

LIAISON PSYCHIATRY AND BARIATRIC SURGERY: DOUBLE STANDARDS

What are the possibilities for the systematization of the pre-operative psychiatric assessment in Belgium?

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SUMMARY

Background: In the context of health care in Belgium, the psychological or psychiatric opinion of a multidisciplinary team is required in the assessment of bariatric surgery candidates. In clinical practice, a wide variety of liaison psychiatry assessment methods exist.

Subjects and methods: On the basis of a post-operative psychiatric comorbidity case report and a literature review on "liaison psychiatry and bariatric surgery" we aim to identify opportunities for the systematization of bariatric pre-surgery psychiatric evaluation.

Results: The bariatric pre-surgery evaluation must be rigorous and founded on evidence-based medicine. On this basis, specific psychiatric criteria may be defined and researched in assessments. The issue remains for psychiatric comorbidities that develop after surgery and for which a preventive framework should be sustained in the liaison psychiatry approach.

Conclusions: The aim of the research is to support an improved systematization of the psychological assessments of pre-operative bariatric surgery candidates. We believe that systematic evaluation tools should be defined for the identification of possible absolute or relative contra-indications and that a preventive approach to post-operative psychiatric disorders should be included in this assessment

Key words: bariatric surgery - liaison psychiatry - eating disorder

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INTRODUCTION

The obesity issue has become a major challenge to health care in Europe and the United States. Obesity defined by a Body Mass Index (BMI) greater than 30 affects an estimated 14% of the Belgian population (WHO, 2010). Still in Belgium, the National Institute for Health and Disability Insurance, public social security institution has defined the criteria and conditions for the reimbursement of bariatric surgery namely: over 18 years of age, a BMI greater than 40 or 30 associated with a disease such as type 2 diabetes, resistant hypertension, sleep apnoea syndrome or the need for revision surgery for complications or poor bariatric surgery results and finally has been the subject of documented dietary follow-up for at least one year. Furthermore it is stated that the decision must be multidisciplinary: surgeon, endocrinologist and psychologist or clinical psychiatrist opinion. This article will look at the issue of psychological and psychiatric evaluation modalities in potential patient candidates for bariatric surgery.

The weight, height and BMI measurements seem to be objective measures, although the BMI is not an accurate definition of the actual amount of excess fat. Quantitative and objective measures also exist for the somatic burden and complications such as diabetes or hypertension. On the other hand, what must the liaison

psychiatrist or psychologist assess? What systematic assessment should be considered and is possible in practice? How should the double standard risk as expressed both objectively and subjectively in the formula be qualified? Finally, it must be recalled that the main difficulty for the various health care providers involved in the bariatric surgery process, is that the prevention issue remains pivotal even if the subject is "curative" treatment-centred. The paradoxical messages in our society where advertising for sugary sodas and various fast food outlets are found together with preventive messages on healthy eating and sport, remain the initial cause of the minimisation process and cognitive distortions in some patients.

SUBJECTS AND METHODS

The thinking developed in this article will build on the case-report of a clinical situation with post-operative psychiatric problems in a bariatric surgery patient, encountered at the University Hospital, UCL in Godinne, Belgium.

After description of the problematics encountered, with a review of the "psychiatry and bariatric surgery" literature on Medline, we will attempt to point out already well known and catalogued pre and post-operative psychiatric comorbidities as well as psychological measurement tools already in-use.

The discussion will then focus on the possibilities of the systematization of liaison psychiatry assessments as well as the implementation difficulties related to the healthcare setting in Belgium.

RESULTS

A 56 year old patient is admitted to the ICU of the University Hospital UCL, Godinne following a voluntary drug overdose with beta blockers.

After stabilization of his organic status, a psychiatric opinion is sought.

The patient lives on his own and has no children. The patient has been on disability for 5 years, he was an employee in an administration post.

Two years ago he underwent bariatric surgery (gastric bypass). The patient then had a BMI of 35 and was suffering from resistant hypertension and type 2 diabetes. His weight was 145 kg. The patient disclosed that he had applied for this procedure and that at the time he had met with a psychologist once, who according to the patient had not given a negative opinion of the procedure.

The surgery took place without significant complication. Weight loss was rapid and steady reaching a weight of 95 kg two years later.

The patient reported a pronounced depressive mood for over six months and meets the criteria for Major Depressive Disorder (MDD) according to DSM-IV. The (Mini) Mini International Neuropsychiatric Interview also highlighted an alcohol consumption problem, no other substance use was noted.

No past psychiatric history among first-degree relatives has been listed. The patient reported a major depressive episode 4 years ago following the weight gain and the onset of diabetes and hypertension.

The patient disclosed having developed a loss of appetite since his operation with the subjective impression that food had lost its flavour and of feeling full very quickly. In a quest to experience food flavour again; the patient developed the eating disorder hyperphagia with salty and fatty foods. This increased fat ingestion led to the appearance of steatorrhea which induced faecal incontinence that severely limited the patient's social life. Avoidance and social withdrawal behaviour settled in. In this context, depressive symptoms developed with the patient resorting to the consumption of alcoholic beverages (6 units in less than three hours). Alcoholic beverage consumption aggravates steatorrhea.

The patient has been prone to suicidal thoughts for the last two months with development of a suicidal plan swallowing beta blockers.

The patient expressed not being able to live anymore like this and could not see a way out. He also expressed that he had not imagined that there would be these

consequences to his surgery. At the beginning of his eating and emotional disorders, the patient disclosed that his social network was very reduced and that he had nobody to confide in. The patient also expressed that he had not thought about making an appointment for a psychiatric or psychological consultation and he had no idea where to turn.

In relation to the suicidal and depressive syndrome the patient's situation improved and stabilised, thanks to the implementation of supportive psychotherapy consultations and a daily prescription of escitalopram 10 mg, with continued monitoring for the management of hyperphagia eating disorder episodes and alcohol abuse prevention.

DISCUSSION

In the literature, a study on the follow-up of 199 patients (Kalarchian et al. 2016) shows that the results of bariatric surgery in terms of weight loss are comparable between individuals with psychiatric disorders versus individuals without psychiatric disorder. However, it explains that poorer results were demonstrated when eating disorders develop post-surgery. Very little research has been conducted on the treatment of eating disorders developed post-surgery and some authors call attention to this need (Axt 2015).

In another study involving 590 patients, including 188 with psychiatric comorbidity (Fuchs et al. 2016), the results among patients with or without psychiatric comorbidities were similar. Regarding psychiatric comorbidities, they are described as being monitored and stabilised.

Several studies show an improvement in the mental health of obese patients after bariatric surgery in adults (Magallares et al. 2015) as well as in adolescents (Hillstrom et al. 2015).

However other studies highlight the increase in suicidal thoughts in adolescents in post-surgery (McPhee et al. 2015) as well as actual suicide attempts (Bhatti et al. 2016).

The central question on the basis of what the literature reports and in connection with this case report is that post-surgery results are good in patients with psychiatric comorbidities if their psychiatric treatment is regular and available. What about patients who develop a mental disorder after surgery? What resources are available to them in terms of psychological or psychiatric assistance?

In Belgium's reimbursement criteria, only dietary monitoring is described as a sustainable process (one year of documented follow-up). Psychiatric or psychological opinion is not part of the long-term evaluation or post-surgery follow-up, but more as part of the exclusion of prior psychiatric contra-indications. Based on the clinical setting encountered, this seems an essential subject of debate to us.

The bariatric pre-surgery assessment including the psychiatric evaluation needs to be rigorous (Ghaferi et al. 2016), but all is not yet founded on evidence-based medicine.

In the field of liaison psychiatry, it would undoubtedly be better to attempt to systematize the bariatric pre-surgery assessment requirements. The use of health questionnaires and quality of life screening should be systematic like for example with the "Patient Health Questionnaire" (Alizai et al. 2015). Moreover, the standard psychiatric assessment with the MINI should also be systematic with particular attention given to eating disorders, in particular bulimia, given their potential impact on surgery and their high frequency in patients suffering from obesity (Mitchell et al. 2015) as well as for substance abuse and depressive symptoms.

An awareness of the actual consequences of the procedure, the potential risks, the need for compliance and follow-up should also be part of the psychiatric assessment consultation.

At this level, psychoeducation and information tools should be developed to fuel patient thinking. Ideally, patient support group initiatives should also receive support.

The medical community itself, still requires educating as it sometimes lacks the awareness of the organic and psychological consequences of this procedure (da S Guedes et al. 2015)

The other very important point is the notion of a true multidisciplinary assessment with sufficient time given to the exchange of information between health care providers in order to guarantee an informed decision

The major difficulty and one that is not very easy to systematize, is the assessment of the denial of the body, minimisations, distortions of bodily perceptions, dissociative states related to traumas not readily expressible at the outset involving an individual dimension to each patient and that can only be assessed over time and dynamically.

It is certainly this point that explains the pitfalls of bariatric surgery, even if the overall results are good, and the merits of developing better prevention strategies in liaison psychiatry, with the maintenance of contact, if not regularly at least once or twice post-surgery. The issue of regulating emotions in the hyperphagia phenomena and substance abuse deserves envisaging either in-depth or support psychotherapy sessions (Shakory et al. 2015).

CONCLUSIONS

Our thinking based on our case report and the literature review leads us to support more research for greater systematization of psychiatric assessments of patient candidates for bariatric surgery as part of the health care service in Belgium.

To reduce the evaluation differences, it would be useful to define questionnaires and a list of psychiatric contra-indications founded on evidence-based medicine.

We believe that psychiatric opinion should not be limited to a dichotomous "favourable or not" type of response, but should identify psychosocial risk factors at work and define regular psychiatric or psychological follow-up indications as an adjunct to bariatric surgery.

In the same manner as dietary monitoring is defined in a dynamic and long-term manner, psychiatric and psychological evaluation should fulfil similar conditions or at least offer a post-surgical follow up consultation.

It also seems necessary to us that psychoeducation tools for patients and health care provider awareness requires development.

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