented that the development of a variety of new endoscopic therapies that replicate the physiological benefits of bariatric surgery in a safe, cost-effective, and minimally invasive fashion may potentially offer the best path to making a meaningful impact on the obesity epidemic, as less than 1% of qualified patients actually undergo bariatric surgery. Currently investigated devices have established promising outcomes in short-term weight loss and in control of the metabolic and other medical adverse events of obesity. Further studies will help define their optimal role in the comprehensive management of obesity (Abu Dayyeh et al., 2015b).

Marinos et al. (2014) conducted a prospective, open-label, nonrandomized, single-center investigational clinical trial performed to evaluate the safety and efficacy of the transpyloric shuttle (TPS) device. The study enrolled twenty patients meeting the criteria in 2 cohorts with treatment periods of 3 and 6 months. Patients were required to be ≥ 18 and ≤ 55 years of age with a BMI between 30 and 50 kg/m^2. Before device placement, patients were provided with nutritional guidelines for a low-calorie diet and no additional dietary counseling was given after the initial consultation. Patients were placed under general anesthesia and the devices were deployed and retrieved with no complications. All 20 patients enrolled in the study had lost weight at the time of device removal. Both the 3- and 6-month patients had statistically significant improvements to the overall IWQOL-Lite score that exceeded the 7.7- to 12-point threshold to define a clinical change. All but two patients completed the planned treatment period; both patients had the device removed due to complaints of epigastric pain. Limitations of the study were small participant size and short treatment duration. The authors concluded the TPS is a promising technology that has potential to benefit obese patients seeking to lose weight.

Eid et al. (2014) conducted a prospective, single-center, randomized, single-blinded study from July 2009 through February 2011, to investigate the safety and effectiveness of endoscopic gastric plication with the StomaphyX device vs. a sham procedure for revisional surgery in RYGB patients to reduce regained weight. Enrollment was closed prematurely because preliminary results indicated failure to achieve the primary efficacy end point in at least 50% of StomaphyX-treated patients. One-year follow-up was completed by 45 patients treated with StomaphyX and 29 patients in the sham treatment group. Primary efficacy outcome was achieved by 22.2% (10) with StomaphyX vs. 3.4% (1) with the sham procedure ($p < 0.01$). Patients undergoing StomaphyX treatment experienced significantly greater reduction in weight and BMI at 3, 6, and 12 months ($p \leq 0.05$). There was one causally related adverse event with StomaphyX, that required laparoscopic exploration and repair.

A case series by Mullady et al. (2009) evaluated 20 patients who underwent restorative obesity surgery, endoluminal (ROSE) procedure due to weight regain post gastric bypass, with a confirmed dilated pouch and gastrojejunal anastomosis (GJA) on endoscopy. Seventeen of 20 (85%) patients had an average reduction in stoma diameter of 16 mm (65% reduction) and an average reduction in pouch length of 2.5 cm (36% reduction). The mean weight loss in successful cases was 8.8 kg at 3 months. The authors concluded that the ROSE procedure is effective in reducing not only the size of the gastrojejunal anastomosis but also the gastric pouch and may provide an endoscopic alternative for weight regain in gastric bypass patients. This study is limited by lack of comparison group, small sample size and short-term follow-up.

The ENDObesity® II Study: TransPyloric Shuttle® System for Weight Loss was completed, however results have not been published. Additional information is available at: https://clinicaltrials.gov/ct2/show/study/NCT02518685.

Endoscopic Sleeve Gastroplasty (OverStitch)

There is insufficient quality evidence regarding the safety and efficacy of endoscopic sleeve gastroplasty for obesity. Future studies including RCTs are needed to assess the safety and efficacy of this procedure along with long-term results.

Current evidence in an evolving technology report from Hayes (2022) identified four comparative studies and two systematic reviews which revealed minimal support for endoscopic sleeve gastroplasty (ESG) with the OverStitch device. Even though the OverStitch device is associated with clinically significant weight loss and fewer AEs, studies did not suggest the weight loss was more beneficial than a LSG.

Singh (2020) conducted a systematic review and found eight studies addressing the OverStitch™ device which included a total of 1,859 patients. Studies were all observational and included single center and multicenter experiences. Primary outcomes measured were %TWL), %EWL, and SAE. The authors found the pooled mean %TWL at 6, 12, and 24 months was 14.86, 16.43, and 20.01. Similarly, %EWL at 6, 12, and 24 months was 55.75, 61.84, and 60.40. The incidence of SAE was 2.26%, and no mortality was reported. Gastrointestinal bleeding was the most common documented SAE and was usually managed conservatively with packed red blood cell transfusion. Based on the analysis, the authors concluded that ESG is a promising technique with effective weight loss outcomes. Limitations included lack of controlled studies, lack of standardization definition for SAE and lack of long-term follow up data.

Hedjoudje et al. (2020) conducted a systematic review and meta-analysis from eight studies which included 1,772 patients that underwent ESG. Primary outcome measurements included relative weight loss, decrease in BMI and relative estimated weight loss. Serious adverse events were reported in all studies with an occurrence of 2.2% and included 18 patients with pain or nausea that required hospitalization, 9 patients that experience upper GI bleeding, 8 patients with peri-gastric leak or collection, one patient experienced pneumoperitoneum and one patient had a pulmonary embolism. The authors found the data suggested ESG gave way to significant sustained weight loss and safety. Patients had a BMI decrease of 5.6 kg/m^2, mean TBWL was 15.1% and relative EWL of 57.7%. These results appear to be sustained through 18-24 months of follow-up. Limitations included lack of control group, large loss to follow-up, lack of reporting for mild adverse events and lack of long-term outcomes; future studies are warranted.

Neto et al. (2020) evaluated 233 patients that underwent ESG between April 2017 and December 2018. The ESG procedure was performed using the OverStitch™ device. The authors found average weight loss was approximately 17% at six months and 19% at 12 months. The short-term results suggest that ESG is safe and effective, however additional studies are warranted.

Lopez-Nava (2017) conducted a retrospective analysis of 248 patients that underwent ESG with the Apollo Overstitch™ device. The average age for the patients was 44 years with 73% being female. The long-term clinical success was defined as achieving ≥ 10% total body weight loss at 2 years. The percent of body weight loss was measured at 6 months and 24 months. 13% of patients were lost to follow-up at 6 months and 38% of patients were lost to follow up at 24 months. The %TWL at 24 months was 18.6% which demonstrated achieved success from the procedure. SAE occurred in five patients; these consisted of two peri-gastric inflammatory fluid collections, one epigastric hemorrhage which required blood transfusion, one pulmonary embolism that occurred 72 hours following the procedure and one pneumothorax which required a chest tube. The authors found 75% of the patients achieved greater than 10% total body weight loss thus stating that ESG is effective and may bridge the gap between surgical and medical interventions. Limitations included lack of control group, limited long-term follow up and significant loss to follow-up at 24 months.

Vagus Nerve Blocking

Currently there is insufficient quality evidence supporting the long-tern effectiveness of vagus nerve blocking for obesity treatment; additional robust studies including randomization are warranted.

Apovian et al. (2017) reported the two-year outcomes from the ReCharge study among participants initially randomized to an active intervention. At 24 months, 123 (76%) vBloc participants remained in the trial. Participants who presented at 24 months (n = 103) had a mean EWL of 21% (8% TWL); 58% of participants had ≥ 5% TWL and 34% had ≥ 10% TWL. Among the subset of participants with abnormal preoperative values, significant improvements were observed in mean LDL (-16 mg/dL) and HDL cholesterol (+4 mg/dL), triglycerides (-46 mg/dL), HbA1c (-0.3%), and systolic (-11 mm Hg) and diastolic blood pressures (-10 mm Hg). QOL measures were significantly improved. Heartburn/dyspepsia and implant site pain were the most frequently reported AEs. The primary related serious AE rate was 4.3%. The findings are limited by lack of comparison group.

Morton et al. (2016) reported 12-month outcomes from the ReCharge study. Fifty-three participants were randomized to vBloc and 31 to sham. Qualifying obesity-related comorbidities included dyslipidemia (73%), hypertension (58%), sleep apnea (33%), and T2D (8%). The vBloc group achieved a %EWL of 33% (11% %TWL) compared to 19% EWL (6% TWL) with sham at 12 months (treatment difference 14 percentage points, 95% CI, 7-22; $p < 0.0001$). Common AEs of vBloc through 12 months were heartburn/dyspepsia and implant site pain; the majority of events were reported as mild or moderate. The authors concluded that vBloc therapy resulted in significantly greater weight loss than the sham control among participants with moderate obesity and comorbidities, and with a well-tolerated safety profile. Longer-term outcomes are needed to demonstrate the continued durability of this procedure.

Shikora et al. (2016) reported two-year outcomes from the VBLOC DM2 study, a prospective, case series of 28 subjects with T2D and BMI between 30 and 40 kg/m^2 who underwent a VBLOC procedure. At 24 months, the mean percentage of EWL was 22% (95% CI, 15 to 28, $p < 0.0001$) or 7.0% TWL (95% CI, 5.0 to 9.0, $p < 0.0001$). Hemoglobin A1c decreased by 0.6 percentage points (95% CI, 0.2 to 1.0, $p = 0.0026$) on average from 7.8% at baseline. Fasting plasma glucose declined by 15 mg/dL (95% CI, 0 to 29, $p = 0.0564$) on average from 151 mg/dL at baseline. Among subjects who were hypertensive at baseline, systolic blood pressure declined 10 mm Hg (95% CI, 2 to 19, $p = 0.02$), diastolic blood pressure declined by 6 mm Hg (95% CI, 0 to 12, $p = 0.0423$), and mean arterial pressure declined 7 mm Hg (95% CI, 2 to 13, $p = 0.014$). Waist circumference was significantly reduced by 7 cm (95% CI, 4 to 10, $p < 0.0001$) from a baseline of 120 cm. The most common AEs were mild or moderate heartburn, implant site pain, and constipation. The authors concluded that improvements in obesity and glycemic control were largely sustained after 2 years of treatment with VBLOC therapy with a well-tolerated risk profile. The findings are limited by lack of comparison group. Randomized controlled studies with larger patient populations are needed to validate these findings.

The ReCharge pivotal study, sponsored by the manufacturer, (Ikramuddin et al., 2014), was a prospective, randomized, double-blind, sham-controlled, multi-center trial to evaluate the safety and effectiveness of the Maestro system in treating obesity. The trial enrolled subjects who had a BMI 40-45 kg/m^2 or a BMI 35-39.9 kg/m^2 with at least one obesity-related co-morbid condition, and who had failed a more conservative weight reduction alternative. A total of 239 subjects were enrolled at 10 investigational sites; 162 subjects were randomized to the device group, and 77 were randomized to the sham control group. Subjects randomized to the sham control group underwent a surgical procedure consisting of anesthesia, implantation of a non-functional neuroregulator, and the same number of incisions an investigator would use during the laparoscopic placement of the leads. The study authors noted that the trial met its primary safety endpoint and helped more than half of patients lose at least 20% of their excess weight. The use of vagal nerve block therapy compared with a sham control device did not meet either of the prespecified coprimary efficacy objectives which were to determine whether the vagal nerve block was superior in mean percentage excess weight loss to sham by a 10-point margin with at least 55% of patients in the vagal block group achieving a 20% loss and 45% achieving a 25% loss.

Sarr et al. (2012) conducted a randomized, prospective, double-blind multicenter trial to evaluate use of intraabdominal vagal blockade (VBLOC Therapy). Five hundred three subjects were enrolled at 15 centers. After informed consent, 294 subjects were implanted with the vagal blocking system and randomized to the treated or control group. Main outcome measures were %EWL at 12 months and serious adverse events. Subjects controlled duration of therapy using an external power source; therapy involved a programmed algorithm of electrical energy delivered to the subdiaphragmatic vagal nerves to inhibit afferent/efferent vagal transmission. Devices in both groups performed regular, low-energy safety checks. Study subjects consisted of 90% females, body mass index of 41 ±1 kg/m^2, and age of 46 ±1 years. There was no mortality. 12-month %EWL was 17 ±2% for the treated and 16 ±2% for the control group. Weight loss was related linearly to hours of device use; treated and controls with ≥ 12 h/day use achieved 30 ±4 and 22 ±8% EWL, respectively. The authors concluded that VBLOC® therapy

to treat morbid obesity was safe, but weight loss was not greater in treated compared to controls; clinically important weight loss, however, was related to hours of device use. Post-study analysis suggested that the system electrical safety checks (low charge delivered via the system for electrical impedance, safety, and diagnostic checks) may have contributed to weight loss in the control group.

In an open-label case series, Camilleri and associates (2008) evaluated the effects of vagal blocking by means of intermittent vagal blocking (VBLOC therapy) on EWL. Electrodes were implanted laparoscopically on both vagi near the esophago-gastric junction to provide electrical block. Patients (obese subjects with BMI of 35 to 50 kg/m^2) were followed for 6 months. The authors concluded that VBLOC therapy is associated with significant EWL and a desirable safety profile. The findings are limited by lack of comparison group. They noted that these findings have resulted in the design and implementation of a randomized, double-blind, prospective, multicenter trial in an obese subject population.

Gastrointestinal Liner (EndoBarrier®)

Currently there is insufficient evidence regarding the effectiveness and safety of gastrointestinal liners for obesity and weight loss; additional well designed RCTs are needed along with long-term effects, and safety and efficacy results. Several clinical trials are in progress for the Endobarrier® device; information can be found at https://www.clinicaltrials.gov.

Ruban et al. (2022) conducted an RCT to study the clinical efficacy and safety of the duodenal-jejunal bypass liner (DJBL). Participants aged 18 to 65 years, with a BMI of 30 to 50 kg/m^2 and confirmed diagnosis of T2D for at least 1 year with inadequate glycemic control and on glucose-lowering medications were included in the trial. 170 patients were originally selected but due to several participants dropping out, 55 and 58 patients (DJBL and control arms, respectively) were included in the primary analysis at one year and 58 and 51 patients were included at year two. All participants received dietary and physical activity counselling. The primary outcome was to achieve an HbA1c reduction of 20% at 12 months post intervention. Secondary outcomes included lowered blood pressure, and a reduction in total body weight loss and the number of medications taken. The authors found that while the addition of the DJBL resulted in superior weight loss and improvement in cardiovascular risk factors, it did not make a significant impact on the patients' HbA1c. The findings are limited by the open-label design of the study and large loss to follow up that could have introduced biases.

Jung et al. (2020) conducted a systematic review and meta-analysis of 22 studies with 2,141 patients to comprehensively evaluate the efficacy of different endoscopic bariatric procedures compared to lifestyle modification in the treatment of morbid obesity. Intragastric balloon, DJBL, aspiration therapy, primary obesity surgery endoluminal (POSE) procedure, and botulinum toxin injection to the stomach were included and the meta-analysis determined the %TWL and %EWL. The authors found the DJBL to be the least effective in terms of %weight loss when compared to aspiration, balloon and POSE. The findings are limited by lack of long-term efficacy and safety quality data.

Quezada et al. (2018) conducted a single-arm, open-label, case series to evaluate the safety and efficacy of endoscopically placed DJBL over a 3-year period. Of 80 patients enrolled in the study, (age: 35 ±10 years; 69% female; weight: 109 ±17 kg; BMI: 42 ±5.4 kg/m^2), 72 AEs were observed in 55 patients (68%). Nine subjects required a prolonged hospital stay and three subjects required major interventions. At 52 weeks (71 patients), 104 weeks (40 patients), and 156 weeks (11 patients), the mean %EWL were 44 ±16, 40 ±22, and 39 ±20, respectively ($p < 0.001$). This study shows significant and sustained weight loss after 3 years of treatment with the new DJBL. However, the high frequency and severity of AEs preclude the use of this prototype for periods longer than 1 year.

Forner et al. (2017) evaluated the outcomes of 114 obese patients treated with a DJBL. Mean total body weight change from baseline was 12.0 kg (SD 8.5 kg, $p < 0.001$). Over an average of 51 weeks, the mean %TWL was 10.5% (SD 7.3%). Mean HbA1c was not significantly improved, but of 10 patients on insulin, 4 ceased insulin and 4 reduced insulin dosages. There was a significant decrease in hemoglobin and total cholesterol and a significant increase in serum alkaline phosphatase. Seventy-four percent of patients experienced at least one AE, some of them serious including 6 device obstructions, 5 gastrointestinal hemorrhages, 2 liver abscesses, and 1 acute pancreatitis. Seventy-four percent of patients experienced weight gain after removal with a mean 4.5 ±6.1 kg ($p < 0.0001$) within the first 6 months after explanation. The authors conclude that the DJBL provides significant but highly variable weight loss, and variable glycemic control. Most patients experienced an adverse event and most regained significant weight after device removal. In addition, the authors observed that major adverse events can occur, including the potentially life-threatening complications of hepatic abscess and gastrointestinal hemorrhage. The findings are limited by lack of comparison group. Further studies are needed to determine the long-term safety and efficacy of this procedure.

In a retrospective review, Betzel et al. (2017) evaluated the efficacy and safety profile of the DJBL. Inclusion criteria for treatment with a DJBL were: age 18-70 years, BMI 28-45 kg/m^2, and T2D with a HbA1c > 48 mmol/mol. Primary outcomes were changes in HbA1c and body weight. Secondary outcomes included changes in blood pressure, lipids, and anti-diabetic medication. Predictive factors for success of treatment with the DJBL were determined. The authors reported that 185 out of 198 patients successfully underwent a DJBL implantation procedure, with an intended implantation time of 12 months. In these 185 patients, body weight decreased by 12.8 ±8.0 kg (total body weight loss of 11.9 ±6.9%, p < 0.001), HbA1c decreased from 67 to 61 mmol/mol (p < 0.001) despite a reduction in anti-diabetic medication, and blood pressure and serum lipid levels all decreased. In total, 57 (31%) DJBLs were explanted early after a median duration of 33 weeks. AE occurred in 17% of patients. C-peptide ≥ 1.0 nmol/L and body weight ≥ 107 kg at screening were independent predictive factors for success. The authors concluded that treatment with the DJBL in patients with T2D and obesity resulted in improvement in glucose control, a reduction in anti-diabetic medication, and significant weight loss. The largest changes are observed within the first 3-6 months. Initial C-peptide levels and body weight may help to select patients with the greatest chance of success. The findings are limited by lack of comparison group.

Vilarrasa et al. (2017) evaluated the efficacy and safety of Endobarrier® in grade 1 obese patients with T2D and poor metabolic control and the role of gastro-intestinal hormone changes on the metabolic outcomes. Twenty-one patients aged 54.1 ±9.5 years, diabetes duration 14.8 ±8.5 years, BMI 33.4 ±1.9 kg/m^2, and HbA1c 9.1 ±1.3%, under insulin therapy, were implanted with Endobarrier®. Fasting concentrations of PYY, ghrelin and glucagon, and AUC for GLP-1 after a standard meal test were determined prior to and at months 1 and 12 after implantation. They found that the Endobarrier® in in this subset of patients is associated with significant weight decrease and moderate reduction in HbA1c at month 12. Longer term outcome data is needed, and the findings are limited by lack of comparison group.

In a systematic review and meta-analysis, Rohde et al. (2016) evaluated the efficacy and safety of the DJBS. Five RCTs (235 subjects) and 10 observational studies (211 subjects) were included. The risk of bias was evaluated as high in all studies. The mean BMI ranged from 30 to 49.2 kg/m^2 and 10-100% of the subjects had T2D. Meta-analysis showed that the DJBS was associated with significant mean differences in body weight and excess weight loss of -5.1 kg [95% confidence interval (CI) -7.3, -3.0; four trials; n = 151; I^2 = 37%] and 12.6% (95% CI 9.0, 16.2; four trials; n = 166; I^2 = 24%), respectively, compared with diet modification. The mean differences in glycated hemoglobin (-0.9%; 95% CI -1.8, 0.0) and fasting plasma glucose (-3.7 mM; 95% CI -8.2, 0.8) among subjects with T2D did not reach statistical significance. Adverse events consisted mainly of abdominal pain, nausea and vomiting. No deaths occurred. Future high-quality long-term RCTs are needed to further assess efficacy and safety of the DJBS for obesity.

Schouten et al. (2010) conducted a RCT of an endoscopically placed duodenal-jejunal bypass sleeve or EndoBarrier Gastrointestinal Liner in 30 patients. An additional 11 patients served as a diet control group with all patients following the same low-calorie diet during the study period. Twenty-six devices were successfully implanted. In 4 patients, implantation could not be achieved, and the devices were explanted prior to the initial protocol end point because of migration (1), dislocation of the anchor (1), sleeve obstruction (1), and continuous epigastric pain (1). The remaining patients all completed the study. Mean EWL after 3 months was 19.0% for device patients versus 6.9% for control patients. Of 8 patients with diabetes, 7 patients showed improvement at follow-up. The authors concluded that the EndoBarrier Gastrointestinal Liner was a safe noninvasive device with excellent short-term weight loss results; however, long-term randomized studies are necessary to determine the role of the device in the treatment of obesity.

A prospective, randomized trial by Gersin et al. (2010) compared 21 patients receiving the duodenojejunal bypass liner (DJBL) with 26 patients undergoing a sham procedure. Primary outcomes measured the difference in the percentage of EWL at week 12 between the 2 groups. Thirteen subjects using DJBL and 24 subjects assigned to sham completed the 12-week study. The DJBL group had a EWL of 11.9% compared to 2.7% in the sham group. Eight patients in the duodenojejunal bypass liner group dropped out of the study early because of GI bleeding (n = 3), abdominal pain (n = 2), nausea and vomiting (n = 2), and an unrelated preexisting illness (n = 1). The authors concluded that DJBL promotes a more significant weight loss beyond a minimal sham effect in candidates for bariatric surgery. This study is limited by small patient sample, short term follow-up, and relatively high complication rates.

Clinical Practice Guidelines

American Diabetes Association (ADA)

The American Diabetes Association (ADA) *Standards of Medical Care in Diabetes – 2022* states that metabolic surgery should be recommended as an option to treat type 2 diabetes in appropriate surgical candidates with a BMI of 40 kg/m^2 (BMI 37.5 kg/m^2 in Asian Americans), regardless of the level of glycemic control or complexity of glucose-lowering regimens, and in adults with a BMI of 35.0–39.9 kg/m^2 (32.5–37.4 kg/m^2 in Asian Americans) when hyperglycemia is inadequately controlled despite lifestyle and optimal medical therapy. Metabolic surgery may be considered as an option for adults with type 2 diabetes and a BMI of 30.0–34.9 kg/m^2 (27.5–32.4 kg/m^2 in Asian Americans) if hyperglycemia is inadequately controlled despite nonsurgical methods. They strongly recommend that long-term lifestyle support and routine monitoring of micronutrient and nutritional status be provided to patients after surgery, according to guidelines for postoperative management of metabolic surgery by national and international professional societies. The ADA's 2017 Standards of Medical Care in Diabetes noted that the ADA now refers to bariatric surgery as metabolic surgery.

The joint statement by international diabetes organizations on metabolic surgery in the treatment algorithm for type 2 diabetes (American Diabetes Association, International Diabetes Foundation, Diabetes UK, Chinese Diabetes Society, and Diabetes India) states that sufficient clinical and mechanistic evidence exists to support inclusion of metabolic surgery among anti-diabetes interventions for people with type 2 diabetes and obesity. The organizations note that additional studies are needed to further demonstrate long-term benefits (Rubino et al., 2016).

American College of Gastroenterology (ACG)

In an ACG Clinical Guideline for the Diagnosis and Management of Gastroesophageal Reflux Disease (Katz, et al. 2022), the following recommendations are made:

- For refractory GERD, recommend optimization of PPI therapy as the first step in management of refractory GERD (Moderate quality of evidence/strong strength of evidence)
- For GERD management, recommend maintenance PPI therapy indefinitely or antireflux surgery for patients with LA grade C or D esophagitis (Moderate quality of evidence/strong strength of evidence)

American Gastroenterological Association (AGA)

In 2021, the AGA conducted a technical review on intragastric balloons (IGB) for the management of morbid obesity (Muniraj et al., 2021).

The review suggests that IGB therapy with lifestyle modification is an effective weight-loss intervention and seems to result in improvements in metabolic parameters and medical comorbidities. Several evidence gaps were addressed in this review and include long-term efficacy of IGB therapy compared with SOC beyond 1 year, variables such as the filling medium (fluid vs. gas) the potential efficacy of an ongoing dietary intervention, pharmacotherapy, or the need for sequential balloon placement for sustained weight loss, and the role of exercise in weight-loss sustainability. Although the risk of serious adverse events appears to be relatively low, early removal due to device intolerance seems to be relatively common. The AGA makes the following recommendations:

- In individuals with obesity seeking a weight-loss intervention who have failed a trial of conventional weight-loss strategies, suggest the use of IGB therapy with lifestyle modification over lifestyle modification alone. (Conditional recommendation, moderate certainty)
- In individuals with obesity undergoing IGB therapy, recommend moderate- to high-intensity concomitant lifestyle modification interventions to maintain and augment weight loss. (Strong recommendation, moderate certainty)
- In individuals undergoing IGB therapy, recommend prophylaxis with proton pump inhibitors. (Strong recommendation, moderate certainty)
- In individuals undergoing IGB therapy, suggest using the intraoperative anesthetic regimens associated with the lowest incidence of nausea along with perioperative antiemetics; suggest a scheduled antiemetic regimen for 2 weeks after IGB placement. (Conditional recommendation, low certainty)
- In individuals undergoing IGB therapy, suggest against perioperative laboratory screening for nutritional deficiencies. (Conditional recommendation, low certainty)
- Suggest daily supplementation with 1–2 adult dose multivitamins after IGB placement. (Conditional recommendation, very low certainty)

- After IGB removal, suggest subsequent weight loss or maintenance interventions that include dietary interventions, pharmacotherapy, repeat IGB or bariatric surgery. The choice of weight loss or maintenance method after IGB is determined based on patient's context and comorbidities following a shared decision-making approach. (Conditional recommendation, low certainty)

American Society for Gastrointestinal Endoscopy (ASGE)

The ASGE Technology Committee conducted a systematic review and meta-analysis to evaluate whether endoscopic technologies have met appropriate thresholds outlined by ASGE by the Preservation and Incorporation of Valuable endoscopic Innovations (PIVI) document (Abu Dayyeh et al., 2015a). The study authors evaluated Orbera intragastric balloon (IGB) (Apollo Endosurgery) and the EndoBarrier duodenal-jejunal bypass sleeve (DJBS) (GI Dynamics). Results of the meta-analysis (17 studies, n = 1,683) indicate that the Orbera IGB satisfies the PIVI thresholds for therapy for primary and non-primary bridge obesity. The percentage of EWL (%EWL) associated with the Orbera IGB at 12 months was 25.44% (95% CI, 21.45 to 29.41%) with a mean difference over controls of 26.9% (%EWL) (95% CI, 15.66% to 38.24%; $p \leq 0.01$) in a total of 3 RCTs. The pooled %TWL after use of Orbera IGW was 13% at 6 months (95% CI, 12.37% to 13.95%) and 11.27% (95% CI, 8.17% to 14.36%), both which exceed the PIVI threshold of 5% TBWL for nonprimary bridge obesity therapy.

In its position statement on EBTs in clinical practice, the ASGE states that EBTs that have been approved by the FDA and meet thresholds of efficacy and safety as defined in the ASGE/ASMBS Preservation and Incorporation of Valuable Endoscopic Innovations should be included in the obesity treatment algorithm as adjunctive therapies to a lifestyle intervention program as outlined in the 2013 American Heart Association(AHA)/American College of Cardiology(ACC)/The Obesity Society (TOS) guidelines for the management of overweight and obesity in adults. ASGE advises that endoscopists performing EBT have a mechanism to enroll patients in long-term follow-up care for weight loss maintenance (Sullivan et al., 2015).

American Association of Clinical Endocrinologists (AACE)/Obesity Society/American Society for Metabolic and Bariatric Surgery (ASMBS)

In a clinical practice guideline for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient, the AACE, the Obesity Society, and the ASMBS (Mechanick, et al., 2019) cite the following:

- Patients with a BMI ≥ 40 kg/m^2 without coexisting medical problems and for whom bariatric surgery would not be associated with excessive risk should be eligible.
- Patients with a BMI ≥ 35 kg/m^2 and one or more severe obesity-related complications remediable by weight loss, including type 2 diabetes (T2D), high risk for T2D (insulin resistance, prediabetes, and/or metabolic syndrome), poorly controlled hypertension, nonalcoholic fatty liver disease/nonalcoholic steatohepatitis, obstructive sleep apnea, osteoarthritis of the knee or hip, and urinary stress incontinence, should be considered for a bariatric procedure. Patients with the following comorbidities and BMI ≥ 35 kg/m^2 may also be considered for a bariatric procedure, though the strength of evidence is more variable: obesity-hypoventilation syndrome and Pickwickian syndrome after a careful evaluation of operative risk; idiopathic intracranial hypertension; gastroesophageal reflux disease; severe venous stasis disease; impaired mobility due to obesity; and considerably impaired quality of life.
- Patients with BMI of 30–34.9 kg/m^2 and T2D with inadequate glycemic control despite optimal lifestyle and medical therapy should be considered for a bariatric procedure; current evidence is insufficient to support recommending a bariatric procedure in the absence of obesity.
- Interventions should first include a multidisciplinary approach, including dietary change, physical activity, behavioral modification with frequent follow up; and then if appropriate, pharmacologic therapy and/or surgical revision.
- Selection of a bariatric procedure should be based on the individualized goals of therapy [e.g., weight loss and/or metabolic (glycemic) control], available local-regional expertise (surgeon and institution), patient preferences, and personalized risk stratification.

In addition, they recommend that all patients seeking bariatric surgery have a comprehensive preoperative evaluation. This assessment is to include an obesity-focused history, physical examination, and pertinent laboratory and diagnostic testing. A detailed weight history should be documented, including a description of the onset and duration of obesity, the severity, and recent trends in weight. Causative factors to note include a family history of obesity, use of weight-gaining medications, and dietary and physical activity patterns.

A brief summary of personal weight loss attempts, commercial plans, and physician-supervised programs should be reviewed and documented, along with the greatest duration of weight loss and maintenance. This information is useful in substantiating

that the patient has made reasonable attempts to control weight before considering obesity surgery. The guidelines state that preoperative weight loss should be considered for patients in whom reduced liver volume can improve the technical aspects of surgery.

American Association of Clinical Endocrinologists (AACE)/American College of Endocrinology (ACE)

The AACE and the ACE developed comprehensive clinical practice guidelines for the medical care of patients with obesity (Garvey, et al., 2016) based on diligent review of clinical evidence with "transparent incorporation of subjective factors." The final recommendations recognize that obesity is a complex, adiposity-based chronic disease, where management targets both weight-related complications and adiposity to improve overall health and quality of life. The detailed evidence-based recommendations allow for nuanced clinical decision-making that addresses real-world medical care of patients with obesity, including screening, diagnosis, evaluation, selection of therapy, treatment goals, and individualization of care. The goal is to facilitate high-quality care of patients with obesity and provide a rational, scientific approach to management that optimizes health outcomes and safety. Included in their clinical guideline are the following recommendations pertaining to BMI:

- Patients with a BMI of ≥ 40 kg/m^2 without coexisting medical problems and for whom the procedure would not be associated with excessive risk should be eligible for bariatric surgery.
- Patients with a BMI of ≥ 35 kg/m^2 and 1 or more severe obesity-related complications, including T2DM, hypertension, obstructive sleep apnea, obesity-hypoventilation syndrome, Pickwickian syndrome, nonalcoholic fatty liver disease or nonalcoholic steatohepatitis, pseudotumor cerebri, gastroesophageal reflux disease, asthma, venous stasis disease, severe urinary incontinence, debilitating arthritis, or considerably impaired quality of life may also be considered for a bariatric surgery procedure.
- Patients with a BMI of 30-34.9 kg/m^2 with diabetes or metabolic syndrome may also be considered for a bariatric procedure, although current evidence is limited by the number of patients studied and lack of long-term data demonstrating net benefit.
- Independent of BMI criteria, there is insufficient evidence for recommending a bariatric surgical procedure specifically for glycemic control alone, lipid lowering alone, or CVD risk reduction alone.

American Heart Association/American College of Cardiology (AHA/ACC)/Obesity Society

The AHA/ACC and the Obesity Society published an updated 2013 Practice Guideline and Management of Overweight and Obesity in Adults (Jensen et al., 2014). The updated guidelines reflect such consensus and offer update regarding treatment for patients who are overweight or obese. While the focus remains on sustained weight loss and decreased waist circumference, the authors also recommend use of bariatric surgery for patients with a BMI ≥ 40, or BMI ≥ 35 with comorbidities.

In a scientific statement on severe obesity in children and adolescents the American Heart Association (Kelly et al., 2013), summarized that RYGB has been associated with improvement or resolution of numerous comorbid conditions, including OSAS,T2DM, features of metabolic syndrome, pseudotumor cerebri, and psychosocial functioning. Controlled, prospective adult studies demonstrate a marked effect of bariatric surgery on mortality, comorbidity reversal, and prevention of comorbidity over ensuing decades; these beneficial effects of bariatric surgery help to inform clinical decision making for severely obese adolescents when no other treatments have demonstrated long-term effectiveness.

American Society for Metabolic & Bariatric Surgery (ASMBS)

Presurgical Evaluations

The ASMBS published recommendations for the presurgical psychosocial evaluation of bariatric surgery patients (Sogg et al., 2016). They recommend that bariatric behavioral health clinicians with specialized knowledge and experience be involved in the evaluation and care of patients both before and after surgery. Given the importance of long-term follow up after weight loss surgery (WLS), the preoperative psychosocial assessment provides a valuable opportunity for patients to establish a trusted connection to a behavioral health provider as an additional resource and integral participant in their postoperative care. The need to ensure that postoperative psychosocial care is available has been noted in established practice guidelines and evidence suggests that such care is associated with better outcomes after surgery.

In a 2016 position statement on preoperative supervised weight loss requirements, the ASMBS noted that there is no data from any randomized controlled trial, large prospective study or meta-analysis to support the practice of mandated preoperative weight loss. Further, there is no Level I data in the surgical literature, or consensus in the medical literature (based on over 40 published RCTs) that has clearly identified any one dietary regimen, duration or type of weight loss program that is optimal for

patients with clinically severe obesity. Finally, they recommend that patients seeking surgical treatment for clinically severe obesity should be evaluated based on their initial BMI and co-morbid conditions.

Nutritional Impact of Bariatric Surgery

In an updated guideline on the integrated health nutritional guidelines for surgical weight loss, the ASMBS (Parrott et al., 2017) states that optimizing postoperative patient outcomes and nutritional status begins preoperatively. Patients should be educated before and after WLS on the expected nutrient deficiencies associated with alterations in physiology. Although surgery can exacerbate preexisting nutrient deficiencies, preoperative screening for vitamin deficiencies has not been the norm in the majority of WLS practices. Screening is important because it is common for patients who present for WLS to have at least 1 vitamin or mineral deficiency preoperatively.

Data continue to suggest that the prevalence of micronutrient deficiencies is increasing, while monitoring of patients at follow-up is decreasing. The ASMBS recommends that their guideline be considered a reasonable approach to patient nutritional care based on the most recent research, scientific evidence, resources, and information available. It is the responsibility of the registered dietitian nutritionist and WLS program to determine individual variations as they relate to patient nutritional care.

Specific Bariatric Procedures

The ASMBS (2016, updated 2019) has approved, and supports the use of the following bariatric procedures and associated devices:

- Roux-en-Y Gastric Bypass
- BPD/Duodenal Switch
- Intragastric Balloon
- Sleeve Gastrectomy
- Adjustable Gastric Banding
- Single Anastomosis Duodenoileostomy with Sleeve

Bariatric Re-operative Procedures

A 2017 ASMBS updated position statement on sleeve gastrectomy (SG) as a bariatric procedure (Ali et al., 2017) summarized that:

- Substantial long-term outcome data published in the peer-reviewed literature including studies comparing outcomes of various surgical procedures, confirm that sleeve gastrectomy (SG) provides significant and durable weight loss, improvements in medical co-morbidities, improved quality of life, and low complication and mortality rates for obesity treatment.
- SG is now the most commonly performed procedure in the United States (~53.8% of all bariatric procedures), followed by Roux-en-Y gastric bypass (RYGB; 23.1% of all procedures) (Chaar et al., 2018).
- In terms of initial early weight loss and improvement of most weight-related co-morbid conditions, SG and RYGB appear similar.
- The effect of SG on GERD is less clear, because GERD improvement is less predictable, and GERD may worsen or develop de novo. Preoperative counseling specific to GERD-related outcomes is recommended for all patients undergoing SG.
- Based on safety and efficacy data, there is a trend toward SG as the procedure of choice for adolescents, although both RYGB and SG are routinely performed in teen weight loss surgery programs.
- As with any bariatric procedure, long-term weight regain can occur after SG and may require one or more of a variety of re-interventions.

The ASMBS Clinical Issues Committee position statement on intragastric balloon therapy endorsed by SAGES (Ali, et al., 2016) includes the following summary and recommendations:

- Level 1 data regarding the clinical utility, efficacy, and safety of intragastric balloon therapy for obesity are derived from randomized clinical studies.
- Implantation of intragastric balloons can result in notable weight loss during treatment.
- Although utilization of intragastric balloons results in notable weight loss, separating the effect of the balloon alone from those of supervised diet and lifestyle changes may be challenging. Of note, recent FDA pivotal trials demonstrated a benefit to balloon use compared with diet alone in their study populations. In general, any obesity treatment, including intragastric balloon therapy, would benefit from a multidisciplinary team that is skilled and experienced in providing in-person medical, nutritional, psychological, and exercise counseling.

- The safety profiles for intragastric balloons indicate a safe intervention, with serious complications being rare. Early postoperative tolerance challenges can be significant but can be controlled with pharmacotherapy in the majority of patients, thereby minimizing voluntary balloon removals. These early symptoms should be discussed with the patient before the procedure.
- Although therapy with prolonged balloon in situ time and the use of sequential treatments with multiple balloons have been studied, awareness and adherence to absolute and relative contraindications of use and timely removal optimize device safety.
- Based on current evidence, balloon therapy is FDA approved as an endoscopic, temporary (maximum 6 months) tool for the management of obesity. Further review will evaluate the impact of diet, lifestyle changes, and pharmacotherapy during and after balloon removal.
- The ability to perform appropriate follow-up is essential when intragastric balloons are used for weight loss to enhance their safety and avoid complications related to spontaneous deflation and bowel obstruction.

The ASMBS (Moore and Rosenthal, 2018) released an addendum to their intragastric balloon therapy position statement in response to the FDA's warnings on complications not identified during initial clinical trials, and worldwide mortalities associated with intragastric balloons. They recommend that:

- As with all procedures, it is important that patients give informed consent and are aware of potential adverse events. Laypeople may need to be counseled to correct a misperception that endolumenal treatments are nonsurgical and thus risk-free.
- When less powerful treatments are chosen, behavioral modification increases in importance and there is risk of weight regain after the device is retrieved. The ASMBS routinely advocates for multidisciplinary care and support of the weight loss patient, and this recommendation is even more crucial for intragastric balloon recipients.

The ASMBS, in their 2015 position statement on vagal blocking therapy for obesity (Papasavas et al., 2016), conclude that the quantity of the data available at this time (6 published studies; approximately 600 implanted devices) and the length of follow-up indicate adequate safety and efficacy in the short term. More prospective studies with longer follow-up are required to establish the clinically significant efficacy and patient tolerance of this device.

In a 2015 position statement on intragastric balloon therapy endorsed by SAGES, the ASMBS acknowledges that although utilization of intragastric balloons results in notable weight loss, separating the effect of the balloon alone from those of supervised diet and lifestyle changes may be challenging (Ali et al., 2016).

Bariatric Surgery in Adolescents

The updated ASMBS pediatric metabolic and bariatric surgery guidelines (Pratt et al., 2018) state that the disease of obesity has become recognized as a metabolic disease controlled by genetic factors, with clear evidence that the physiologic control of weight is through neuroendocrine pathways that regulate body mass by affecting satiety, hunger, and metabolism. The recognition that weight is largely not under volitional control leads to a strong need to offer effective, sustainable, proven therapies to children with obesity.

The summary of major changes in the guideline includes:

- Patient selection criteria of a BMI ≥ 120% of the 95th percentile with a co-morbidity or a BMI ≥ 140% of the 95th percentile should be used when determining weight cut offs for adolescents to undergo metabolic and bariatric surgery (MBS). In their opinion, Tanner stage and linear growth should not be used to determine readiness for MBS.
- Preoperative attempts at diet and exercise: there are no data that the number of weight loss attempts correlates with success after MBS. Compliance with a multi- disciplinary preoperative program may improve out-comes after MBS but prior attempts at weight loss should be removed as a barrier to definitive treatment for obesity.
- Requiring adolescents with a BMI > 40 to have a co-morbidity (as in the old guidelines) puts children at a significant disadvantage to attaining a healthy weight. Earlier surgical intervention (at a BMI > 45 kg/m^2) can allow adolescents to reach a normal weight and avoid lifelong medication therapy and end organ damage from co-morbidities.
- Certain co-morbidities should be considered in adolescents, specifically the psychosocial burden of obesity, the orthopedic diseases specific to children, GERD, and cardiac risk factors. Given the poor outcomes of medical therapies for type 2 diabetes in children, these co-morbidities may be considered an indication for MBS in younger adolescents or those with lower obesity percentiles.

- Nonalcoholic fatty liver disease (NAFLD) and steatohepatitis (NASH): NAFLD may be present in at least 59% of adolescent patients referred for MBS. Given complete resolution of NASH in approximately 85% of patients who undergo VSG or RYGB, NAFLD should be considered a strong indication for MBS in adolescents with severe obesity.
- OSA has been shown to cause significantly decreased health-related quality of life (HRQoL) with increased risk of morbidity and mortality in adolescents. MBS in adolescents results in significant improvement or resolution of OSA. Thus, OSA should be considered a strong indication for MBS.
- Multidisciplinary teams should stabilize and treat preexisting eating disorders, assure stable social support, assess and assist with nutrition and activity knowledge, and consider the addition of medications when appropriate.
- The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) guidelines should be followed when building an adolescent MBS program. It is the responsibility of the adolescent MBS program to have a transition plan in place for adolescents to transition to an adult MBS program for lifelong care.

The ASMBS Pediatric Committee (Michalsky et al., 2012) best practice guidelines state that the associated risk/benefit analysis of bariatric surgery in adolescents should also include the consideration of the potential long-term health risks of untreated or inadequately treated obesity for the individual candidate. In addition, patients with a greater BMI and more serious medical illness are at increased risk of complications after bariatric surgery. Providing access to bariatric surgery earlier in life when the disease burden and severity is lower might decrease the operative risk, morbidity, and mortality. Additionally, earlier surgical intervention alters the natural course of many obesity-related co-morbidities that otherwise would put the patient at risk of long-term complications and early mortality.

Impact of Obesity and Obesity Treatment on Fertility and Fertility Therapy

In a position statement endorsed by the American College of Obstetricians and Gynecologists (ACOG) and the Obesity Society (Kominiarek et al., 2017), the ASMBS summarized that:

- Bariatric surgery is effective in achieving significant and sustained weight loss in morbidly obese women and has been shown in case-control studies to improve fertility.
- Pregnancy is not recommended during the rapid weight-loss phase after bariatric surgery; therefore, counseling and follow-up regarding contraception during this period is important.
- The specific impact of either medical weight-loss treatments or bariatric surgery on the responsiveness to subsequent treatments for infertility in both men and women is not clearly understood at this time.

Revisional Bariatric Surgery

In a systematic review of re-operative bariatric surgery, the ASMBS Revision Task Force (Brethauer et al., 2014) states that the indications and outcomes for re-operative bariatric surgery are procedure-specific, but the current evidence does support additional treatment for persistent obesity, co-morbid disease, and complications. Additional surgical therapy may benefit patients who present with insufficient weight loss, continued co-morbid disease, or weight gain after the index bariatric procedure. A thorough evaluation should be conducted by a multi-disciplinary program to determine the potential causes for their poor responses.

As the risks of re-operative bariatric surgery are higher than with the primary procedure, evidence suggests the need for careful patient selection. In addition, the specific type of re-operative procedure performed should be based on the patient's primary procedure, the patient's anatomy, the patient's weight and co-morbidities, and the experience of the surgeon.

An ASMBS Task Force (Sudan et al., 2015) on reoperative surgery provided the updated definitions for re-operative surgery as follows:

- Any operation after the first bariatric operation which qualified toward center of excellence volume requirements is considered a re-operation. Re-operations were further divided into corrective operations or conversions.
- An operation is considered corrective when complications or incomplete treatment effect of a previous bariatric operation was addressed but the initial operation was not changed.
- Conversions involve changing an index bariatric operation (first operation) to a different type of bariatric operation, and reversal restored original anatomy.

The Task Force also conducted a systematic review to evaluate morbidity, mortality, and weight loss outcomes after re-operative bariatric surgery. Data on reoperations was compared to that from patients who had initial bariatric operations but did not undergo reoperations. Reoperations were subdivided into corrective operations and conversions.

- Out of 449,753 bariatric operations, 28,720 (6.3%) underwent reoperations of which 19,970 (69.5%) were corrective and 8,750 (30.5%) were conversions.
- The mean % EBWL after conversion to a different bariatric operation was 39.3% and was 35.9% after a corrective operation. Although this % EBWL was lower than that after a primary operation (43.5%), it is still considered by the Task Force to be substantial and excellent weight loss. However, not all reoperations will result in further weight loss or resolution of comorbidity.
- Restorative operations necessitated by intolerable side effects or complications of the index procedure such as removal of the laparoscopic adjustable gastric band for band intolerance or dilated esophagus, or reversing a duodenal switch or a gastric bypass for severe malabsorption, may in fact result in weight gain and return of comorbidities.
- Elderly patients (> 60 years of age) comprised 11% of the primary and 12% of the re-operative group of patients. The data suggests an overall improvement in the rates of morbidity and mortality after bariatric operations in recent years, even for higher risk populations.

The Task Force concluded that although most patients do not require re-operative surgery, among those who do, the complication rate is low, and outcomes are clinically comparable to primary procedures.

American Society for Metabolic and Bariatric Surgery (ASMBS)/National Lipid Association (NLA)/Obesity Medicine Association (OMA)

The ASMBS, NLA and OMA published a 2-part joint scientific statement on lipids and bariatric procedures. Part 1 concluded that bariatric procedures reduce body fat and have favorable effects on adipocyte and adipose tissue function, which contributes to improvement in metabolic diseases such as dyslipidemia, high glucose levels, and high blood pressure. Among the mechanisms by which bariatric procedures may improve dyslipidemia includes favorable alterations in endocrine and inflammatory homeostasis. Bariatric procedures may also have favorable effects on bile acid metabolism and the intestinal microbiome, which may also improve dyslipidemia (Bays et al., 2016a).

Part 2 of this joint scientific statement summarized that the principles that apply to bariatric procedures and lipid levels include the following: (1) The greater the fat mass loss, the greater the improvement in lipid parameters such as triglycerides and especially LDL cholesterol; (2) bariatric procedures allow for a decrease in the use of drug treatment for dyslipidemia; and (3) after bariatric procedures, HDL cholesterol may transiently decrease for the first 3–6 months after the procedure, which is usually followed by an increase in HDL cholesterol above the baseline value before the bariatric procedure. Finally, the authors observed that data are scarce regarding the effects of bariatric procedures on some of the lipid parameters such as non-HDL cholesterol, apolipoprotein B, and lipoprotein particle number and remnant lipoproteins (Bays et al., 2016b).

Endocrine Society

In its updated guideline for the assessment, prevention and treatment of pediatric obesity (Styne et al., 2017) the Endocrine Society's recommendations include the following:

- Diagnose a child or adolescent > 2 years of age as overweight if the BMI is ≥ 85th percentile but < 95th percentile for age and sex, as obese if the BMI is ≥ 95th percentile, and as extremely obese if the BMI is ≥ 120% of the 95th percentile or ≥ 35 kg/m^2
- Children or adolescents with a BMI of ≥ 85th percentile should be evaluated for potential comorbidities
- Insulin concentrations should not be utilized when evaluating children or adolescents for obesity
- Bariatric surgery is suggested only under the following conditions:
  - The patient has attained Tanner 4 or 5 pubertal development and final or near-final adult height, the patient has a BMI of > 40 kg/m^2 or has a BMI of > 35 kg/m^2 and significant, extreme comorbidities
  - T2DM, moderate to extreme sleep apnea, pseudotumor cerebri, debilitating orthopedic problems, and nonalcoholic steatohepatitis with advanced fibrosis
  - Extreme obesity and comorbidities persist despite compliance with a formal program of lifestyle modification, with or without pharmacotherapy
  - BMI of > 40 kg/m^2 with mild comorbidities (hypertension, dyslipidemia, moderate orthopedic problems, mild sleep apnea, nonalcoholic steatohepatitis, and extreme psychological distress that is secondary to their obesity)
  - Psychological evaluation confirms the stability and competence of the family unit [psychological distress due to impaired quality of live (QOL) from obesity may be present, but the patient does not have an underlying untreated psychiatric illness]
  - The patient demonstrates the ability to adhere to the principles of healthy dietary and activity habits

- There is access to an experienced surgeon in a pediatric bariatric surgery center of excellence that provides the necessary infrastructure for patient care, including a team capable of long-term follow-up of the metabolic and psychosocial needs of the patient and family
- Bariatric surgery should not be performed in preadolescent children, pregnant or breast-feeding adolescents (and those planning to become pregnant within 2 years of surgery), and in any patient who has not mastered the principles of healthy dietary and activity habits and/or has an unresolved substance abuse, eating disorder, or untreated psychiatric disorder

Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)

A 2010 guideline by SAGES states that due to concerns for higher failure rates after fundoplication in the morbidly obese patient (BMI > 35 kg/m^2) and the inability of fundoplication to address the underlying problem (obesity) and its associated co-morbidities, gastric bypass should be the procedure of choice when treating GERD in this patient group. The benefits in patients with BMI > 30 is less clear and needs further study (Stefanidis et al., 2010).

In its 2008 *Guidelines for Clinical Application of Laparoscopic Bariatric Surgery*, endorsed by the ASMBS, SAGES confirms that bariatric surgery is medically indicated for morbidly obese patients who fail to respond to dietary, behavioral, nutritional, and medical therapies, with clear evidence of efficacy and safety. BMI and age-based candidacy guidelines should not limit access for patients suffering with progressive or poorly controlled obesity-related comorbidities if the risk-versus-benefit analysis favors surgery. Laparoscopic RGB, AGB, and BPD have all been proven effective. They do not make a definitive recommendation for one procedure over another and note that at the present time, decisions are driven by patient and surgeon preferences, as well as considerations regarding the degree and timing of necessary outcomes versus tolerance of risk and lifestyle change.

Further, the 2008 guidelines state that there are no absolute contraindications to bariatric surgery. Relative contraindications to surgery may include severe heart failure, unstable coronary artery disease, end-stage lung disease, active cancer diagnosis/treatment, cirrhosis with portal hypertension, uncontrolled drug or alcohol dependency, and severely impaired intellectual capacity. Crohn's disease may be a relative contraindication to Roux-en-Y gastric bypass and biliopancreatic diversion.

Multidisciplinary Care Task Group

Greenberg et al. (2005) found a high incidence of depression, negative body image, eating disorders, and low quality of life (QoL) in patients with severe obesity and that perceived obesity-related health problems, motivation, and sense of coherence (SoC) predicted better weight loss. Although their investigation showed there are no predictive relationships between preoperative psychological evaluations and postoperative weight loss, the Behavioral and Psychological subgroup of the Multidisciplinary Care Task Group recommended that all bariatric surgery candidates be evaluated by a licensed mental health care provider experienced in the treatment of severely obese patients and working with a multidisciplinary team. Although research supports the association of psychological problems such as depression and personality disorder with less successful obesity surgery outcomes, rarely are the psychological problems cited as contraindications for surgery (Greenberg et al., 2005).

National Institute for Health and Care Excellence (NICE)

The National Institute for Health and Care Excellence (NICE) 2014 guideline on obesity identification, assessment and management offers bariatric surgery as a treatment option for people with obesity when they have: a BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 40 kg/m^2 and other significant disease (for example, type 2 diabetes or high blood pressure) that could be improved if they lost weight; all appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss; have a multi-disciplinary team approach; the person is generally fit for surgery and anesthesia; and the person commits to the need for long-term follow-up. In addition, the NICE guideline notes that bariatric surgery is the option of choice (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m^2 when other interventions have not been effective. Further, surgical intervention is not generally recommended in children or young people, however, it may be considered only in exceptional circumstances, and if they have achieved or nearly achieved physiological maturity.

A 2015 NICE interventional procedure guidance on managing type 2 diabetes states that current evidence on the safety and efficacy of implantation of a duodenal–jejunal bypass liner for managing type 2 diabetes is limited in quality and quantity. Therefore, the procedure should only be used in the context of research. Further research should give details of patient selection, including information about use of the procedure in patients with different levels of BMI. The research should provide information on complications; reasons for early removal of the device; medication used for treating type 2 diabetes, both when

the device is in place and after its removal; and control of type 2 diabetes after device removal. In 2018, the following statement was added to this guidance: The device used in this procedure (EndoBarrier) no longer has a current CE mark. The CE mark is necessary for medical devices to be marketed in the European Union. A non-CE marked device can only be used in the context of clinical investigations with MHRA and research ethical approval.

Interventional procedures guidance (IPG569) from NICE (2016) indicates the evidence is limited in both quality and quantity when it comes to the safety of SADI-S for treating moderate obesity and that this procedure should only be used with special arrangements.

American Academy of Sleep Medicine (AASM)

The American Academy of Sleep Medicine commissioned a task force of experts in sleep medicine, otolaryngology, and bariatric surgery to develop recommendations based on a systematic review of the literature (Kent, 2021). The following are recommendations intended as a guide for clinicians who treat overweight adults with OSA:

- Recommend clinicians discuss referral to a sleep surgeon with adults with OSA and BMI < 40 who are intolerant or unaccepting of CPAP (Strong)
- Recommend clinicians discuss referral to a bariatric surgeon with adults with OSA and obesity (class II/III, BMI ≥ 35) who are intolerant or unaccepting of PAP (Strong)
- Suggest clinicians discuss referral to a sleep surgeon with adults with OSA, BMI < 40 and persistent inadequate PAP adherence due to pressure-related side effects (Conditional)
- Suggest clinicians recommend PAP as an initial therapy for adults with OSA and a major upper airway anatomic abnormality prior to consideration of referral for upper airway surgery (Conditional)

Department of Veterans Affairs (VA)/Department of Defense (DoD)

The 2020 guideline from the VA/DoD (Mayer et al., 2020) for the management of adult overweight or obesity makes the following suggestions or recommendations:

- In patients with a body mass index of ≥ 30 kg/m^2 and type 2 diabetes mellitus, suggest offering the option of metabolic/bariatric surgery, in conjunction with a comprehensive lifestyle intervention.
- In adult patients with a body mass index ≥ 40 kg/m^2 or those with body mass index ≥ 35 kg/m^2 with obesity-associated condition(s), suggest offering the option of metabolic/bariatric surgery, in conjunction with a comprehensive lifestyle intervention, for long-term weight loss/maintenance and/or to improve obesity-associated condition(s).
- In patients with obesity (body mass index ≥ 30 kg/m^2) who prioritize short-term (up to six months) weight loss, suggest offering intragastric balloons in conjunction with a comprehensive lifestyle intervention.
- There is insufficient evidence to recommend for or against metabolic/bariatric surgery to patients over age 65.
- There is insufficient evidence to recommend for or against percutaneous gastrostomy devices for weight loss in patients with obesity.
- There is insufficient evidence to recommend for or against intragastric balloons for long-term weight loss to support chronic weight management or maintenance.

Thoracic Society

In a clinical practice guideline from the Thoracic Society (Hudgel, 2018), the following recommendations are made for patients who are overweight and suffer from OSA:

- Reduced-calorie diet, and
- Exercise or increased physical activity, and
- Behavioral guidance.

In addition, it was stated that pharmacological therapy and bariatric surgery are appropriate for selected patients who require further assistance with weight loss.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Bariatric surgical procedures are not subject to FDA regulation. FDA approval information for several devices related to bariatric surgery is described below.

The FDA approved the ORBERA™ Intragastric Balloon System (Apollo Endosurgery, Inc.) on August 5, 2015. The ORBERA System is indicated for use as an adjunct to weight reduction in obese adults with BMI ≥ 30 and ≤ 40 kg/m^2. It is to be used in conjunction with a long term supervised diet and behavior modification program designed to increase the likelihood of significant long-term weight loss and weight loss maintenance. It is indicated for adults who have failed conservative weight reduction strategies, such as supervised diet, exercise and behavior modification program. ORBERA has a maximum placement period of 6 months. For more information, refer to:

- https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=p140008
- https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P140008S016

(Accessed August 16, 2022)

The FDA approved the implantable EnteroMedics Maestro Rechargeable System to be marketed on January 4, 2015). The Maestro Rechargeable System is an implantable pacemaker-like device for patients who are morbidly obese or who are obese with one or more obesity-related conditions. For more information, refer to: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm?id=P130019. (Accessed August 16, 2022)

Gastric banding involves the use of an adjustable or nonadjustable gastric band, which is subject to FDA marketing approval. In 2001, the BioEnterics® LAP-BAND System was approved by FDA for marketing under the premarket approval process. According to the FDA labeling, this is approved for surgical treatment for severely obese adults for whom more conservative treatments (e.g., diet, exercise, behavioral modification) have failed. The LAP-BAND System is indicated for use in weight reduction for severely obese patients with a Body Mass Index (BMI) of at least 40 or a BMI of at least 35 with one or more severe co-morbid conditions, or those who are 100 lbs. or more over their estimated ideal weight according to the 1983 Metropolitan Life Insurance Tables (use the midpoint for medium frame). It is indicated for use only in severely obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise and behavior modification programs.

In February 2011, the FDA approved the Lap-Band Adjustable Gastric Banding System, by Allergan, for weight reduction in obese patients, with a Body Mass Index (BMI) of at least 40 kg/m^2 or less obese patients who have at least a body mass index (BMI) of 30 kg/m^2 and one or more additional obesity-related co-morbid condition, such as diabetes or hypertension. Additional information is available at: http://www.accessdata.fda.gov/cdrh_docs/pdf/p000008s017a.pdf.
(Accessed August 16, 2022)

On September 28, 2007, the FDA approved the REALIZE™ Adjustable Gastric Band (REALIZE Band) manufactured by Ethicon Endo-Surgery, Inc. The REALIZE Band also consists of a silicone band, tubing, and an injection port. Additional information is available at: http://www.accessdata.fda.gov/cdrh_docs/pdf7/P070009b.pdf. (Accessed August 16, 2022)

In October 2010, the manufacturer voluntarily recalled the REALIZE Band due to the potential for a small ancillary component called the Strain Relief to move out of its intended position. The device was changed to add a silicone adhesive to bond the strain relief sleeve and the locking connector components of the injection port. Additional information is available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfres/res.cfm?id=95101. (Accessed August 16, 2022)

Adjustable gastric bands are contraindicated in patients younger than 18 years of age.

Surgical stapling devices are used in all bariatric surgical procedures except gastric banding. These devices have been approved by FDA for use in various general surgical procedures. One device is the Endo Gia Universal Auto Suture, which inserts six parallel rows of staples into tissue. Other surgical staplers are manufactured by Ethicon Endo-Surgery. Additional information, product code GDW and GAG, is available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRL/listing.cfm.
(Accessed August 16, 2022)

StomaphyX was granted 510(k) marketing approval on March 9, 2007. EndoGastric Solutions StomaphyX™ endoluminal fastener and delivery system is substantially equivalent in intended use and method of operation to a combination of the LSI Solutions Flexible Suture Placement Device and the Bard Endoscope Suturing System/Bard Endocinch. According to the FDA, the StomaphyX system is indicated for use in endoluminal trans-oral tissue approximation and ligation in the gastrointestinal

tract. Additional information is available at: http://www.accessdata.fda.gov/cdrh_docs/pdf6/K062875.pdf. (Accessed August 16, 2022)

According to EndoGastric Solutions, StomaphyX is no longer being manufactured.

The OverStitch™ Endoscopic Suturing System was granted 510(k) marketing approval on June 27, 2018. According to the FDA, it is intended for endoscopic placement of suture(s) and approximation of soft tissue within the gastrointestinal tract. The device can utilize either a single- or dual-channel endoscope. Additional information is available at: https://www.accessdata.fda.gov/cdrh_docs/pdf18/K181141.pdf. (Accessed August 16, 2022)

The AspireAssist received FDA pre-market approval on June 14, 2016 for adults who are at least 22 years old and are obese, with a BMI of 35.0-55.0 kg/m^2 who have failed to achieve and maintain weight loss with non-surgical weight loss therapy. The AspireAssist is intended for long-term use in conjunction with lifestyle therapy (to help patients develop healthier eating habits and reduce caloric intake) and continuous medical monitoring. Additional information is available at: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm?id=P150024. (Accessed August 16, 2022)

Transoral gastroplasty (TOGA) is not currently FDA approved.

The TransPyloric Shuttle/TransPyloric Shuttle Delivery Device was granted Premarket Approval on April 18, 2019 and is indicated for weight reduction in adult patients with obesity with a BMI of 35.0-40.0 kg/m^2 or a BMI of 30.0 to 34.9 kg/m^2 with one or more obesity related comorbid conditions and intended to be used in conjunction with a diet and behavior modification program. https://www.accessdata.fda.gov/cdrh_docs/pdf18/P180024a.pdf. (Accessed August 16, 2022)

In August of 2018, the FDA granted GI Dynamics Inc., Boston, MA an Investigational Device Exemption for the EndoBarrier® gastrointestinal liner. Additional information is available at: https://www.fda.gov/medical-devices/how-s©tudy-and-market-your-device/investigational-device-exemption-ide. (Accessed August 16, 2022)

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Policy History/Revision Information

Date	Summary of Changes
03/01/2024	**Coverage Rationale** ***State-Specific Criteria*** • Added notation to indicate bariatric procedures must be performed at a Bariatric Surgery Center of Excellence according to the Nebraska Administrative Code (NAC) ***Additional Non State-Specific Criteria*** • Added language to indicate: ○ The following bariatric surgical procedures are proven and medically necessary for treating obesity: ▪ Adjustable gastric banding (using open or laparoscopic approaches) for individuals ≥ 18 years of age; refer to the *U.S. Food and Drug Administration (FDA)* section [of the policy] for additional information ▪ Sleeve gastrectomy (vertical sleeve gastrectomy) ▪ Vertical banded gastroplasty ○ In adults, bariatric surgery using one of the procedures identified above for treating obesity is proven and medically necessary when **all of the following** criteria are met: ▪ **One** of the following: – Class III obesity – Class II obesity in the presence of one or more of the following co-morbidities: • Type 2 diabetes • Cardiovascular disease [e.g., history of stroke and/or myocardial infarction, poorly controlled hypertension (systolic blood pressure greater than 140 mmHg or diastolic blood pressure 90 mmHg or greater, despite pharmacotherapy)] • History of coronary artery disease with a surgical intervention such as coronary artery bypass or percutaneous transluminal coronary angioplasty • History of cardiomyopathy

Date	Summary of Changes
	• Obstructive Sleep Apnea (OSA) confirmed on polysomnography with an AHI or RDI of ≥ 30 ▪ The individual must also meet the following criteria: – **Both** of the following: • Completion of a preoperative evaluation that includes a detailed weight history along with dietary and physical activity patterns • Psychosocial-behavioral evaluation by an individual who is professionally recognized as part of a behavioral health discipline to provide screening and identification of risk factors or potential postoperative challenges that may contribute to a poor postoperative outcome – Participation in a Multidisciplinary surgical preparatory regimen ○ In Adolescents, the bariatric surgical procedures identified above are proven and medically necessary for treating obesity when **all of the following** criteria are met: ▪ **One** of the following: – Class III obesity – Class II obesity in the presence of one or more of the following co-morbidities: • Type 2 diabetes • Poorly controlled hypertension (systolic blood pressure greater than 140 mmHg or diastolic blood pressure 90 mmHg or greater, despite pharmacotherapy) • Obstructive Sleep Apnea confirmed on polysomnography with an AHI or RDI of ≥ 30 ▪ The individual must also receive an evaluation at, or in consultation with, a multidisciplinary center focused on the surgical treatment of severe childhood obesity; this may include adolescent centers that have received accreditation by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) or can demonstrate similar programmatic components ○ Revisional Bariatric Surgery using one of the procedures identified above is proven and medically necessary when due to a technical failure or major complication from the initial procedure; potential failure/complications include but are not limited to the following: ▪ Bowel perforation (including adjustable gastric band erosion) ▪ Adjustable gastric band migration (slippage) that cannot be corrected with manipulation or adjustment; records must demonstrate that manipulation or adjustment to correct band slippage has been attempted ▪ Leak ▪ Obstruction (confirmed by imaging studies) ▪ Staple-line failure ▪ Mechanical adjustable gastric band failure ▪ Uncontrollable reflux related to sleeve gastrectomy when **all** the following criteria are met: – Maximum nonpharmacological medical management failure (e.g., positional, dietary modification, and behavioral changes) – Maximum pharmacological medical management failure (e.g., at least one month of double dose PPI, H2 blocker, and/or sucralfate) – Severe esophagitis (class C or D) confirmed by endoscopy despite maximum medical management ○ Removal of adjustable gastric band and all related components which does not result in a revisional surgery is proven and medically necessary ○ The following procedures are unproven and not medically necessary for treating obesity due to insufficient evidence of efficacy: ▪ Revisional Bariatric Surgery for any other indication than those listed above ▪ Bariatric surgery as the primary treatment for any condition other than obesity ▪ Bariatric interventions for the treatment of obesity including but not limited to: – Bariatric artery embolization (BAE) – Gastric electrical stimulation with an implantable gastric stimulator (IGS) – Intragastric balloon

Date	Summary of Changes
	– Laparoscopic greater curvature plication, also known as total gastric vertical plication – Mini-gastric bypass (MGB)/laparoscopic mini-gastric bypass (LMGBP) – Single-anastomosis duodenal switch [also known as duodenal switch with single anastomosis, or stomach intestinal pylorus sparing surgery (SIPS)] – Stomach aspiration therapy (AspireAssist®) – Transoral endoscopic surgery [includes TransPyloric Shuttle® (TPS®) Device, endoscopic sleeve gastroplasty] – Vagus nerve blocking (VBLOC®) ○ Gastrointestinal liners (EndoBarrier®) are investigational, unproven, and not medically necessary for treating obesity due to lack of FDA approval and insufficient evidence of efficacy **Definitions** • Added definition of: ○ Adolescent ○ Body Mass Index (BMI) ○ Los Angles (LA) Classification of Oesophagitis ○ Multidisciplinary ○ Obstructive Sleep Apnea (OSA) ○ Revisional Bariatric Surgery **Supporting Information** • Added *Description of Services*, *Clinical Evidence*, and *FDA* sections • Updated *References* section to reflect the most current information • Archived previous policy version CS007NE.R

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

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