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Bariatric Tourism: Cheap costs can be costly

Alejandro Hueso, Alberto Díaz, Juan Manuel Sánchez, Alejandro Menéndez, Marta Rojas, Jorge Abellán, Vanesa Concepción, Carmen Díaz, Rajesh Gianchandani, Modesto Enrique Moneva, Julio César Jordán-Balanzá

Hospital Universitario Nuestra Señora de la Candelaria.

E-mail: Alejandrohuesomor@gmail.com

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Abstract

Introduction: Medical tourism is rising due to lower costs. 2% bariatric surgeries are performed in this context. There's a higher rate of complications caused by laxity in indication and inadequate follow-up. Clinical Case: 56-year-old patient with three bariatric surgeries performed abroad (no reports). While in Turkey for another procedure, she experienced abdominal pain requiring urgent surgery (without reports). One month later, she came to our center with abdominal pain. CT scan confirmed an occlusive condition. An initial laparoscopic approach with open conversion due to technical difficulties was needed Findings: Antecolic alimentary limb (1m), gastrojejunal anastomosis, tubulized remnant stomach, biliary limb (0.7m), with good appearence. At 10cm from the distal limb: T-L anastomosis where one end formed an omega-blind loop (1.7m) adhered to the limb's base. The other end, a 1m limb connected to the ileocecal valve. Resection was performed above the T-L anastomosis and on both sides of the ileal limb. An anastomosis was created 1m from the ileocecal valve. The blind loop was released and anastomosed to the common limb at 10cm, creating common limb of 2.7m. Patient discharged after one week. Conclusions: Medical tourism is rising due to lower costs. Laxity in indications and inadequate follow-up increase complications.

Keywords:

- Medical tourism
- Metabolic surgery
- Bariatric surgery
- Emergency surgery

Introduction

Medical tourism is on the rise due to lower costs, increased accessibility to treatment, and reduced waiting times [(1)(2)].

Since 2003, worldwide bariatric surgery rates have surged by 300% [(2)], and approximately 2% of all global bariatric surgeries are conducted within the realm of medical tourism [(3)].

It is well-established that metabolic surgery represents the most cost-effective approach to managing obesity, targeting individuals with a Body Mass Index (BMI) exceeding 40 or those with a BMI exceeding 35 alongside comorbidities. Clinical guidelines advocate for a comprehensive multidisciplinary assessment, encompassing psychiatry, dietetics, and endocrinology, as a prerequisite for surgical consideration. However, it is noteworthy that in certain regions, this pivotal aspect receives relatively diminished attention[(2)(3)].

The foremost complications in this context encompass bleeding, leakage, and thrombosis[(4)].

Additionally, postoperative follow-up in this scenario frequently exhibits a less comprehensive nature, compounded by the circumstance wherein numerous patients return to their home countries bearing medical reports composed in a foreign language, resulting in an elevated incidence of complications and delayed detection [(5)].

Clinical Case

A 56-year-old woman with a history of three gastric sleeve surgeries in Peru, Spain, and Colombia (no medical reports available) recently traveled to Istanbul for a dental procedure. During her stay in Istanbul, she developed severe abdominal pain and sought medical attention at a local hospital, where she was diagnosed with a benign intestinal

lesion. The patient was informed that this condition required urgent surgical intervention, although the specific nature of the procedure was not specified, and no medical records were provided.

One month later, the patient presented to our center with complaints of abdominal pain and nausea lasting for 24 hours. A CT scan was performed, revealing an obstructive condition. The patient underwent surgery, initially through a laparoscopic approach. However, due to difficulties in achieving a complete anatomical assessment, it was decided to convert to an open procedure.

During the surgery, we observed a 100 cm antecolic alimentary loop with a gastrojejunostomy anastomosis in good condition. The remaining tubular stomach appeared minimally distended, obviating the need for a gastrostomy. A 70 cm biliary loop was found to be slightly dilated. At the base of the loop, approximately 10 cm from that point, a T-L anastomosis was identified. One end formed an omega-shaped blind loop of 170 cm closely adhered to the base of the loop, while the other end extended into a 100 cm loop that entered the ileocecal valve.

The decision was made to perform a resection above the T-L anastomosis and on both sides of the ileal loop, allowing the creation of a new anastomosis 1 meter from the ileocecal valve. The blind loop adhered to the base of the loop was released, and an L-L anastomosis was carried out 10 cm from the initial common loop, resulting in a common loop of 270 cm.

The patient progressed favorably and was discharged on the 8th day without any incidents.

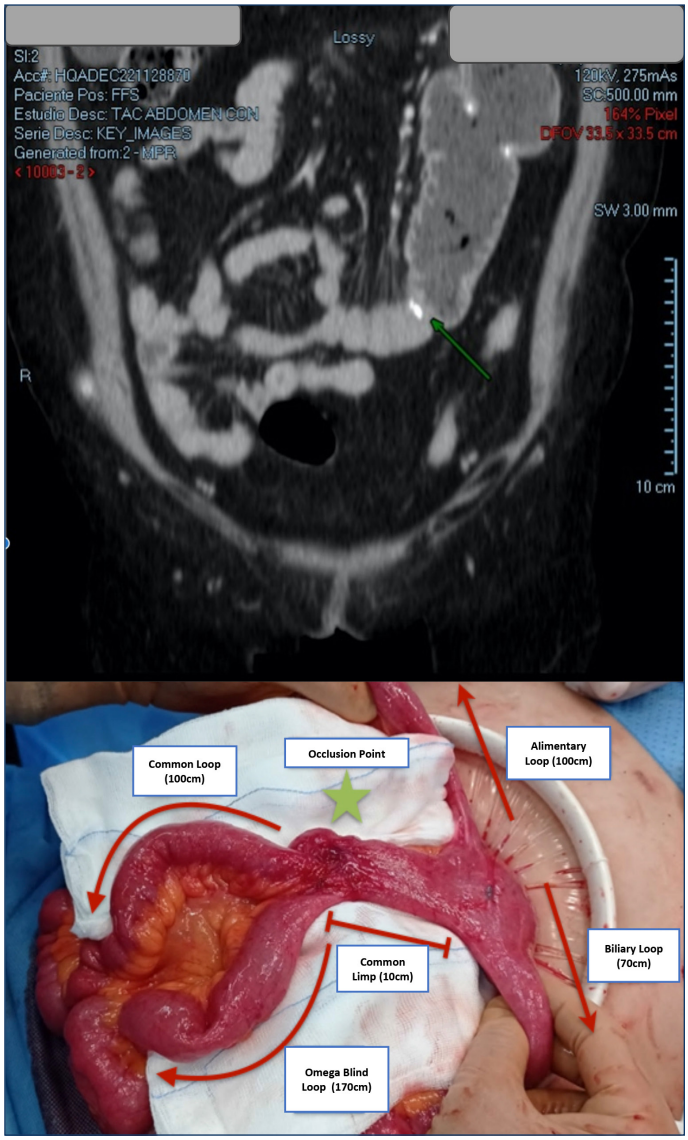

Figure 1: CT and Surgical findings

Conclusions

As can be observed in the consulted bibliography, metabolic surgery is the most cost-effective treatment in the management of obesity and its comorbidities. In our country and in neighboring countries, protocols have been established for its performance [4] [5].

In recent years, medical tourism has been on the rise as it allows people to access treatments in a more laxed manner than through conventional means and with cheaper prices. Regarding bariatric surgery performed in this context, preoperative prehabilitation is often neglected without endocrine, nutritional, and psychological evaluations. Early discharge with reports in a foreign language and a lack of follow-up makes complications more frequent and severe than in native cases [1] [3].

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