



In Response to: Impact of COVID-19 Lockdown on Short-Term Weight Loss in a Single Italian Institution—1-Year Updated Data

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Several recent studies have used the COVID-19 pandemic to explore the effects of a lockdown on weight loss. This period became an unintentional randomization of patients to partial support; they were largely cut off from their clinical and environmental adjuncts to weight loss surgery. While there are no ethical grounds for providing patients with support below the standard of care, we are compelled to learn from how our patients performed during this period. Therefore, we would like to address the points made by Vitiello et al. regarding the impact of COVID-19 lockdown on patients who underwent bariatric surgery immediately prior and their conclusions in terms of lessons extrapolated from this time [1].

Their letter referenced our study but heeded against learning directly from the results. As a point of caution, they outlined that “despite the larger samples provided by our study, we may have also included individuals who were submitted to surgery long before the full lockdown.”

The goal of our study, with results reported in “The COVID-19 Pandemic Did Not Affect Target Weight Loss at 1 Year Post Bariatric Surgery,” was to address the effect of the restrictions placed by the COVID-19 pandemic on weight loss [2]. We looked at patients who had undergone bariatric surgery in January, February, and the first week of March of 2020 just before the New York State ban on elective surgery. This time period is similar to the reported time period of Vitiello et al. selected in their own cohort. Furthermore, the groups were largely matched to two additional cohorts in preceding years in terms of demographics, pre-operative clinical parameters, and post-operative outcomes.

While we saw statistical differences in our groups at 3 months, by 1 year, these differences had disappeared. Similarly, Vitiello et al. showed a statistically significant difference in weight loss at 6 months that also seemed to dissipate by the 1-year mark. In their discussion for this finding, they focus on the resumption of bariatric ancillary services in the second part of 2020 as a main reason for why weight disadvantaged patients were able to “make up” their lack of weight loss. While there is no argument that a successful bariatric program requires a multidisciplinary approach in the early post-operative period, we learned that temporary suspension of our arsenal was far from catastrophic for our patients.

When we conducted this study, we expected these discrepancies in weight loss to persist throughout the first year, which, as we know, can be a herald of future success [3]. We were surprised to find that our data did not reflect what many others had found in terms of decreased weight loss and increased poor dietary habits and emotions [4–6]. Our discussion included the postulation that perhaps the metabolic effects predominate in the first year following weight loss surgery. But these results also compel us to reckon with our current strategies to truly optimize the durability of this invasive intervention. A successful bariatric program may require extensive resources, but it is certainly thought provoking to glean no differences in weight loss in groups who had limited and prolonged access to ancillary post-operative care.

Our data certainly reflects the challenges experienced our institution in the first 3 months of the pandemic. Our robust bariatric program, including nurse practitioners, physician assistants, nutritionists, as well as our surgeons themselves, was deployed to COVID-19 units at our hospital. Everyone in our department, from our clinicians to our administrative staff, was grappling to optimize our current technology in support of our patients. However, this proved to be a challenge during the initial and exponential rise in the number

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of COVID cases within our system. In fact, during this time, tele visits were almost exclusively over telephone and largely without video capability. As our system adapted and bariatric surgery resumed on July 2, 2020, we were not only equipped to operate in our new environment, but also had the tools in place to continue to support bariatric patients on a systemic level. As a result, tele visits have become a regular and powerful tool for ongoing patient engagement to this day.

Even before the pandemic, there is robust data in support of utilizing tele visits and self-monitoring measures as both adjuncts and replacements for some of our traditional interventions. Recently noted was the use of telemedicine to increase access in this vulnerable patient population [7]. In fact, in our study, we equated tele visits with in-person visits [2]. There is also data to support that self-monitoring can be correlated with even more success [8]. Perhaps patients who may be eligible for bariatric surgery but who don't live near a tertiary referral center might still be served well by having bariatric surgery and then conducting their entire follow up course via telehealth. Overall, we have seen that there are new, creative ways to support our patients, ones that we were first forced to explore during the pandemic.

At our institution, about 80% of patients who undergo bariatric surgery are Hispanic or Black, two populations that are routinely disadvantaged in terms of access to bariatric surgery [9]. Ultimately, our goal as agents of public health is to leverage our findings to best utilize our resources in service of our population. There is data to support that minority patients are more open to bariatric surgery than their white counterparts [10], which further compels us to allocate resources towards outreach within our communities about the benefits of bariatric surgery.

The pandemic forced us to look at our current practices and highlighted areas of improvement, to internalize what we learned, and to help develop ideas and resources that continue to ensure long-term success for our bariatric patients.

Declarations

Conflict of Interest The authors declare no competing interests.

References

1. Vitiello A, Berardi G, Musella M. Impact of COVID-19 lockdown on short-term weight loss in a Single Italian Institution: 1-year updated data. *Obes Surg.* 2021;1–2. <https://doi.org/10.1007/s11695-021-05759-2>
2. Pereira X, et al. The COVID-19 pandemic did not affect target weight loss 1 year post bariatric surgery. *Obes Surg.* 2021;31(11):4926–32.
3. Odom J, et al. Behavioral predictors of weight regain after bariatric surgery. *Obes Surg.* 2010;20(3):349–56.
4. El Moussaoui I, et al. Impact of COVID-19 lockdown on short-term results after laparoscopic sleeve gastrectomy. *Obes Surg.* 2021;31(6):2614–8.
5. Conceição E, et al. Eating behaviors and weight outcomes in bariatric surgery patients amidst COVID-19. *Surg Obes Relat Dis.* 2021;17(6):1165–74.
6. Barranquero AG, et al. Impact of the COVID-19 pandemic and lockdown on gastric bypass results at 1-year follow-up. *Obes Surg.* 2021;31(10):4511–8.
7. Chao GF, Ehlers AP, Telem DA. Improving obesity treatment through telemedicine: increasing access to bariatric surgery. *Surg Obes Relat Dis.* 2021;17(1):9–11.
8. Huang X, et al. Impact of self-monitoring on weight loss after bariatric surgery. *Obes Surg.* 2021;31(10):4399–404.
9. Browning MG, Pessoa BM, Campos GM. Comment on: racial disparities may impact referrals and access to bariatric surgery. *Surg Obes Relat Dis.* 2019;15(6):e23–4.
10. Wee CC, et al. Sex, race, and the adverse effects of social stigma vs. other quality of life factors among primary care patients with moderate to severe obesity. *J Gen Intern Med.* 2015;30(2):229–35.

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