Very often while we are teaching in our informational seminars or during our support meetings I am asked the same question:

How long in advance of my surgery do I need to quit smoking?

And the very next question is often:

How long after my procedure I can start smoking again?

For this newsletter I feel compelled to talk a little about this.

Recently the *Bariatric Times* published a great article by Dr. Windover, a Psychologist at the Cleveland Clinic. In her article she clearly describes that tobacco use persists as the leading cause of preventable death in the United States and the world[1,2] and that the prevalence of its use among bariatric surgery candidates is similar to, if not greater than, the general population with estimates ranging from 12.9 to 38 percent.[3-7]

Tobacco use is a well-documented surgical risk factor.[8] Substantial research has examined the impact of tobacco use on bariatric surgery in particular. For instance, while the mortality risk associated with bariatric surgery is generally low (less than 1%),[9] death is twice as likely for active tobacco users.[5]

A history of and/or active smoking has also been shown to increase the risk of developing postoperative complications among bariatric surgery patients.[10] Patients who smoked within one year of having bariatric surgery, compared to their nonsmoking counterparts, were 1.5 times more likely to develop any surgery-related problem within one month of having surgery,[11] including increased risk for venous thromboembolism (VTE).[12]
In fact, research has demonstrated that the risk for VTE persists at least six months after surgery.[13]

Smoking can potentially disrupt breathing capacity and lung function in patients. Research reveals an association between tobacco use and respiratory complications following bariatric surgery. Patients who smoked cigarettes within one year of having bariatric surgery were at increased risk for developing pneumonia.[14] In a study of 575 veterans who underwent bariatric surgery,[6] patients who had not smoked in the year prior to surgery, but reported a 20-pack year history were at greater risk of failing to wean from the ventilator within 48 hours of surgery compared to their counterparts with no smoking history (5.8 percent vs. 1.8 percent, respectively). Patients who smoked within one year of surgery and reported a 20-pack year history demonstrated an astounding 11.1 percent rate of failure to wean from the ventilator machine and an overall complication rate of 26.7 percent compared to 1.8 and 19.7 percent, respectively, for their no smoking history counterparts.[6]

Smoking, defined as smoking one or more cigarettes per day, was shown to increase the likelihood of developing marginal ulcers (ulcers that are located at the area of the surgical connection) and wound leakage postoperatively.[15] A history of or active tobacco use was also shown to predict not only the development but also recurrence of marginal ulcers up to 12 months after bariatric surgery.[16] Slower rates of wound healing and infection have been noted more generally among surgery candidates who use tobacco.[17-19]

With higher complication rates during and after surgery, the potential for prolonged hospitalization also increases.[14]

Preliminary research suggests patients who smoke within a month of surgery may also require higher dosing of opioid medication for postoperative pain management [20] making it even more challenging to control the incisional pain that our patients experience after the bariatric operations.

So to summarize, the increase risk of mortality, 30-day morbidity, venous thromboembolism (VTE), respiratory and pulmonary complications, marginal ulcers, and slowed/poor wound healing are only some of the reasons why we are so emphatic about our patients quitting smoking prior to their weight loss procedures.

With the adequate support we hope that once they decide to quit smoking, they will remain tobacco free for the long run as they become healthier in their bariatric journey.

“Weight Loss Surgery and Tobacco Use”
By Leonardo Claros, MD, FACS, FASMBS
References


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