

ONLINE EXCLUSIVE

**A skeptic's view
of bariatric surgery**

Like *JFP's* Editor-in-Chief, Dr. John Hickner, I have been skeptical about bariatric surgery (A [former] skeptic's view of bariatric surgery. *J Fam Pract.* 2018;67:600), but I will recommend it for a select few patients who are unable or unwilling to undergo significant lifestyle changes. My experience in clinic has done nothing to change this skeptical view. I have many patients who opted for bariatric surgery, but did not change their lifestyle habits. These patients often regain weight and accumulate chronic diseases 2 to 7 years postop. In the end, if a patient does not change their lifestyle, bariatric surgery can push the consequences of obesity out 5 to 10 years, but at a very significant risk.

The most significant problem I see is that many primary care providers do not feel qualified to impart meaningful lifestyle recommendations to patients, which often leads to guidance that is inadequate and, in some cases, inaccurate. Furthermore, assuming patients have received evidence-based instructions, they often lack the support and means to apply these lifestyle changes. I would be very hesitant to recommend bariatric surgery before addressing all of these concerns.

An interesting study done by Lingway et al¹ showed that postsurgical starvation (600 kcal/d) without the bariatric surgery had better short-term outcomes than surgery with calorie restriction, which suggests that a period of starvation is better than surgery.

In general, the results of evidence-based lifestyle changes far surpass any medical or surgical treatment for obesity and its associated chronic diseases. The evidence for this is overwhelming. (See books by Drs. Joel Fuhrman, Michael Greger, Neal Barnard, Dean Ornish, and Garth Davis, as well as the hundreds of peer-reviewed studies cited in these books.) Yet most patients undergoing bariatric surgery never receive proper instructions or attempt any meaningful lifestyle changes.



I think it is far more prudent to refer potential surgical candidates to someone who understands good nutrition and lifestyle changes, such as a doctor certified by the American College of Lifestyle Medicine (lifestylemedicine.org). Surgery, in my opinion, is a very poor and dangerous second choice.

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**Another look at overdiagnosis/
remission of asthma**

I appreciated the PURL, "Should you reassess your patient's asthma diagnosis?" (*J Fam Pract.* 2018;67:704-707) that reminded clinicians to taper asthma controller medications in asymptomatic patients. The articles cited^{1,2} by Drs. Stevermer and Hayes documented that one-third of the adults enrolled in the respective study with physician-diagnosed asthma did not have objective evidence for asthma and were either over-diagnosed or had remitted. These articles also contained evidence that: 1) over-diagnosis was likely much more common than remission,¹ and 2) there was a significant temporal trend towards increasing over-diagnosis/remission during the last several decades. The authors of the cited article¹ suggested that the temporal trend could be explained by increased public awareness of respiratory symptoms, more aggressive marketing of asthma medications, and a lack of objective measurement of reversible airway obstruction in primary care. These assertions deserve careful consideration as we strive to diagnose asthma appropriately.

Over-diagnosis/remission is almost certainly not as prevalent (33%) as the authors of the cited articles^{1,2} reported. The reason is simple selection bias: 1) the cited study² excluded asthma patients who smoked >10 pack-years (it enrolled 701 asthma patients and excluded



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Heat-not-burn aerosols deliver many of the same dangerous compounds as traditional cigarettes, including carbon monoxide, tar, and aromatic hydrocarbons.

812 asthma patients with a >10 pack-year smoking history), and 2) this study likely did not include asthma patients with the asthma-COPD overlap syndrome, which is treated as asthma and comprises an additional 30% of our patients with chronic airflow limitation (the asthma-COPD spectrum).³ Asthma patients who smoke and/or have the overlap syndrome are prone to severe asthma that is refractory to inhaled corticosteroids.^{3,4}

In addition to making the correct diagnosis, it is equally important to be aware of efficacious therapies for severe refractory asthma that primary care clinicians can easily use. There is now good evidence that azithromycin is efficacious for severe refractory asthma⁵ and should be considered prior to referral for immunomodulatory asthma therapies.⁶

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Authors' response

We appreciate Dr. Hahn's observations about the PURL¹ on overdiagnosis of asthma. This article focused on the results of a prospective, multicenter cohort study² that evaluated the feasibility of tapering, and in many patients, stopping asthma medications. We agree that if the study had included people diagnosed with asthma who also had smoked at least 10 pack-years or who also had COPD, the proportion of those who would eventually no longer meet diagnostic criteria for asthma would be lower than in this study. We are

uncertain of the relative proportion of cases that were overdiagnosis, when compared with true remission of disease, as only 43% of those no longer meeting the diagnostic criteria for asthma had evidence of prior lung function testing, whether by formal spirometry, serial peak function testing, or bronchial challenge testing.

We agree that using efficacious therapies for severe refractory asthma is essential, but the selection of those therapies was outside the scope of this PURL.

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We must counsel against heat-not-burn cigarettes

Tobacco companies are marketing a new version of cigarettes dubbed heat-not-burn (HNB) cigarettes.^{1,2} Offered as a "modified-risk tobacco product," HNB cigarettes utilize a lithium battery-powered heating element and are available all over the world.^{1,2} Like conventional smokes, they contain tobacco, but deliver nicotine by heating leaves at 350° C rather than burning them at 600° C.¹⁻³ Heating the tobacco produces an inhalable aerosol with tobacco flavor and nicotine, without smoke. These HNB cigarettes are also different from e-cigarettes that aerosolize a liquid.

Tobacco companies contend that HNB cigarettes are safer than smoking tobacco.¹ Consumers inhale a heated tobacco aerosol that reportedly contains less nicotine and fewer toxicities; yet, HNB are not independently substantiated as being healthier, nor proven safe.¹⁻⁵ Thermal decomposition, rather than combustion, may afford a less dangerous nicotine consumption; however, HNB aerosols deliver many of the same dangerous compounds as traditional cigarettes, including carbon monoxide, tar, and aromatic hydrocarbons.²⁻⁶ Despite possible harm reduction in the short-run, long-term safety remains unconfirmed.

Safety in passive environmental inhalations is not established.² HNB cigarettes are contraindicated during pregnancy and/or lactation. Nicotine is provided in addictive quantities, enough to foster continued dependence. Exposure to HNB products can promote longer-term usage or lead to smoking traditional tobacco cigarettes. There is also an increased risk to non-smokers of exposure to HNB aerosols. Additionally, lithium batteries have been known to burn or explode. HNB devices may even lead to privacy concerns due micro-controller chips contained within that harvest information. These chips could inform manufacturers about device usage.⁷

Tobacco is a global health hazard and smoking is the number one preventable cause of disease.^{1,5,8} Global smoking prevalence is nearing 19%.⁹ There are concerns about dual use, rather than HNB cigarettes alone as a substitute for conventional smoking. The ultimate hope is to abstain from all tobacco and nicotine. Although HNB inhalations contain fewer toxic chemicals than by smoking, evidence regarding mitigation of tobacco-related diseases is inconclusive.¹⁰

Physicians have an obligation to minimize tobacco and nicotine-related hazards. Ongoing research and clinical exposure might better document the health impact

of HNB cigarettes. Until the risks and benefits of HNB cigarettes are confirmed, health care professionals would be wise to counsel against their use.

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