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## **Abstract**

*Introduction:* Cardiovascular and renal diseases account for a substantial proportion of the morbidity and mortality associated with obesity and type 2 diabetes mellitus. Bariatric surgery addresses multiple aspects of the pathophysiology of cardiorenal syndrome in obesity and is associated with improved long-term cardiovascular and renal outcomes.

*Areas covered:* All major case-control, cohort, and randomised controlled trial studies of bariatric surgery in adults with type 2 diabetes mellitus were screened and data on anthropometric measures, metabolic parameters, and pre-specified cardiovascular and renal outcomes collated. Bariatric surgery results in greater weight loss and better metabolic control than best medical therapy. Bariatric surgery reduces all-cause mortality and risk of cardiovascular disease, albuminuria and progressive chronic kidney disease. Patients with poorer glycaemic control and established microvascular disease preoperatively may stand to benefit the most from the surgical approach, particularly in the context of reasonable pancreatic reserve. Preclinical and clinical studies offer insights into the mechanisms potentially underpinning cardiovascular and renal protection after bariatric surgery. Reduced sympathetic drive, remission of glomerular hypertension, enhanced natriuresis, gut microbiota shifts, reduced systemic and renal inflammation, improved lipoprotein profiles and reductions in chronic cardiac remodelling may all be implicated.

*Expert commentary:* Higher level evidence regarding the impact of bariatric surgery on end-organ complications of diabetes, including cardiovascular and renal disease, is required. Ongoing RCTs of bariatric surgery selectively recruiting patients with class 1 obesity and established microvascular complications of diabetes will help to better characterise which subgroups of patients benefit most from this effective therapy.

## **Keywords**

Bariatric surgery; metabolic surgery; obesity; type 2 diabetes mellitus; cardiovascular disease; hypertension; diabetic kidney disease; diabetic nephropathy; albuminuria

## **1. Introduction**

Obesity is a disease characterised by excess hunger and/or reduced satiety after a meal. Cardiovascular and renal diseases account for a significant proportion of the morbidity and excess mortality associated with obesity. Obesity and type 2 diabetes mellitus constitute inter-related pandemics that independently increase the risk of both cardiovascular and renal diseases [1, 2]. Overweight and obesity are more prevalent in individuals subsequently diagnosed with type 2 diabetes mellitus [3]. Data from NHANES demonstrate that elevated body mass index (BMI) is strongly associated with the development of common risk factors for both cardiovascular and renal diseases such as hypertension, type 2 diabetes mellitus, dyslipidaemia, endothelial dysfunction, albuminuria, and systemic inflammation [4]. Excess visceral adipose tissue is in particular strongly associated with a network of inter-related atherogenic and diabetogenic abnormalities including increases in insulin resistance/hyperinsulinaemia and pathogenic alterations in plasma lipid profiles. [5].

The INTERHEART and INTERSTROKE studies have highlighted that visceral adiposity, type 2 diabetes mellitus, hypertension, and dyslipidaemia constitute independent and modifiable risk factors for coronary artery disease and cerebrovascular disease [6, 7]. Furthermore, United States Renal Data System (USRDS) data consistently highlight diabetes mellitus and hypertension as the leading causes of end-stage renal disease [8].

Bariatric surgery is gaining momentum as a treatment of cardiovascular and renal diseases in the context of obesity given its propensity to simultaneously reprogramme multiple pathophysiological processes which characterise obesity-associated cardiorenal syndrome [13]. The focus has shifted from purely weight loss-related outcomes to the consideration of end-organ status such as cardiovascular and renal outcomes [14]. In this narrative review, we will highlight the evidence for bariatric or 'metabolic' surgery in terms of anthropometric measures, metabolic parameters, and cardiovascular and renal disease outcomes.

## **2. Aims**

We aimed to screen all major case-control, cohort, and randomised controlled trial (RCT) studies of bariatric surgery in adults with type 2 diabetes mellitus. Although individuals with established microvascular complications of diabetes may benefit from metabolic surgery, they have been under-represented in studies of bariatric surgery in this population to date. We therefore aimed to highlight the prevalence of microvascular and macrovascular disease at the time of recruitment to studies of bariatric surgery in type 2 diabetes mellitus. Using the PICO (population, intervention, comparison, outcomes) framework, our approach is summarised as:

- Population: Individuals  $\geq 18$  years with obesity ( $\text{BMI} \geq 30 \text{ kg/m}^2$ ) and type 2 diabetes mellitus.
- Intervention: Bariatric surgery (adjustable gastric banding, vertical sleeve gastrectomy, Roux-en-Y gastric bypass surgery, or biliopancreatic diversion with or without concomitant duodenal switch).
- Control group: Lifestyle intervention and/or best medical therapy.
- Outcomes:

- Primary reported outcomes of studies, including anthropometric measures and metabolic parameters.
- Pre-specified secondary cardiovascular and renal outcomes (absolute values of systolic and diastolic blood pressure (mmHg), antihypertensive medication usage, major adverse cardiovascular events including myocardial infarction, stroke, heart failure, and cardiovascular death, albuminuria, glomerular filtration rate, and end-stage renal disease).

### **3. Cardiovascular and Renal Disease Outcomes in Studies of Bariatric Surgery**

#### *3.1 Randomised Controlled Trials.*

RCTs of bariatric surgery in obese patients with T2DM to date have mainly focused on anthropometrics and glycaemia as outcomes of interest, with inconsistent reporting of the impact of bariatric surgery on microvascular outcomes of diabetes. Some RCTs have excluded patients with longer diabetes duration or at high-risk for microvascular disease, based on the suggestion that early intervention with bariatric surgery in T2DM may achieve complete diabetes remission with minimal residual burden of diabetes complications. T2DM patients with established microvascular complications are under-represented in RCTs of bariatric surgery. Average glycated haemoglobin values were higher at baseline in STAMPEDE and Mingrone et al's RCT compared with CROSSROADS [15, 16, 17]. Interestingly, the degree of postoperative metabolic improvement was less pronounced in CROSSROADS compared with STAMPEDE and Mingrone et al.'s RCT [15], suggesting that individuals with longer diabetes duration and established microvascular complications may derive the most benefit from bariatric surgery [18].

Diabetes remission was defined as  $\text{HbA1c} \leq 6\%$  without use of hypoglycaemic medications in STAMPEDE [19], whereas diabetes remission in Mingrone et al.'s RCT required a fasting plasma glucose  $\leq 5.6$  mmol/L and  $\text{HbA1c} \leq 6.5\%$  without use of hypoglycaemic medications for one year [20]. Neither study demonstrated complete remission of diabetes at 5-year follow-up [19, 20]. Thus, the role of bariatric surgery in T2DM is increasingly viewed as that of an adjunctive therapy for those patients not meeting treatment targets despite best medical therapy with the aim of achieving disease control rather than complete disease remission [14]. In this regard, knowledge of the impact of bariatric surgery on end-organ effects of diabetes (including cardiovascular and renal disease) is important to help stratify which patients will benefit most from this therapy. Tables 1 and 2 present renal and cardiovascular outcomes in RCTs of bariatric surgery to date.

Two RCTs have reported data on albuminuria (defined as urine albumin: creatinine ratio  $\geq 3\text{mg}/\text{mmol}$ ) at 5-year follow-up after bariatric surgery [19, 20] (Table 1). 34%, 24%, and 20% individuals had albuminuria at baseline in the RYGB, VSG, and IMT arms of STAMPEDE, respectively [17]. Albuminuria was present in 19% and 11% of the RYGB and VSG arms at 5-year follow-up, respectively, compared with persistence of albuminuria in 22% of the IMT arm [19]. In Mingrone et al.'s cohort, 16%, 11%, and 27% had albuminuria at baseline in the RYGB, BPD, and IMT arms, respectively [16]. Albuminuria was present in 0% of the RYGB and BPD arms at 5-year follow-up compared with persistence of albuminuria in 27% of the IMT arm [20]. These results suggest that durable and sustained reductions in albuminuria are achieved in approximately 50% of patients at 5-year follow-up after bariatric surgery, compared with persistence or progression of albuminuria in those treated with best medical therapy alone. Baseline serum creatinine and/or estimated glomerular filtration rate (eGFR) data are presented in two RCTs of bariatric surgery in T2DM [17, 21], while the STAMPEDE RCT also

presents eGFR data at 5-year follow-up [19]. Mean baseline serum creatinine values in the Diabetes Surgery Study were  $0.8 \pm 0.2$  mg/dL in the RYGB + IMT and IMT alone arms, respectively [21]. Median baseline serum creatinine values in STAMPEDE were: 0.7 [0.6,0.8] mg/dL (eGFR 110 [98, 119] mL/min/BSA) in the RYGB + IMT arm, 0.7 [0.6,0.8] mg/dL (eGFR 109 [97, 114] mL/min/BSA) in the VSG + IMT arm, and 0.7 [0.6,0.8] mg/dL (eGFR 106 [97, 112] mL/min/BSA) in the IMT arm [17]. Median percentage reductions in eGFR at 5-year follow up in STAMPEDE were -8 [-16, 0] % in the RYGB + IMT arm, -6 [-16, -1] % in the VSG + IMT arm, and -1 [-11, 3] % in the IMT alone arm [19]. This change in eGFR may be due to the reduction in muscle mass post-bariatric surgery [22]. However, in combination with a reduction in albuminuria, the reduction in eGFR at 5-year follow-up in the surgical arms of STAMPEDE may represent a remission of glomerular hyperfiltration after RYGB and VSG, compared with persistence of albuminuria and glomerular hyperfiltration in those treated medically [23].

Despite a potential beneficial impact on diabetic kidney disease, some concern exists that bariatric surgery, particularly RYGB and BPD, may be associated with adverse renal consequences such as hyperoxaluria and consequent nephrolithiasis [24, 25]. A composite outcome of 'nephropathy' (defined as one or more of doubling of the serum creatinine level or reduction in eGFR >20%, acute increase in serum creatinine >290 micromol/L, need for renal replacement therapy, or development of macroalbuminuria (urine albumin: creatinine ratio  $\geq 30$  mg/mmol)) was not significantly different between the subgroups in STAMPEDE, developing in 22% of the RYGB arm, 18% of the VSG arm, and 14% of the IMT arm at 5-year follow-up [19]. Nephrolithiasis also did not significantly differ between the subgroups in STAMPEDE at 5-year follow-up (12%, 10%, and 14% in the RYGB, VSG, and IMT arms, respectively) [19]. In the Diabetes Surgery Study, 2% in each of the RYGB and IMT arms developed nephrolithiasis by 24-month follow-up [26]. Similarly, 5%, 11%, and 0% in the

RYGB, BPD, and IMT arms, respectively, of Mingrone et al.'s cohort developed nephrolithiasis at 5-year follow-up [20]. 'Nephropathy' (defined as proteinuria > 0.5g/24 hours) was also not significantly different between subgroups at 5-year follow-up in Mingrone et al.'s cohort (5%, 0%, and 7% in the RYGB, BPD, and IMT arms, respectively) [20].

RCTs of bariatric surgery in T2DM have demonstrated a dramatic reduction in the need for antihypertensive drug therapy to achieve comparable blood pressure control compared to those treated medically (Table 2). For example, in STAMPEDE, mean absolute changes in systolic and diastolic blood pressure at 5-year follow up were  $-3\pm 23$  mmHg and  $-6\pm 13$  mmHg in the RYGB + IMT arm,  $-8\pm 20$  and  $-8\pm 15$  in the VSG + IMT arm, and  $-4\pm 20$  and  $-4\pm 11$  in the IMT alone arm, with no significant between-group differences observed [19]. However, antihypertensive medication usage had decreased from 78% at baseline to 33% at 12 months in the RYGB + IMT arm ( $p<0.001$ ), 67% to 27% in the VSG + IMT arm ( $p<0.001$ ), and was similar at baseline (76%) and 12 months (77%) in the IMT arm [17].

Major adverse cardiovascular event rates in RCTs of bariatric surgery in T2DM have been low, likely reflecting the relatively young age, short duration of diabetes, and low prevalence of established microvascular disease amongst recruited individuals. No significant differences in the occurrence of such events between surgically and medically treated patients has been demonstrated to date. Two fatal acute coronary syndromes have occurred during 5-year follow-up (both in the medically treated arms): 1 each in STAMPEDE and Mingrone et al.'s cohort [19, 20]. A single participant in the medical arm of the Diabetes Surgery Study developed heart failure by 24-month follow-up [26], while 1 individual in the VSG + IMT arm of STAMPEDE developed a non-fatal stroke by 5-year follow-up [19].



### *3.2 Observational Studies.*

RCTs of bariatric surgery in T2DM have recruited relatively small numbers of subjects (maximum n=150 [17]) with maximum 5-year follow-up reported to date [19, 20]. In contrast, there have been several large, retrospective and prospective observational studies evaluating bariatric surgeries in T2DM which provide important insights into their impact on cardiovascular and renal disease outcomes. Principle studies of interest include the Swedish Obese Subjects (SOS) cohort, the Longitudinal Assessment of Bariatric Surgery (LABS) study, and Adams' et al.'s 'Utah' cohort.

The SOS cohort is a prospective, matched, controlled, non-randomised intervention study comparing bariatric surgery to usual care in a cohort of 4,047 obese adults enrolled between 1987 and 2001 [27]. 2,037 individuals received usual care while 2,010 received bariatric surgery (376 (18%) underwent adjustable or nonadjustable gastric banding (GB), 1,369 (68%) underwent vertical banded gastroplasty (VBG), and 265 (13%) underwent gastric bypass). Over mean follow-up of  $11\pm4$  years, mortality was lower in subjects who underwent bariatric surgery (hazard ratio of 0.71 ( $p=0.01$  after adjustment for age, sex, and baseline risk factors)) [28]. Eliasson et al. assessed mortality risk after RYGB in obese adults with diabetes by comparing 6,132 cases who underwent RYGB (identified from the SOS registry and other Swedish databases) with 6,132 matched controls identified from the Swedish diabetes registry who did not undergo bariatric surgery [29]. Over median follow-up of 4 years, significant reductions in overall mortality (hazard ratio 0.42,  $p<0.0001$ ), myocardial infarction (hazard ratio 0.51,  $p=0.021$ ), and cardiovascular death (hazard ratio 0.41,  $p=0.026$ ) were observed in the RYGB group [29]. Data on impact of bariatric surgery on prespecified secondary cardiovascular and renal outcomes from the SOS cohort have also been published.

Gastric bypass was associated with significant reductions in blood pressure and antihypertensive medication usage in the SOS cohort at 10-year follow-up, while vertical banded gastroplasty and gastric banding were not [30]. Reductions in systolic blood pressure of -5 mmHg and diastolic blood pressure of -6 mmHg were observed in the gastric bypass group at 10 years compared with baseline [30]. Furthermore, 35% of patients in the gastric bypass group were taking antihypertensives at 10 years, compared with 45% in the VBG/GB group ( $p<0.01$ ) and 53% in the medically managed group ( $p<0.001$ ) [30]. Bariatric surgery also reduced the number of fatal cardiovascular deaths (adjusted hazard ratio of 0.47,  $p=0.002$ ) and total cardiovascular events (adjusted hazard ratio of 0.67,  $p<0.001$ ) after median follow-up of 15 years in the SOS cohort [31]. Baseline BMI did not predict reduction in cardiovascular events after bariatric surgery ( $p=0.58$ ). However, higher baseline plasma insulin values predicted lower incidence of CVD after bariatric surgery: subjects with a baseline plasma insulin value above compared with at or below the median had NNTs of 21 and 173, respectively, to prevent incident cardiovascular disease after bariatric surgery [31].

After median 10 years of follow-up of 3,108 SOS participants without albuminuria at baseline, 246 patients in the control group and 126 patients in the bariatric surgery group, respectively, had developed albuminuria (adjusted hazard ratio of 0.37,  $p<0.001$ ) [32]. All 3 types of bariatric surgery employed in the SOS cohort were associated with a reduced incidence of albuminuria during follow-up compared with usual care [32]. No differences between the bariatric surgical groups in terms of albuminuria reduction were noted, although low event rates in the cohort limited statistical power [32]. In addition to reduction in the incidence of albuminuria, bariatric surgery has also been demonstrated to reduce the incidence of all diabetic microvascular and macrovascular complications in those with T2DM at baseline ( $n=603$ ) [33]. Over a median follow-up period of 18 (IQR 14-20) years and 18 (IQR 15-21) years

for the usual care and surgery groups, respectively, bariatric surgery reduced the incidence of microvascular (adjusted hazard ratio of 0.43,  $p<0.001$ ) and macrovascular (adjusted hazard ratio of 0.74,  $p=0.01$ ) complications of diabetes. Thus, reductions in albuminuria and other microvascular complications of diabetes appear to be greater than 50% at almost 20 years of prospective follow-up after bariatric surgery.

The LABS-2 cohort is a prospective observational study coordinated across 11 hospitals in 6 centres in the USA that recruited 2,458 individuals to their first bariatric surgical procedure during 2006 to 2009 [34]. There is no control group. 1,738 (71%) individuals underwent RYGB, 610 (25%) underwent LAGB, and 110 (5%) had other bariatric surgical procedures including sleeve gastrectomy, banded gastric bypass, and biliopancreatic diversion with duodenal switch performed. 1,931 (79%) participants were female; 773 (33%) and 199 (9%) had diabetes and abnormal kidney function at baseline, respectively [34]. 7-year follow-up outcomes for those that underwent RYGB and LAGB have been reported. RYGB resulted in sustained reductions in the prevalence of diabetes, high LDL-C, high triglycerides, low HDL-C, and hypertension at 7 years ( $p<0.001$  for all), while LAGB reduced the prevalence of high triglycerides and low HDL-C at 7 years ( $p<0.01$  for both) but not the prevalence of diabetes or hypertension [35].

Kidney disease was a prespecified outcome of the LABS-2 study. Serial serum creatinine and cystatin C along with urine ACR values were collected. Renal functional trends 7 years post-bariatric surgery in LABS-2 have been published [36]. 2,144 individuals in the LABS-2 cohort had baseline data available for CKD risk stratification; 1,696 (80%) were female and 691 (32%) had diabetes. 824 individuals had data available for CKD risk stratification at year 7 [36]. Risk of chronic kidney disease (CKD) was assigned using KDIGO criteria at baseline, annually for 5

years, and in a subset of patients for 7 years. Four KDIGO CKD risk categories are recognised based on eGFR and urine ACR values [37]:

1. Low risk: eGFR  $\geq 60$  mL/min/BSA and urine ACR  $< 3$  mg/mmol;
2. Moderate risk: eGFR 45-59 mL/min/BSA and urine ACR  $< 3$  mg/mmol or eGFR  $\geq 60$  mL/min/BSA and urine ACR 3-30 mg/mmol;
3. High risk: eGFR 30-44 mL/min/BSA and urine ACR  $< 3$  mg/mmol, eGFR 45-59 mL/min/BSA and urine ACR 3-30 mg/mmol, or eGFR  $\geq 60$  mL/min/BSA and urine ACR  $\geq 30$  mg/mmol;
4. Very high risk: eGFR  $< 30$  mL/min/BSA and urine ACR  $< 3$  mg/mmol, eGFR  $< 45$  mL/min/BSA and urine ACR 3-30 mg/mmol, or eGFR  $< 60$  mL/min/BSA and urine ACR  $\geq 30$  mg/mmol.

1,788 (83%), 254 (12%), 73 (3%), and 29 (1%) individuals were at low, moderate, high, and very high CKD risk, respectively [36]. CKD risk worsened in those with low baseline CKD risk in a relatively small proportion (4-9%) of patients between baseline and years 1-7. In the moderate baseline CKD risk group, 53% improved and 5-8% worsened their CKD risk category by year 7. In the high baseline CKD risk group, 56% improved and 3-10% worsened their CKD risk category by year 7. 23% of the very high baseline CKD risk group improved their CKD risk by year 7. Five patients developed end-stage renal disease during 7-year follow-up. Overall, CKD risk categories improved for a substantial proportion of patients over 7 years after bariatric surgery, particularly in those with baseline moderate and high CKD risk [36].

Adams et al. examined mortality after RYGB amongst 9,949 individuals who had surgery at a single centre in Utah, USA between 1984-2002 [38]. The surgical group were compared with 9,628 randomly selected individuals with a BMI  $\geq 35$  kg/m<sup>2</sup> who did not undergo bariatric surgery. 86% of individuals in the RYGB arm were female and mean BMI was  $45 \pm 8$  kg/m<sup>2</sup>.

Over mean follow-up of 7 years, overall mortality (HR 0.63,  $p<0.001$ ), death from cardiovascular disease (HR 0.50,  $p<0.001$ ), and death from diabetes (HR 0.10,  $p=0.003$ ) were lower in the RYGB group [38]. Reduction in death from cardiovascular disease was primarily driven by a reduction in coronary artery disease-related deaths (HR 0.36,  $p<0.001$ ), and not mortality from heart failure or stroke [38]. Rate of diabetes-related deaths was low ( $n=26$  for the whole cohort) [38]. Information on renal outcomes was not provided.

#### **4. Improved Cardiovascular and Renal Disease Outcomes after Bariatric Surgery: Putative Mechanisms**

Bariatric surgery is effective at achieving sustained weight loss, with approximate sustained reductions in weight of 25% reported after RYGB [28, 39], the most commonly performed bariatric surgical procedure worldwide. A phenotype of severe insulin resistance characterises T2DM patients with progressive diabetic kidney disease and other advanced microvascular complications [40, 41]. The reduction in adipose tissue mass and systemic inflammation that accompanies bariatric surgery improves peripheral insulin resistance, to the point where pre-morbid diabetes may undergo partial or complete remission postoperatively [42]. Blood pressure and dyslipidaemia are also more effectively controlled and with fewer medications after bariatric surgery compared with medically treated patients. Thus, common risk factors for both cardiovascular disease and chronic kidney disease improve after bariatric surgery. Additionally, independent of the degree of postoperative weight loss achieved, bariatric surgery can modulate multiple signalling pathways to further ameliorate the dysmetabolic milieu of obesity and to directly exert renoprotective and cardioprotective benefits [43].

#### *4.1 Alterations in adipocytokine signalling.*

Obesity-associated hypertension is characterised by a relatively higher degree of sympathetic nervous system activation than hypertension in lean individuals [44]. Leptin is an adipocyte-derived hormone which acts on the hypothalamus to decrease food intake and increase energy expenditure. Numerous studies have demonstrated reductions in plasma leptin after bariatric surgery which is proportional to the degree of weight loss achieved [45], a finding which is congruent with the concept that leptin is secreted in proportion to adipose tissue mass. Postoperative reductions in leptin secretion minimise tachycardia and hypertension caused by sympathetic nervous system activation, and at least partially account for reductions in blood pressure after bariatric surgery.

Obesity-associated hypoadiponectinaemia impairs insulin signalling and secretion to increase risk for T2DM [46]. Adiponectin levels were measured in a subgroup of 1,570 participants in the SOS study, and increased by 1,807-1,958 ng/mL per 10 kg weight loss at 2-year follow-up [47]. At 12- and 24-month follow-up of participants in the VSG and RYGB arms of STAMPEDE, plasma adiponectin levels were significantly higher in those who achieved remission of T2DM compared with those who did not [48]. Plasma adiponectin levels are negatively correlated with albuminuria in obese individuals [49]. Murine models have demonstrated that adiponectin deficiency impairs podocyte function to result in albuminuria and accelerated renal functional decline [50, 51], while administration of adiponectin to cultured podocytes upregulates AMPK activity and downregulates NADPH oxidase activity to minimise podocyte oxidative stress and albuminuria [50]. Thus, restoration of adiponectin release from adipose tissue after bariatric surgery may confer metabolic benefits as well as direct renoprotective effects through enhanced podocyte differentiation.

#### *4.2 Remission of glomerular hypertension.*

Glomerular haemodynamics are altered in patients with obesity and diabetes due to activation of the renin-angiotensin-aldosterone system (RAAS) [52]. Angiotensin II-mediated efferent arteriolar vasoconstriction via AT<sub>1</sub> receptors coupled with afferent arteriolar vasodilatation due to reduced tubuloglomerular feedback elevates intra-glomerular blood pressures in patients with diabetic kidney disease [53]. High intra-abdominal pressures in obese individuals increase renal venous pressure, which exacerbates glomerular hypertension [54]. Glomerular capillary wall stress promotes reorganisation of the podocyte cytoskeleton to result in foot process effacement, which in turn compromises the glomerular filtration barrier and serves as a nidus for the development of albuminuria [55].

Although kinetics and mediators of early reductions in albuminuria post-bariatric surgery remain to be fully elucidated, improved glycaemia and blood pressure post-RYGB closely tracks reductions in glomerular hyperfiltration-mediated podocyte injury and albuminuria [56]. Elevated urinary albumin excretion independently and continuously predicts a higher risk of cardiovascular disease, even at levels below the threshold for diagnosis of microalbuminuria [57, 58]. Hyperglycaemia-induced alterations in the extracellular matrix increase microvascular permeability, resulting in albuminuria at the level of the glomerulus and increased lipoprotein deposition in peripheral vessels [59]. Albuminuria likely reflects systemic endothelial dysfunction rather than directly contributing to elevated risk of cardiovascular disease [60]. Nevertheless, reductions in albuminuria post-bariatric surgery independently confer a lower risk of fatal cardiovascular disease.

#### *4.3 Natriuresis.*

In the SOS cohort, 24-hour urine output and sodium excretion were 0.17L and 20mmol higher, respectively, in those who underwent gastric bypass compared with vertical banded

gastroplasty or gastric banding at 10-year follow-up [30]. Higher urine volume and sodium excretion independently predicted lower blood pressure in the gastric bypass group. In a prospective, observational study of 5 normotensive female patients undergoing RYGB, median urinary sodium increased by 2.3-fold from 0.9 mEq/kg/24 hours preoperatively to 1.9 mEq/kg/24 hours at 20 months postoperatively [61]. Thus, increased urinary sodium excretion appears to be an important determinant of postoperative blood pressure reductions after RYGB, but not restrictive bariatric surgical procedures.

Natriuresis post-RYGB may be explained by physiological responses of the RAAS and cardiac natriuretic peptide systems, the two principal determinants of renal sodium handling, to postoperative weight loss [62]. For example, reduced RAAS activity may be explained by reduced renin release in response to lower intra-abdominal pressure [63] decreased leptin concentrations and a reduction in sympathetic tone [64], as well as lower angiotensinogen levels occurring as a consequence of less adipose tissue mass [65]. Furthermore, weight loss may promote increased natriuretic peptide release [66] and reduced circulating neprilysin [67], the major peptidase involved in the degradation of natriuretic peptides.

The enhancement of gut-kidney signalling involving glucagon-like peptide-1 (GLP-1) after RYGB or VSG to augment natriuresis is also plausible [68]. The secretion of GLP-1, a 30-amino acid peptide, from enteroendocrine L-cells in response to nutrient intake is enhanced post-RYGB [69, 70]. GLP-1 enhances glucose-dependent insulin secretion from pancreatic beta-cells and lowers glucagon secretion [71], and is thus centrally implicated in observed improvements in glycaemia post-RYGB. In addition to its anti-diabetic effect post-RYGB, GLP-1 may also lower cardiovascular morbidity through its antihypertensive natriuretic effect. In rodent models, oral sodium loading induces a significant increase in plasma GLP-1 levels within 5 minutes, and infusion of the GLP-1 mimetic Exenatide increases urinary fractional



sodium excretion [72]. GLP-1 infusion over 3 hours in healthy and obese men increased urinary sodium excretion by reducing proximal renal tubular sodium reabsorption, an effect that reduced glomerular hyperfiltration [73].

#### *4.4 Gut microbiota shifts.*

Alterations in the gut microbiome have been noted post-bariatric surgery and are implicated in improved energy homeostasis, incretin release, and weight loss [74]. Furet et al. demonstrated that faecal samples are selectively enriched for Proteobacteria, specifically in the *Escherichia* genus, at 6 months post-RYGB [75]. Colonic short-chain fatty acids, generated through bacterial fermentation of dietary fibre, triggered an incretin response by stimulation of the FFAR2 receptor for short-chain fatty acids on intestinal L-cells in mice [76]. In humans, daily direct colonic delivery of 10 grams of the short-chain fatty acid propionate enhanced GLP-1 and PYY secretion from colonic cells, which was associated with improvements in weight, intra-abdominal adiposity, insulin sensitivity, and intrahepatic steatosis [77]. Thus, gut microbiota shifts post-RYGB may result in improved glycaemia and blood pressure control through enhanced GLP-1 secretion from colonic L-cells. Similar metabolic benefits may be achieved in medically treated patients with T2DM by direct colonic delivery of short-chain fatty acids.

#### *4.5 Reduced systemic and renal inflammation.*

Obesity is a state of chronic, low-grade inflammation. Endothelial dysfunction, oxidative stress, and inflammation promote the progression of atherosclerosis and diabetic kidney disease. Serum levels of high-sensitivity C-reactive protein and multiple pro-inflammatory cytokines such as IL-1, IL-6, IL-18, and TNF-alpha correlate with progression of both atherosclerotic cardiovascular disease and diabetic kidney disease [78, 79, 80]. There is substantial preclinical and clinical trial activity in the area of anti-inflammatory therapeutics

for both atherosclerotic disease and diabetic kidney disease [81, 82, 83]. Bariatric surgery simultaneously targets multiple pathophysiological processes to ameliorate inflammation accompanying obesity, resulting in reductions in pro-inflammatory cytokines and enhanced secretion of anti-inflammatory cytokines [84]. Bariatric surgery reduces renal inflammation, a finding which correlates with improved renal function after bariatric surgery [85]. Comparable reductions in urinary MCP-1/creatinine ratios were observed after RYGB, VSG, and LAGB at 12 months. However, RYGB appeared to reduce urinary CCL-18/creatinine ratios more than VSG and LAGB [85].

#### *4.6 Role of high-density lipoprotein cholesterol.*

Obesity induces endothelial dysfunction which is an early event in the progression of atherosclerosis, but also contributes to insulin resistance in peripheral tissues. Obesity, insulin resistance, and endothelial dysfunction share a common defect in reduced nitric (NO) oxide bioavailability [86, 87]. Obesity is characterised by a triad of atherogenic dyslipidaemia, high LDL-C and triglyceride levels combined with low HDL-C levels [88], but also dysfunctional HDL-C which is less effective at preserving endothelial NO bioavailability and thus further exacerbating endothelial dysfunction [89].

In a rodent model of diet-induced obesity, RYGB was associated with higher plasma GLP-1 levels, improved nitric oxide bioavailability, and enhanced endothelium-dependent vasorelaxation compared with sham-operated rats [90]. Additionally, RYGB resulted in improved HDL-C functionality, characterised by increased endothelial NO synthase activation and HDL-C-mediated efflux of cholesterol from blood vessel walls. The protective effects of RYGB were prevented after administration of the GLP-1 receptor antagonist Exendin (9-39) and mimicked in control rats treated with Liraglutide, demonstrating the central role of GLP-1 in improved endothelial function after RYGB.

#### *4.7 Cardiac repair.*

Obesity may result in maladaptive left ventricular modelling progressing to non-ischaemic dilated cardiomyopathy and the clinical syndrome of heart failure [91]. Weight loss after bariatric surgery may minimise and reverse obesity-associated left ventricular remodelling. In a recent systematic review of studies evaluating cardiac structure and function before and after bariatric surgery using echocardiography or cardiac MRI, bariatric surgery was associated with improvements in cardiac structure (decreased left ventricular mass index, decreased left ventricular end-diastolic volume, and left atrial diameter) as well as cardiac function (increased left ventricular ejection fraction and increased E/A ratio) [92]. Similar improvements in right ventricular structure and function have also been reported after bariatric surgery [93]. Improvements in cardiac imaging characteristics after bariatric surgery translate into clinically meaningful outcomes such as a reduction in the incidence of heart failure. Follow-up of 1,724 patients who underwent RYGB over a median of 5.8 years demonstrated an adjusted hazard ratio of 0.38 (95% CI, 0.22-0.64,  $p=0.0003$ ) for the development of heart failure compared with medically managed controls [94].

## 5. Expert commentary

Over the past 10 years, several RCTs with modest numbers of participants have demonstrated the efficacy of bariatric surgery in treating the metabolic dysfunction which accompanies obesity and T2DM [15, 16, 17, 21, 95], the results of which which have been durable at up to 5 years of follow-up [19, 20]. Obese individuals with T2DM randomised to bariatric surgery have experienced greater weight loss and better glycaemic and blood pressure control using less hypoglycaemic and antihypertensive medications compared with their counterparts treated with best medical therapy. Observational studies demonstrate that bariatric surgery reduces the risk of cardiovascular disease, progressive chronic kidney disease, and mortality in the setting of obesity [28, 31, 36, 38].

The question remains which obese patients with T2DM stand to benefit most from bariatric surgery. RCTs of bariatric surgery in T2DM have mainly focused on glycaemic control and diabetes remission to date, rather than end-organ complications related to microvascular and macrovascular complications of diabetes. The magnitude of metabolic improvement after bariatric surgery in CROSSROADS was lower compared with other RCTs, possibly reflecting a lower average glycated haemoglobin level at baseline in the surgical arm of this study [15]. Higher glycated haemoglobin levels for longer durations preoperatively predicts a higher risk of microvascular disease [96], and the greater metabolic improvements after bariatric surgery in STAMPEDE and Mingrone et al.'s RCT compared with CROSSROADS suggest that those with established microvascular disease may benefit the most from bariatric surgery [15, 19, 20].

Durable reductions in albuminuria at 5-year follow-up in STAMPEDE correlate with findings from the SOS cohort, where there were reductions in the incidence of microvascular complications of greater than 50% approaching 20 years post-operatively [19, 33]. The Diabetes Control and Complications Trial (DCCT) confirmed the glucose hypothesis, whereby

intensive glycaemic control (median HbA<sub>1c</sub> 7%) compared with conventional therapy (HbA<sub>1c</sub> 9%) in patients with type 1 diabetes mellitus reduced the onset of microvascular disease by 35-76% at mean 6.5 years of follow-up [97]. Intensive glycaemic control plays an important role in the reducing the burden of microvascular disease in patients with T2DM also, although the microvascular benefit appears to be less pronounced and potential risks and benefits must be carefully considered [98]. Bariatric surgery dramatically improves glycaemic control in T2DM and holds promise in reducing the burden of microvascular disease more effectively and with a more favourable side-effect profile than intensive medical therapy. Thus, patients with diabetic kidney disease appear to be a subgroup of obese T2DM patients who may particularly benefit from bariatric surgery.

BMI has traditionally been a key measure in the selection of patients for bariatric surgery, with bariatric surgery being reserved for those with the highest BMIs. 34% of participants in STAMPEDE had a BMI <35 kg/m<sup>2</sup> [17], while BMI <35 kg/m<sup>2</sup> was an exclusion criterion for Mingrone et al.'s RCT [16]. However, BMI does not predict the presence of microvascular complications of diabetes nor does it predict improvements in metabolic parameters such as glycated haemoglobin after bariatric surgery. Traditional BMI cut-offs to bariatric surgery are being challenged as they may deny suboptimally controlled T2DM patients from an effective therapy. In response to this, the International Diabetes Federation has suggested that bariatric surgery be considered in T2DM with a BMI <35 kg/m<sup>2</sup> who are not meeting targets on medical therapy alone [99], although this has failed to significantly impact clinical practice. This has also been endorsed by the second Diabetes Surgery Summit in 2016 [14].

## 6. Five-year view

Two RCTs are underway to assess the potential renal benefits of bariatric surgery in obese T2DM patients with lower BMIs and established microvascular disease: Prevention and Treatment of Diabetes Complications with Gastric Surgery or Intensive Medicines (PRODIGIES) and Metabolic Outcomes after Microvascular Surgery (MOMS). PRODIGIES (NCT01974544) involves 3 study arms (RYGB + IMT vs VSG + IMT vs IMT alone), has selectively recruited individuals with class 1 obesity (BMI <35 kg/m<sup>2</sup>) and established or at high-risk for microalbuminuria, and will follow patients to 36 months postoperatively [100]. MOMS (NCT01821508) incorporates 2 study arms (RYGB + IMT vs IMT alone), has also selectively recruited individuals with class 1 obesity (BMI <35 kg/m<sup>2</sup>), and will follow patients to 60 months postoperatively [101]. The final 60-month follow-up visit is scheduled for April 2021 in the MOMS study [101]. The RYGB + IMT group in MOMS achieved greater complete remission of albuminuria compared with IMT alone at 12 months post-operatively (unpublished data). Individuals with chronic kidney disease stages 4 and 5 have been excluded from both PRODIGIES and MOMS.

Recent RCTs of bariatric surgery in obese patients with T2DM have cemented its role as an adjunctive therapy in those not meeting treatment targets despite optimal medical therapy. Higher level evidence regarding the impact of bariatric surgery on end-organ complications of diabetes, including cardiovascular and renal disease, is required. Ongoing RCTs of bariatric surgery which are selectively recruiting patients with class 1 obesity and established microvascular complications of diabetes will help to better characterise which subgroups of patients benefit most from this effective therapy. We hypothesise that the PRODIGIES and MOMS RCTs will demonstrate that bariatric surgery substantially improves glycaemic control, stabilises or improves estimated glomerular filtration rate, and reduces albuminuria.

Accordingly, we anticipate that type 2 diabetic kidney disease will become an important indication for bariatric surgery in obese adults.

## 7. Key issues:

- Cardiovascular and renal diseases account for a substantial proportion of the morbidity and mortality associated with obesity and type 2 diabetes mellitus (T2DM).
- Obese individuals with T2DM randomised to bariatric surgery have experienced greater weight loss and better glycaemic, blood pressure, and lipid control at up to 5-year follow-up compared with their counterparts treated with best medical therapy. These RCTs include STAMPEDE, the Diabetes Surgery Study, CROSSROADS, and Mingrone et al., and have collectively enrolled a relatively low proportion of individuals with established microvascular complications of T2DM.
- Prospective observational studies with extended follow-up (primarily the Swedish Obese Subjects [SOS] cohort and Longitudinal Assessment of Bariatric Surgery [LABS] cohort) in patients who are not exclusively diabetic have demonstrated that bariatric surgery reduces the risk of cardiovascular disease, albuminuria and progressive chronic kidney disease, and mortality in the setting of obesity.
- Multiple factors confer cardiovascular and renal protection after bariatric surgery, including reduced sympathetic drive, remission of glomerular hypertension, enhanced natriuresis, gut microbiota shifts, reduced systemic and renal inflammation, enhanced high-density lipoprotein functionality, and reductions in adverse cardiac remodelling.
- Higher level evidence regarding the impact of bariatric surgery on end-organ complications of diabetes, including cardiovascular and renal disease, is required. Ongoing RCTs of bariatric surgery which are selectively recruiting patients with class 1 obesity and established microvascular complications of diabetes will help to better characterise which subgroups of patients benefit most from this effective therapy. We anticipate that type 2 diabetic kidney disease will become an important indication for bariatric surgery in obese adults.



## 8. Reference annotations

**\*\* Schauer PR, Bhatt DL, Kirwan JP, et al. Bariatric Surgery versus Intensive Medical Therapy for Diabetes - 5-Year Outcomes. The New England journal of medicine. 2017 Feb 16;376(7):641-651. doi: 10.1056/NEJMoa1600869. PubMed PMID: 28199805; PubMed Central PMCID: PMC5451258. eng.**

This RCT enrolled the largest number of T2DM patients to a bariatric surgery study and highlights substantial improvements in glycaemic control, blood pressure control, and lipid values at 5-year follow-up after bariatric surgery.

**\*\* Mingrone G, Panunzi S, De Gaetano A, et al. Bariatric-metabolic surgery versus conventional medical treatment in obese patients with type 2 diabetes: 5 year follow-up of an open-label, single-centre, randomised controlled trial. Lancet (London, England). 2015 Sep 5;386(9997):964-73. doi: 10.1016/s0140-6736(15)00075-6. PubMed PMID: 26369473; eng.**

This is one of two RCTs to complete 5-year follow-up after bariatric surgery in patients with T2DM and highlights substantial improvements in metabolic parameters and blood pressure control.

**\*\* Ikramuddin S, Billington CJ, Lee WJ, et al. Roux-en-Y gastric bypass for diabetes (the Diabetes Surgery Study): 2-year outcomes of a 5-year, randomised, controlled trial. The lancet Diabetes & endocrinology. 2015 Jun;3(6):413-422. doi: 10.1016/s2213-8587(15)00089-3. PubMed PMID: 25979364; PubMed Central PMCID: PMC4477840. eng.**

This RCT of bariatric surgery in T2DM has demonstrated significant metabolic improvements at 2-year follow-up and will soon report 5-year outcomes.

**\*\* Cummings DE, Arterburn DE, Westbrook EO, et al. Gastric bypass surgery vs intensive lifestyle and medical intervention for type 2 diabetes: the CROSSROADS randomised controlled trial. Diabetologia. 2016 May;59(5):945-53. doi: 10.1007/s00125-016-3903-x. PubMed PMID: 26983924; PubMed Central PMCID: PMC4826815. eng.**

This RCT highlights improved metabolic parameters with RYGB at 1-year follow-up compared with a very intensive lifestyle and medical intervention in T2DM.

**\* Carlsson LM, Romeo S, Jacobson P, et al. The incidence of albuminuria after bariatric surgery and usual care in Swedish Obese Subjects (SOS): a prospective controlled intervention trial. International journal of obesity (2005). 2015 Jan;39(1):169-75. doi: 10.1038/ijo.2014.72. PubMed PMID: 24798033; PubMed Central PMCID: PMC4285618. eng.**

This paper demonstrates reduced incidence of albuminuria with all types of bariatric surgery over extended follow-up in the SOS cohort.

**\* Friedman AN, Wahed AS, Wang J, et al. Effect of Bariatric Surgery on CKD Risk. Journal of the American Society of Nephrology : JASN. 2018 Apr;29(4):1289-1300. doi: 10.1681/asn.2017060707. PubMed PMID: 29335242; PubMed Central PMCID: PMC5875949. eng.**

This study demonstrates improved CKD risk stratification for the majority at 7-year follow-up after bariatric surgery, particularly in those with baseline moderate and high CKD risk.

\* Sjostrom L, Peltonen M, Jacobson P, et al. Bariatric surgery and long-term cardiovascular events. *Jama*. 2012 Jan 4;307(1):56-65. doi: 10.1001/jama.2011.1914. PubMed PMID: 22215166; eng.

This paper highlights a significant reduction in cardiovascular mortality after bariatric surgery in the SOS cohort.

## References

1. Bhupathiraju SN, Hu FB. Epidemiology of Obesity and Diabetes and Their Cardiovascular Complications. *Circulation research*. 2016;118(11):1723-1735. doi: 10.1161/CIRCRESAHA.115.306825. PubMed PMID: PMC4887150.
2. Maric-Bilkan C. Obesity and Diabetic Kidney Disease. *The Medical clinics of North America*. 2013 11/27;97(1):59-74. doi: 10.1016/j.mcna.2012.10.010. PubMed PMID: PMC3539140.
3. Preis SR, Pencina MJ, Mann DM, et al. Early-adulthood cardiovascular disease risk factor profiles among individuals with and without diabetes in the Framingham Heart Study. *Diabetes care*. 2013 Jun;36(6):1590-6. doi: 10.2337/dc12-1121. PubMed PMID: 23340887; PubMed Central PMCID: PMCPMC3661800. eng.
4. Saydah S, Bullard KM, Cheng Y, et al. Trends in cardiovascular disease risk factors by obesity level in adults in the United States, NHANES 1999-2010. *Obesity (Silver Spring, Md)*. 2014 Aug;22(8):1888-95. doi: 10.1002/oby.20761. PubMed PMID: 24733690; PubMed Central PMCID: PMCPMC4560453. eng.
5. Bastien M, Poirier P, Lemieux I, et al. Overview of epidemiology and contribution of obesity to cardiovascular disease. *Progress in cardiovascular diseases*. 2014 Jan-Feb;56(4):369-81. doi: 10.1016/j.pcad.2013.10.016. PubMed PMID: 24438728; eng.
6. O'Donnell MJ, Xavier D, Liu L, et al. Risk factors for ischaemic and intracerebral haemorrhagic stroke in 22 countries (the INTERSTROKE study): a case-control study. *The Lancet*. 2010;376(9735):112-123. doi: 10.1016/S0140-6736(10)60834-3.
7. Yusuf S, Hawken S, Ōunpuu S, et al. Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study): case-control study. *The Lancet*. 2004;364(9438):937-952. doi: 10.1016/S0140-6736(04)17018-9.
8. 2017 USRDS Annual Data Report: Executive Summary. *American Journal of Kidney Diseases*. 2018;71(3):S1-S8. doi: 10.1053/j.ajkd.2018.01.003.
9. Weisstuch JM, Dworkin LD. Does essential hypertension cause end-stage renal disease? *Kidney international Supplement*. 1992 May;36:S33-7. PubMed PMID: 1614065; eng.
10. Bui AL, Horwich TB, Fonarow GC. Epidemiology and risk profile of heart failure. *Nature reviews Cardiology*. 2011 11/09;8(1):30-41. doi: 10.1038/nrcardio.2010.165. PubMed PMID: PMC3033496.
11. Kazancioğlu R. Risk factors for chronic kidney disease: an update. *Kidney International Supplements*. 2013 11/27;3(4):368-371. doi: 10.1038/kisup.2013.79. PubMed PMID: PMC4089662.
12. Djousse L, Kurth T, Gaziano JM. Cystatin C and risk of heart failure in the Physicians' Health Study (PHS). *American heart journal*. 2008 Jan;155(1):82-6. doi: 10.1016/j.ahj.2007.08.023. PubMed PMID: 18082494; PubMed Central PMCID: PMCPMC2179893. eng.
13. Fenske W, Athanasiou T, Harling L, et al. Obesity-related cardiorenal disease: the benefits of bariatric surgery. *Nature reviews Nephrology*. 2013 Sep;9(9):539-51. doi: 10.1038/nrneph.2013.145. PubMed PMID: 23917797; eng.
14. Rubino F, Nathan DM, Eckel RH, et al. Metabolic Surgery in the Treatment Algorithm for Type 2 Diabetes: A Joint Statement by International Diabetes Organizations [10.2337/dc16-0236]. *Diabetes care*. 2016;39(6):861.

15. Cummings DE, Arterburn DE, Westbrook EO, et al. Gastric bypass surgery vs intensive lifestyle and medical intervention for type 2 diabetes: the CROSSROADS randomised controlled trial. *Diabetologia*. 2016 May;59(5):945-53. doi: 10.1007/s00125-016-3903-x. PubMed PMID: 26983924; PubMed Central PMCID: PMC4826815. eng.
16. Mingrone G, Panunzi S, De Gaetano A, et al. Bariatric Surgery versus Conventional Medical Therapy for Type 2 Diabetes. *New England Journal of Medicine*. 2012;366(17):1577-1585. doi: 10.1056/NEJMoa1200111. PubMed PMID: 22449317.
17. Schauer PR, Kashyap SR, Wolski K, et al. Bariatric Surgery versus Intensive Medical Therapy in Obese Patients with Diabetes. *The New England journal of medicine*. 2012 03/26;366(17):1567-1576. doi: 10.1056/NEJMoa1200225. PubMed PMID: PMC3372918.
18. Neff KJ, le Roux CW. Bariatric surgery: traversing the CROSSROADS into mainstream diabetes care. *Diabetologia*. 2016 03/16;59(5):942-944. doi: 10.1007/s00125-016-3928-1. PubMed PMID: PMC4826826.
19. Schauer PR, Bhatt DL, Kirwan JP, et al. Bariatric Surgery versus Intensive Medical Therapy for Diabetes - 5-Year Outcomes. *The New England journal of medicine*. 2017 Feb 16;376(7):641-651. doi: 10.1056/NEJMoa1600869. PubMed PMID: 28199805; PubMed Central PMCID: PMC451258. eng.
20. Mingrone G, Panunzi S, De Gaetano A, et al. Bariatric-metabolic surgery versus conventional medical treatment in obese patients with type 2 diabetes: 5 year follow-up of an open-label, single-centre, randomised controlled trial. *Lancet (London, England)*. 2015 Sep 5;386(9997):964-73. doi: 10.1016/s0140-6736(15)00075-6. PubMed PMID: 26369473; eng.
21. Ikramuddin S, Korner J, Lee WJ, et al. Roux-en-Y gastric bypass vs intensive medical management for the control of type 2 diabetes, hypertension, and hyperlipidemia: the Diabetes Surgery Study randomized clinical trial. *Jama*. 2013 Jun 5;309(21):2240-9. doi: 10.1001/jama.2013.5835. PubMed PMID: 23736733; PubMed Central PMCID: PMC3954742. eng.
22. Nair M, le Roux CW, Docherty NG. Measuring changes in renal function after bariatric surgery: Why estimated glomerular filtration rate is not good enough. *Surgery for Obesity and Related Diseases*. 2016;12(10):1897-1898. doi: 10.1016/j.soard.2016.03.027.
23. Li K, Zou J, Ye Z, et al. Effects of Bariatric Surgery on Renal Function in Obese Patients: A Systematic Review and Meta Analysis. *PloS one*. 2016;11(10):e0163907. doi: 10.1371/journal.pone.0163907. PubMed PMID: 27701452; PubMed Central PMCID: PMC4509777. eng.
24. Sinha MK, Collazo-Clavell ML, Rule A, et al. Hyperoxaluric nephrolithiasis is a complication of Roux-en-Y gastric bypass surgery. *Kidney international*. 2007 Jul;72(1):100-7. doi: 10.1038/sj.ki.5002194. PubMed PMID: 17377509; eng.
25. Duffey BG, Alanee S, Pedro RN, et al. Hyperoxaluria is a long-term consequence of Roux-en-Y Gastric bypass: a 2-year prospective longitudinal study. *Journal of the American College of Surgeons*. 2010 Jul;211(1):8-15. doi: 10.1016/j.jamcollsurg.2010.03.007. PubMed PMID: 20610243; eng.
26. Ikramuddin S, Billington CJ, Lee WJ, et al. Roux-en-Y gastric bypass for diabetes (the Diabetes Surgery Study): 2-year outcomes of a 5-year, randomised, controlled trial. *The lancet Diabetes & endocrinology*. 2015 Jun;3(6):413-422. doi: 10.1016/s2213-

- 8587(15)00089-3. PubMed PMID: 25979364; PubMed Central PMCID: PMC4477840. eng.
27. Sjöström L. Review of the key results from the Swedish Obese Subjects (SOS) trial - a prospective controlled intervention study of bariatric surgery. *Journal of internal medicine*. 2013 Mar;273(3):219-34. doi: 10.1111/joim.12012. PubMed PMID: 23163728; eng.
  28. Sjöström L, Narbro K, Sjöström CD, et al. Effects of Bariatric Surgery on Mortality in Swedish Obese Subjects. *New England Journal of Medicine*. 2007;357(8):741-752. doi: 10.1056/NEJMoa066254. PubMed PMID: 17715408.
  29. Eliasson B, Liakopoulos V, Franzen S, et al. Cardiovascular disease and mortality in patients with type 2 diabetes after bariatric surgery in Sweden: a nationwide, matched, observational cohort study. *The lancet Diabetes & endocrinology*. 2015 Nov;3(11):847-54. doi: 10.1016/s2213-8587(15)00334-4. PubMed PMID: 26429401; eng.
  30. Hallersund P, Sjöström L, Olbers T, et al. Gastric bypass surgery is followed by lowered blood pressure and increased diuresis - long term results from the Swedish Obese Subjects (SOS) study. *PloS one*. 2012;7(11):e49696. doi: 10.1371/journal.pone.0049696. PubMed PMID: 23209592; PubMed Central PMCID: PMC3510228. eng.
  31. Sjöström L, Peltonen M, Jacobson P, et al. Bariatric surgery and long-term cardiovascular events. *Jama*. 2012 Jan 4;307(1):56-65. doi: 10.1001/jama.2011.1914. PubMed PMID: 22215166; eng.
  32. Carlsson LM, Romeo S, Jacobson P, et al. The incidence of albuminuria after bariatric surgery and usual care in Swedish Obese Subjects (SOS): a prospective controlled intervention trial. *International journal of obesity (2005)*. 2015 Jan;39(1):169-75. doi: 10.1038/ijo.2014.72. PubMed PMID: 24798033; PubMed Central PMCID: PMC4285618. eng.
  33. Sjöström L, Peltonen M, Jacobson P, et al. Association of bariatric surgery with long-term remission of type 2 diabetes and with microvascular and macrovascular complications. *Jama*. 2014 Jun 11;311(22):2297-304. doi: 10.1001/jama.2014.5988. PubMed PMID: 24915261; eng.
  34. Belle SH, Berk PD, Chapman WH, et al. Baseline characteristics of participants in the Longitudinal Assessment of Bariatric Surgery-2 (LABS-2) study. *Surgery for obesity and related diseases : official journal of the American Society for Bariatric Surgery*. 2013 Nov-Dec;9(6):926-35. doi: 10.1016/j.soard.2013.01.023. PubMed PMID: 23602493; PubMed Central PMCID: PMC3990409. eng.
  35. Courcoulas AP, King WC, Belle SH, et al. Seven-Year Weight Trajectories and Health Outcomes in the Longitudinal Assessment of Bariatric Surgery (LABS) Study. *JAMA surgery*. 2017 Dec 6. doi: 10.1001/jamasurg.2017.5025. PubMed PMID: 29214306; eng.
  36. Friedman AN, Wahed AS, Wang J, et al. Effect of Bariatric Surgery on CKD Risk. *Journal of the American Society of Nephrology : JASN*. 2018 Apr;29(4):1289-1300. doi: 10.1681/asn.2017060707. PubMed PMID: 29335242; PubMed Central PMCID: PMC5875949. eng.
  37. Stevens PE, Levin A. Evaluation and management of chronic kidney disease: synopsis of the kidney disease: improving global outcomes 2012 clinical practice guideline.

- Annals of internal medicine. 2013 Jun 4;158(11):825-30. doi: 10.7326/0003-4819-158-11-201306040-00007. PubMed PMID: 23732715; eng.
38. Adams TD, Gress RE, Smith SC, et al. Long-Term Mortality after Gastric Bypass Surgery. *New England Journal of Medicine*. 2007;357(8):753-761. doi: 10.1056/NEJMoa066603. PubMed PMID: 17715409.
  39. Sjostrom L, Lindroos AK, Peltonen M, et al. Lifestyle, diabetes, and cardiovascular risk factors 10 years after bariatric surgery. *The New England journal of medicine*. 2004 Dec 23;351(26):2683-93. doi: 10.1056/NEJMoa035622. PubMed PMID: 15616203; eng.
  40. Montero RM, Herath A, Qureshi A, et al. Defining Phenotypes in Diabetic Nephropathy: a novel approach using a cross-sectional analysis of a single centre cohort. *Scientific Reports*. 2018 2018/01/08;8(1):53. doi: 10.1038/s41598-017-18595-1.
  41. Groop PH, Forsblom C, Thomas MC. Mechanisms of disease: Pathway-selective insulin resistance and microvascular complications of diabetes. *Nature clinical practice Endocrinology & metabolism*. 2005 Dec;1(2):100-10. doi: 10.1038/ncpendmet0046. PubMed PMID: 16929378; eng.
  42. Purnell JQ, Selzer F, Wahed AS, et al. Type 2 Diabetes Remission Rates After Laparoscopic Gastric Bypass and Gastric Banding: Results of the Longitudinal Assessment of Bariatric Surgery Study. *Diabetes care*. 2016 Jul;39(7):1101-7. doi: 10.2337/dc15-2138. PubMed PMID: 27289123; PubMed Central PMCID: PMC4915561. eng.
  43. Tham JC, le Roux CW, Docherty NG. Cardiovascular, Renal and Overall Health Outcomes After Bariatric Surgery [journal article]. *Current Cardiology Reports*. 2015 April 18;17(5):34. doi: 10.1007/s11886-015-0588-6.
  44. Hall JE, da Silva AA, do Carmo JM, et al. Obesity-induced hypertension: role of sympathetic nervous system, leptin, and melanocortins. *The Journal of biological chemistry*. 2010 Jun 4;285(23):17271-6. doi: 10.1074/jbc.R110.113175. PubMed PMID: 20348094; PubMed Central PMCID: PMC2878489. eng.
  45. Beckman LM, Beckman TR, Earthman CP. Changes in Gastrointestinal Hormones and Leptin after Roux-en-Y Gastric Bypass Procedure: A Review. *Journal of the American Dietetic Association*. 2010;110(4):571-584. doi: 10.1016/j.jada.2009.12.023. PubMed PMID: PMC4284064.
  46. Nigro E, Scudiero O, Monaco ML, et al. New insight into adiponectin role in obesity and obesity-related diseases. *BioMed research international*. 2014;2014:658913. doi: 10.1155/2014/658913. PubMed PMID: 25110685; PubMed Central PMCID: PMC4109424. eng.
  47. Herder C, Peltonen M, Svensson PA, et al. Adiponectin and bariatric surgery: associations with diabetes and cardiovascular disease in the Swedish Obese Subjects Study. *Diabetes care*. 2014 May;37(5):1401-9. doi: 10.2337/dc13-1362. PubMed PMID: 24574342; eng.
  48. Malin SK, Bena J, Abood B, et al. Attenuated improvements in adiponectin and fat loss characterize type 2 diabetes non-remission status after bariatric surgery. *Diabetes, obesity & metabolism*. 2014 Dec;16(12):1230-8. doi: 10.1111/dom.12376. PubMed PMID: 25132119; PubMed Central PMCID: PMC4227926. eng.

49. Sharma K. The link between obesity and albuminuria: adiponectin and podocyte dysfunction. *Kidney international*. 2009 Jul;76(2):145-8. doi: 10.1038/ki.2009.137. PubMed PMID: 19404275; eng.
50. Sharma K, Ramachandrarao S, Qiu G, et al. Adiponectin regulates albuminuria and podocyte function in mice. *The Journal of clinical investigation*. 2008 May;118(5):1645-56. doi: 10.1172/jci32691. PubMed PMID: 18431508; PubMed Central PMCID: PMC2323186. eng.
51. Rutkowski JM, Wang ZV, Park AS, et al. Adiponectin promotes functional recovery after podocyte ablation. *Journal of the American Society of Nephrology : JASN*. 2013 Feb;24(2):268-82. doi: 10.1681/asn.2012040414. PubMed PMID: 23334396; PubMed Central PMCID: PMC3559480. eng.
52. Thethi T, Kamiyama M, Kobori H. The Link Between the Renin-Angiotensin-Aldosterone System and Renal Injury in Obesity and the Metabolic Syndrome. *Current Hypertension Reports*. 2012;14(2):160-169. doi: 10.1007/s11906-012-0245-z. PubMed PMID: PMC3337881.
53. Siragy HM, Carey RM. Role of the intrarenal renin-angiotensin-aldosterone system in chronic kidney disease. *American journal of nephrology*. 2010;31(6):541-50. doi: 10.1159/000313363. PubMed PMID: 20484892; PubMed Central PMCID: PMC3202956. eng.
54. Wickman C, Kramer H. Obesity and kidney disease: potential mechanisms. *Seminars in nephrology*. 2013 Jan;33(1):14-22. doi: 10.1016/j.semnephrol.2012.12.006. PubMed PMID: 23374890; eng.
55. Endlich N, Kress KR, Reiser J, et al. Podocytes respond to mechanical stress in vitro. *Journal of the American Society of Nephrology : JASN*. 2001 Mar;12(3):413-22. PubMed PMID: 11181788; eng.
56. Navarro-Diaz M, Serra A, Romero R, et al. Effect of drastic weight loss after bariatric surgery on renal parameters in extremely obese patients: long-term follow-up. *Journal of the American Society of Nephrology : JASN*. 2006 Dec;17(12 Suppl 3):S213-7. doi: 10.1681/asn.2006080917. PubMed PMID: 17130264; eng.
57. Gerstein HC, Mann JF, Yi Q, et al. Albuminuria and risk of cardiovascular events, death, and heart failure in diabetic and nondiabetic individuals. *Jama*. 2001 Jul 25;286(4):421-6. PubMed PMID: 11466120; eng.
58. Arnlov J, Evans JC, Meigs JB, et al. Low-grade albuminuria and incidence of cardiovascular disease events in nonhypertensive and nondiabetic individuals: the Framingham Heart Study. *Circulation*. 2005 Aug 16;112(7):969-75. doi: 10.1161/circulationaha.105.538132. PubMed PMID: 16087792; eng.
59. Stehouwer CD, Nauta JJ, Zeldenrust GC, et al. Urinary albumin excretion, cardiovascular disease, and endothelial dysfunction in non-insulin-dependent diabetes mellitus. *Lancet (London, England)*. 1992 Aug 8;340(8815):319-23. PubMed PMID: 1353802; eng.
60. Cosson E, Pham I, Valensi P, et al. Impaired coronary endothelium-dependent vasodilation is associated with microalbuminuria in patients with type 2 diabetes and angiographically normal coronary arteries. *Diabetes care*. 2006 Jan;29(1):107-12. PubMed PMID: 16373905; eng.
61. Docherty NG, Fandriks L, le Roux CW, et al. Urinary sodium excretion after gastric bypass surgery. *Surgery for obesity and related diseases : official journal of the*

- American Society for Bariatric Surgery. 2017 Sep;13(9):1506-1514. doi: 10.1016/j.soard.2017.04.002. PubMed PMID: 28571926; eng.
62. Hall JE, do Carmo JM, da Silva AA, et al. Obesity-induced hypertension: interaction of neurohumoral and renal mechanisms. *Circulation research*. 2015 Mar 13;116(6):991-1006. doi: 10.1161/circresaha.116.305697. PubMed PMID: 25767285; PubMed Central PMCID: PMC4363087. eng.
  63. Sugerman H, Windsor A, Bessos M, et al. Intra-abdominal pressure, sagittal abdominal diameter and obesity comorbidity. *Journal of internal medicine*. 1997 Jan;241(1):71-9. PubMed PMID: 9042096; eng.
  64. Carlyle M, Jones OB, Kuo JJ, et al. Chronic cardiovascular and renal actions of leptin: role of adrenergic activity. *Hypertension (Dallas, Tex : 1979)*. 2002 Feb;39(2 Pt 2):496-501. PubMed PMID: 11882597; eng.
  65. Marcus Y, Shefer G, Stern N. Adipose tissue renin-angiotensin-aldosterone system (RAAS) and progression of insulin resistance. *Molecular and cellular endocrinology*. 2013 Sep 25;378(1-2):1-14. doi: 10.1016/j.mce.2012.06.021. PubMed PMID: 22750719; eng.
  66. Savoia C, Volpe M, Alonzo A, et al. Natriuretic peptides and cardiovascular damage in the metabolic syndrome: molecular mechanisms and clinical implications. *Clinical science (London, England : 1979)*. 2009 Nov 9;118(4):231-40. doi: 10.1042/cs20090204. PubMed PMID: 19886866; eng.
  67. Standeven KF, Hess K, Carter AM, et al. Neprilysin, obesity and the metabolic syndrome. *International journal of obesity (2005)*. 2011 11/02;35(8):1031-1040. doi: 10.1038/ijo.2010.227. PubMed PMID: PMC3040694.
  68. Docherty NG, le Roux CW. Improvements in the metabolic milieu following Roux-en-Y gastric bypass and the arrest of diabetic kidney disease. *Experimental physiology*. 2014 Sep;99(9):1146-53. doi: 10.1113/expphysiol.2014.078790. PubMed PMID: 25085842; eng.
  69. le Roux CW, Aylwin SJ, Batterham RL, et al. Gut hormone profiles following bariatric surgery favor an anorectic state, facilitate weight loss, and improve metabolic parameters. *Annals of surgery*. 2006 Jan;243(1):108-14. PubMed PMID: 16371744; PubMed Central PMCID: PMC449984. eng.
  70. le Roux CW, Welbourn R, Werling M, et al. Gut hormones as mediators of appetite and weight loss after Roux-en-Y gastric bypass. *Annals of surgery*. 2007 Nov;246(5):780-5. doi: 10.1097/SLA.0b013e3180caa3e3. PubMed PMID: 17968169; eng.
  71. Holst JJ. The physiology of glucagon-like peptide 1. *Physiological reviews*. 2007 Oct;87(4):1409-39. doi: 10.1152/physrev.00034.2006. PubMed PMID: 17928588; eng.
  72. Marina AS, Kutina AV, Shakhmatoba EI, et al. Involvement of Glucagon-Like Peptide-1 in the Regulation of Selective Excretion of Sodium or Chloride Ions by the Kidneys. *Bulletin of experimental biology and medicine*. 2017 Feb;162(4):436-440. doi: 10.1007/s10517-017-3634-0. PubMed PMID: 28243920; eng.
  73. Gutzwiller JP, Tschopp S, Bock A, et al. Glucagon-like peptide 1 induces natriuresis in healthy subjects and in insulin-resistant obese men. *The Journal of clinical endocrinology and metabolism*. 2004 Jun;89(6):3055-61. doi: 10.1210/jc.2003-031403. PubMed PMID: 15181098; eng.
  74. Tremaroli V, Karlsson F, Werling M, et al. Roux-en-Y Gastric Bypass and Vertical Banded Gastroplasty Induce Long-Term Changes on the Human Gut Microbiome



- Contributing to Fat Mass Regulation. *Cell Metabolism*. 2015;22(2):228-238. doi: 10.1016/j.cmet.2015.07.009.
75. Furet JP, Kong LC, Tap J, et al. Differential adaptation of human gut microbiota to bariatric surgery-induced weight loss: links with metabolic and low-grade inflammation markers. *Diabetes*. 2010 Dec;59(12):3049-57. doi: 10.2337/db10-0253. PubMed PMID: 20876719; PubMed Central PMCID: PMC2992765. eng.
  76. Tolhurst G, Heffron H, Lam YS, et al. Short-Chain Fatty Acids Stimulate Glucagon-Like Peptide-1 Secretion via the G-Protein–Coupled Receptor FFAR2 [10.2337/db11-1019]. *Diabetes*. 2012;61(2):364.
  77. Chambers ES, Viardot A, Psichas A, et al. Effects of targeted delivery of propionate to the human colon on appetite regulation, body weight maintenance and adiposity in overweight adults. *Gut*. 2015 Nov;64(11):1744-54. doi: 10.1136/gutjnl-2014-307913. PubMed PMID: 25500202; PubMed Central PMCID: PMC4680171. eng.
  78. Moss JWE, Ramji DP. Cytokines: Roles in atherosclerosis disease progression and potential therapeutic targets. *Future medicinal chemistry*. 2016 06/30;8(11):1317-1330. doi: 10.4155/fmc-2016-0072. PubMed PMID: PMC5382975.
  79. Ridker PM. From CRP to IL-6 to IL-1: Moving Upstream To Identify Novel Targets for Atheroprotection. *Circulation research*. 2016;118(1):145-156. doi: 10.1161/CIRCRESAHA.115.306656. PubMed PMID: PMC4793711.
  80. García-García PM, Getino-Melián MA, Domínguez-Pimentel V, et al. Inflammation in diabetic kidney disease. *World Journal of Diabetes*. 2014 08/15 10/04/received 02/24/revised 06/10/accepted;5(4):431-443. doi: 10.4239/wjd.v5.i4.431. PubMed PMID: PMC4127580.
  81. Charo IF, Taub R. Anti-inflammatory therapeutics for the treatment of atherosclerosis. *Nature reviews Drug discovery*. 2011;10(5):365-376. doi: 10.1038/nrd3444. PubMed PMID: PMC3947588.
  82. Ridker PM, Luscher TF. Anti-inflammatory therapies for cardiovascular disease. *European heart journal*. 2014 Jul 14;35(27):1782-91. doi: 10.1093/eurheartj/ehu203. PubMed PMID: 24864079; PubMed Central PMCID: PMC4155455. eng.
  83. Perez-Gomez MV, Sanchez-Nino MD, Sanz AB, et al. Targeting inflammation in diabetic kidney disease: early clinical trials. *Expert opinion on investigational drugs*. 2016 Sep;25(9):1045-58. doi: 10.1080/13543784.2016.1196184. PubMed PMID: 27268955; eng.
  84. Rao SR. Inflammatory markers and bariatric surgery: a meta-analysis. *Inflammation research : official journal of the European Histamine Research Society [et al]*. 2012 Aug;61(8):789-807. doi: 10.1007/s00011-012-0473-3. PubMed PMID: 22588278; eng.
  85. Fenske WK, Dubb S, Bueter M, et al. Effect of bariatric surgery-induced weight loss on renal and systemic inflammation and blood pressure: a 12-month prospective study. *Surgery for Obesity and Related Diseases*. 2013;9(4):559-568. doi: 10.1016/j.soard.2012.03.009.
  86. Mauricio MD, Aldasoro M, Ortega J, et al. Endothelial dysfunction in morbid obesity. *Current pharmaceutical design*. 2013;19(32):5718-29. PubMed PMID: 23448493; eng.
  87. Iantorno M, Campia U, Di Daniele N, et al. Obesity, inflammation and endothelial dysfunction. *Journal of biological regulators and homeostatic agents*. 2014 Apr-Jun;28(2):169-76. PubMed PMID: 25001649; eng.

88. Bays HE, Toth PP, Kris-Etherton PM, et al. Obesity, adiposity, and dyslipidemia: a consensus statement from the National Lipid Association. *Journal of clinical lipidology*. 2013 Jul-Aug;7(4):304-83. doi: 10.1016/j.jacl.2013.04.001. PubMed PMID: 23890517; eng.
89. Lüscher TF, Landmesser U, von Eckardstein A, et al. High-Density Lipoprotein [10.1161/CIRCRESAHA.114.300935]. *Circulation research*. 2014;114(1):171.
90. Osto E, Doytcheva P, Corteville C, et al. Rapid and body weight-independent improvement of endothelial and high-density lipoprotein function after Roux-en-Y gastric bypass: role of glucagon-like peptide-1. *Circulation*. 2015 Mar 10;131(10):871-81. doi: 10.1161/circulationaha.114.011791. PubMed PMID: 25673670; eng.
91. Abel ED, Litwin SE, Sweeney G. Cardiac remodeling in obesity. *Physiological reviews*. 2008 Apr;88(2):389-419. doi: 10.1152/physrev.00017.2007. PubMed PMID: 18391168; PubMed Central PMCID: PMC2915933. eng.
92. Aggarwal R, Harling L, Efthimiou E, et al. The Effects of Bariatric Surgery on Cardiac Structure and Function: a Systematic Review of Cardiac Imaging Outcomes. *Obesity surgery*. 2016 May;26(5):1030-40. doi: 10.1007/s11695-015-1866-5. PubMed PMID: 26328532; eng.
93. Garza CA, Pellikka PA, Somers VK, et al. Structural and functional changes in left and right ventricles after major weight loss following bariatric surgery for morbid obesity. *The American journal of cardiology*. 2010 Feb 15;105(4):550-6. doi: 10.1016/j.amjcard.2009.09.057. PubMed PMID: 20152253; eng.
94. Benotti PN, Wood GC, Carey DJ, et al. Gastric Bypass Surgery Produces a Durable Reduction in Cardiovascular Disease Risk Factors and Reduces the Long-Term Risks of Congestive Heart Failure. *Journal of the American Heart Association: Cardiovascular and Cerebrovascular Disease*. 2017 05/23 01/23/received
- 04/12/accepted;6(5):e005126. doi: 10.1161/JAHA.116.005126. PubMed PMID: PMC5524077.
95. Dixon JB, O'Brien PE, Playfair J, et al. Adjustable gastric banding and conventional therapy for type 2 diabetes: a randomized controlled trial. *Jama*. 2008 Jan 23;299(3):316-23. doi: 10.1001/jama.299.3.316. PubMed PMID: 18212316; eng.
96. Stratton IM, Adler AI, Neil HAW, et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. *BMJ : British Medical Journal*. 2000 03/20/accepted;321(7258):405-412. PubMed PMID: PMC27454.
97. Nathan DM. The diabetes control and complications trial/epidemiology of diabetes interventions and complications study at 30 years: overview. *Diabetes care*. 2014;37(1):9-16. doi: 10.2337/dc13-2112. PubMed PMID: 24356592; PubMed Central PMCID: PMC3867999. eng.
98. Ismail-Beigi F, Craven T, Banerji M, et al. Effect of intensive treatment of hyperglycemia on microvascular complications of type 2 diabetes in ACCORD: a randomized trial. *Lancet (London, England)*. 2010 06/30;376(9739):419-430. doi: 10.1016/S0140-6736(10)60576-4. PubMed PMID: PMC4123233.
99. Dixon JB, le Roux CW, Rubino F, et al. Bariatric surgery for type 2 diabetes. *The Lancet*. 2012;379(9833):2300-2311. doi: 10.1016/S0140-6736(12)60401-2.

100. NIH US National Library of Medicine. Prevention and treatment of diabetes complications with gastric surgery or intensive medicines (PRODIGES). 2013, November 1. Available from: <https://clinicaltrials.gov/ct2/show/NCT01974544>
101. Cohen RV, Pereira TV, Aboud CM, et al. Microvascular Outcomes after Metabolic Surgery (MOMS) in patients with type 2 diabetes mellitus and class I obesity: rationale and design for a randomised controlled trial [10.1136/bmjopen-2016-013574]. BMJ Open. 2017;7(1).
102. Schauer PR, Bhatt DL, Kirwan JP, et al. Bariatric Surgery versus Intensive Medical Therapy for Diabetes — 3-Year Outcomes. New England Journal of Medicine. 2014;370(21):2002-2013. doi: 10.1056/NEJMoa1401329. PubMed PMID: 24679060.

**Conflict of interest**

The authors declare that they have no conflict of interest.

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