Interdisciplinary Discussion: Excess Body Weight and Gastrointestinal Disease

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Kähler: Obesity Sometimes Compromises Diagnostic Procedures

A. Do You Prefer Abdominal CT Scan to Abdominal Ultrasound in Obese Patients?

Otto

We prefer ultrasound. However, as BMI increases, ultrasound becomes less often successful and then a CT is necessary, even to answer simple questions. In the investigation of postbariatric pain, we consider a CT to be essential.

Kahl

No, generally, I do not prefer CT. If all structures can be visualized in the transabdominal ultrasound examination, I trust the ultrasound. There are certainly situations in which sensible imaging is not possible with ultrasound, and then CT is required. Ultrasound is essentially a bedside examination that can be done quickly in experienced hands.

Willeke

In general, emergency diagnostics in obese patients in my department are guided by CT scan. The great individual differences in ultrasound expertise lead to the indication for CT regarding all questions related to abdominal pain in obese patients.

Gossner

We always choose abdominal ultrasound as the first option. In the majority of these patients, ultrasound can answer the diagnostic questions.

B. Do You Omit or Avoid Sedation for Endoscopic Exams in Obese Patients?

Otto

Patients with a BMI >50 receive sedation only if an anesthetist is present.

Willeke

I would not recommend altering the sedation standards for endoscopic examinations in obese patients.

Gossner

No, all our patients receive conscious sedation with propofol under specific surveillance.

Sendt

During an endoscopic examination, all patients are sedated. Our preferred sedative is a combination of propofol and midazolam.

C. Do You Use EUS and MR Cholangiopancreatography (MRCP) more often in Obese Patients than Lean Patients to Diagnose Gall Stones?

Otto

MRI is usually not possible in very heavy patients, so ultrasound is mostly the only remaining option. In this context, EUS is the absolute exception.

Kahl

No, I will not do that. Endoscopic ultrasound (EUS), in particular (regardless of whether the patient is obese or not), is the method of choice when it comes to identifying bile duct stones that have not already been seen on trans-abdominal ultrasound. Since this situation occurs especially with a nondilated bile duct system, EUS is far more accurate than MRI.

Willeke

In general, obese patients receive more diagnostic procedures than lean patients. This includes EUS and MRCP. However, the latter is regularly restricted by our MR scanner only accepting patients with a body weight of up to 150 kg.

Sendt

In obese patients, we start our diagnostic algorithms with an abdominal ultrasound, but then realise that many patients need an additional abdominal CT scan. These tools help us in most cases to find the underlying disease. EUS and MRCP are preferred methods for the diagnosis of gall stones in the common bile duct. Rarely, we use them only to detect gall stones.

Gossner

We normally prefer EUS due to higher sensitivity and specificity for microlithiasis.

Kähler: Does Obesity Influence Your Decision-Making and the Timing of (Early) Surgery for Appendicitis, Diverticulitis, and Cholecystitis?

Willeke

Appendicitis. Since the clinical presentation of obese patients with any infections in the abdomen regularly shows a lack of clear evidence, we are very generous in indicating laparoscopies for suspected appendicitis in these patients. This also includes a relaparoscopy if there is any suspicion of persisting peritonitis or a clinical course that does not represent the standard recovery. Here, we trust the relaparoscopy much more than diagnostic procedures like CT or MRT.

Diverticulitis. Irrespective of the staging, I do not feel that we have a different approach to obese or lean patients. We never took up the idea of laparoscopy and drainage only, and try to treat all patients irrespective of their BMI.

Cholecystitis. Obese patients regularly undergo more diagnostic procedures than lean patients. If the ultrasound examination is not clear, we precede to CT or MRT. However, if in doubt, laparoscopy and laparoscopic cholecystectomy will be performed. Again, here, I do not see a big difference between lean and obese patients regarding the timing of an indication.

Gossner

Appendicitis. No, these decisions are usually made by our surgeons according to clinical symptoms, lab parameters, ultrasound, or CT scan.

Diverticulitis/Cholecystitis. No, together with our surgeons, we handle this problem very carefully/restrictively according to the new guidelines. Our surgeons make these decisions according to clinical symptoms, lab parameters, ultrasound, or CT scan.

Otto

Overall, the physical examination becomes less important in overweight people and therefore surgery should be performed earlier.

Kahl

No, the same standards apply to obese patients and nonobese patients with these diseases.

Sendt

Obesity usually does not influence our timing for surgery. For appendicitis and cholecystitis, we prefer “early” operation. The decision-making process for diverticulitis depends on the stage of inflammation (CDD classification). Besides free perforations, we would try to treat all other stages conservatively (optional intervention in CDD 2b).

Kähler: Endoscopic Access to the Common Bile Duct Is Compromised after Y-en-Roux Gastric Bypass. When Do You Recommend (Prophylactic) Cholecystectomy with Bariatric Surgery?

Otto

Only if there is an independent indication for a cholecystectomy. In our opinion, the data do not show any benefit of prophylaxis.

Kahl

If a patient is suffering from symptomatic cholelithiasis or has already had pancreatitis, I would recommend a cholecystectomy, which is, in my opinion, not strictly a prophylactic cholecystectomy. The data that would justify performing a prophylactic cholecystectomy are not convincing, in my opinion.

Endoscopic bile duct stone therapies postoperatively after obesity surgery belong in an endoscopy center with the appropriate expertise.

Willeke

In my reduced personal experience of gastric bypass, cholecystectomy is a reasonable option. This avoids the problem of stone management of the common bile duct in the future.

Sendt

We do not perform any bariatric surgery, but approximately 1% of our patients admitted for cholecystectomy are patients who developed gall stones after a previous Y-en-Roux gastric bypass. As simultaneous cholecystectomy has very low morbidity and mortality, I would suggest prophylactic cholecystectomy.

Gossner

If gallstones in the gallbladder are diagnosed, we talk to the patient about the potential risks and recommend cholecystectomy.

Conflict of Interest Statement

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