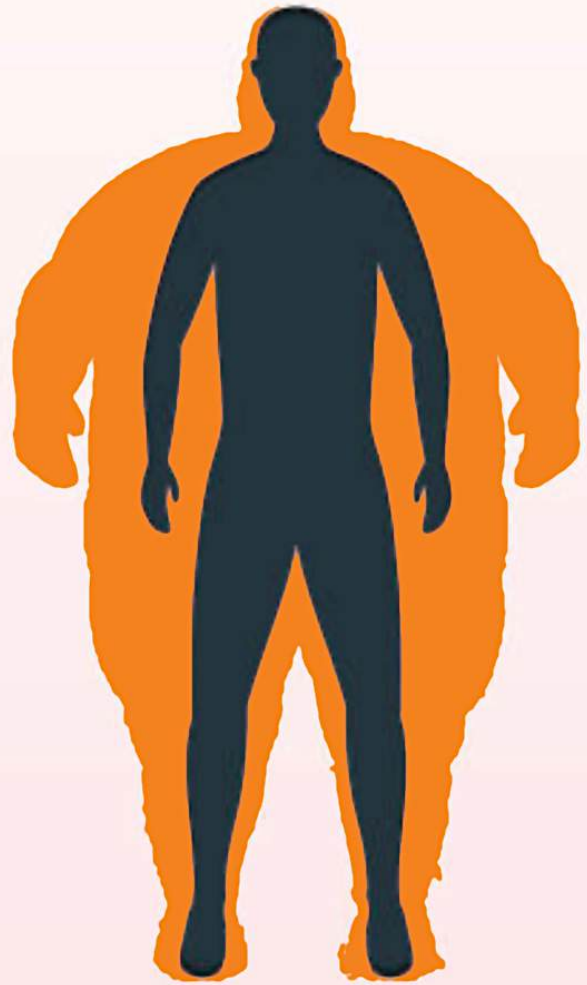


**OSSI**

**OBESITY AND  
METABOLIC  
SURGERY  
SOCIETY  
OF INDIA**



# **OSSI GUIDELINES FOR BARIATRIC AND METABOLIC SURGERY**

Version - 3

## Preamble

India is the largest hub for bariatric and metabolic surgery in Asia. As the national body of bariatric and metabolic surgeons in India, OSSI is committed to improving the quality of care and setting standards for its practice. These revised guidelines supersede the 2023 edition and are aligned with the landmark 2022 ASMBS/IFSO joint guidelines and the IFSO-Asia Pacific Chapter (IFSO-APC) Consensus Statements. They recognize the unique metabolic phenotype of South Asian patients, who carry a disproportionate burden of obesity-related comorbidities at lower BMI thresholds than Western populations.

These guidelines postulate:

- Obesity is a chronic, progressive, relapsing disease and not merely a lifestyle disorder.
- Bariatric and metabolic surgery (MBS) are gastrointestinal surgeries that improve, prevent and/or treat obesity and its comorbidities, including type 2 diabetes mellitus (T2DM).
- MBS is a life-altering and potentially life-saving intervention — not cosmetic surgery.
- Asian, and particularly Indian, patients require more aggressive thresholds for intervention due to higher morbidity and mortality at lower BMI values.
- Current MBS procedures work via restriction, metabolic/hormonal modulation, and/or selective malabsorption.
- Metabolic surgery for T2DM and metabolic syndrome has anti-diabetic effects independent of weight loss.
- Anti-obesity medications (AOMs), including GLP-1 receptor agonists, are complementary to — not a replacement for — MBS in appropriately selected patients.

## Section 1: Indications for Surgery

### 1.1 BMI-Based Criteria (Asian/Indian Thresholds)

OSSI upholds the BMI-based criteria established by the 2022 ASMBS/IFSO guidelines, adapted for the Asian population in accordance with the IFSO-APC Consensus. In Asian individuals, a BMI of 25 kg/m<sup>2</sup> or above denotes clinical obesity, and the following surgical thresholds apply:

| BMI Threshold            | Indication               | Comorbidity Requirement                                          |
|--------------------------|--------------------------|------------------------------------------------------------------|
| ≥ 27.5 kg/m <sup>2</sup> | MBS may be recommended   | Life-threatening disorders like T2DM, OSA or cardiomyopathy      |
| ≥ 30 kg/m <sup>2</sup>   | MBS may be recommended   | T2DM or metabolic syndrome inadequately controlled               |
| ≥ 32.5 kg/m <sup>2</sup> | MBS recommended          | Presence of at least one significant obesity-related comorbidity |
| ≥ 35 kg/m <sup>2</sup>   | MBS highly recommended   | With or without obesity-related comorbidities                    |
| ≥ 37.5 kg/m <sup>2</sup> | MBS strongly recommended | Comorbidities not required for consideration                     |

Note: The 27.5 kg/m<sup>2</sup> threshold applies primarily to patients with T2DM or metabolic syndrome inadequately controlled by lifestyle modification and pharmacotherapy, consistent with IFSO-APC guidance and the 2024 IFSO/ASMBS scientific evidence update. Surgery at BMI 27.5-30 kg/m<sup>2</sup> without metabolic comorbidity is not currently supported by sufficient evidence.

## 1.2 Waist Circumference as an Adjunct Criterion

In recognition of the central adiposity pattern prevalent in Indians, OSSI continues to endorse waist circumference as an additional criterion:

- Waist circumference 80 cm or more in females, or 90 cm or more in males, in the presence of obesity-related comorbidities may support the decision to proceed with surgery, even in patients at the lower end of the BMI range.

## 1.3 General Patient Selection Criteria

- Patient must be motivated to achieve sustainable weight loss and committed to long-term multidisciplinary follow-up.
- Prior documented failure of conservative weight management (structured lifestyle modification, dietary intervention, pharmacotherapy for 6 months or more) is preferred, except in patients with life-threatening comorbidities where urgent surgical intervention is warranted.
- Comprehensive pre-operative multidisciplinary assessment is mandatory, including surgical, medical/endocrinological, nutritional, psychological, and anaesthetic evaluation.
- Patient must be able to understand the risks, benefits, and long-term requirements of MBS, and provide informed consent.

## 1.4 Age Considerations

- Adults (18-65 years): Standard indication range.
- Patients above 65 years: MBS may be considered in the presence of severe obesity-related comorbidities or disability. Risk-benefit assessment by a multidisciplinary team (MDT) is mandatory. Biological age and functional status should be considered over chronological age.
- Patients below 18 years (Adolescents): MBS may be considered for appropriately selected adolescents, consistent with 2022 ASMBS/IFSO guidance, when:
  - BMI is 35 kg/m<sup>2</sup> or above with significant comorbidity, or 40 kg/m<sup>2</sup> or above with or without comorbidity;
  - Skeletal maturity has been achieved (Tanner stage IV or above, or bone age 13 years or above in females, 15 years or above in males);
  - Formal paediatric/endocrinology certification and psychological clearance are obtained;
  - The patient and family demonstrate capacity for informed consent and commitment to long-term follow-up.

## 1.5 Metabolic Surgery for T2DM

Metabolic surgery should be considered a therapeutic option for T2DM management in Indian patients when diabetes is inadequately controlled despite optimal medical therapy, at the following BMI thresholds:

- BMI 32.5 kg/m<sup>2</sup> or above: MBS recommended.
- BMI 30-32.4 kg/m<sup>2</sup>: MBS recommended if diabetes is uncontrolled and life-threatening.
- BMI 27.5-29.9 kg/m<sup>2</sup>: MBS may be considered under clinical study protocol with ethics committee approval and patient informed consent (IFSO-APC).
- BMI 27.5 kg/m<sup>2</sup> or below: MBS for metabolic indications must be performed strictly within a clinical study protocol with ethics committee and ICMR approval.

## Section 2: Contraindications

### 2.1 Absolute Contraindications

- Active substance use disorder (alcohol or drugs). Psychiatrist clearance must be obtained.
- Uncontrolled or unstable psychiatric illness that precludes informed consent or compliance with post-operative requirements (e.g., active psychosis, severe uncontrolled depression or eating disorder).
- Pregnancy — surgery must be deferred until after delivery and completion of breastfeeding.
- Inability to comply with nutritional requirements or long-term follow-up.
- Malignancy with life expectancy less than 5 years (unless palliative/quality-of-life indication is specifically discussed by MDT).

### 2.2 Relative Contraindications (requiring MDT review)

- Unstable cardiovascular disease — requires cardiac optimization prior to surgery.
- Severe gastroparesis or oesophageal dysmotility — procedure selection must be individualized.
- Significant coagulopathy or bleeding diathesis.
- Portal hypertension or severe hepatic disease.
- Autoimmune or inflammatory bowel conditions — risk-benefit discussion required.

## Section 3: Accepted Bariatric and Metabolic Procedures

### 3.1 Standard Procedures

The following procedures have established safety and efficacy data and are endorsed by IFSO, ASMBS, and IFSO-APC:

- Sleeve Gastrectomy (SG / VSG)
- Roux-en-Y Gastric Bypass (RYGB)
- One Anastomosis Gastric Bypass (OAGB / MGB)
- Biliopancreatic Diversion with Duodenal Switch (BPD-DS)
- Single Anastomosis Duodeno-Ileostomy with Sleeve Gastrectomy (SADI-S / SADS)

Note: Adjustable Gastric Band (AGB) is no longer recommended as a primary procedure due to significant long-term failure and complication rates. Its use should be restricted to exceptional clinical circumstances with full MDT agreement.

### 3.2 Revision and Conversion Surgery

Revision bariatric surgery is appropriate for:

- Insufficient weight loss or weight regain after primary MBS.
- Resolution of comorbidities that is inadequate or short-lived.
- Complications of a primary procedure (e.g., band erosion, slippage, severe GORD after sleeve gastrectomy).

Revision surgery must be performed by surgeons with specific expertise and experience in revisional MBS, at a Centre of Excellence with appropriate infrastructure.

### 3.3 Non-Standard and Experimental Procedures

- Procedures published by an Indian author in a peer-reviewed journal are eligible as non-standard procedures under OSSI guidelines.
- All other unpublished procedures are classified as experimental/novel and may only be performed under a clinical trial approved by a recognised ethics committee (ICMR), with registration on clinicaltrials.gov or CTRI ([www.ctri.nic.in](http://www.ctri.nic.in)).

### 3.4 Endoscopic Bariatric Procedures

Endoscopic bariatric and metabolic therapies (EBMTs), including Endoscopic Sleeve Gastroplasty (ESG), Stomal reduction (ESR), Intragastric balloon (IGB), and other endoluminal procedures, represent an emerging complementary option. They may be appropriate for:

- Patients who do not meet BMI criteria for surgery but require weight management support.
- As a bridge to definitive surgery in super-obese patients.
- Patients who decline or are unfit for surgical intervention.

EBMTs should be performed by credentialed endoscopist / surgeon as a part of structured program.

## Section 4: Multidisciplinary Team and Pre-operative Assessment

All MBS ideally must be delivered within a structured, multidisciplinary bariatric program. An ideal MDT must include:

- Bariatric/Metabolic Surgeon
- Physician / Endocrinologist / Diabetologist
- Registered Dietitian / Clinical Nutritionist
- Psychologist / Psychiatrist / Behavior Therapist
- Anaesthesiologist with bariatric experience
- Nurse Coordinator or Patient Navigator

Additional specialists (Cardiologist, Pulmonologist, Hepatologist, Pediatrician, Gynecologist, Gastroenterologist, orthopedician, etc) should be involved as indicated by patient profiles.

### Pre-operative Evaluation Must Include

- Complete clinical assessment including body composition analysis (BMI, BMR, WC, WHR, SMM, PBF, Visceral fat, etc).
- Biochemical profile: CBC, FBS, HbA1c, Insulin (F), Lipid profile, LFT, RFT, Thyroid profile, Vitamin B12, D, Iron studies, Folate, Calcium, Zinc, Prolactin, Cortisol, PTH, etc.
- Cardiopulmonary assessment: ECG, 2D Echocardiogram, Polysomnography (PFT)/sleep study for OSA screening.
- Abdominal ultrasound.
- Upper GI endoscopy as indicated.
- Psychological evaluation.
- Nutritional counseling.

OSSI endorses its separately published Guidelines on Bariatric and Metabolic Surgery for guidance.

## Section 5: Anti-Obesity Medications and MBS

Anti-obesity medications (AOMs), particularly GLP-1 receptor agonists (e.g., semaglutide, liraglutide) and dual/triple agonists (Tirzepatide), are an important adjunct in obesity management. OSSI recognizes the following positions, consistent with the 2024 IFSO consensus and 2026 OSSI-ESI joint consensus on AOMs and MBS:

- AOMs as bridge to surgery: GLP-1 RAs may be used pre-operatively to reduce operative risk in super-obese patients, reduce liver size, and improve glycaemic control. Cessation at least 1-2 weeks before surgery is recommended to reduce aspiration risk.
- AOMs as adjunct post-surgery: In patients with suboptimal weight loss or weight recurrence after MBS, AOM therapy may be used as an adjunct to re-establish metabolic control.
- AOMs are not a replacement for MBS in patients who meet surgical criteria and have no contraindications to surgery. Long-term durability of AOMs alone remains significantly inferior to MBS.
- Combined therapy: Evidence for concurrent AOM use with MBS is emerging. Decisions should be made on an individual MDT basis.

OSSI endorses its separately published Position Statement on Anti-Obesity Medications and Obesity Management for detailed guidance.

## Section 6: Post-operative Care and Long-term Follow-up

### 6.1 Nutritional Supplementation

Long- term. Mostly life-long nutritional supplementation is mandatory after all MBS procedures. Minimum recommended supplementation:

- Vitamin B12.
- Vitamin D3 and Calcium.
- Iron.
- Additional supplementation (thiamine, zinc, copper, folate) as indicated by periodic laboratory monitoring

### 6.2 Follow-up Schedule

- Post-operative follow-up: 1 week followed by 1, 3, 6, 12, 18, 24 months and then annually.
- Annual laboratory monitoring: CBC, Metabolic panel, HbA1c, Lipids, Liver enzymes, Vitamin B12, D, Folate, Iron studies, and PTH.
- Dietary counseling at every follow-up visit.
- Psychological support as needed.
- Long-term follow-up should continue indefinitely - patients must be counseled on this at the time of surgery.

### 6.3 Pregnancy After MBS

- Pregnancy must be planned and contraception to be used for a minimum of 12-18 months after surgery or until weight stabilization is achieved, whichever is later.
- Artificial reproductive technology (ART) may be initiated 12 months after surgery.

- All pregnancies post-MBS are high-risk and require joint obstetric and bariatric monitoring with enhanced nutritional supplementation.
- Screening for gestational diabetes, nutritional deficiencies, and foetal growth restriction is mandatory.

## **Section 7: Surgeon Credentialing and Centre of Excellence**

- Centres performing MBS are encouraged to apply for OSSI Centre of Excellence (COE) designation, which requires compliance with infrastructure, volume, and quality outcome standards.
- OSSI members are expected to maintain active participation in the OSSI National Registry to contribute to quality benchmarking and outcomes research.
- Clinical studies involving novel procedures or interventions outside these guidelines must be registered on ClinicalTrials.gov or CTRI and must receive prior ICMR-approved ethics committee clearance.

## **Section 8: Alignment with International Guidelines**

These OSSI guidelines are developed in alignment with and reference to the following current international guidelines:

- 2026 Treatment Algorithm for Patients with Obesity in India: A Joint Consensus by Endocrine Society of India (ESI) & Obesity and Metabolic Surgery Society of India (OSSI)
- 2024 IFSO/ASMBS Scientific Evidence Update — Provides strengthened evidence base for the 2022 recommendations across all BMI classes including Asian populations.
- IFSO Consensus on Anti-Obesity Medications and MBS 2024 — Guidance on GLP-1 RA integration with surgical care.
- 2022 ASMBS/IFSO Indications for Metabolic and Bariatric Surgery — The landmark update replacing the 1991 NIH guidelines; endorsed by OSSI as the primary international reference.
- IFSO-APC Consensus Statements 2011 — Asia Pacific-specific BMI thresholds and metabolic surgery criteria; remains the foundational regional reference.

OSSI encourages all members to refer to the guidelines of IFSO, ASMBS, and BOMSS, accessible through their respective official websites, as complementary reference documents.

### **Disclaimer**

These guidelines represent the current consensus of the OSSI Executive Committee and are intended as a framework for clinical decision-making. They do not replace individualized clinical judgement. OSSI guidelines are reviewed and updated regularly in accordance with emerging evidence.

For the complete published OSSI guidelines document and position statements, visit: [www.theossi.com/guidelines](http://www.theossi.com/guidelines). You can also reach us through [info@theossi.com](mailto:info@theossi.com).