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EDITORIAL

RICIBA, what do we know about bariatric surgery in Spain?☆

RICIBA, ¿qué sabemos sobre la cirugía bariátrica en España?

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The progressive increase in the prevalence of obesity, related to the discouraging mid- and long-term results provided by dietary and behavioral treatments and the virtually nonexistent drug treatment, has led to an exponential increase in use of surgery to treat obesity in Western countries.^{1,2} Thus, while 40,000 bariatric surgery procedures were recorded in 1988 in countries affiliated to the International Federation for the Surgery of Obesity (IFSO), the figure increased to 146,301 procedures in 2003, and to 344,221 in 2008.¹ That is, in the decade from 1998 to 2008, obesity-related surgical procedures increased by 761%. However, despite these striking figures and the popularity achieved by bariatric surgery, access to this procedure of patients affected by such a prevalent disease should still be considered as very limited.

Two percentages again call our attention. First, only 1% of patients with morbid obesity eventually undergo surgery for this reason.^{2,3} Second, only 1% of patients who meet the out-of-date 1992 guidelines of the National Institutes of Health⁴ would choose the surgical option if this was proposed to them. How can we explain these figures? Determinant factors undoubtedly include the impossibility to access bariatric surgery in some healthcare systems, the lack of knowledge of the surgical option in some regions and of adequate obesity management by physicians, and prejudices still existing against obesity in our environment.

It is also striking that Spain is the third leading country by number of surgeons who state that they perform some type of bariatric surgery (400), only excelled by the United States/Canada (1625 surgeons) and Brazil (700).⁵ In addition, with 6000 surgical procedures every year, Spain ranks seventh in the list of countries performing more surgical procedures to treat obesity after the United States/Canada, Brazil, France, Mexico, Australia/New Zealand, and Belgium/Luxembourg. However, we do not know the actual impact of these data in our country. Such impact is even more difficult to assess now that bariatric surgery, regardless of the procedure used and in accordance to the definition proposed by Buchwald et al. in 1978 (*we define metabolic surgery as the operative manipulation of a normal organ or organ system to achieve a biological result for a potential health gain*), is starting to be recognized as a metabolic surgery.⁶

In recent years, the Obesity Group of the Spanish Society of Endocrinology and Nutrition (GOSEEN) raised the need to ascertain the characteristics of bariatric surgery in Spain. It was of particularly interest to know as accurately as possible to which patients is this treatment prescribed, use of different surgical procedures, distribution by communities and centers, progression of laparoscopic surgery, factors that may influence weight loss. In this setting, it was decided to create the Computer Registry of Bariatric Surgery (RICIBA, from the Spanish name, *Registro Informatizado de Cirugía Bariátrica*), which was finally implemented on May 2011 during the 53rd Meeting of SEEN, held in Santiago de Compostela.

RICIBA is a multicenter, multidisciplinary project currently being expanded to the different hospitals all over

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Spain and approved by the ethics committee of Hospital Clínic in Barcelona. The registry is accessed through the website of SEEN, and its main purpose is to have a wide database that allows for obtaining quality information about bariatric surgery in Spain to help understand and better treat obese subjects.

In its first three months of operation, data from 1472 records of procedures performed between 2001 and 2011 at 11 public Spanish hospitals have been entered into RICIBA (of which 41% refer to surgical procedures performed in 2010). These procedures were performed in patients with a body mass index of $47.1 \pm 6.0 \text{ kg/m}^2$. As usual in studies on bariatric surgery, patients registered are relatively young (43.1 ± 10.8 years) and are predominantly females (76%). As a reflection of the increasing multiculturalism in Spain, race of 6% of subjects recorded is not Caucasian. The disease most commonly associated to obesity is arterial hypertension (48.5%), followed by type 2 diabetes mellitus in 30.9% of patients, and by lipid metabolism changes in 24.7%.

Surgical procedures have traditionally been described as restrictive, malabsorptive, or mixed based on the initial procedures performed in the 1950s. The IFSO report published in 2009 stated that the surgical procedures most commonly used worldwide (in 48.6% of patients) were purely restrictive techniques (adjustable gastric band, ring vertical gastropasty, and tubular gastrectomy), followed by mixed techniques (Roux-en-Y gastric bypass) in 49% of patients, while purely malabsorptive procedures were used in less than 2% of cases.⁵ This same report also shows that the procedure most widely used is gastric bypass (49.3% when open and laparoscopic procedures are combined), followed by adjustable gastric and (32.3%), and laparoscopic sleeve gastrectomy (5.1%). Similarly, the most widely used procedure in the 1472 records analyzed in RICIBA is gastric bypass (75.2%), but there has been in the past 4 years a gradual increase in sleeve gastrectomy, and the first cases of use of gastric bands have been reported. RICIBA data also show a significant increase in the laparoscopic approach, although in 2010, 21.9% of all procedures were still performed by open surgery. Finally, as regards morbidity and mortality at 30 days of surgery, 7 deaths (0.47%) and a major complication rate of 9.4% have been recorded. The most common major complications included wound dehiscence and gastrointestinal bleeding.

To sum up, a new tool is available to allow us for a more thorough understanding of the characteristics of bariatric

surgery performed in Spain and its efficacy and safety. This tool will promote the exchange of information between healthcare professionals and will allow for the conduct of joint studies intended to improve care to obese patients. Data collected during the few months of operation of RICIBA as discussed in the previous paragraphs are currently purely nominal. They should, however, act as a stimulus for all concerned professionals to continue entering information on new patients, thus strengthening the registry and allowing for answering with certainty the question posed in the title of this editorial.

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