



Il paziente in chirurgia bariatrica
e metabolica: il percorso
multidisciplinare
e la meta in un centro d'eccellenza

CASTELLANA GROTTE

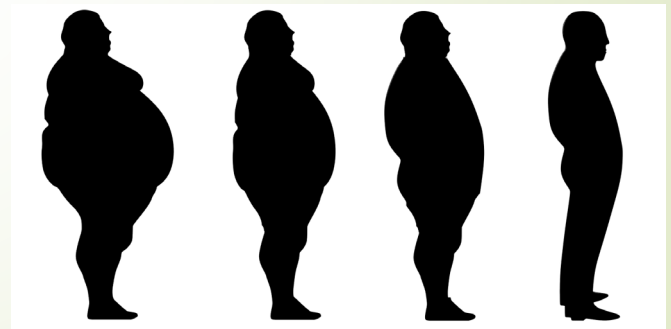
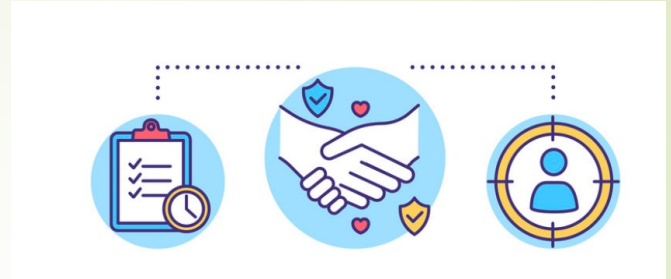
12 - 13 Giugno 2025

Presidenti: **C. Giardiello - R. Isernia**

Le dimissioni e il continuum care:
l'organizzazione infermieristica

Dott.ssa Luisa Cucinotta
Centro SICOB Messina
Direttore Prof. G. Navarro

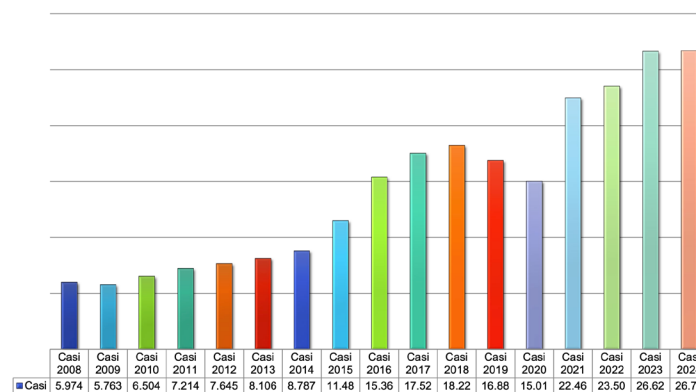
Le dimissioni e il continuum care: l'organizzazione infermieristica



- Crescita degli interventi bariatrici in Italia
- Impatto sul sistema sanitario
- Transizione ospedale-territorio come momento critico



Trend delle procedure eseguite dal 2008 al 2024



Non solo Chirurgia...

OBESITA'



TEAM
MULTIDISCIPLINA
RE



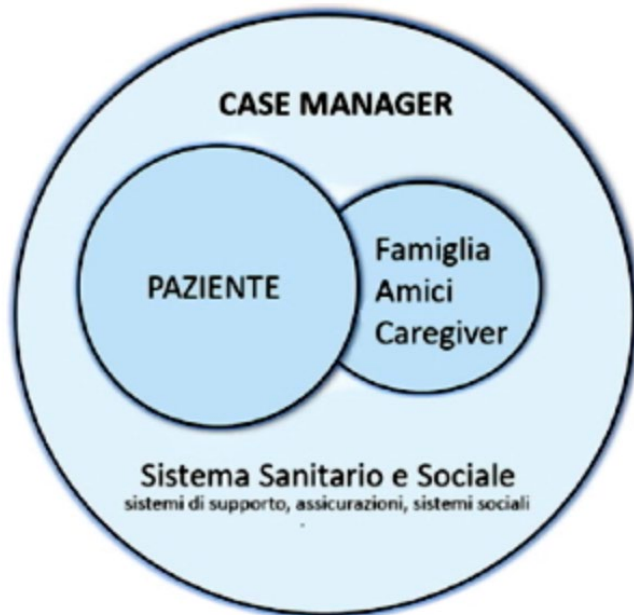


La dimissione: un momento strategico

- Passaggio strutturato
- Necessità di valutazione globale: clinica, nutrizionale, psicosociale
- Tempo, ascolto e pianificazione
- Corretta informazione

Compiti dell'infermiere

- Verifica dell'autonomia del paziente
- Educazione su fasi alimentari, attività fisica, segni d'allarme
- Attivazione follow-up e servizi territoriali



Follow - Up post intervento



24-48 h



Strumenti operativi

- ▶ PAI infermieristico personalizzato
- ▶ Check-list di dimissione
- ▶ Schede informative e diario del paziente
- ▶ Comunicazione strutturata con MMG e territorio

hospital discharge checklist

☐ Medication list	
☐ Follow-up appointments	additi
☐ Discharge summary	☐
☐ Instructions for care	☐
☐ Medical equipment	☐
☐ Prescriptions filled	☐
☐ Home care services	☐
☐ Transportation arranged	
☐ Insurance information	notes:
☐ Personal belongings gathered	
☐ Payment arrangements made	
☐ Dietary restrictions noted	
☐ Emergency contact information	
☐ Pain management plan	
☐ Wound care instructions	

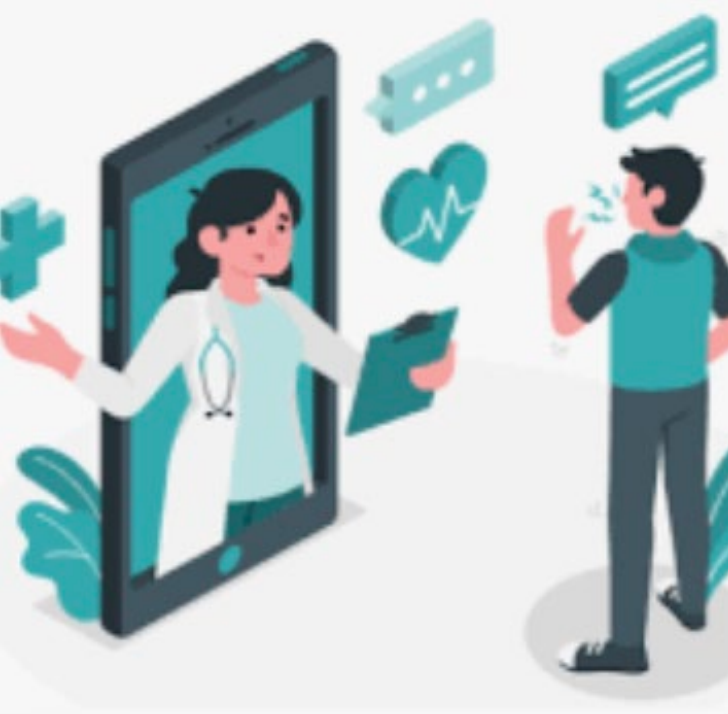
Il ruolo centrale del PDTA

Secondo Livello:

Centri spoke per la cura dell'obesità - ossia centri specialistici ambulatoriali o ospedalieri, pubblici o privati convenzionati, deputati alla valutazione del rischio e alla gestione di soggetti con obesità non in condizioni di criticità. I centri spoke sono composti da figure professionali multispecialistiche (specialista in scienza dell'alimentazione, internista, gastroenterologo, diabetologo, endocrinologo, dietologo, psicologo, **infermiere dedicato**) e possono essere dotati di una unità di chirurgia bariatrica e devono rispondere a criteri minimi di attività che possono essere individuati in 1500 prime visite/controlli per anno e un numero di interventi **>50 interventi annui**.

Requisiti centri terzo livello

- **Team multidisciplinare** (medico-paramedico-chirurgico) dedicato all'attività assistenziale del paziente obeso, composto da professionisti (internisti/endocrinologi, dietologi, dietisti, psicologi/psichiatri, chirurghi, anestesisti-rianimatori, **infermieri**) **con competenze specifiche e comprovata esperienza nel campo dell'obesità**, in grado di applicare tutti i percorsi diagnostico-terapeutici previsti dalle linee guida per l'obesità e per le complicanze ad essa associate (terapia dietetico-comportamentale, farmacologica, chirurgica).



I protocolli ERAS

- Ruolo centrale dell'infermiere nella fase post- dimissione, nella corretta adesione del paziente al follow-up e nel raggiungimento degli outcomes post operatori.

L'adozione del protocollo ERAS riduce il tempo di degenza senza aumentare il numero di complicanze o il tasso di riammissione^{1,8,40,372,380} (LE 2, RE B).

La dimissione in 1° giornata o in 2° giornata postoperatoria non aumenta il tasso di complicanze, di riammissioni ospedaliere, di consulti telefonici,^{4,5,371,384,385,398} in particolare in assenza di comorbidità significative^{187,188} (LE 1, RE A).

Il dosaggio di markers sierologici (proteina C reattiva, procalcitonina), assieme alla valutazione delle condizioni cliniche, può rappresentare un ausilio nel predire il rischio della insorgenza di complicanze postoperatorie^{183,184,185,186} (LE 1, RE A).

Tuttavia, alcuni markers non sono dosabili routinariamente presso tutti centri¹⁸⁷ e non c'è concordanza sul marker e sul timing del dosaggio rispetto alla giornata postoperatoria^{187,188,189,190} (LE 3, RE D).

Lo studio radiologico con mezzo di contrasto routinario postoperatorio aumenta i costi e prolunga la durata della degenza ospedaliera^{191,192}, non sembra in grado di fornire una valutazione attendibile delle complicanze postoperatorie e non è raccomandato^{193,194,195} (LE 2, RE D).

Studi clinici randomizzati dimostrano l'efficacia del protocollo ERAS nella riduzione della degenza media, dopo i principali interventi bariatrici. Una certa inconsistenza statistica è data dalla eterogeneità dei protocolli adottati nei diversi studi¹⁹⁶ (LE 2, RE B).

La dimissione il giorno dell'intervento è praticabile in pazienti selezionati.^{196,197} Il livello di sicurezza della dimissione il giorno dell'intervento è ancora dibattuto, e non è quindi raccomandata^{198,199} (LE 3, RE D).

Raccomandabile è l'adozione e la verifica in fase di dimissione di una Check-list di dimissione¹⁹⁵ (LE 3, RE B).

I criteri di dimissibilità dovrebbero comprendere almeno i seguenti:

- adeguato controllo del dolore mediante farmaci analgesici orali non oppioidi;
- parametri vitali nella norma (frequenza cardiaca <100 bpm, temperature corporea <37.6°C, frequenza respiratoria <20 atti/minuto);
- adeguato introito idrico (>1000-1500 mL di liquidi chiari per os), dieta liquida tollerata;
- non evidenza di sepsi o segni di complicanza postoperatoria (LE 4, RE C).

Alla dimissione il paziente deve essere istruito sui sintomi di possibile complicanza post-intervento e deve essere contattato telefonicamente dallo staff per monitorare il suo stato di salute^{54,385,55} (LE 2, RE B).



SIAARTI
PRO VITA CONTRA DOLORIS SEMPER





Criticità nella transizione ospedale-territorio

Frammentazione informativa

Poca formazione specifica sul paziente bariatrico

Scarso supporto familiare

Drop-out dal follow-up

Table 4. Comparison of physical function, general health, social function, emotional role, and mental health between the two groups (score, $\bar{x} \pm sd$)

Quality of life score	Research group (n=164)	Control group (n=164)	t	P
Physical function	78.22±11.32	65.79±9.30	10.865	<0.001
General health	91.62±10.21	85.51±12.27	4.902	<0.001
Social function	72.33±11.28	65.49±10.31	5.732	<0.001
Emotional role	63.86±9.23	55.96±7.24	8.624	<0.001
Mental health	68.56±10.22	57.46±7.41	11.261	<0.001

Table 2. Comparison of body weight, BMI and %EWL between the two groups ($\bar{x} \pm sd$)

Group	Body weight (kg)	BMI (kg/m ²)	%EWL	Fasting blood glucose (mmol/L)
Research group (n=164)	99.43±6.89	32.39±6.46	43.77±7.12	6.56±1.65
Control group (n=164)	110.96±5.04	37.05±5.44	33.51±6.76	7.75±3.03
t	-18.527	-7.081	10.876	-4.417
P	<0.001	<0.001	<0.001	0.002

Note: BMI: Body Mass Index; EWL: Excess Weight Loss Percentage.

Table 3. Comparison of dietary, exercise and rest compliance between the two groups [n (%)]

Group	Cases	Diet		Exercise		Rest
		Compliance	Non-Compliance	Compliance	Non-Compliance	
Research group (n=164)	164	40 (24.39%)	124 (75.61%)	35 (21.34%)	129 (78.66%)	124 (75.61%)
Control group (n=164)	164	135 (79.27%)	29 (17.73%)	34 (20.73%)	130 (79.27%)	29 (17.73%)
χ^2		96.853		140.853		96.853
P		<0.001		<0.001		<0.001

Am J Transl Res 2024;16(12):7582-7590
www.ajtr.org |ISSN:1943-8241/AJTR01556137

Original Article

Application value of continuous nursing in the treatment of obese patients with laparoscopic sleeve gastrectomy

Ling Deng, Nianling Li, Yinyin Fan

Department of Pancreatic and Metabolic Surgery, Nanjing Drum Tower Hospital, Affiliated Hospital of Medical School, Nanjing University, Nanjing 210006, Jiangsu, China

Received May 29, 2024; Accepted November 22, 2024; Epoch December 15, 2024; Published December 30, 2024

Nursing method: The control group received routine care, including initial assessments of body weight, blood sugar, and blood pressure by specialized weight reduction nurses, who also had preoperative discussions with patients and their families about precautions, monitored patients' activities and diet postoperatively, and provided guidance on wound care, dietary adjustments, and exercise before discharge.

The research group received continuous nursing on the basis of routine care, which included the following measures: (1) **Forming a project team comprising a 10-person continuous care team** consisting of the head of the surgical department, surgeons, head nurses, case managers (specialist nurses), endocrinologists, dietitians, and rehabilitation doctors; (2) **Establishing patient records** involving the

recording of patients' information such as name, admission number, age, diagnosis, date of surgery, type of surgery, admission and discharge times, treatment during hospitalization, physical recovery at discharge, contact phone number, and home address; (3) **Formulating and distributing health manuals** containing dietary, exercise, and psychological counseling, with an emphasis on consuming easy-to-digest foods, limiting mealtime to 20-30 minutes, recommending moderate exercise 30 minutes after meals, avoiding unrealistic expectations, and encouraging timely follow-up medical visits; (4) **Providing regular counseling services, including a 30-40 minute "face-to-face" counseling session for patients every two weeks after discharge, covering topics such as post-operative recovery, diet adjustment, exercise recommendations and psychological counseling [15].**

Effects of Nurse-Led Education on Quality of Life and Weight Loss in Patients Undergoing Bariatric Surgery

Betül Güven, RN, PhD,¹ and Neriman Akyolcu, RN, PhD²

TABLE 3. WEIGHT, BODY MASS INDEX, AND WAIST CIRCUMFERENCE MEASUREMENTS OF THE INTERVENTION AND CONTROL GROUPS OF PATIENTS AT 3 MONTHS AFTER SURGERY (N=102)

Variable	Intervention group (n=51) Mean ± SD	Control group (n=51) Mean ± SD	p ^a
Weight (kg)			
T2	97.35 ± 15.51	100.42 ± 19.47	0.562
T1–T2 change ^b	27.63 ± 5.82	26.24 ± 4.95	0.617
BMI (kg/m ²)			
T2	35.55 ± 4.66	36.78 ± 6.09	0.826
T1–T2 change ^b	10.82 ± 1.77	9.58 ± 1.43	0.564
Waist circumference (cm)			
T2	119.42 ± 11.53	120.88 ± 12.17	0.535
T1–T2 change ^b	17.67 ± 3.48	14.88 ± 3.84	0.001*

^aStudent's *t*-test.

^bPreoperative and postoperative change of patients' weight, BMI, and waist circumference measurements.
Paired samples test, **p* < 0.01.

Telephone follow-ups in the intervention group. Post-operative educational sessions consisted of calling patients in the intervention group by phone every 15 days after the surgery and collecting data by filling out the Post-Discharge Follow-up Form. The researcher conducted a total of six educational session, each lasting 30 to 60 min. After explaining the main objective of the phone calls, the patients were asked about their surgery-related health problems. In the case that patients were experiencing any surgery-related health problems or problems related to adaptation to medical treatment, nutrition regulations, or exercise regimes, the researcher provided additional education or directed the patient to his/her doctor or associated medical department.

The last interview (T2: postoperative period) with patients in the intervention group was conducted face-to-face in the 3 months after surgery. During these interviews, body weight and waist circumference were measured, and patients filled out the SF-36 and the Assessment Form for Nurse-led Educational Activities.

TABLE 2. SHORT-FORM HEALTH SURVEY (SF-36) SCORES OF THE INTERVENTION AND CONTROL GROUP OF PATIENTS (N=102)

Characteristic dimensions of SF-36	Intervention group (n=51) Mean ± SD	Control group (n=51) Mean ± SD	p ^a
Physical functioning			
T2	89.31 ± 8.40	81.57 ± 10.5	0.001**
T1–T2 change ^b	36.57 ± 20.70	24.02 ± 17.00	0.003**
Physical role			
T2	93.63 ± 14.90	75.00 ± 26.50	0.001**
T1–T2 change ^b	62.75 ± 36.20	26.47 ± 38.50	0.001**
Bodily pain			
T2	83.76 ± 18.80	73.51 ± 20.50	0.011*
T1–T2 change ^b	20.92 ± 23.60	11.90 ± 27.10	0.131
General health			
T2	82.57 ± 9.50	70.55 ± 18.40	0.001**
T1–T2 change ^b	44.31 ± 18.30	27.82 ± 23.00	0.001**
Vitality			
T2	80.29 ± 10.70	70.10 ± 12.40	0.001**
T1–T2 change ^b	29.51 ± 16.1	16.27 ± 18.60	0.001**
Social functioning			
T2	90.44 ± 13.10	83.09 ± 16.70	0.016*
T1–T2 change ^b	27.45 ± 25.70	17.16 ± 23.20	0.046*
Emotional role			
T2	92.81 ± 21.40	85.62 ± 30.00	0.250
T1–T2 change ^b	46.41 ± 49.90	20.91 ± 37.70	0.006**
Mental health			
T2	80.39 ± 11.60	72.63 ± 14.20	0.007**
T1–T2 change ^b	20.16 ± 15.80	14.98 ± 18.50	0.055

^aMann–Whitney *U* test.

^bPreoperative and postoperative change of Short-Form Health Survey (SF-36) subdimensions.

Wilcoxon Signed-Ranks test, **p* < 0.05; ***p* < 0.01.

T1, preoperative period; T2, postoperative period.



Ambulatory bariatric surgery: a prospective single-center experience

Abdulaziz Karam Ali¹ · Ali Safar¹ · Phil Vourtzoumis¹ · Sebastian Demyttenaere¹ · Olivier Court¹ · Amin Andalib^{1,2} 

Received: 21 April 2024 / Accepted: 6 July 2024 / Published online: 15 July 2024

© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2024

standard PACU discharge requirements [19]. The patients who were successfully discharged from PACU, had two early phone follow-ups by the surgical team (the surgeon or bariatric nurse) 4–6 h after discharge on the same night of surgery and the following morning on postoperative day (POD) 1 to screen for any alarming symptoms (including fever, shortness of breath, severe pain, inability to hydrate, and nausea/vomiting) that would necessitate the patient to present to the emergency department (ED). It should be

Nella chirurgia barbarica ambulatoriale, l'infermiere assume un ruolo chiave nel continuum care post-dimissione.



Same-Day Discharge After Laparoscopic Roux-en-Y Gastric Bypass: a Cohort of 500 Consecutive Patients

Suzanne C. Kleipool¹ · Leontien M. G. Nijland¹ · Steve M. M. de Castro¹ · Marlou Vogel² · H. Jaap Bonjer³ · Hendrik A. Marsman¹ · Pim W. J. van Rutte¹ · Ruben N. van Veen¹

Received: 28 October 2022 / Revised: 9 January 2023 / Accepted: 17 January 2023 / Published online: 24 January 2023

© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2023

Before discharge, all patients received an information sheet describing symptoms that require emergency consultation and the hospital's 24-h emergency telephone numbers. A pulse oximeter (Nonin Onyx Vantage 9590) and a tympanic thermometer (Covidien Genius 2) were provided to all patients. During 48 h postoperatively, patients were instructed to report on pain, heart rate, oxygen saturation, and body temperature three times a day on their information sheet, in order to detect early complications. In case of severe pain (numeric rating scale > 4), hematemesis, rectal blood loss, or divergent vital signs, patients had to reach out to the hospital. Patients were contacted by telephone by their surgeon on postoperative day (POD) 1, for assessment of potential complications. On POD 2 or 3, patients had an appointment at the outpatient clinic for a thorough medical check-up by a specialized bariatric nurse.

Original article

Implementation of a same-day discharge bariatric surgery program and follow-up with a telemonitoring platform



Albert Caballero,^{a,b,*} Jordi Tarascó,^{a,b} Pau Moreno,^{a,b} Laura López-Vendrell,^c Sílvia Pellitero,^d Eva Martínez,^d Glòria Bonet,^e José M. Balibrea^{a,b,f}

^a Unidad de Cirugía Endocrino-Metabólica y Bariátrica, Hospital Universitario Germans Trias i Pujol, Spain

^b Universitat Autònoma de Barcelona, Spain

^c Servicio de Cirugía General y Digestiva, Hospital Universitario Germans Trias i Pujol, Spain

^d Servicio de Endocrinología, Nutrición y Dietética. Hospital Universitario Germans Trias i Pujol, Spain

^e Unidad de Hospitalización Domiciliaria, Hospital Universitario Germans Trias i Pujol, Spain

^f Cátedra de Investigación en Cirugía iVascular-UAB, Spain



Figure 2 – REVITA® telemonitoring device.

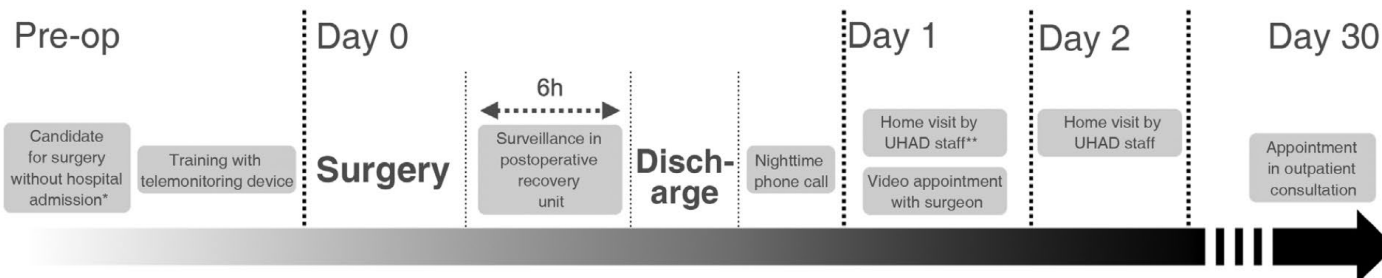


Figure 1 – Bariatric surgery circuit, without hospital admission.

Buone pratiche infermieristiche post-dimissione



FOLLOW-UP
TELEFONICO DOPO
24/48H



DIARIO ALIMENTARE E
IDrataZIONE



TELEASSISTENZA
INFERMIERISTICA
PROGRAMMATA



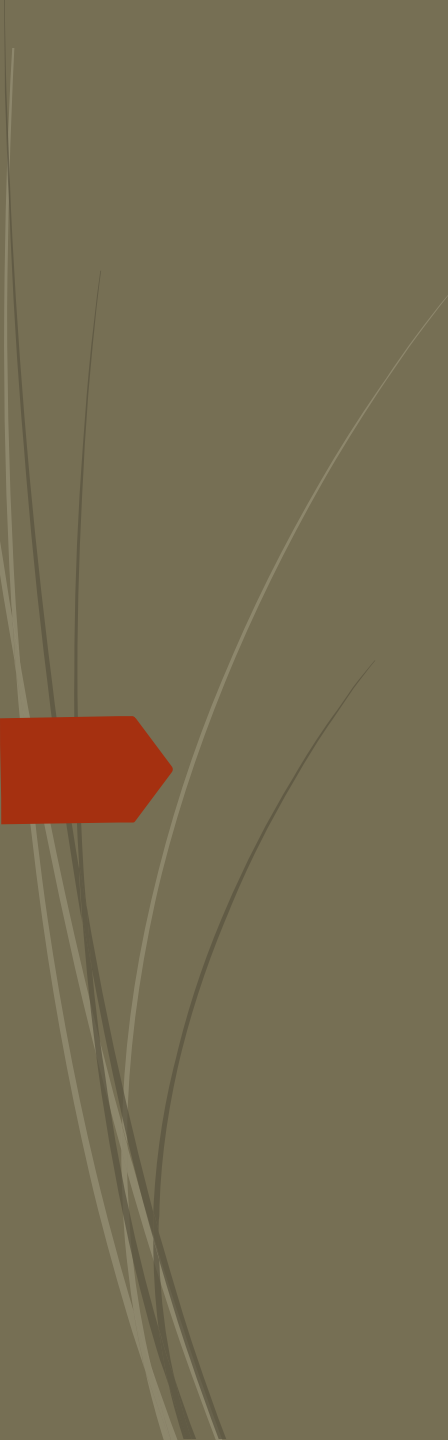
EDUCAZIONE
CONTINUA E
COINVOLGIMENTO
DEL CAREGIVER

Focus: Educazione del paziente

- Individualizzata, multicanale, iterativa
- Temi chiave: alimentazione, attività fisica, integrazione, cura della ferita, segni di allarme, gestione del dolore

Conclusioni

- L'infermiere è essenziale per garantire continuità di cura e sicurezza
- Favorisce empowerment e prevenzione delle complicanze
- Serve investire in formazione e percorsi integrati



Grazie per
l'attenzione