Executive summary:

Obesity is a significant risk factor in terms of COVID-19 morbidity and mortality impact.

Treatment pathways for obesity, including elective surgery (bariatric surgery), have come to a halt as resources have been diverted elsewhere to manage the COVID situation.

Provision of obesity treatment pathways and therefore access to care within the NHS pre-COVID were already insufficient to meet the national need (as highlighted in a recent report by the All Party Parliamentary Group on Obesity).

Concern exists around current plans on increasing elective capacity that bariatric surgery will be low priority and will face extended delays to return of service provision.

Bariatric surgery is a clinically and economically cost effective treatment for severe and complex obesity which improves obesity, associated comorbidities, notably type 2 diabetes (the cost burden of which represents up to 10% of the entire NHS budget).

BAME communities, who appear particularly susceptible to risk from COVID are also particularly at risk from the effects of severe and complex obesity which are particularly prevalent in BAME communities.

Treatment of severe and complex obesity, including provision of elective bariatric surgery will help counter the morbidity and mortality risk from COVID-19 in this group of patients.

Current situation:

Obesity treatment is often overlooked due to the fact that the condition of obesity is often depicted inaccurately, as being self-inflicted, which leads to stigmatisation and lack of access to appropriate care. Resource stress in healthcare brought about by the COVID-19 impact causes concern that treatment of this cohort of patients will become an even lower priority, resulting in exacerbation of their condition which will lead to further deterioration in quality of life and increased future healthcare costs.

It is likely one of the COVID-19 impacts will be to exacerbate the obesity epidemic overall. In addition those with morbid obesity and metabolic conditions are at higher risk of dying. This may become even more significant as we seek to avoid 2nd and 3rd wave impacts of COVID-19.

Around 65% of the UK adult population currently class as being overweight or as having obesity. With the arrival of Covid-19, evidence, which has been well reported in the mainstream media, suggests that those at greatest risk are our older population and then secondarily, those with a BMI over 30.

Those who have a BMI over 35 must be prioritised for treatment, particularly those patients with severe metabolic syndromes plus obesity. Furthermore, bariatric surgery is linked to diabetes resolution (diabetes being more prevalent in the BAME community - another group identified as increased risk from COVID-19 mortality), and appropriate provision of treatment is part of the armoury in the long-term fight against COVID.
We wish to avoid the further stigmatisation of our patients in terms of healthcare resource allocation and access to care. We draw attention to The International Consensus Statement for ‘Ending Stigma of Obesity’ published in Nature Medicine in March 2020(1). The articles of reference within this important guidance include the following which we believe are of particular current relevance:

6. Quality of Care, Access to Care
6.1. Quality of health care is adversely affected by weight-based stigma
6.2. Fear of prejudice and internalized weight bias cause direct and indirect harm to patients with obesity, as they are less likely to seek and receive appropriate treatment for obesity or other conditions.
6.3. Despite the well-recognized risks of obesity and related illnesses, it is common for health insurance companies to have significant limitations or complete lack of coverage for evidence-based treatments of obesity—especially bariatric/metabolic surgery. These policies can cause harm, are indefensible and ethically objectionable

11. Obesity: “Condition” or “Disease”?
11.1. There is objective evidence that in many patients, obesity presents the typical attributions of a disease status, which include specific signs and/or symptoms, distinct pathophysiology, reduced quality of life, and increased risk of complications/mortality.
11.2. Although prevailing evidence supports a rationale for obesity to be defined as a disease, as recognized by leading worldwide authority bodies and medical associations, current diagnostic criteria for obesity (only based on BMI levels) are inadequate to accurately diagnose obesity.

FROM THE RECOMMENDATIONS

8. Given the prevalence of obesity and obesity-related diseases, appropriate infrastructure for the care and management of people with obesity, including severe obesity, must be standard requirement for accreditation of medical facilities and hospitals.

13. Policies and legislation to prohibit weight discrimination are an important and timely priority to reduce/eradicate weight-based inequities

Effectiveness of Weight loss Surgery:

Bariatric surgery is the most effective treatment currently available for severe and complex obesity in terms of clinical and cost effectiveness. The NHS preforms approximately 6,000 bariatric surgical procedures per year. This is amongst the lowest number of procedures for any country in the developed world, despite the UK having the second highest prevalence of severe and complex obesity in Europe. The benefits are well described in addition to delivering sustained weight loss and include:

- Diabetes: Improvement and remission Cardiovascular events
- Cardiovascular risk: Reduced incidence of cardiovascular events mortality
Infectious and respiratory disease: reduced risk
Cancer: reduced risk
Quality of life: Marked improvement

Safety of bariatric surgery and COVID

Safety of our patients is of paramount concern to our society and members. Bariatric surgery delivers rapid loss in weight and improvement in weight related co-morbidities and hence will improve risks of weight related health conditions, that are likely to include response to infection with COVID-19.

Bariatric Surgery in the UK is safe with mortality rate less than 1:1000, which is comparable to routine surgical procedures such as cholecystectomy (gallbladder removal).

Laparoscopic surgery is used to perform over 90% of bariatric surgery in the UK. Evidence and guidance relating to the safety of laparoscopic surgery in the current environment is evolving, and is likely to be considered safe in patients who have tested COVID negative. Provided laparoscopic surgery is considered safe in elective surgery then bariatric surgical procedures can be delivered safely.

Enhanced recovery pathways means that for the majority a post-operative stay of only one or 2 nights is required, with the vast majority of patients being cared for in a ward environment. Unplanned critical care admission is unusual (<5% of patients) and resuming bariatric surgery will not therefore place undue pressure on this resource during the next phase of COVID.

All surgical pathways will need to be minimise risk to both patients and attending clinical staff, and will include pre-operative COVID screening of patients and NHS staff, and will therefore be delivered in a relatively controlled COVID environment. The precise details of such pathways is not yet clear.

Because surgery can be delivered safely and our patients experience early major benefits from surgical treatment likely to include susceptibility harm arising from COVID bariatric surgery should be included in a high priority basket of elective surgical treatments in the next phase of COVID.

Summary:

Severe and complex obesity patients are at increased risk if morbidity and mortality if they develop COVID.

BAME are at increased risk of complications of severe and complex obesity as well as COVID itself.

Bariatric surgery is safe and effective.

Services meeting the needs of patients in the UK with severe and complex obesity have been stopped during the initial phase of the COVID pandemic.

Patients with severe and complex obesity already deal with stigma and difficulties accessing healthcare, which will have been exacerbated by the effects of the COVID pandemic.
Bariatric surgery can, subject to appropriate infection prevention measures, be delivered safely with low risk in the next phase of COVID and will deliver rapid health gains to these patients.

Treatment of patients with severe and complex obesity must be given a high priority in the next phase of COVID when elective surgical activity will be reintroduced.

**Appendix: British Obesity and Metabolic Surgery Society (BOMSS)**

BOMSS is the professional body representing surgeons and integrated health professionals involved in the surgical treatment of obesity with over 500 members ([www.bomss.org.uk](http://www.bomss.org.uk)) Our members include surgeons, specialist nurses, dieticians, and psychologists.

BOMSS sets professional standards for the provision and delivery of bariatric surgery in the UK.

BOMSS also hosts the national bariatric surgery registry, containing pooled national outcome data for bariatric and metabolic surgery in the United Kingdom, published on an annual basis by HQIP.

*May 2020*

**References:**