Postoperative outcomes after outpatient cancer procedures for super morbidly obese patients at a freestanding surgery center

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Abstract

Was this study was industry sponsored?

Introduction

The number and type of ambulatory procedures, including cancer procedures, has grown over the last few decades. This expansion involves inclusion of carefully selected higher risk patients, including morbidly obese patients. Evidence suggests that the rates of postoperative complications are comparable for nonobese and obese patients [1] as well as for morbidly (BMI >40 and < 50 kg/m2) and super morbidly obese (BMI ≥50 kg/m2).[2] Continuous evaluation of safety outcomes is key to offering more same-day discharge cancer procedures for morbidly obese patients, especially in freestanding outpatient settings lacking overnight capabilities and continuous positive airway

pressure machines.

We describe the characteristics and postoperative outcomes for super morbidly obese patients who underwent procedures at the Memorial Sloan Kettering (MSK) Cancer Center Monmouth, a freestanding oncologic ambulatory surgery center.

Methods

This retrospective study was approved by the institutional review board. MSK Monmouth is located over 50 miles away from the main hospital and offers mainly minor outpatient surgeries and interventional radiology procedures among other outpatient cancer services. From 1/2/2017 and 1/10/2023, 94 (0.5%) cases at MSK Monmouth included super morbidly obese patients (BMI >50 kg/m2); 23 patients received repeat procedures at MSK Monmouth.

Results

We obtained patient, procedure characteristics and postoperative outcomes. Table 1 contains the patient characteristics. Fifty one percent were either diagnosed or at risk for obstructive sleep apnea, however, it is possible some were undiagnosed. The majority were female (78%) and American Society of Anesthesiologists physical status 3 (93%).
Table 2 contains procedure characteristics. Interventional Radiology procedures accounted for 45% of cases (distribution of services in Figure 1). Fifty three percent of cases were with monitored anesthesia care; 2% converted to general anesthesia. Median post anesthesia case unit stay was 1.2 hours; there was only one case with prolonged stay (4.2 hours). There were no transfers and no same-day cancellations. The rates of adverse events, urgent care visits, and 30-day unanticipated hospital admissions were 1%, 6%, and 1% respectively. Of the six cases followed by one or more urgent care visits within 30 days after the procedure, three were likely procedure related. There were no adverse events attributable to anesthesia. There were no deaths within 30 days post procedure.

Conclusion

The reported postoperative adverse outcomes for super morbidly obese patients after outpatient cancer surgery and interventional procedures are comparable to the overall rates at MSK Monmouth (0.5% transfer rate; 2.4% 7-day urgent care visits; 2% 7-day unanticipated hospital admissions). Of note, planned procedures involving super morbid patients are flagged for closer evaluation and careful planning. This workflow and perioperative team collaboration allow super morbidly obese patients to receive outpatient cancer procedures with no added risk close to home.

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