



IFSO ACCEPTED DEFINITIONS FOR PUBLICATIONS

People's first language/ IFSO accepted nomenclature:

- Eliminate "success/failure" "recidivism" "non-compliant" "gold-standard" "last-resort" sort of language
- Imagery (no headless, stereotypical/stigma = takeaway boxes, fast food, ill-fitting clothes, etc.)

New reporting standards and nomenclature to use as Obesity Surgery Journal/ IFSO policy:

Old and not accepted per Journal Policy	New replacement nomenclature
Morbid obesity	Severe obesity
Obese	Patient or individual with obesity
Subject/s	Patient/s or individual/s
Comorbidity/ies	Obesity complication/s. Comorbidity/ies can only still be used for medical problems that are seen in patients with obesity but not directly caused by obesity as defined by the medical community
Weight loss surgery	Bariatric & metabolic surgery
Super or super-super obesity	Please use Body Mass Index reference BMI>50 or BMI>60 to refer to this patient population respectively
Gold standard	Avoid using this term please
Revision procedure	'Revision or modification' for any procedure that does not encompass conversion to a new procedure with a new mechanism of action or reversal of the anatomy. Revision or

	encompasses correction or an enhancement of the same procedure (revision of a gastric pouch, <u>distalization</u> of gastric bypass)
Conversion procedure	'Conversion' entails converting one <u>procedure</u> to another with a different mechanism of action. Revision is not accepted as a substitution anymore
Reversal procedure	Term can still be used to describe reversing a procedure to the normal standard anatomy
Insufficient or inadequate weight loss	'Suboptimal initial clinical response' encompasses maximum total weight loss outcome (TWL%) <20%, while also covering no improvement or worsening of any obesity complication that was present preoperatively
Weight loss failure	Failure is not an acceptable term anymore. Use suboptimal initial clinical response if fits <u>this criteria</u>
Adequate weight loss	Optimal initial clinical response which follows the criteria of TWL% >20% and/or improvement of obesity complication/s
Success	Term is not acceptable anymore. Please use Optimal initial clinical response for primary procedures or optimal clinical response for

REPORTING DEFINITIONS

A suboptimal initial response to metabolic/bariatric surgery (MBS) is demonstrated either by inadequate weight loss OR by an unusually modest improvement in a significant obesity complication.

A late post-operative clinical deterioration is demonstrated either by recurrent weight gain OR by worsening of a significant obesity complication that occurs after an initially adequate post-operative clinical response.

The degree to which the clinical response to MBS is suboptimal or there is a late post-operative clinical deterioration can vary widely from patient to patient. The severity of the suboptimal response should guide clinical treatment.

The baseline weight for assessing weight loss after MBS should be a weight determined before starting preoperative weight reduction.

In patients who have been treated with AOM before undergoing MBS, who STOP it at the time of or shortly after surgery, the baseline weight for assessing the effect of surgery on bodyweight should generally be a weight determined BEFORE the AOM was started.

In patients who have been treated with AOM before undergoing MBS and CONTINUE this medication post-op., the baseline weight used to assess the effect of surgery on body weight should generally be measured on the day of surgery.

The initial surgical weight loss (defined as maximum weight loss within the first 2 years after MBS) should be determined in a manner that excludes any post-plateau weight loss caused by adding AOM, any endoscopic intervention, or any calorie-restricted diet.

Surgical or endoscopic procedures to convert to a new type of metabolic/bariatric operation (conversion surgery) and those to re-establish normal anatomy (reversal surgery) should be clearly distinguished and considered separately from procedures to modify or enhance the effects of a previous operation (revision or modification surgery).

Modification or revision procedures are typically designed to optimize the effectiveness of previous operations, while conversion procedures most commonly introduce additional mechanisms of therapeutic action.

The term "obesity complication" mostly describes diseases, conditions, and symptoms for which there is published evidence that obesity is a contributing cause or exacerbating factor. When such a causative relationship has not been established or accepted, the associated disorder is more accurately labelled an obesity comorbidity.

When considering the effects of MBS on intestinal nutrient absorption, diminished absorption (hypo-absorption or malabsorption) of micronutrients should be clearly distinguished from the hypo-absorption or malabsorption of macronutrients or ingested calories.

Characterization of the absorptive effects of an MBS procedure should not be used to imply that these effects are the mechanisms of action of weight loss associated with the operation. It is preferable to describe such procedures by their anatomical features (e.g., "bypass," "diversion," or more generally, "gastrointestinal") rather than by their inferred mechanism of action.

Characterization of the changes in the physical structure of the gut produced by an MBS procedure – including the size & shape of GI segments or anastomoses – should not be used to imply that these changes "restrict" food intake as a mechanism of associated weight loss. It is preferable to describe such procedures by their anatomical features (e.g., "gastrectomy," "banding" or, more generally, "gastric") rather than by their inferred mechanism of action.

REPORTING STANDARDS

In general, a suboptimal initial clinical response to MBS is demonstrated either by total body weight or BMI loss of less than 20% OR by inadequate improvement in an obesity complication that was a significant indication for surgery.

In general, a late post-operative clinical deterioration after MBS is demonstrated either by recurrent weight gain of more than 30% of the initial surgical weight loss OR by worsening of an obesity complication that was a significant

MBS = metabolic-bariatric surgery; AOM = anti-obesity medication; GI = gastrointestinal; BMI = body mass index.