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Correspondence and Communications

Improving access and evaluation for body contouring surgery in massive weight loss patients with unified, public guidelines

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KEYWORDS

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Dear Editor,

Obesity is a global health concern worldwide. Bariatric surgery (BS) is an effective long-term treatment for extreme obesity that leads to massive weight loss (MWL).¹ Body contouring surgery (BCS) is essential for optimizing the outcomes of MWL by surgically removing the excess skin. Although BCS can greatly enhance a patient's quality of life and body image, it is not without its challenges and risks. Complications following BCS are a significant concern, and various risk factors have been identified, including a high body mass index (BMI), gender, age, weight loss, tissue removal, and comorbidities.² Therefore, adherence to established departmental surgical criteria for BCS is crucial (Table 1). This study aimed to analyze the patient group referred to a

plastic surgeon for BCS after MWL, and to identify the primary sources of these referrals in healthcare.

Methods

We conducted a retrospective chart review of patients who had outpatient clinic visits for excess skin issues following MWL between 2017 and 2019 at the Department of Plastic Surgery in Helsinki, Finland. The data included age, gender, smoking status, maximum lifetime weight, BMI, weight loss method, and BS details. We examined the outcomes of these patients within 12 months of their initial outpatient clinic appointment and extended the outcome period to the end of 2020.

Results

We identified 106 patients, mostly women (77.4%), with an average age of 47 years (range 20-79). Their mean BMI was

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Table 1 Departmental inclusion criteria for BCS after MWL.

Health, Functional and/or psychosocial problems due to redundant skin after MWL
BMI ≤ 30 kg/m ²
Weight has been stable for at least six months
Non-smoker at least three months before the operation

32.4 kg/m², and they had lost an average of 51.4 kg. While 60.4% of the patients were post-bariatric, 39.6% lost weight through non-bariatric methods. The majority (58.5%) of the referral notes were sent from local healthcare centers, 18.9% from another department of the Helsinki University Hospital, 18.9% from private practice, and 3.8% from another hospital district (Table 2).

Only 42/106 (39.6%) met the criteria for BCS at their first outpatient visit. A high BMI was the primary reason for exclusion, with 43.9% exceeding the 30 kg/m² threshold. Smoking (4.7%), unstable weight (7.5%), and failure to meet public healthcare criteria (3.7%) were other reasons for not being placed on the BCS waiting list.

A total of 64/106 (60.4%) patients did not meet the initial criteria. Altogether, 38/64 (59.4%) patients were advised to book an appointment within a year when they had reached their target weight, achieved weight stability or had stopped smoking for at least three months. Only 8/38 (21.1%) patients did so, and were placed on the waiting list. Seven of the eight patients underwent surgery. The remaining 4/64 (6.3%) patients were scheduled for a new appointment, and 22/64 (34.4%) were advised to return with a new referral note.

Ultimately, 50% of the 106 patients were placed on the waiting list for BCS, with 7.5% of the procedures canceled owing to patients regaining weight over the criteria while waiting. Four patients underwent surgery despite having a preoperative BMI of ≥ 30 kg/m².

Discussion

In our retrospective study of MWL patients intended for BCS in Helsinki, Finland, we found that less than 40% met the operation criteria at their initial outpatient clinic visits, with high BMI being the primary reason for exclusion. Only a minority achieved a BMI ≤ 30 kg/m². Of the planned BCS

procedures, 7.5% were canceled because of weight gain while waiting to undergo surgery.

After undergoing BS, weight reduction was rapid and effective. However, it has been observed that for some patients, weight loss plateaus or even start to rise again approximately two-three years after BS. Weight stability is crucial before BCS.³ Residual obesity at the time of BCS is associated with a higher risk of complications. It is important to note that BCS complements weight loss, rather than serving as an alternative.

BCS should be carefully considered because of potential medical issues and complications. In collaboration with the patient, the plastic surgeon determines the necessity of the surgery, evaluates the patient's suitability, and discusses the associated surgical risks. It is also crucial that general practitioners providing comprehensive patient care be well-informed about the criteria and risks associated with post-MWL BCS. According to our study, more than half of the referral notes came from outside specialized healthcare. To address potential weight, regain more effectively, primary healthcare can monitor weight stability for at least six months before referring patients to a plastic surgery unit. Additionally, support for smoking cessation can be offered and medication can be initiated if needed. This approach eases the burden on specialized healthcare, reduces costs, and enhances the overall outcomes.

In conclusion, adherence to standardization guidelines in BCS after MWL reduces unnecessary referrals and financial costs and ensures consistent patient information in the era of social media discussions.

Funding

This study received no funding.

Ethical approval

This retrospective chart review and protocol was approved by the hospital's institutional review board.

Declaration of Competing Interest

The authors declare no conflicts of interest.

Table 2 Referral notes stratified the demographic data of patients at the time of first outpatient clinic visit Department of Plastic Surgery.

	from Health Care Center	from an Another speciality	from Private Practice	from Other hospital district
n (%)	62 (58.5%)	20 (18.9%)	20 (18.9%)	4 (3.8%)
Mean age (SD)	45.9 (14.5)	49.4 (8.5)	46.5 (13.1)	55.0 (8.8)
Mean Weight, kg (median)	91.3 kg (84.0)	90.7 kg (85.9)	86.9 kg (85.0)	80.3 kg (75.0)
Mean BMI (median)	32.8 kg/m ² (29.8)	33.3 kg/m ² (30.7)	30.4 kg/m ² (30.0)	32.0 kg/m ² (28.8)

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