INTRODUCTION

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When a patient weighs more or less twice the ideal body weight, a state of morbid obesity is defined; in which a sharply increased risk of cardiovascular, pulmonary and orthopedic problems can be expected. (Cohn, et al, 1981).

So, morbid obesity is considered as a serious psychological, social, economical and medical problem. It has been calculated that only one out of seven persons with morbid obesity has a full life expectancy. (Drenick et al., 1980).

Whatever biochemical basis, there might be for the excess deposition of fat, the final common pathway must be by an intake of calories inappropriate for efficient utilization. Therefore, obesity may be regarded as a behavioural problem in which appetite and food intake exceeds the metabolic requirements. (Cohn, et al, 1981).

Morbid obesity has been reported with an increased incidence of heart attacks, strockes, hypertension, diabetes, pulmonary insufficiency and other potentially leathal diseases.

Medical treatment of morbid obesity has yielded discouraging results and has a very low success rate. The deletrious effects of morbid obesity and the failure of non-operative weight control programs, have created a demand for the now popular surgical procedures to control weights. (Griffen et al., 198I).

Surgical treatment of morbid obesity has undergone significant changes in the past 25 years. It is now a common procedure. Apart from the major almost classical

methods, jejuno-ilea hypass and gastric hypass, other less used methods have appeared. Gomez and Hallberg 1980.

A review of the metabolic factors in obesity with reference to the present status of surgical treatment as well as the early and late morbidity and mortality in relation to each procedure will be discussed. Also, the risks and complications of obesity in patients undergoing different surgical procedures, other than the treatment of obesity, will be discussed in details.