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**DEPRESSION BEFORE SURGERY DOES NOT INTERFERE
WITH WEIGHT LOSS AFTER SURGERY, NEW STUDY SHOWS**
Antidepressant Use Drops by 20 Percent

ORLANDO, FL – June 15, 2011 – Depression and anxiety do not seem to interfere with the amount of weight loss or the improvement of obesity-related conditions after bariatric surgery, according to a new study* of more than 25,000 patients presented here at the 28th Annual Meeting of the American Society for Metabolic & Bariatric Surgery (ASMBS).

Whether depressed or not, patients with morbid obesity lost about 60 percent of their excess weight within one year and reported an average 30 percent improvement in quality of life. Patients with clinically diagnosed depression, however, had a higher rate of minor complications (4.0% vs. 3.3%) than non-depressed patients. There were no significant differences in major complications. Among patients with depression, use of antidepressant medication dropped by about 20 percent (72% to 60%) one year after surgery and remained at that level after three years of follow-up.

“Depression and anxiety are relatively common among those with chronic diseases like obesity and Type 2 diabetes, and these conditions can sometimes interfere with treatment,” said Jonathan F. Finks, MD, Assistant Professor of Surgery at the University of Michigan, and lead study author. “This study suggests bariatric patients suffering from depression can experience health outcomes and quality of life improvements comparable to non-depressed patients. However, doctors and patients still need to consider psychological issues, state of mind and commitment to lifestyle changes after surgery in assessing whether bariatric surgery is appropriate and indicated for any particular patient.”

University of Michigan researchers examined data from 25,469 patients across 29 hospitals in the Michigan Bariatric Surgery Collaborative (MBSC), a consortium of the state's hospitals and surgeons that maintains a prospective registry of bariatric surgery patients. Between 2006 and 2010, researchers found 11,687 bariatric patients (46%) were being treated for at least one psychiatric disorder, with depression (41%) and anxiety (15%) among the most common. Follow-up surveys of these patients were conducted each year for three years after surgery.

Excess weight loss at one year was similar between patients suffering from a psychiatric disorder and those with no known disorder (57.2% vs. 58.7%). All patients reported 28 to 32 percent improvement in quality of life measures including increased mobility, family life, social interactions and independent living.

“The relationship between obesity and psychiatric disorders has been established,” said James E. Mitchell, MD, Professor and Chair, Department of Clinical Neuroscience, University of North Dakota School of Medicine and Health Sciences and author of the book, *“Bariatric Surgery: A Guide for Mental Health Professionals.”* “But often obesity isn't the only reason for psychological issues. Further study is needed to determine what else health professionals and patients can do before and after an obesity intervention to further enhance mental health and health status, particularly as people go from high BMIs to low ones and vice versa over time.”

Bariatric surgery has been shown to be the most effective and long lasting treatment for morbid obesity and many related conditions.¹ People with morbid obesity have BMI of 40 or more, or BMI of 35 or more with an obesity-related disease such as Type 2 diabetes, heart disease or sleep apnea. Recently the FDA approved the use of an adjustable gastric band for BMI 30 and above, recognizing that there is an increase in mortality and medical complications of obesity at even this level of obesity.

According to the ASMBS, more than 15 million Americans have morbid obesity. Studies have shown patients may lose 30 to 50 percent of their excess weight 6 months after surgery and 77 percent of their excess weight as early as one year after surgery.²

The most common methods of bariatric surgery are laparoscopic gastric bypass and laparoscopic adjustable gastric banding (LAGB). Bariatric surgery limits the amount of food the stomach can hold, and/or limits the amount of calories absorbed, by surgically reducing the stomach's capacity to a few ounces.

The federal government estimated that in 2008, annual obesity-related health spending reached \$147 billion,³ double what it was a decade ago, and projects spending to rise to \$344 billion each year by 2018.⁴ The Agency for Healthcare Research and Quality (AHRQ) reported significant improvements in the safety of bariatric surgery due in large part to improved laparoscopic techniques and the advent of bariatric surgical centers of excellence. The risk of death from bariatric surgery is about 0.1 percent⁵ and the overall likelihood of major complications is about 4 percent.⁶

In addition to Dr. Finks, study co-authors include Arthur Carlin MD, Wayne English MD, Bruno Giordani MD, Kevin Krause MD, Abdelkader Hawasli MD, Nancy Birkmeyer PhD.

About the ASMBS

The ASMBS is the largest organization for bariatric surgeons in the world. It is a non-profit organization that works to advance the art and science of bariatric surgery and is committed to educating medical professionals and the lay public about bariatric surgery as an option for the treatment of morbid obesity, as well as the associated risks and benefits. It encourages its members to investigate and discover new advances in bariatric surgery, while maintaining a steady exchange of experiences and ideas that may lead to improved surgical outcomes for morbidly obese patients. For more information about the ASMBS, visit www.asmb.org

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***PL-103 - PREVALENCE OF PSYCHIATRIC DISEASE AMONG MORBIDLY OBESE PATIENTS UNDERGOING BARIATRIC SURGERY: RESULTS FROM THE MICHIGAN BARIATRIC SURGERY COLLABORATIVE**

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¹ RA Weiner. "Indications and Principles of Metabolic Surgery." U.S. National Library of Medicine. 2010; 81(4):379-94

² AC Wittgrove et al. "Laparoscopic Gastric Bypass, Roux-en-Y: Technique and Results in 75 Patients With 3-30 Months Follow-up." *Obesity Surgery*. 1996. 6:500-504.

³ EA Finkelstein. "Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates." *Health Affairs*. 2009. 28(5):822-831.

⁴ K Thorpe. America's Health Rankings. "The Future Costs of Obesity." 2009.

⁵ Agency for Healthcare Research and Quality (AHRQ). Statistical Brief #23. Bariatric Surgery Utilization and Outcomes in 1998 and 2004. Jan. 2007.

⁶ Flum et al. "Perioperative Safety in the Longitudinal Assessment of Bariatric Surgery." *New England Journal of Medicine*. 2009. 361:445-454. <http://content.nejm.org/cgi/content/full/361/5/445>