

# Obesity: Body Relief Surgeries before Bariatric Surgery for Risk Reduction

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## Abstract

Depending on the treatment and weight of the breasts or abdomen, they may exceed volumes considered giant and morbidly obese. In these cases, and when the patient's BMI is high above 40 kg/m<sup>2</sup>, the weight of the breasts or abdomen produces what we consider suffocation when the patient is placed in horizontal position on surgical tables, decreasing his respiratory capacity and increasing the difficulty in treating respiratory or embolic risks. An 8-kg breast on the patient's chest prevents normal breathing. An abdomen with a volume of 30 kg causes difficulties in all senses, making the physiological expansion of the lungs impossible and even preventing surgical assistance to patients. These patients are almost always customers who sleep in the sitting position to breathe better. The gigantic extirpation of the surgical parts facilitates a better respiratory expansion reducing by a large percentage the risk of death, what we call body relief. This relief does not free the patient from bariatric surgery for a possible weight loss, which is vital for the proper functioning of the organs and decreasing arterial hypertension and diabetes.

## Keywords

Obesity, Disease, Surgery, Bariatric, Risk, Hypertension and Diabetes

## 1. Introduction

The risks and impossibilities of the human being are directly linked in alarming percentages to cases of morbid obesity, when the Body Mass Index (BMI) reaches values far beyond normality or beyond the phase when the person is called

“chubby” [1]. The largest amount of surgical part we removed was of 32 kg, but the average in cases of extirpations for body relief is of 8 kg (Figure 1). These surgeries require a larger number of surgical assistants, a prepared nursing team, a proper operating table, a larger surgical team, and surgical preparation under a thorough and complete anamnesis [2]. In all cases, we always monitor a weight loss by own free will of 8 to 10 kg before surgery. Only then does relief surgery take place. After 6 months, we release the patient for bariatric surgery or intestinal and gastric bypass to achieve the desired weight loss (Figure 2 and Figure 3) [3]. All patients followed the preoperative protocols of the Plastic Surgery Service, such as: hematocrit greater than 38%; blood pressure less than 150 × 100 mmHg; blood glucose less than 100 mg/dL; normal chest X-ray; surgical risk and electrocardiogram approved by the cardiologist.

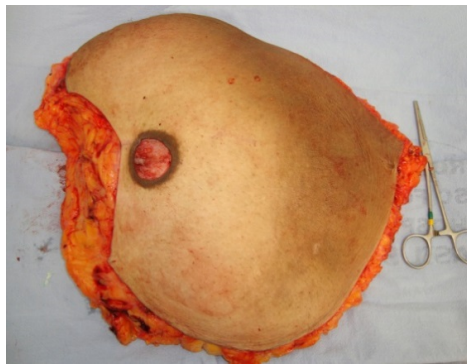


Figure 1. Surgical specimen.



Figure 2. Pre-surgery.



**Figure 3.** Post-surgery.

## 2. Material and Method

The patients mentioned in this manuscript are often abandoned in countryside cities, receive little attention and are neglected even by physicians due to lack of conditions to provide adequate care to alleviate the tensions and provide a better quality of social life [4]. We consider these as public health cases. We selected some patients to show our intention to achieve satisfactory results with zero death.

Metabolic surgeries are indicated in the case of two more harmful pathologies, namely, breast gigantism or abdominal gigantism. These are rare cases, because morbid obesity usually causes deformation of the whole body. Hypertension and diabetes are common in all cases. All patients sign the Informed Consent for the surgeon and for the hospital where they will be operated. They are aware of the possible surgical risks. They also authorize the use of pre- and post-operative images for scientific articles.

**Breast gigantism:** We have published extreme cases in which breasts prevented women from working to provide for their own livelihoods with professions such as ironers, cleaners, washers, seamstresses and others (Figure 4 and Figure 5). Furthermore, obesity is a disease that causes hypertension and diabetes. It affects in all cases the ability to walk and the quality of life of these patients. Pre-operative care is meticulous; the patient goes through several workshop sessions (meetings) for clarifications and is informed about post-operative care measures.

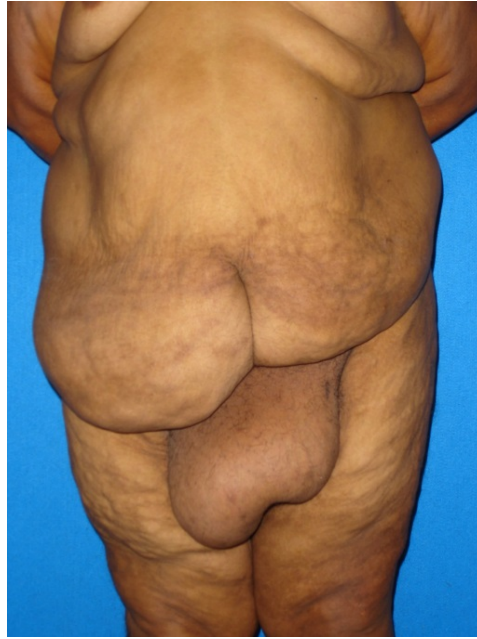


**Figure 4.** Giant breasts.

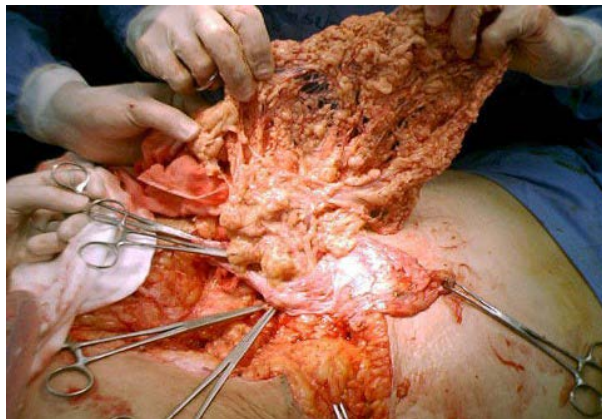


**Figure 5.** Post-operative of reduction mammoplasty.

Abdominal gigantism: Distinction of sex becomes difficult in extreme cases (**Figure 6**), except for the beard when present. Surgical incisions in body relief surgeries are difficult and delicate because of the weight that medical assistants will have to handle. Hernias and eviscerations are frequently found during surgery (**Figure 7**). The postoperative is delicate and strict to avoid bruising and surgical wound dehiscence due to weight and change of position. The nature of the material is human and all methods are of gigantic and terrifying amputations.



**Figure 6.** Male abdomen.



**Figure 7.** Hernia and evisceration.

In all cases of obesity surgeries, complications may happen in the post-operative period, including surgical site infection, seromas, surgical wound dehiscence, bleeding, deep thrombosis, and respiratory [5] or embolic infections. Cases reach a rate of up to 10%. According to Sergerman (1997), seromas can sometimes be treated at home or on an outpatient basis. Fistulas have decreased considerably in the last 30 years of history of bariatric surgery [6].

After Roux-en-Y gastric bypass, more control over morbid obesity was possible [7]. The hospital mortality rate was 5.5 per 1000 patients in the Unified Health System (SUS) in recent years [8] [9]. This rate varies from hospital to hospital and between different countries. The nutritional problem after bariatric surgery [10] deserves attention, including B12 deficiency. Nutritional issues are also present after body relief surgeries. In the United States, obesity has become synonymous with heart disease and causes of death [11].

### 3. Discussion

Many medical experts have sent these patients to specialized hospitals, which are non-existent in Brazil yet, but we are engaged in their implementation by means of the submission of projects to competent agencies. Cases like these are not so rare, and they imply a loss of self-esteem and will to live, as these patients think that they will not find doctors willing to assume the almost impossible task of helping them return to society healthy and enter the job market. In almost all cases, obesity is treated with general surgery, and there are no specific services aimed at obese people.

Body relief cases are usually addressed in plastic surgery services. We have not yet been supplied with suitable surgical centers with wide surgical tables, stretchers with larger dimensions, and increased circulation space for the work of the professionals involved in these cases. We created a masonry toilet of lower cost and stronger material and wider doors in order to facilitate the transport of obese patients.

Each bariatric surgeon will choose the most appropriate technique for each patient. We advise all obese people to participate in the Obesity Workshops, which are meetings where comprehensive instructions relevant to the pre- and postoperative procedures are provided, useful for all cases, including feeding and changes in behavior and habits.

### 4. Conclusion

We need to publish works and open the path for other physicians to deal with this situation. We need to have the boldness to raise awareness among national leaders about the urgent need to create specialized hospitals to assist part of the morbidly obese population, as these people are on the fringes of society, deprived of conditions or will to live. We go to the point of the exaggeration of suggesting the creation of new entities, such as a Post-Weight Loss Plastic Surgery Association, in order to provide more specific care for obese people, allowing the creation of more services for the preparation of medical residents.

### Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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