



Complete Summary

GUIDELINE TITLE

Role of endoscopy in the bariatric surgery patient.

BIBLIOGRAPHIC SOURCE(S)

ASGE Standards of Practice Committee, Anderson MA, Gan SI, Fanelli RD, Baron TH, Banerjee S, Cash BD, Dominitz JA, Harrison ME, Ikenberry SO, Jagannath SB, Lichtenstein DR, Shen B, Lee KK, Van Guilder T, Stewart LE. Role of endoscopy in the bariatric surgery patient. *Gastrointest Endosc* 2008 Jul;68(1):1-10. [108 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

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SCOPE

DISEASE/CONDITION(S)

Severe obesity requiring bariatric surgery

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Evaluation
Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Gastroenterology
Internal Medicine
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide evidence-based recommendations for the role of gastrointestinal (GI) endoscopy in bariatric surgery patients

TARGET POPULATION

Patients undergoing bariatric surgery* for severe obesity

*Bariatric surgical procedures include laparoscopic or open Roux-en-Y gastrojejunal bypass, laparoscopic adjustable gastric banding (LAGB), vertical banded gastroplasty (VBG), and sleeve gastrectomy alone or with duodenal switch and biliopancreatic diversion (DS/BPD).

INTERVENTIONS AND PRACTICES CONSIDERED

1. Use of upper endoscopy in the preoperative evaluation of patients undergoing bariatric surgery
2. Use of endoscopy in patients following bariatric surgery
3. Use of endoscopy in patients after gastric bypass or with a previous bypass to evaluate symptoms and postsurgical complications
4. Use of endoscopic retrograde cholangiopancreatography (ERCP) or magnetic resonance cholangiopancreatography (MRCP) for the evaluation of choledocholithiasis in patients who have had previous bariatric bypass surgery
5. Endoscopic treatment of obesity

MAJOR OUTCOMES CONSIDERED

- Effectiveness of endoscopy in evaluating the anatomical alterations created by bariatric surgery
- Expected complications and considerations for endoscopic evaluation in the bariatric surgery patient

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

MEDLINE and PubMed databases were used to search for publications from the last 15 years that are related to endoscopy by using the keyword "endoscopy" and each of the following: "bariatric," "obesity," "gastroplasty," "gastric bypass,"

"Roux-en-Y," and "weight loss." The search was supplemented by accessing the "related articles" feature of PubMed with articles identified on MEDLINE and PubMed as the references. Pertinent studies published in English were reviewed. Studies or reports that described fewer than 10 patients were excluded from analysis if multiple series with more than 10 patients that addressed the same issue were available. The resultant quality indicators were adequate for analysis.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

See "Rating Scheme for the Strength of the Recommendations."

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Guidelines for the role of endoscopy are based on critical review of the available data and expert consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grade of Recommendation	Clarity of Benefit	Methodologic Strength Supporting Evidence	Implications
1A	Clear	Randomized trials without important	Strong recommendation; can be applied to

Grade of Recommendation	Clarity of Benefit	Methodologic Strength Supporting Evidence	Implications
		limitations	most clinical settings
1B	Clear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Strong recommendation; likely to apply to most practice settings
1C+	Clear	Overwhelming evidence from observational studies	Strong recommendation; can apply to most practice settings in most situations
1C	Clear	Observational studies	Intermediate-strength recommendation; may change when stronger evidence is available
2A	Unclear	Randomized trials without important limitations	Intermediate-strength recommendation; best action may differ depending on circumstances or patients' or societal values
2B	Unclear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Weak recommendation; alternative approaches may be better under some circumstances
2C	Unclear	Observational studies	Very weak recommendation; alternative

Grade of Recommendation	Clarity of Benefit	Methodologic Strength Supporting Evidence	Implications
			approaches likely to be better under some circumstances
3	Unclear	Expert opinion only	Weak recommendation; likely to change as data become available

*Adapted from Guyatt G, Sinclair J, Cook D, et al. Moving from evidence to action. Grading recommendations: a qualitative approach. In: Guyatt G, Rennie D, editors. Users' guides to the medical literature. Chicago: AMA Press; 2002. p. 599-608.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This document was reviewed and approved by the Governing Board of the American Society for Gastrointestinal Endoscopy.

This document was reviewed and endorsed by the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) Guidelines Committee and Board of Governors.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the grades of recommendation (1A to 3) are provided at the end of the "Major Recommendations."

Summary and Recommendations:

Bariatric surgical intervention presents new challenges to the endoscopist:

- An upper endoscopy should be performed in all patients with upper-gastrointestinal (GI)-tract symptoms who are to undergo bariatric surgery. **(Level 2C)**
- Upper endoscopy should be considered in all patients who are to undergo a Roux-en-Y gastrojejunal bypass (RYGB), regardless of the presence of symptoms. **(Level 3)**
- In patients without symptoms and who are not undergoing an endoscopy, noninvasive *Helicobacter pylori* testing followed by treatment, if positive, is recommended. **(Level 3)**
- In patients without symptoms and who were undergoing gastric banding, a preoperative upper endoscopy should be considered to exclude large hernias that may change the surgical approach. **(Level 2C)**
- An endoscopic evaluation is useful for diagnosis and management of postoperative bariatric surgical symptoms and complications. **(Level 2C)**
- An endoscopic retrograde cholangiopancreatography (ERCP) is difficult in patients who had an RYGB, and a magnetic resonance cholangiopancreatography (MRCP) should be performed in cases where other noninvasive imaging studies are inconclusive. An ERCP in RYGB patients should be selectively performed. **(Level 3)**

Table. Signs and Symptoms Prompting Possible Endoscopic Evaluation after Bariatric Surgery
Upper GI symptoms <ul style="list-style-type: none"> • Nausea • Vomiting • Dysphagia • Pain • Reflux
Diarrhea
Anemia/bleeding
Weight regain

Definitions:

Grade of Recommendation	Clarity of Benefit	Methodologic Strength Supporting Evidence	Implications
1A	Clear	Randomized trials without important limitations	Strong recommendation; can be applied to most clinical settings
1B	Clear	Randomized	Strong

Grade of Recommendation	Clarity of Benefit	Methodologic Strength Supporting Evidence	Implications
		trials with important limitations (inconsistent results, nonfatal methodologic flaws)	recommendation; likely to apply to most practice settings
1C+	Clear	Overwhelming evidence from observational studies	Strong recommendation; can apply to most practice settings in most situations
1C	Clear	Observational studies	Intermediate-strength recommendation; may change when stronger evidence is available
2A	Unclear	Randomized trials without important limitations	Intermediate-strength recommendation; best action may differ depending on circumstances or patients' or societal values
2B	Unclear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Weak recommendation; alternative approaches may be better under some circumstances
2C	Unclear	Observational studies	Very weak recommendation; alternative approaches likely to be better under some circumstances

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CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate use of endoscopy in the bariatric surgery patient

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Further controlled clinical studies may be needed to clarify aspects of this statement, and revision may be necessary as new data appear. Clinical consideration may justify a course of action at variance to these recommendations.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Jul

GUIDELINE DEVELOPER(S)

American Society for Gastrointestinal Endoscopy - Medical Specialty Society

SOURCE(S) OF FUNDING

American Society for Gastrointestinal Endoscopy

GUIDELINE COMMITTEE

Standards of Practice Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [American Society for Gastrointestinal Endoscopy Web site](#).

Print copies: Available from the American Society for Gastrointestinal Endoscopy, 1520 Kensington Road, Suite 202, Oak Brook, IL 60523

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on September 15, 2008. The information was verified by the guideline developer on October 31, 2008.

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