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Editorial

Bariatric surgery and inflammatory bowel disease: An increasingly frequent reality



Cirugía bariátrica y enfermedad inflamatoria intestinal: una realidad cada día más frecuente

For years now, obesity has become a leading public health problem, to the point that 60% of citizens in Europe are either overweight or obese, according to the WHO report published in 2022.¹ The latest IFSO guidelines indicate bariatric and metabolic surgery as the recommended treatment for patients with a BMI over 35 kg/m² (with or without associated pathology)² as they achieve good medium to long-term weight loss results, in addition to improving a significant percentage of comorbidities in this type of patient (diabetes mellitus, hypertension, dyslipidemia, etc.) and reducing the risk of mortality due to cardiovascular disease.³ Meanwhile, inflammatory bowel disease (IBD), characterized by a state of chronic inflammation (whose etiology is unknown and is probably the result of a combination of genetic, immunologic, and environmental factors), has also increased in incidence in recent decades, especially in developed or developing countries.^{4,5} Despite the fact that obesity has traditionally been considered an unusual characteristic in patients with IBD, the parallel increase in the prevalence of both conditions has caused this patient population to grow, and we are having to assess these patients more frequently in our consultations and offer them the best therapeutic option.

Obesity has become one more piece of the intricate puzzle that is the pathophysiology and management of IBD; it has been suggested to be a proinflammatory condition because adipose tissue is responsible for the secretion of pro- and anti-inflammatory adipokines and may exacerbate activity in autoimmune diseases, including IBD.⁶ Furthermore, recent studies have suggested that mesenteric fat may contribute to the inflammatory response of patients with Crohn's disease, as opposed to subcutaneous adipose tissue and obesity *per se*.⁷ There is also evidence suggesting that "dysbiosis" (alterations in intestinal signaling and consequent changes in the hormone response), together with the use of immunosuppressive medication, could contribute to weight gain.

This leads both coloproctologists and bariatric surgeons to wonder, what is the best technique to perform in these patients while also acting with caution when confronted with a chronic disease with uncertain progression? First of all, if we opt for restrictive techniques so as to not manipulate the small intestine (mainly in patients affected by Crohn's disease), we could carry out laparoscopic sleeve gastrectomies in these patients, while assuming that the long-term weight results may not be the best. However, if we opted for mixed or malabsorptive techniques with the idea of obtaining the best results in terms of weight loss or improved comorbidities, we would have to use intestinal manipulation in patients who may possibly require some type of intervention in the future, with all that this entails.

To date, few series have been published. In fact, our country has just presented the first results of our national registry of patients previously diagnosed with IBD who are candidates for bariatric surgery (ReNacEIBar). Most series conclude that bariatric surgery can be considered safe and effective in patients diagnosed with IBD, and laparoscopic sleeve gastrectomy is the most frequently performed technique (mainly in patients with Crohn's disease). One of the main concerns in this type of patient is the fact that the percentage of complications may exceed what is established within the standards⁸ as a consequence of luminal inflammation, as well as the chronic use of various treatments (immunomodulators, aminosalicylates, corticosteroids, etc.). In their systematic review and meta-analysis of 10 studies, Garg et al.⁹ reported rates of early and late adverse effects of 15.9% and 16.9%, respectively, after bariatric surgery in patients with IBD. In terms of weight results, they presented combined rates of excess weight loss (EWL) and BMI reduction 12 months after bariatric surgery of 66.1% (95% CI, 59.8–72.3) and 13.7 kg/m² (95% CI, 12.5–14.9), respectively. The most commonly used bariatric procedure was sleeve gastrectomy (58%, *n* = 97), followed by Roux-en-Y gastrojejunum bypass (30%, *n* = 51), adjustable gastric banding (12%, *n* = 20), and vertical banded gastroplasty (*n* = 1).

There is much we still do not know about the evolution of IBD. If we look at published review articles, most describe an improvement associated with a reduction in the maintained treatment of these patients. Thus, in the previously discussed review, half of the patients had no change in their IBD medications, while 45% decreased their use of medication, and 11% required an increase in their IBD medications (Crohn's disease being more responsive to bariatric procedures with higher rates of induced decrease and increase of their IBD medications).⁹

On the other hand, there are various cases published in the literature of *de novo* IBD after bariatric surgery, which seems to be more related to Crohn's disease than to ulcerative colitis (and to Roux-en-Y gastrojejunum bypass than with restrictive techniques). However, although the degree to which obesity and bariatric surgery are associated with the development of *de novo* IBD has not yet been determined, everything points to the fact that a genetically predisposed individual, together with the anatomical alteration caused by these techniques bariatric diseases, as well as the change in the microbiome, could be the great predisposing factor in the development of this condition.^{10,11}

In short, there are still many answers to be resolved in patients diagnosed with IBD who suffer from morbid obesity, and only time and well-designed long-term studies will assist decision-making in these patients. For this reason, we at the AEC encourage you to participate in our ReNacEIBar registry, whose objective is to facilitate its use in clinical practice.

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Conflicts of interest

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