FRCA Podcast

Episode 5 - Anaesthesia for Bariatric Surgery

Candidates for surgery

BMI > 40 kg/m^2
BMI > 35 kg/m^2 with comorbidities that can be improved by weight loss (usually type 2 diabetes mellitus or hypertension)

Failure of non-surgical weight loss programmes.

Medical modalities

Pancreatic lipase inhibitors (Orlistat) - reduction in fat absorption
GLP-1 receptor agonists (Semaglutide, Tirzepatide, Liraglutide) - appetite suppression

Types of surgery (laparoscopic)

Restrictive	Gastric band or sleeve gastrectomy Smaller stomach volume
Malabsorptive	Gastric bypass Bypassing duodenum

Conduct of anaesthesia

Positioning - before induction of anaesthesia; 45^o head up tilt, arms out on arm boards, foot rests to prevent slipping. Higher risk of pressure sores or nerve injuries.

Monitoring - standard

Airway - difficult ventilation, normal laryngoscopy. Large bore orogastric tube (36-38 F). Methylene blue passed down this tube to check for leaks at the end of the case.

Breathing and circulation - reduced FRC, increased cardiac output, increased oxygen consumption (rapid desaturation).

Analgesia - local anaesthetic infiltration, Paracetamol, NSAIDs, intraoperative Fentanyl, postoperative Morphine or Oxycodone PCA (unless contraindicated).

Recovery - 45^o head up tilt, high dependency unit if significant comorbidities (e.g. OSA)

Complications

Early	30-day mortality < 0.5%
Infection	Antibiotics
Anastomotic leak	
Venous thromboembolism	Low molecular weight heparin
Late	5 year all cause mortality 5%
Gastro-oesophageal reflux	Proton pump inhibitor (RSI for any future anaesthesia)
Dumping syndrome	10% of patients. Rapid stomach emptying. Carbohydrate entering small bowel leads to abdominal cramps, diarrhoea, palpitations, sweating, anxiety (vasoactive neurotransmitters, fluid shifts)
Malabsorption	Vitamins A, D, E, K, iron, B12, folate, calcium.