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Reply from the authors

Editor—We would like to thank the Society of Bariatric Anaesthetists (SOBA) for their very positive comments on fourth National Audit project (NAP4). In addition to these, they suggest some lengthy additional recommendations. While much of the information presented by SOBA is included in the NAP4 report, this was not intended to be a textbook of anaesthesia and should not be regarded as a primary source of information on specialist topics within anaesthesia.

The NAP4 report represents a description of the events reported to the project and analysis of issues pertinent to these cases. Analysis was performed by a broad selection of health-care professionals, drawn from a spectrum of disciplines. SOBA is a relatively young specialist society and was formed after the start of the NAP4 project and therefore, unfortunately, was not represented in the process. Some of their comments, particularly about airway device selection and spontaneous ventilation, although reasonable might not be supported by the broader anaesthetic community and need to be bolstered by clear scientific evidence. No doubt in due course SOBA will produce and justify their own guidelines and recommendations on the management of this challenging group of patients.

Conflict of interest

None declared.

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Obstructive sleep apnoea and perioperative complications in bariatric patients

Editor—I read with great interest the article by Weingarten and colleagues. The authors reported data on 797 patients undergoing bariatric operations and concluded that the severity of obstructive sleep apnoea (OSA) is not associated with the rate of perioperative complications. I would like to point out two limitations of the study that were not discussed but may have had significant impact on the results. First, the non-uniformity of surgical procedure may have influenced their results, although the hospital length of stay among groups was similar. This only indirectly indicates that a similar number of patients underwent banding, sleeve gastrectomy, or gastric bypass surgery. The second point has direct implications on the authors’ conclusion. The utilization of continuous positive airway pressure (CPAP) increased significantly with the severity of OSA, indicating that patients were more likely to experience a subjective benefit from the treatment. The clinical goal of CPAP treatment is to reduce the apnoea–hypopnoea index (AHI). A patient with severe OSA without CPAP may only have an AHI indicative of mild or no OSA with CPAP. Obviously, an increase in the modality (CPAP) to treat the variable that is being investigated (increase in severity of OSA) will affect the results and mitigate any differences that may have been observed, if CPAP would not have been applied or not used. This only allows the conclusion that patients who were adequately treated for OSA with CPAP do not show an increased risk of postoperative complications.

Conflict of interest

P. Z.-G. is Speaker for Cadence, Speaker for Baxter, Shareholder Cadence, and Johnson & Johnson.

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Reply from the author

Editor—We wish to thank Dr Ziemann-Gimmel for his interest in our study examining the relationship between obstructive sleep apnoea (OSA) and complications in obese patients undergoing bariatric surgery. He raises two important questions. First, the overall number of patients undergoing laparoscopic gastric banding and sleeve gastrectomy surgeries comprised only 2.5% of our entire cohort (19 = bandings and 1 = sleeve). The length of stay after these two procedures was 1.6 days. In response to this letter, we performed an additional analysis of the length of stay among patients who underwent laparoscopic surgery excluding those patients who underwent banding and sleeve procedures. Mean length of stay with the new analysis was 3.9 days, compared with 3.7 days reported in our initial study. As with our initial reported analysis, length of stay did not vary by OSA severity (P = 0.27).