Clinical Challenges of Bariatric Surgery for Patients with Psychiatric Disorders. Commentary on: “Lithium Toxicity Following Roux-en-Y Gastric Bypass”¹

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AS THE INCIDENCE of morbid obesity rises, we are gaining a more complete understanding of the collective impact of the associated medical comorbidities from both personal and societal standpoints. Increasing numbers of morbidly obese patients who have failed conservative treatments are being referred for surgical evaluation. Bariatric surgery is currently considered the most effective and durable treatment for morbid obesity, with a lack of efficacy or durability a hallmark of the course of conservative therapies.

Several associations have been demonstrated between morbid obesity and psychiatric disease. People suffering from bipolar disease are twice as likely as the standard population to be obese. The development of metabolic syndrome itself has been associated with stress, childhood parental loss, maladaptive parental treatment, and parental neglect.² These associations lead to the observation that patients presenting for evaluation for bariatric procedures have a higher than normal incidence of psychiatric illnesses, including depression and bipolar disorder. Kalarchian *et al.* reported that 66% of patients presenting for bariatric surgery have a lifetime history of an Axis I psychiatric disorder (major depression, anxiety, eating, psychotic disorders, etc.), 38% have a current mood disorder, and 6% have a lifetime history of bipolar disorder.³

In the oft-cited 1992 National Institutes of Health (NIH) consensus statement on surgical treatment of morbid obesity, the panel statement included a recommendation for preoperative psychological assessment for patients being considered for bariatric procedures, but the text of the statement contained little in the way of data for support.⁴ This statement was an effort to provide standardization and improved outcomes for surgical procedures, which require lifelong ongoing follow-up for medical, nutritional, and psychiatric illnesses for optimized results. Given that hallmark characteristics of bipolar disorder include maladaptive personality traits such as lack of insight, adaptivity, mental flexibility, and stability, it would be logical that these could compromise patient compliance with a bariatric program. This recommendation was based on the potential deleterious effects of untreated or undertreated psychiatric illnesses in a population known to be at increased risk for such conditions. In practice, the preoperative psychological assessment probably varies

widely between practitioners. There exists no standard instrument or consistent assessment tool, although most do use some formal tool for the evaluation. There is also a broad range of experience in conducting such evaluations. These variations lead to variability in recommendations that are made, although in general about 85% of patients undergoing evaluation receive an unconditional recommendation to proceed, with around 15% of patients either encouraged to seek additional preoperative treatment or denied altogether.⁵

There has been very little published to either support or refute these recommendations. In general, patients with these histories have not been considered proper candidates for surgical procedures, although recently this has come to be more of a relative contraindication, and more patients have been granted access to surgery. Published outcomes in bipolar patients undergoing bariatric procedures have shown mixed results and remain incomplete. A few series demonstrated no difference in weight loss in bipolar patients,^{6,7} but another showed significantly less weight loss in this same group.⁸ A report from the integrated managed care system Kaiser Permanente in California reported no observable difference in psychiatric outcomes (outpatient visits or psychiatric admissions) during the first postoperative year. These studies all have significant limitations and leave considerable questions regarding bariatric surgery in bipolar patients:

- (1) Are patients able to complete recommended follow-up after surgery?
- (2) Is there observable improvement in either medical or psychiatric disease burden that justifies the surgical procedure over controls?
- (3) Are there increased uses of resources peri- and postoperatively that affect the ability of bariatric surgeons to deliver the care as they are used to?
- (4) Is there a higher incidence of chronic complications such as nausea and pain following these procedures?
- (5) Are patients healthier, and does their medical care cost less?

The surgeon's comfort in managing patients with significant psychiatric disorders probably plays a role in access to surgery. This case report provides one example of a very real unknown for bariatric surgeons, who are typically not trained

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in the clinical or medical management of patients with bipolar disorder. The most standard psychiatric medical therapies for bipolar disorder today include use mood stabilizers (lithium, depakote, carbamazepine, lamictal) and antipsychotics (lurasidone, aripiprazole, quetiapine, olanzapine, risperidone). None of these drugs are typically prescribed by a surgeon, and in many cases, most of them were developed after the time of the last pharmacology class the surgeon attended. Quick literature searches typically yield very little information regarding the absorption of these drugs, much less the absorption that would be expected after a bariatric procedure. This casts a shadow on the expected psychiatric outcomes, particularly for malabsorptive procedures such as Roux-en-Y gastric bypass (RYGB). Surgeons are aware of both anecdotal and published reports of gastrointestinal symptoms leading to intolerance of per oral medications and psychiatric complications. In addition, many of these medications can be associated with significant weight gain (mood stabilizers) or decrease in cognition (lithium), which may affect a patient's ability to adhere to postoperative protocols.

Surgeons and psychiatrists often practice in very different professional circles. There is often no rounding service for inpatient psychiatric consultations available, unless patients proclaim suicidal ideations. There is a mutual reticence of psychiatrists to care for perioperative patients who may be having GI symptoms, and surgeon reluctance to manage psychiatric issues when a consultant is not readily available. When patients with significant psychiatric conditions suffer loss of stability on surgical floors, it can be very difficult, time consuming, and disconcerting for surgical teams to manage. In my own practice, my personal phone contains at least a few numbers for the treating psychiatrists of my bariatric patients who required treatment and medication adjustment in the hospital that could only be done by phone due to differing practice locations. This raises a host of risks to the physician, which ultimately they may choose not to incur.

Patients are presenting for bariatric evaluation with significant psychiatric disorders with increasing frequency. Existing data do suggest that the benefits of bariatric surgery in terms of weight loss are real, and that surgical outcomes should be good. There is a glaring lack of any information regarding the effect on the person as a whole to guide us as surgeons. The best evidence continues to suggest that in carefully selected patients, bipolar disorder or other Axis I disorders are not be a contraindication to bariatric surgery. This requires a means and willingness for surgeons and psychiatrists to work closely together to deliver coordinated care and to ensure recommended follow-up is achieved.

Currently, this is not an easy task in most institutions. Lastly, while patients with significant psychiatric conditions may not be contraindicated for bariatric surgery, neither is bariatric surgery a treatment for these conditions, and this fact does not always match up with preoperative patient expectations. This is an area that is ripe for research, so that bridges may be crossed.

Author Disclosure Statement

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