Pre-operative psychological evaluation: Is it worthwhile?

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Role of psychology…

- Some patients have:
  - Complex psychological histories
  - Positive psychological outcomes post surgery
  - Poorer psychological outcomes post surgery
  - Poor weight loss / weight regain
  - May relate to baseline psychology

Asked to develop guidelines

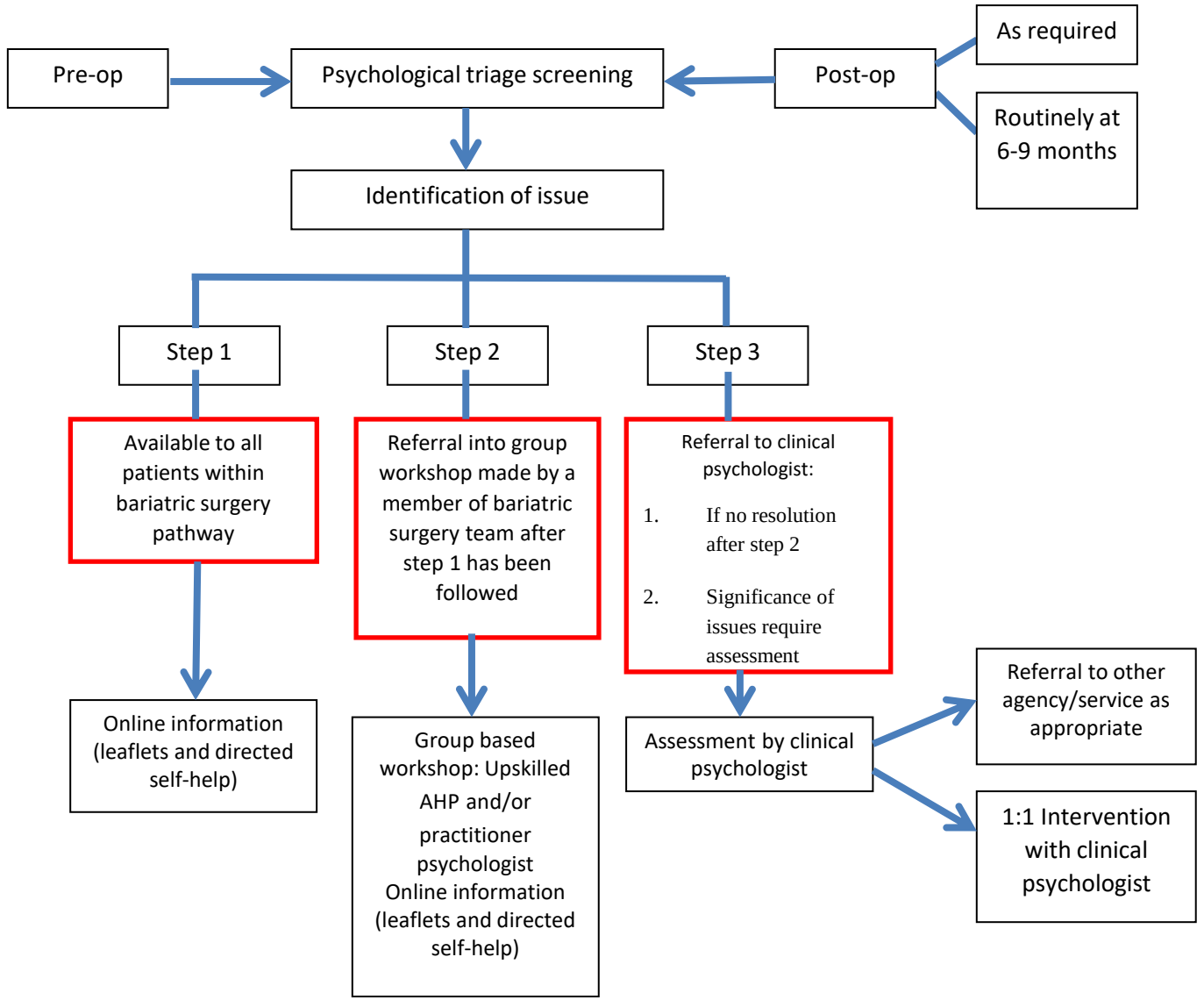
- Review of the evidence
- Expert input
- Feedback from:
  - BOMSS delegates
  - Special interest group (SIG)
  - Service users
- Presentation to BOMSS council
- Presentation to ASO
- Presentation to IFSO

Our guidelines

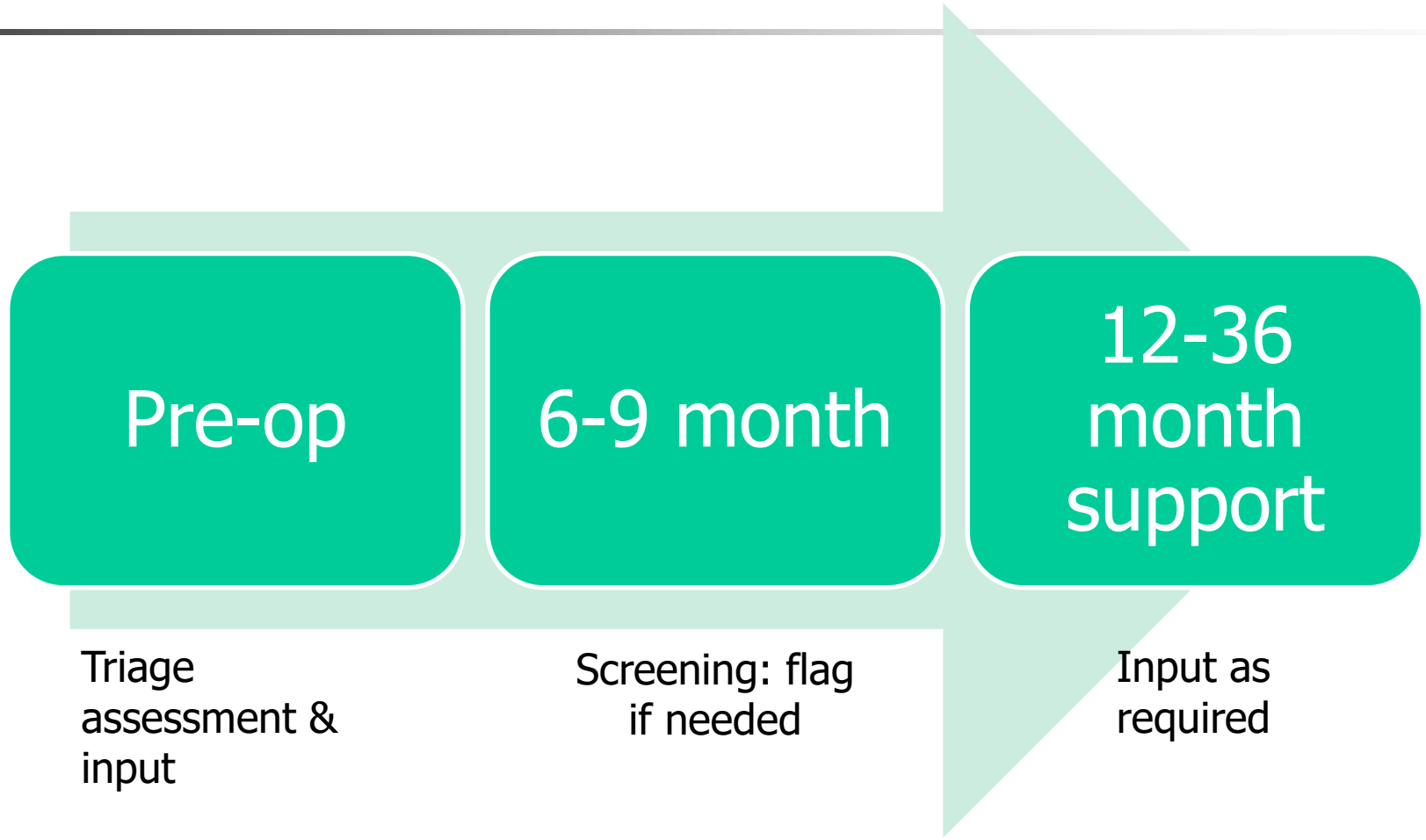
- Include psychology in all services
- Use stepped care model
  - Step 1: Online resources
  - Step 2: Group workshops
  - Step 3: One to one support
- Pre surgery
- Post surgery (6-9 months)

(Ogden, Ratcliffe & Snowden-Carr (2019). Clinical Obesity)

Guidelines: Stepped care model for psychological care before and after MBS



In essence



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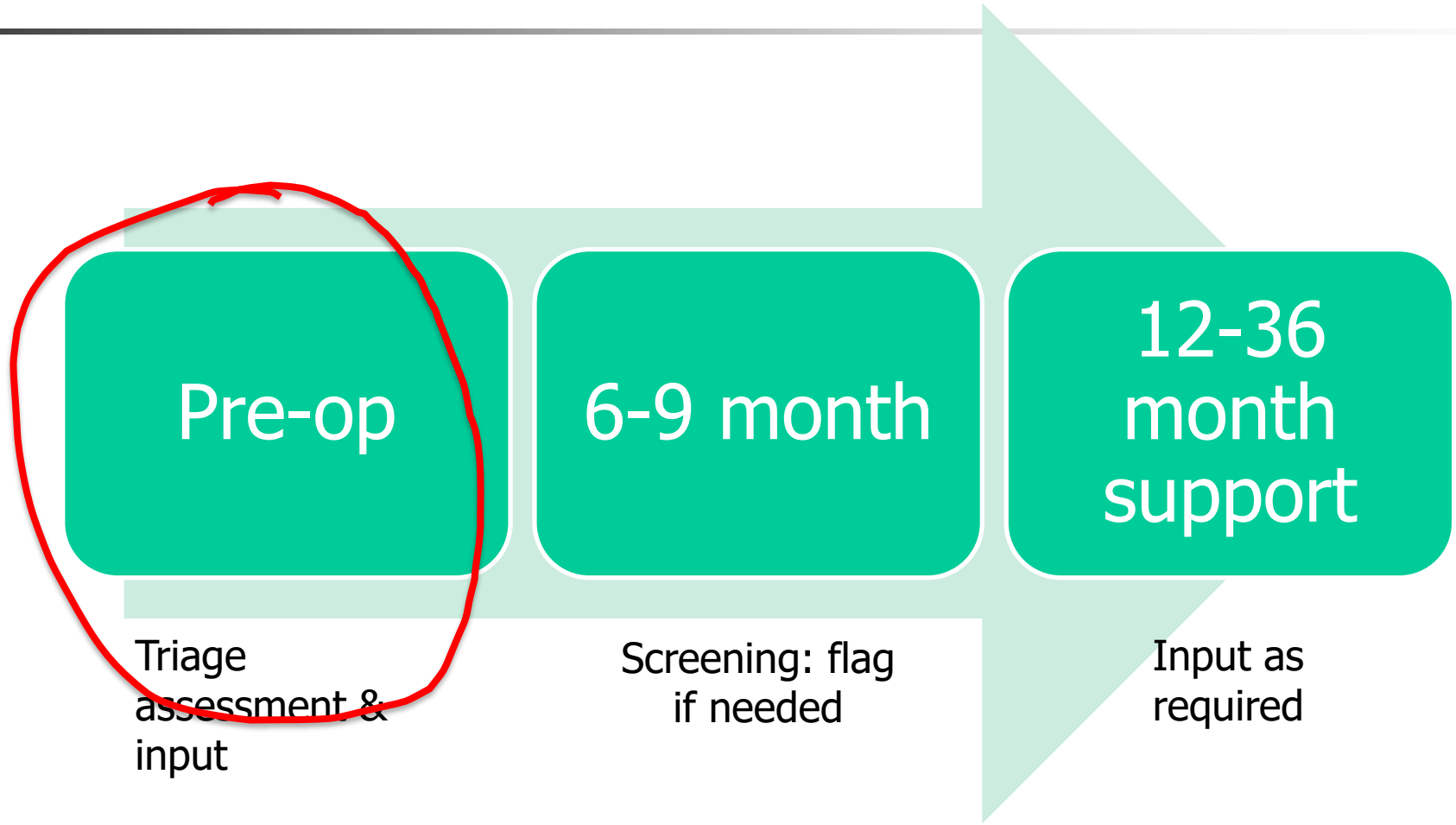


- Is it worthwhile??

  (And what should it consist of??)

Pre-Surgery….problems

- depression
- anxiety
- poor self-esteem
- poor body image
- eating disorder symptoms
- self-harm
- addiction
- suicidality
- trauma or abuse

(See Sogg et al, 2016; Ogden et al, 2019 for reviews)

Post surgery… improvements

- Weight loss
- Improved self identified health status/ QoL
- Increased self-esteem
- Decreased preoccupation with food
- Decreased depression
- Decreased anxiety

(Ogden et al, 2005; 2006; Burgmer et al, 2014; Strain et al, 2014; Rausa et al, 2019)

BUT …. Also some problems

- Alcohol use
- Drug use
- Loss of control / Binge eating
- Divorce

(Bak et al, 2016; Sogg et al, 2016; King et al, 2017; Bruze et al, 2018)

PLUS .....

- Pre surgery evaluation costs time AND money
- BUT
- Post surgery problems cost time AND money

Simple cost benefit analysis

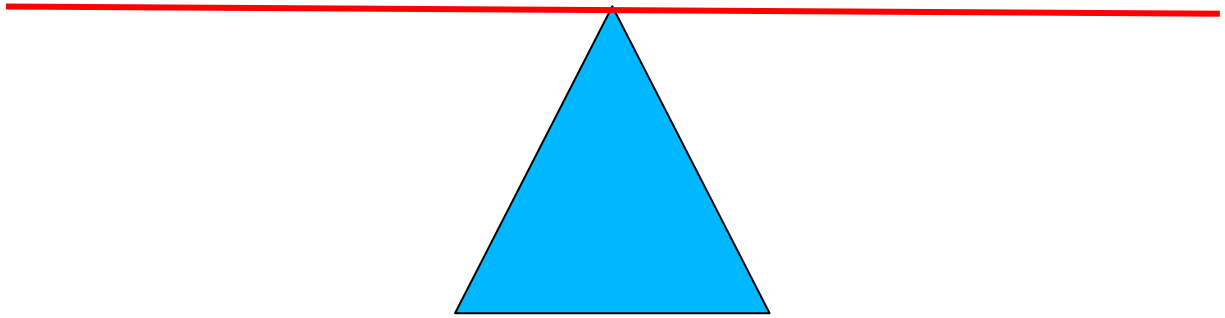
Benefits

↑ Weight loss
Health status
Self esteem

↓ Pre-occ food
Depression
Anxiety

Costs ↑

Alcohol use
Drug use
Binge eating
Divorce
Time
Money



Weighing it up….

Depends on …..

(not so simple!)

Depends on ..who you ask?

- Evidence?
- Surgeons?
- Patients?

Ask the evidence…

- Mixed and inconclusive
- Baseline problems **do and do not** predict outcomes
- Bottom line
  - Suicidality
  - drug abuse
  - alcohol abuse
  - eating disorders

(Karmali et al, 2013; Wimmlemann et al, 2014; Rish et al, 2015; Sogg et al, 2016)

Ask the surgeons…(n=10)

- Why do patients show less than optimal weight loss

Underlying psychological issues

'*Many patients do suffer reactions you would not think are appropriate or normal because of an underlying psychological trait or history that colours their expectations and coping mechanisms'*

Non adherence

'*She's eating in an unhealthy way sort of, she's not eating… she eats what she wants when she wants to, she'll do whatever she chooses to do'*

Non disclosure

I' think she did also slightly manipulate the system by hiding things from us'

(Ward & Ogden, 2019)

What can be done about it??

Ideal world

'I think the ideal service would have a proper trained psychologist seeing everyone andhaving time to assess them fully and then I think that person would have time spent – 10, 12 and 16 sessions – doing whatever to provide them with new tools, new coping strategies etc'

Real world compromise

'If we start charging our bill for psychology and it goes up by 200–300 grand a year then the CCG (clinical commissioning group) would stop it'

YET

'I think some patients are enough well read that when they see you they sometimes give you what they think you want to hear rather than the reality… I'm not saying that they're lying but you know, they've attended enough groups to know'

Ultimately…

Exclude

I definitely don't think we'd have given her a band had we appreciated her mental state

Include

Part of me does believe that we just have to deal with everyone and then pick up the pieces after for those who need it – that's one strategy isn't it, when you've got so many patients to deal with and you know some of them are probably going to be ok

Help!

We're damned one way or another

Ask the patients ….

Most just want surgery and feel better afterwards

'Everything about me is a lot better and it's just healthier and I just feel normal as opposed to some freak…I've grown completely in confidence…I know I'm a different person now and its because my confidence has grown and that has affected every area of my life'

Many want psychological support afterwards

'we know how to cut you open, we know how to solve all that problem side of things, we get all that done and you get on with it… everybody takes care of the physical but nobody takes care of the mental side of it. Nobody's actually dealt with that'

A minority show regret

'What have I done? Maybe it was a mistake'

(Ogden et al, 2005; 2006; 2008; 2011; 2014)

Who you ask??

- Mixed evidence
- We don’t know
- How can we know??
- Population vs individual data

Depends on … function of evaluation?

- Exclude from surgery
- Monitor
- Educate
- Build relationships should problems arise

Depends on …type of evaluation?

- F2F assessment with Psychologist for everyone?
- Online assessment for everyone?
- F2F assessment with Psychologist for some?
- Online education for everyone?

Simple cost benefit analysis

Benefits

↑ Weight loss
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↓ Pre-occ food
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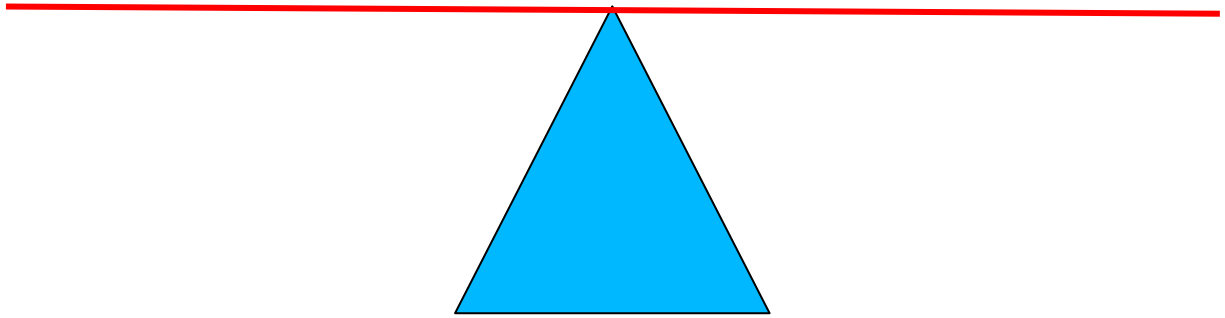
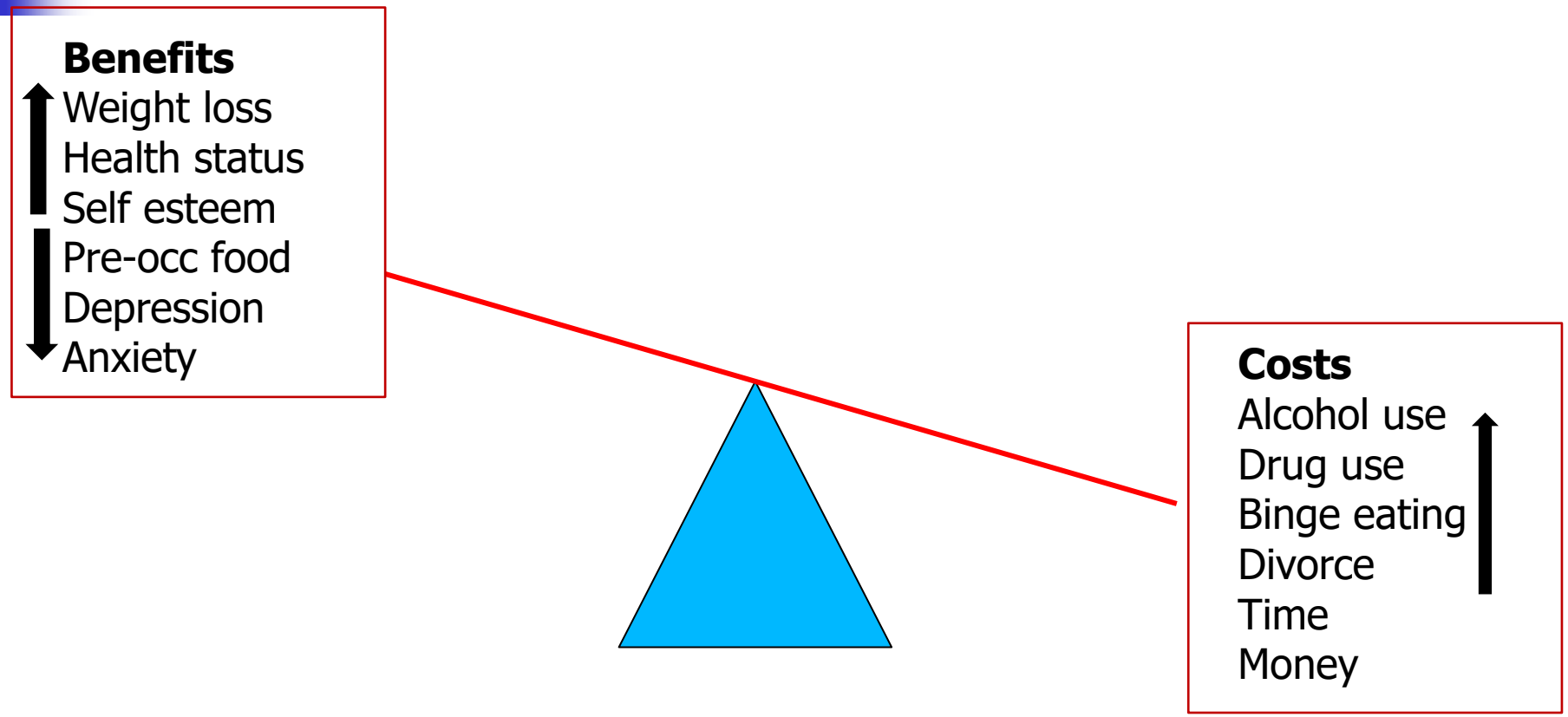
Anxiety

Costs

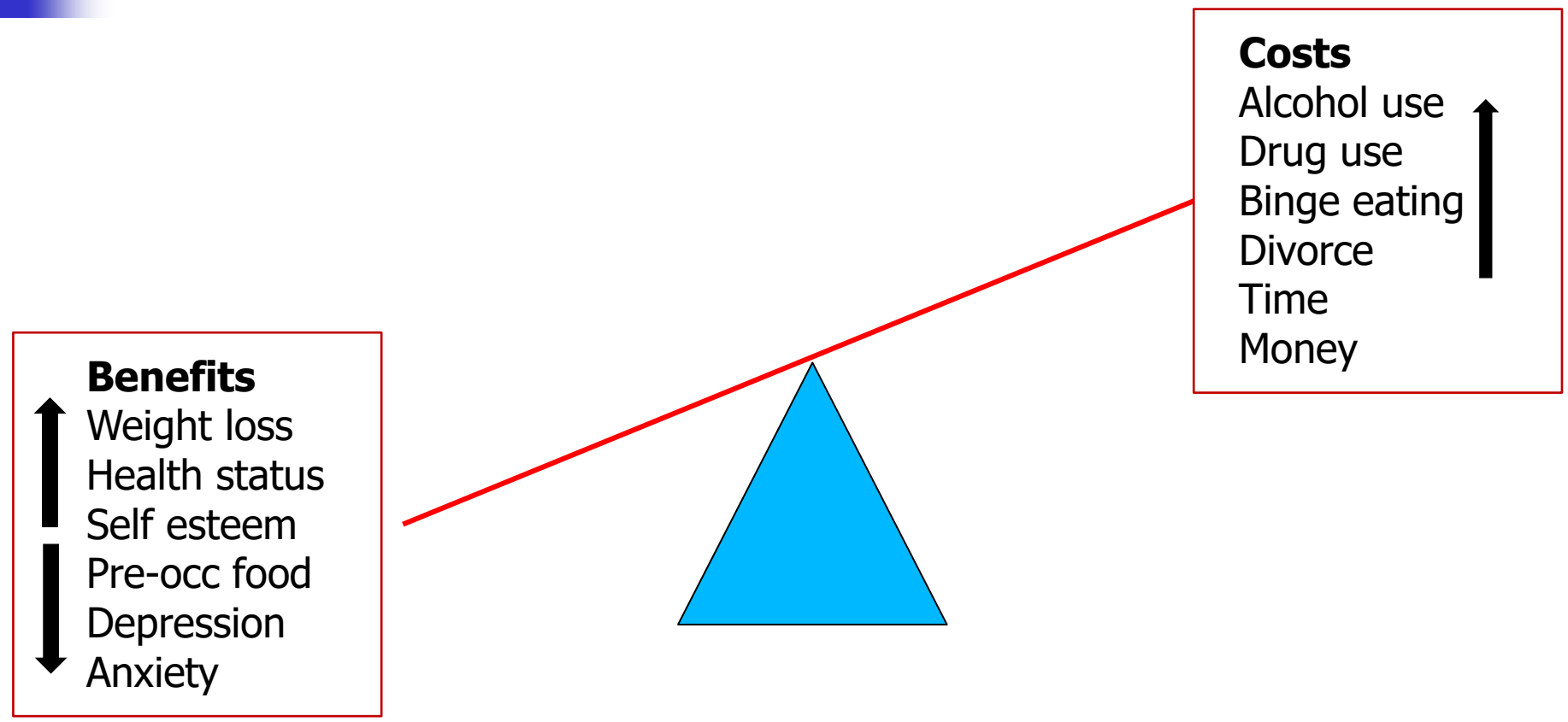
Alcohol use
Drug use
Binge eating
Divorce
Time
Money
↑



Simple cost benefit analysis



Simple cost benefit analysis



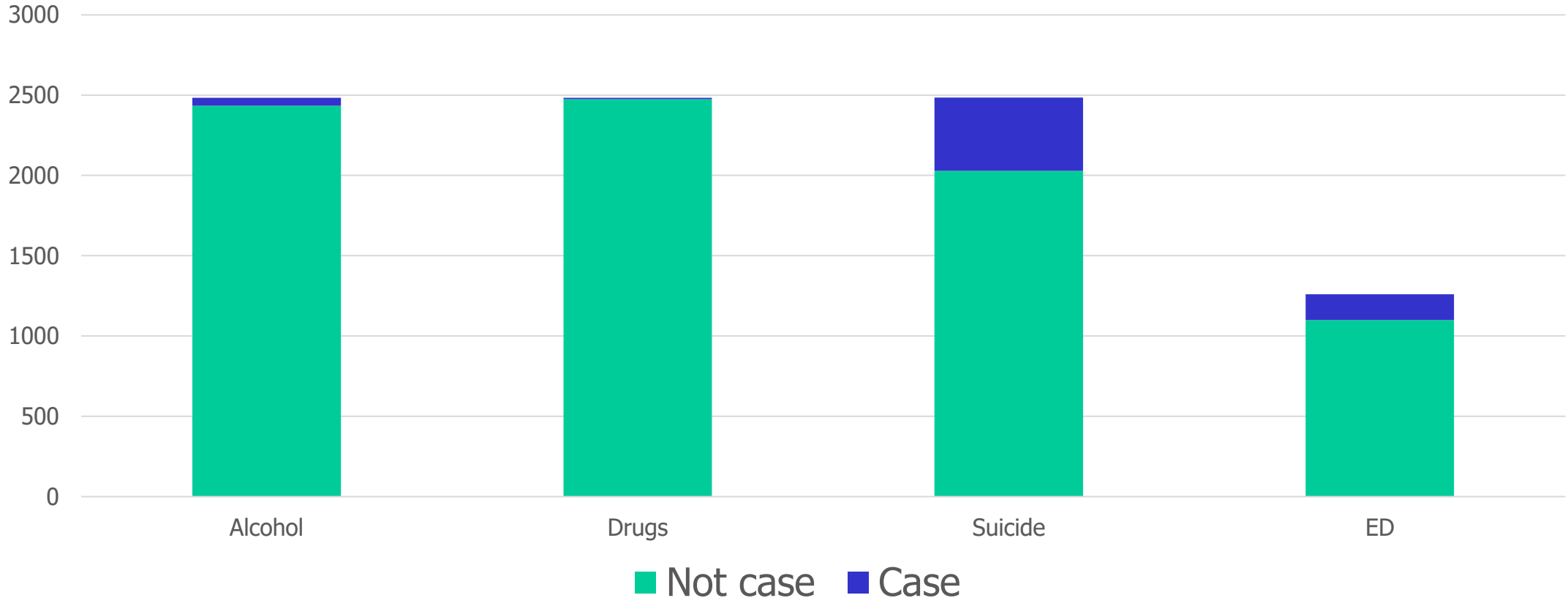
What I think!

- Stepped care approach to support
- **ALSO stepped care approach to pre-op evaluation**
- Online assessment
- Identify high risk pts
- Refer to MDT – discuss
- THEN – discuss with patient
- Then AGREE to exclude (defer) as minority
- Include with education and post surgical support to rest

Our data

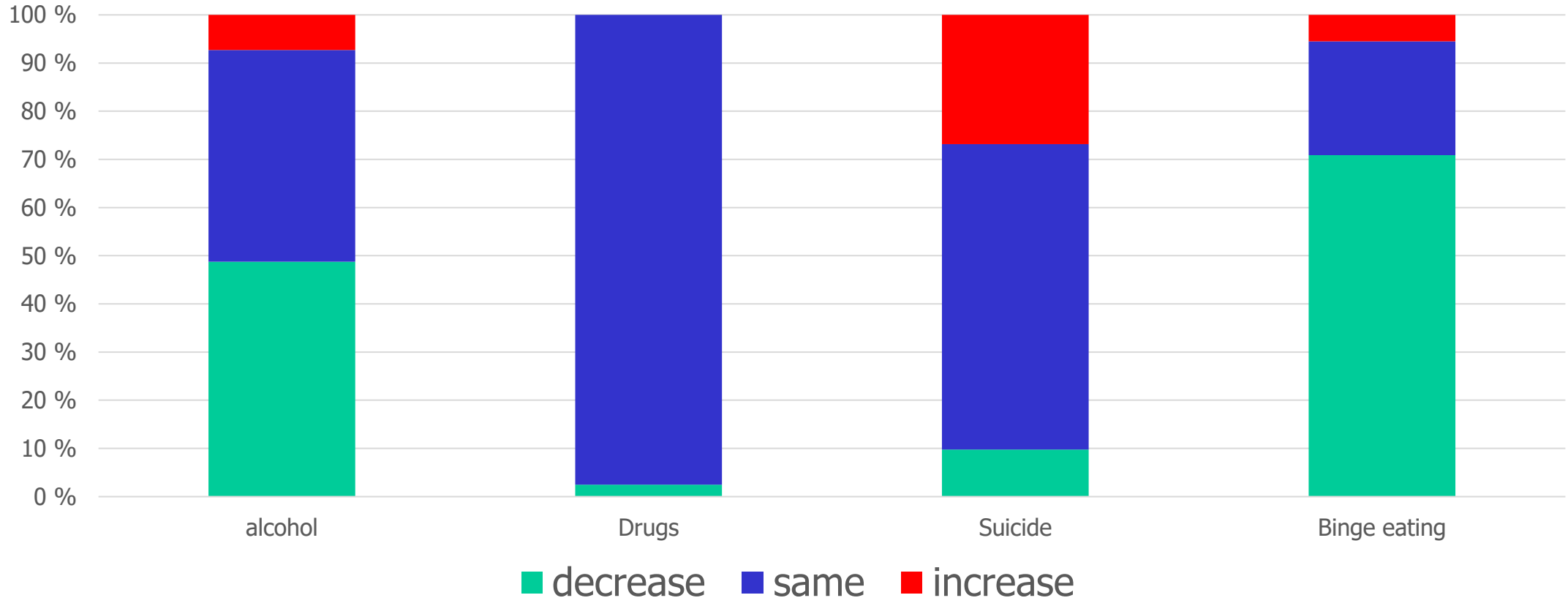
- Triage tool (Ogden et al, 2019 PLUS EAT)
  - AUDIT (alcohol), DAST-10 (drugs); SBQ-R (Suicidality); EAT-26 (eating disorders)
- Since 27th Nov 2017 to 2nd May 2023 total number of pts:
  - AUDIT (alcohol) *n*=2485; DAST-10 (drugs) *n*=2484; SBQ-R (suicidality) *n*=2485; EAT-26 (eating disorder risk) *n*=1259.
- Pts above the cut offs:
  - In total, 682/3059 (22.3%) pts scored above the recommended cut-off on one or more of the BTT measures
  - Referred by the MDT for further psychological assessment
  - *So far ..1.4% removed from surgical pathway*

Cases at baseline (n=2485 / n=1259)



AUDIT: *n*=50; (4.7%); DAST-10: *n*=16 (0.6%); SBQ-R: *n*=456 (18.3%); EAT-26: *n*=160 (18.2%).

Change before and after surgery (n=41)



NO new cases of alcohol, drugs, ED; 4 new cases of suicidality

Ultimately..

- Surgery changes people
  - Creates many benefits
  - May do some harm
  - Compared to what? – costs of NOT doing?
- Need patient centred tailored approach
  - BUT don't and can't know with certainty
- So use resources efficiently
  - Maximise effectiveness of surgery
  - Protect most at risk patients
  - Use cheap and quick evaluation for all with FU when needed

- Two last things …

1st…. It works

- Number Needed to Treat (NNT)

- 1 – it works
- 2 – 2 people take it / 1 person benefits
- 650 – 650 people take it / 1 person benefits

Condition	Treatment	Duration of treatment	Outcome	NNT
Acute otitis media	Antibiotics	short course	No symptoms at 7-14 days	7
AIDS	indinavir	38 weeks	first clinical event (AIDS or death)	19
Angina	isosorbide dinitrate	4 to 6 weeks	prevention exercise induced angina	5.0
Arthritis	glucosamine	3 to 8 weeks	improved symptoms	5
back pain	epidural steroid		75% relief at 60 days	6
Childhood depression	Antidepressants	not stated	Improved	Not
Dementia	gingko	one year	ADAS-Cog 4 points better	7.9
Erectile dysfunction	alprostadil (transurethral)	over 3 month period	erection enabling intercourse	2.3
Flu	vaccination		no flu	23
Fungal nail infection	Terbinafine	12/24 weeks	Cured at 48 weeks	2.7
Gastric ulcer with NSAID - prevention	misoprostol	4 weeks	presence of gastric ulcer	13
H pylori	triple therapy		eradication	1.1

Head lice	**Permethrin**	**14 days**	**Cure**	**1.1**
Hip fracture prevention	calcium and vitamin D	3 years	prevent one fracture	20
Hypertension in the elderly	Drug treatments	at least 1 year	Prevention of CV over 5 years	18
Lipid lowering	statins	mean 4 years plus	all bad things	35
GI bleeding NSAID use	Misoprostol	6 months	Prevent any GI complication	166
MI	ACE inhibitor [AIRE trial]		death within 6 months	18
Migraine	Oral sumatriptan	single dose	Headache relieved at 2 hours	2.6
MI	Aspirin plus streptokinase	1 infusion of streptokinase, 1 mnth of aspirin	5 wk vascular mortality, prevent one death	20*
Peptic ulcer	Triple therapy	6-10 weeks	Ulcers remaining cured at one year	1.8
Stroke primary prevention				
MRC:17,354 **WOSCOPS 6595**	benzoflurazide propranolol privastatin	5.5 yrs 4.9yrs	Prevent one stroke at one year	850 641
Stroke secondary prevention				
CATS 1072 **SALT 1360** **4S 4444**	Ticlopidine Aspirin simvastatin	2 years 2.7yrs 5.4yrs		15 38 83

Our most effective drugs...

- **statins** after a stroke or heart attack (**NNT: 83** for deaths prevented by five years or **415** in any one year)

- **Bariatric surgery: 1.5???**
- **Dieting: 50???**

2nd …??

- Informed Patient choice?
- Do we have the right to not???