Published in final edited form as:

Surg Obes Relat Dis. 2020 October ; 16(10): 1489–1490. doi:10.1016/j.soard.2020.06.047.

Comment on: Predictors of Postoperative Emergency Department Visits without Readmission after Laparoscopic Bariatric Surgery

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The per-capita volume of bariatric surgery has increased more than 10-fold over the past several decades, while complication and mortality rates have dropped nearly 90% [1]. Despite these outcome improvements, emergency department (ED) visits remain relatively common after bariatric surgery. A 2018 study using MarketScan data reported that 15% of patients presented to the ED within 30 days of bariatric surgery [2]. While some of these ED visits are unavoidable due to conditions that require emergency medical and/or surgical care, retrospective studies estimate that 14-50% of ED visits within 30 days of bariatric surgery may be preventable [2–4]. These visits are considered preventable because they do not result in hospital readmission.

In this issue of *Surgery for Obesity and Related Diseases*, Leonard-Murali *et al.* analyzed 2015-2017 Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) data to identify predictors of ED visits that did not result in readmissions within 30 days of undergoing a laparoscopic sleeve gastrectomy (LSG) or Roux-en-Y gastric bypass (LRYGB) [5]. Of the nearly 300,000 patients who underwent bariatric surgery, 6.6% experienced a preventable ED visit. In adjusted regression analyses, the odds of having an ED visit were 20 times higher for patients who underwent outpatient treatment for dehydration. Other predictors of having a preventable ED visit included urinary tract infection (UTI) and wound complications.

Although there were study limitations – the dataset did not indicate whether an ED visit or a postoperative complication occurred first, and it was unknown if patients were advised to go to the ED by providers – this study adds to the body of literature identifying targets for decreasing ED visits following bariatric surgery. If complications like dehydration, UTI, and wound management can typically be treated in an outpatient setting, why do patients still present to the ED for these conditions? A recent mixed-methods study found that 36% of bariatric surgery patients who presented to the ED believed their symptoms required

immediate attention [6]. More than 90% felt that the surgical team could not have prevented the ED visit. Three-fourths of the visits were outside of traditional office hours.

These findings suggest that there may be some targets for decreasing preventable ED visits after bariatric surgery. While preoperative and discharge teaching efforts cannot involve every conceivable complication scenario, education about how to recognize and react to the most common causes of preventable ED visits seems essential. Furthermore, bariatric teams might want to ensure that patients can contact a bariatric care provider at all hours. If bariatric team providers and clinics are not available (e.g. weekends), lower acuity options, like urgent care centers, rather than the ED, may be advisable from a resource utilization perspective. Bariatric centers should be also equipped to treat common postoperative complications, which may require IV infusions or medications. Although bariatric surgery complications are uncommon, patients need to know where to seek care after surgery, and bariatric programs need to empower them to do so.

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