APPENDIX A. SEARCH STRATEGIES

BARIATRIC SURGERY – MALADAPTIVE EATING (From Livhits and colleagues)

SEARCH METHODOLOGY

SEARCH #1:

DATABASE SEARCHED & TIME PERIOD COVERED:

PubMed -10/1/2009-12/6/2013

LANGUAGE:

English

SEARCH STRATEGY:

[bariatric OR obesity/su OR (obesity AND (surgery OR surgical OR operation OR pre-operation)) OR (obese OR (weight AND reduce) OR (weight AND reducing) OR (weight AND reduction) OR weight-reducing OR (decreas* AND weight) OR "weight loss" OR (weight AND lost) OR overweight) AND (surgery OR surgical OR operation OR pre-operation)) OR gastric band* OR gastric bypass OR stomach bypass OR (laparoscop* AND band) OR (laparoscop* AND bands) OR (laparoscop* AND banding) OR lapband* OR "lap band" OR "lap bands" OR "lap banding" OR gastrectom* sleeve* OR sleeve gastrectom* OR biliopancreatic bypass OR duodenal switch* OR duodenum switch* OR biliopancreatic diver* OR gastroplasty OR gastric restrict*

AND

"adaptation, psychological" OR psychology OR psychological OR psychiatry OR psychiatric OR mental illness OR mentally ill OR binge eating" OR bulimia OR bulimic OR eating disorder* OR feeding behavio* OR eating behavio* OR maladaptive eating OR "portion size" OR "sweet eater" OR "volume eater"

NUMBER OF RESULTS: 1127

TOTAL AFTER FILTERING IN ENDNOTE TO REMOVE ANIMAL-ONLY STUDIES AND NON-RELEVANT MATERIAL (ARTICLES NOT RELATING TO BARIATRIC SURGERY OR OBESITY): 462

Search updated on 8/13/2014, number of results: 230

SEARCH #2:

DATABASE SEARCHED & TIME PERIOD COVERED:

PubMed -10/1/2009-12/6/2013

LANGUAGE:

English

SEARCH STRATEGY:

[bariatric OR obesity/su OR (obesity AND (surgery OR surgical OR operation OR pre-operation))

OR

gastric band* OR gastric bypass OR stomach bypass OR (laparoscop* AND band) OR (laparoscop* AND bands) OR (laparoscop* AND banding) OR lapband* OR "lap band" OR "lap bands" OR "lap banding" OR gastrectom* sleeve* OR sleeve gastrectom* OR biliopancreatic bypass OR duodenal switch* OR duodenum switch* OR biliopancreatic diver* OR gastroplasty OR gastric restrict*]

AND

"adaptation, psychological" OR psychology OR psychological OR psychiatry OR psychiatric OR mental illness OR mentally ill OR binge eating" OR bulimia OR bulimic OR eating disorder* OR feeding behavio* OR eating behavio* OR maladaptive eating OR "portion size" OR "sweet eater" OR "volume eater"

AND

predict* or pre-surgical or pre-surgery or presurgery or presurgical or candidate*

NUMBER OF RESULTS: 217

TOTAL AFTER FILTERING IN ENDNOTE TO REMOVE ANIMAL-ONLY STUDIES: 172

Search updated on 8/13/2014, number of results: 53

SEARCH #3:

DATABASE SEARCHED & TIME PERIOD COVERED:

MEDLINE ON OVID -1/1/2009-2014

LANGUAGE:

English

SEARCH STRATEGY:

obese or obesity or (weight adj3 reduce) or (weight adj3 reducing) or (weight adj3 reduction) or weight-reducing or (decreas* adj3 weight) or "weight loss" or (weight adj3 lost) or overweight) IN ALL FIELDS

AND

surgery or surgical or operation or pre-operation or pre-operative or presurgery or presurgical or pre-surgery or pre-surgical (((obese or obesity) adj3 surgery) or surgical)IN ALL FIELDS

OR

gastric band* or "gastric bypass" or "stomach bypass" or laparoscop*) adj3 band) or laparoscop*) adj3 bands) or laparoscop*) adj3 banding) or lapband* or "lap band" or "lap bands" or "lap banding") OR

(gastrectom* adj3 sleeve*) or (sleeve adj3 gastrectom*) or (biliopancreatic adj3 bypass) or (duodenal adj3 switch*) or (duodenum adj3 switch*) or (biliopancreatic adj3 diver*) or gastroplasty or (gastric adj3 restrict*) OR bariatric OR ((obese or obesity) adj3 surgery or surgical) IN ALL FIELDS

AND

"adaptation, psychological" or psychology or psychological or psychiatry or psychiatric or mental illness or mentally ill OR (binge adj3 eating) or bulimia or bulimic or (eating adj3 disorder*) or (feeding adj behavio*) or (eating adj3 behavio*) or (maladaptive adj3 eating) or "portion size" or "sweet eater" or "volume eater" IN ALL FIELDS

AND

(predict* or pre-surgical or pre-surgery or presurgery or presurgical or candidate*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept, rare disease supplementary concept, unique identifier]

NUMBER OF RESULTS: 1030

NUMBER AFTER INTERNAL DUPLICATE REMOVAL: 911

TOTAL AFTER REMOVAL OF DUPLICATES WITH PUBMED SEARCHES, ALONG WITH ANIMAL-ONLY STUDIES AND NON-RELEVANT MATERIAL: 40

Search updated on 8/14/2014, number of results: 92

SEARCH #4:

DATABASE SEARCHED & TIME PERIOD COVERED:

PsycINFO - 10/1/2009-12/10/2013

LANGUAGE:

English

SEARCH STRATEGY:

bariatric OR obese OR obesity OR (weight AND reduce) OR (weight AND reducing) OR (weight AND reduction) OR weight-reducing OR (decreas* AND weight) OR "weight loss" OR

(weight AND lost) OR overweight) AND (surgery OR surgical OR operation OR pre-operation OR pre-surgical or pre-surgery or presurgery or presurgical)) OR (gastric band* OR gastric bypass OR stomach bypass OR (laparoscop* AND band) OR (laparoscop* AND bands) OR (laparoscop* AND banding) OR lapband* OR "lap band" OR "lap bands" OR "lap banding" OR gastrectom* sleeve* OR sleeve gastrectom* OR biliopancreatic bypass OR duodenal switch* OR duodenum switch* OR biliopancreatic diver* OR gastroplasty OR gastric restrict*

AND

predict* OR candidate*

NUMBER OF RESULTS: 178

NUMBER AFTER REMOVAL OF DUPLICATES, ANIMAL-ONLY STUDIES AND NON-RELEVANT MATERIAL: 78

Search updated on 8/14/2014, number of results: 21

BARIATRIC SURGERY – PSYCHIATRIC DISORDERS (From Livhits and colleagues)

SEARCH METHODOLOGY

DATABASE SEARCHED & TIME PERIOD COVERED:

PubMed – 10/1/2009-12/11/2013

LANGUAGE:

English

SEARCH STRATEGY:

gastric band* OR gastric bypass OR stomach bypass OR (laparoscop* AND band) OR (laparoscop* AND bands) OR (laparoscop* AND banding) OR lapband* OR "lap band" OR "lap bands" OR "lap banding" OR gastrectom* sleeve* OR sleeve gastrectom* OR biliopancreatic bypass OR duodenal switch* OR duodenum switch* OR biliopancreatic diver* OR gastroplasty OR gastric restrict*

OR

bariatric OR obesity/su OR (obesity[ti] AND (surgery OR surgical OR operation OR pre-operation OR pre-operative OR pre-surgical or pre-surgery or presurgery or presurgical))

OR

(obese[ti] OR (weight AND reduce) OR (weight AND reducing) OR (weight AND reduction) OR weight-reducing OR (decreas* AND weight) OR "weight loss" OR (weight AND lost) OR overweight) AND (surgery OR surgical OR operation OR pre-operation)

AND

“Adjustment Disorders” [Mesh] OR adjustment[tiab] OR “Affective Disorders, Psychotic” [Mesh] OR affective disorder*[tiab] OR psychotic[tiab] OR psychosis[tiab] OR “Bipolar

Disorder" [Mesh] OR bipolar[tiab] OR counsel*[tiab] OR "Depression" [Mesh] OR depression[tiab] OR depressive[tiab] OR "Depression, Chemical" [Mesh] OR "Depressive Disorder" [Mesh] OR "Depressive Disorder, Major" [Mesh] OR "Dysthymic Disorder" [Mesh] OR dysthymic OR "Psychiatric Counseling" OR "Psychiatric evaluation" OR "Seasonal Affective Disorder" [Mesh] OR "seasonal affective disorder" OR psychopatholog*

NUMBER OF RESULTS: 680

NUMBER AFTER REMOVAL OF DUPLICATES WITH MALADAPTIVE EATING SEARCHES: 473

NUMBER AFTER MANUAL FILTERING IN ENDNOTE TO REMOVE ANIMAL-ONLY STUDIES & NON-RELEVANT MATERIAL: 108

Search updated 8/15/2014, number of results: 174

TARGETED PSYCHOLOGICAL LITERATURE DATABASE SEARCH

SEARCH METHODOLOGY

DATABASE SEARCHED & TIME PERIOD COVERED:

PsycINFO – 1/1/2009-12/12/2013

LANGUAGE:

English

SEARCH STRATEGY:

gastric band* OR gastric bypass OR stomach bypass OR (laparoscop* AND band) OR (laparoscop* AND bands) OR (laparoscop* AND banding) OR lapband* OR "lap band" OR "lap bands" OR "lap banding" OR gastrectom* sleeve* OR sleeve gastrectom* OR biliopancreatic bypass OR duodenal switch* OR duodenum switch* OR biliopancreatic diver* OR gastroplasty OR gastric restrict*

OR

(bariatric OR obese OR obesity OR (weight AND reduce) OR (weight AND reducing) OR (weight AND reduction) OR weight-reducing OR (decreas* AND weight) OR "weight loss" OR (weight AND lost) OR overweight) AND (surgery OR surgical OR operation OR pre-operation OR pre-surgical or pre-surgery or presurgery or presurgical)

AND

psychopatholog* OR adjustment OR affective OR psychotic OR psychosis OR bipolar OR counsel* OR depression OR depressive OR dysthymic OR "Psychiatric Counseling" OR "Psychiatric evaluation" OR "seasonal affective disorder"

Search modes - Find all search terms

NUMBER OF RESULTS: 205

NUMBER OF RESULTS AFTER MANUAL FILTERING IN ENDNOTE TO REMOVE DUPLICATES, ANIMAL-ONLY STUDIES AND NON-RELEVANT MATERIAL: 55

Search updated 8/15/2014, number of results: 23

RELATED ARTICLE SEARCH FOR MALIK AND COLLEAGUES' KEY ARTICLE

DATABASE SEARCHED & TIME PERIOD COVERED:

PubMed– 1/1/1990-12/12/2013

LANGUAGE:

English

SEARCH STRATEGY:

"RELATED ARTICLES" SEARCH ON THE FOLLOWING REFERENCE:

S. Malik, J. E. Mitchell, S. Engel, R. Crosby and S. Wonderlich (2013)."Psychopathology in bariatric surgery candidates: A review of studies using structured diagnostic interviews." Compr Psychiatry. Oct 24

Search updated 8/15/2014, number of results: 3

APPENDIX B. STUDY SELECTION

Question	Answer
Study Design	Randomized clinical trial
	Controlled clinical trial
	Case series ≥ 10 subjects
	Other (specify)
	Case series < 10 subjects (STOP)
	Other kind of review (commentary, editorial non-systematic review, etc) (STOP)
	Systematic review/Meta-analysis (STOP)
Does article study bariatric surgery? (check all that apply)	Bariatric surgery candidates
	Gastric bypass
	Adjustable banding
	Biliopancreatic diversion
	Vertical banded gastroplasty
	Banded gastric bypass
	Sleeve gastrectomy
	Mix of common bariatric surgeries
	Other bariatric surgery, NOS
	Other bariatric surgeries (STOP)
	Not bariatric surgery (STOP)
Are data presented on patients with BMI≥ 35?	Yes
	No (STOP)
What is the number of sites included in the study?	1
	2
	3
	4
	Other (specify)
What is the (approximate) sample size?	10-50
	51-150
	151-500

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	>500
	Not reported
Does the sample specifically include Veterans?	Yes
	No
Is the purpose of the study to: (check all that apply)	Report prevalence of psychological or other conditions
	Report associations between pre- Operative characteristics and post- operative outcomes
	Report results of an intervention to improve pre-operative status
	Test instrument for psychiatric Screening of bariatric candidates
	Other (STOP)
If the study is about prevalence, what percentage of subjects received surgery?	100%
	Other % (specify)
	Not stated
What domains of pre-operative comorbidities or conditions are measured? (Check all that apply)	Mood disorders (depression, bipolar, *etc*)
	Anxiety disorders (anxiety, OCD, PTSD)
	Personality disorders (Axis 2 disorders, borderline, schizotypal, narcissistic, histronic, *etc*)
	Sexual abuse
	Substance abuse
	Psychotic disorders
	ADHD
	MMPI or subscales
	Other psychiatric disorders (specify)
	Maladaptive eating
	Self-esteem
	Cognitive dysfunction (dementia, developmental delay/ mental retardation, unspecified memory issues)
	Other mental health traits (specify)
	Non-psychiatric comorbidities (diabetes, *etc*)
	Quality of life
	Mandatory pre-operative weight loss

What post-operative outcomes are reported?	N/A this is not a study that includes post-operative outcomes
	Weight, BMI
	Psychiatric conditions
	Suicide
	Substance abuse
	Quality of life
	Eating patterns
	Other (specify)

APPENDIX C. PEER REVIEW COMMENTS/AUTHOR RESPONSES

Page # Section	Comment	Response
Executive Summary		
Page 1 Executive Summary	In the executive summary on page 1, it would be helpful to include a brief definition of bariatric surgeries.	We have included brief descriptions.
Page 2 Executive Summary	On p. 2, line 14, it would be helpful to add a brief explanation of the Cochrane Risk of Bias Tool.	We have added a brief explanation.
Page 1 Executive Summary	On page 1 under Methods, state the years (Oct 2009-Dec 2013) for which you did the updated search. That will provide readers a clear sense upfront.	We have added dates for the updated search.
Page 3 Executive Summary	On page 3, the 7% rate of substance abuse disorders is for any disorder? Might want to state that SUD is broad in this consideration.	We have added a sentence to clarify this.
Page 3 Executive Summary	(summary of KQ2 results): It would be useful to state weight loss at X months to reinforce the point that there is very little evidence and all of it is on short-term outcomes	We have clarified that measurements took place at one year and 4 years.
Page 4 Executive Summary	(discussion): It would be worth stating the specific number of veterans examined in the single-site VA studies in sentence: "all estimates for Veterans are judged low due to the small number of patients that have been assessed."	Changed as suggested.
Page 4 Executive Summary	(discussion): The statement "Concurrent depression at the time of surgery may negatively impact weight loss outcomes, especially in the long term." Should drop the "long term" statement since there are no studies of long-term weight change from US	Corrected.
Introduction		
Page 6 Intro	Evidence Report Introduction; Page 6. Suggest updating references regarding recommendations for Bariatric Surgery to include the newly released VA/DoD Clinical Practice Guideline (CPG) for Screening and Management of Overweight and Obesity (http://www.healthquality.va.gov/guidelines/CD/obesity/), as well as the recently published AHA/ACC/TOC Guideline (Jensen MD, Ryan DH, Apovian CM, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: A report of the American College of Cardiology/American Heart Association task force on practice guidelines and the Obesity Society. J Am Coll Cardiol.Nov 7 2013), both of which include recommendations for considering bariatric surgery that are similar to the NHLBI Guideline cited in the report.	We have added references to these guidelines.
Intro	The report states that the reason for screening for psychiatric disorders in the preoperative assessment is "to select patients with the highest likelihood of success." However, no robust predictors of success following bariatric surgery have been identified. Most teams requiring psychological clearance for bariatric surgery do so for reasons relating to patient safety rather than gatekeeping. For example, the preoperative psychiatric evaluation can be used to screen for	We have revised this sentence to clarify the potential reasons for pre-operative screening, including issues with compliance and patient safety.

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	current severe or uncontrolled psychopathology, inability to provide informed consent, or history of noncompliance that could interfere with the postoperative regimen. Additionally, screening for a history of substance abuse or dependence may be important in light of a growing body of evidence that alcohol problems may worsen for patients with a history of problems, especially after gastric bypass. I recommend consulting the literature on preoperative screening in bariatric surgery and presenting a more detailed and complete description of why preoperative psychiatric evaluations are utilized.	
Page 6 Intro	In the introduction, on page 6, line 13-14, there is a notable gap on information on the BMI range of 30-40 kg/m2. Behavioral modification is routinely used in this range, corresponding to class I and II obesity.	We have added a sentence on the treatment of class I and II obesity.
Page 6 Intro	(intro, end of 2nd paragraph): Might be worth stating that "concerns remain about the durability of the improvements and the risks of surgery" because outcomes beyond 5 years are largely unknown for US-based samples. The lack of long-term outcomes is problematic and the basis for a new RFA from NIDDK & NIDA.	Changed as suggested.
Intro	May help to clarify the definition of a bariatric candidate in the introduction (*eg*, patients evaluated for surgery versus receiving surgery or both), as this may vary across studies.	We added a clarification of the term "candidates."
Methods		
Page 23 Methods	The selection criteria are not sufficiently justified and some studies included do not appear to meet the criteria. For example, Kalarchian et al. (2013) is included in Table 1, page 23, yet this study reports mean BDI scores, but not actual prevalence data (p. 2, line 2).	We included studies using a scale to measure mental health conditions only when a specific cut-off value was stated in the text (*ie*, depression was defined as patients with a BDI>10). This has been clarified in the methods section.
Methods	Criterion 2, a threshold of 500 patients, seems to be particularly high for the bariatric surgery literature. This cutoff may miss several studies recognized for high quality psychiatric assessments in this patient population [Rosenberger et al. (2006) n = 174; Kalarchian et al. (2007) n = 288; Mauri et al. (2008) n= 282; and Mühlhans et al. (2009) n = 146].	Based on this suggestion we expanded our threshold to include studies with data from 200 or more patients. This generated an additional 8 studies for KQ1 and 4 studies for KQ2. The median estimates of the prevalence of mental health conditions were unchanged by the inclusion of the additional studies, and therefore we are confident that any additional relaxation of the sample size threshold would not change the results.
Page 13 Methods	Criterion 3 initially specifies data from "clinical trials," but p. 13 refers to "RCTs", which is a related, but different concept. For example, on page 20, the Longitudinal Assessment of Bariatric Surgery (LABS) study is included. LABS is a clinical trial, but not an RCT.	We added language to clarify that clinical trials could include studies with random or non-random patient assignment.
Page 1 Methods	The report body states PsycINFO was searched on p. 1 line 31, but later specifies MEDLINE, OVID, *etc*	Corrected
Page 2 Methods	Some of the language describing the methods is awkward. For example, p. 2, "…study had to report post-operative assessments of an included outcome."	Corrected
Page 8	And on page 8, "Studies had to report actual prevalence data and not simply scores on a sale."	We added language to the methods to clarify

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Methods	Also on p. 8, reference to "the Structured Clinical Interview" is unclear whether this means any structured clinical interview or the Structured Clinical Interview for DSM (SCID).	when scores were used in calculating the prevalence of mental health conditions. We also separated studies using the "SCID" from those using other types of "clinical interview."
Page 7 Methods	(end of topic development): "out" should be "our", I think.	Corrected
Page 7 Methods	(end of topic dev): Is there value in defining what is included in the general category of SUD?	This was clarified as mentioned above.
Page 8 Methods	(data abstract): What study design abstracted? If so, please say so in detail.	Study design was abstracted and is included in Appendix B. We have added language to clarify this.
Page 9 Methods	(quality assessment): Not a problem that you can solve, but the Cochrane Risk of Bias tool deals largely with design criteria of RCTs, not with design criteria of non-randomized studies. So, can't differentiate high quality observational studies from low quality observational studies. Might note that here.	We clarified the purpose and limitations of the Risk of Bias tool. While we understand its primary role in RCTs, we believe that a number of its criteria (*eg*, outcomes, confounders) may reasonably be applied to non-randomized interventions.
Page 7 Methods	Line 35- The description of the search result is somewhat odd. Too much emphasis is given to it being based on a publication by Livhits et al. This publication is in a journal known to have limited editorial quality (Obesity Surgery). The way the search methodology is presented, it seems like the search was subordinate to this rather minor publication. It would be better to present the search strategy as is done for most systematic reviews with a general description of the search strategy including naming all the databases searched and a brief description of the major search terms. If the search was somehow supplemented by references found in Livhits paper, this should be discussed after describing the overall search strategy. It is also unclear how the Livhits search differs from that of this review such that many more articles were found for this review than Livhits found.	We have clarified our search strategy in the methods section, including explicitly stating the role of other reviews (*eg*, Livhits et al.) and input from clinical experts.
Page 7 Methods	Line 37-The average reader will not know what 'reference mined' means.	Clarified.
Page 8 Methods	Line 2 – Specify what databases were searched. Only PsychInfo is named.	Clarified
Page 12 Methods	It is not clear from the search methodology section why the Livhits search results are different than the main search strategy. If the Livhits review yielded articles not found with the initial search and 3 papers were identified by experts that were missing, was the initial search strategy deficient? If so, should it be re-run such that it yields all these papers and more?	This has been clarified as mentioned above. We believe the Livhits search and selection criteria were sufficient. The three articles in questions were all suggested by one TEP member and all were more recent (published in 2014) than our original search (ended in December 2013). We identified and included these studies in our updated search (Dec

		2013-Aug 2014).
Page 7 Methods	It would make sense to exclude "grazing" and "cognitive restraint" (page 7, line 31-32) since these have not been adequately studied, but none-the-less may be important and I would state this.	We have clarified that, while important, other psychosocial predictors of bariatric surgery outcomes were outside our scope of analysis.
Results		
Page 2 KQ 1	On p. 2 and at other places in the report, it would be helpful to delineate the percentages of eating disorder by subtype (*eg*, anorexia nervosa, bulimia, etc).	Clarified
Page 17 KQ 1	On p. 17, Legenbauer (2011) is referenced but the term "anoxia" is used and this appears to have been "anorexia."	Corrected.
KQ 2	On p. 29-31, KQ 2 references are not made to psychosis – were there any particular findings related to psychosis and relationship to bariatric surgery outcomes?	We have added all available information on psychosis to the results section as well as a statement regarding possible bias due to the frequent exclusion of these patients from bariatric surgery studies to our limitations section.
KQ 3	The 4 studies that were selected to address this question are not summarized concisely and are characterized as low quality, yet one of the studies is an NIH funded trial. Also may wish to consider Leahey et al. (2009), which includes a subset of preoperative and/or Brandenburg & Kotlowski (2005).	We have edited the text to better summarize our results. We reviewed both suggested articles, however, neither met criteria for inclusion as we only considered pre-operative interventions targeting a mental health condition.
Page 13 KQ 1	(KQ1): 1st and 3rd bullets outlining studies considered, want to consider adding "regardless of sample size" to the end of each description?	Corrected.
Page 15 KQ 1	(last study summarized): Need to add cite about study of 25 San Diego VA patients.	Added.
Page 29 KQ 2	Cites 50&51 in the 1st paragraph don't seem like the right citations.	These have been checked and appear to be correct.
Page 29 KQ 2	Note specifically in each study whether depression was assessed via SCID, BDI, Dx or Rx. Be consistent.	We have specified the method used to assess mental health conditions, including depression, in Table 2. We have also included a reference to this in the text.
Page 29 KQ 2	For cite 56, change 93% and 87% to change in % with depression to be consistent with statement of depression rates after surgery as in cite 25 above.	Corrected.
Page 29 KQ 2	(KQ2 summary): I think this section would benefit from 3 subheadings of: 1) Impact of Bariatric Surgery on Psychiatric Disorders, 2) Impact of Baseline Psychiatric Disorders on Post-surgical Weight change, 3) Impact of Baseline Psychiatric Disorders on Other Post-surgical Outcomes (quality of life, suicide, *etc*). This would clearly differentiate the different types of studies reviewed into specific sub-questions and enable one to understand the main points of each subgroup of studies. As currently organized, a reader has to work very hard to understand these	Thank you for this suggestion. We have reorganized the results section using these headings.

	different threads and might miss 2 important but distinct points: 1) Bariatric surgery appears to improve post-surgical psychiatric disorders with most evidence on depression 2) Not clear how baseline psychiatric disorders impact post-surgical weight change and post-surgical outcomes of other sorts	
Page 31 KQ 2	(KQ2 quality of evidence): can you state briefly what design improvements (particularly for non-randomized studies) would make the quality of studies better? For example, control groups, measurement via SCID as ideal but validated instruments as 2nd best	We added this information to the future research section.
Page 37 KQ 3	(KQ3): The intro 2 sentences are very confusing. As written, the interventions described in the 2nd sentence appear to map to the types of studies sought in the 1st sentence. I think the confusion arises in the vagueness in sentence 1 about which specific "post-operative outcomes" were of interest (I guessed from later reading that WEIGHT) is the relevant post-operative outcome that was of interest. If so, please say that here. Then, state in sentence 2 what post-operative outcomes these 4 studies actually assessed, which appears to be psychiatric disorders (NOT weight).	Corrected
Page 38 KQ 3	Should the study by Wild be included given that there were only 10 patients and no control group?	Due to the general lack of intervention studies meeting our criteria, we elected to be more inclusive of smaller studies for this section. We included this study in particular because of the intensity and length of the intervention.
Page 4 KQ 2 Summary	Line 28-What is meant by 'concurrent' depression?	Removed.
Page 13 KQ 1	Line 25 – The data are presented for individual diagnoses but some patients probably have many concurrent mental health disorders. It is important to know what fraction of patients undergoing bariatric surgery have any psych disorder. This would provide a better estimate for the magnitude of the problem. Even though this review is inconclusive, mental health disorders are common in bariatric surgery patients and this must be accounted for in policy planning. If the fraction is very high, it will suggest an urgent need to better understand the relationship between mental health disorders and bariatric surgery.	Thank you for this suggestion. We have now included estimates in Key Question 1 with any mood disorder and included "any" mental health condition in the Key Question synthesis.
KQ 2	A major question physicians have who take care of these patients is what the relationship is between preoperative MH disorders and post-operative weight loss. Apparently, the review did not find enough evidence about this question. To highlight this findings, a simple declarative statement such as 'Our systematic review found insufficient evidence to determine the relationship between preoperative MH disorders and postoperative weight loss outcomes' should be included. It is important to call this out. This reviewer practiced bariatric surgery in a region where the CMS carrier specifically barred bariatric surgery in patients with any evidence of prior MH treatments or disorders. The current review has the potential for countermanding such policies that have no evidence base to support them.	Changed as suggested. We also added a heading to summarize the evidence regarding the relationship between mental health conditions and weight loss in the results section of KQ2.
Page 31 KQ 2	Summary of findings- this is not well written. A great deal of passive language is used. Consequently, the results are difficult to grasp. It would be best to clearly state where there were	Corrected.

	positive associations, then negative associations and then what relationships were indeterminate. If there were no clear positive or negative associations, clearly state that.	
Page 29 KQ 2	Key Question 2, one of the studies (50) is discussed. My understanding is that the results of (50) indicated that psychiatric diagnoses did not predict 1 year WL totals, but number of psychiatric diagnoses predicted WL after 1 year. Patients with 2 or more psych conditions were 6 x more likely to either not lose weight or regain weight than those with no psychiatric diagnoses. However, on page 29, these findings are not mentioned, and yet they have a bearing on Key Question 2.	This article was re-reviewed, but no additional data were available for inclusion.
Page 3 KQ 2	Line 20 and later in the text you refer to the studies addressing suicide, and only reference the study from Pennsylvania. There are suicide data, however, in both the Ted Adams reports that you have referenced. You concentrated on other variables but you might wish to mine those studies for the suicide data as well.	Thank you for this suggestion. We were unable to find relevant data in Adams et al. 2010, but have added data from Adams et al. 2012 to our results.
Page 26 KQ 1 Fig 2	I found the graphic on page 26 a little hard to understand although I was able to figure it out. Also it isn't clear what you mean by "suicide"; successful suicide, attempt, successful attempt? Please clarify.	Clarified.
Page 30 KQ 2	Another issue that comes up on page 30 (line not shown) is the issue of "current and lifetime". This is the only place it was addressed as far as I can tell, and these are issues that need to be clarified. My assumption is that most of what you are interested in is "current", but this could be in error.	We have added language to clarify this issue. We used "current" data when both "current" and "lifetime" data were available, and made the assumption that data presented without description are "current" prevalence.
Conclusion		
Summary Discussion	Yes, it would be helpful to clearly delineate implications for surgeons and mental health providers in the conclusion. For example, while the findings currently do not support recommending for or against pre-surgical mental health evaluations for bariatric surgical candidates, it does confirm that mental health disorders are common in this population. Thus providing potential options for care to meet the mental health needs of these Veterans may be helpful. It would also be helpful to make suggestions for further VA research study related to the utilization of mental health evaluations for clearance for bariatric surgeries.	We have added language to the discussion to reflect the implications of our findings on clinical providers.
Summary Discussion	Though the updated VA/DOD CPG had not yet been released when this ESP was conducted, it will be valuable to refer to the CPG and, in the implications section, discuss if and how the findings of the ESP support the current CPG recommendations. The CPG includes the following recommendation for all patients who are overweight or obese, based on Expert Opinion, "Perform a targeted assessment on overweight and obese patients. In addition to the basic medical history and physical examination, assess for factors contributing to obesity." This recommendation also applies to candidates for Bariatric Surgery. The text accompanying this recommendation suggests including an assessment of current and past psychiatric history (including substance abuse and disordered eating), and assessment of medications, including psychiatric medications, that may be contributing to obesity. In addition, the VA/DoD CPG also recommends, in the section on Bariatric Surgery	Added as described above.

	recommendations: • Engage all patients who are candidates for bariatric surgery in a general discussion of the benefits and potential risks. If more detailed information is requested by the patient to assist in the decision-making process, a consultation with a bariatric surgical team should occur. [EO] • Provide lifelong follow-up after bariatric surgery to monitor adverse effects and complications, dietary restrictions, adherence to weight management behaviors, and psychological health. [EO] Though these are EO recommendations, it would be useful to mention them and/or refer to them in the implementation section. Appendix K of the CPG Guideline offers more discussion on the risks and benefits of Bariatric Surgery (see pages 148 – 153), including risks associated with disordered eating, depression, risky alcohol use and suicide. The discussion in Appendix K notes, "although often required preoperatively, no evidence supports routine preoperative assessment by mental health providers. [267,268] As with all general surgical procedures, a complete history and physical is required and the preoperative evaluation should include a review of the assessment elements noted in the Screening and Assessment section of this CPG. This includes identification of problematic eating patterns that may require further assessment or management. "The section on suicide risk (pg. 152) concludes, "Nonetheless, because depression is not uncommon after bariatric surgery, increased vigilance for suicidal ideation and other risk factors for suicide (*eg*, alcohol and other substance use disorder) is warranted. [280,281]" In our opinion, the ESP findings support these EO recommendations and suggestions in the text. If the researchers agree, a statement to this effect in the implications section would be quite valuable. Note also, the VA/DoD CPG also made recommendations for future research, which included addressing the following questions: • Are there individual differences that predict response to comprehensive lifestyle intervention, a specific pharmacotherapy, or a specific bariatric procedure? • How should a clinician prioritize choice of intervention based on presence of specific obesity-associated conditions? Again, there is alignment with the ESP Report!	
Page 42 Summary Discussion	There are also some areas where more supporting information is needed. For example, bottom of page 42, LABS is cited as a study of exceptionally high quality without explanation as to why. If that information does not appear anywhere else in the report it should be added. Some conclusions would benefit from additional support or referencing, such as the statement that, "Concurrent depression at the time of surgery may negatively impact weight loss outcomes, especially in the long-term." And the information on research gaps and future research is relatively underdeveloped.	We have added the characteristics of LABS-2 that separate it from many of the other studies, namely its multi-site nature, clear eligibility criteria, standardized assessments of mental health conditions, and clear follow-up rate. We have removed the statement regarding depression and long-term weight loss as we believe our updated evidence does not support this claim.
Page 43 Summary	The report notes that the demographics including gender of patients in the VA may differ from the samples of bariatric surgery patients. It would help to provide any VA demographic data that may	We have added language clarifying potential differences between VA and non-VA

Discussion	be available. Consider adding increased emphasis that some psychiatric disorders vary significantly in prevalence by gender (*eg*, mood, substance).	samples. Unfortunately, there is insufficient demographic data to formally compare the populations or to estimate the impact on the prevalence of mental health conditions (*eg*, Veterans may have different rates of mental health conditions because they are predominantly male, however, the relationship between mental health and gender in the larger population may not hold among Veterans due to the influence of other demographic and experiential factors). Instead, we chose to include this as a limitation.
Page 42 Summary Discussion	(summary of KQ1): A 25% rate of depression is reasonably called "common", but 1-16% rates of psychosis to eating disorders do not seem well described by the word "common". Maybe refer to depression as common and the others as less common or something. Also, note that VA studies were small samples and single site studies. Same suggestion for Conclusions on page 43.	Corrected.
Page 42 Summary Discussion	(summary of KQ3): Want to state that there were no studies that assessed "post-operative WEIGHT CHANGE outcomes following bariatric surgery…"	Corrected
Page 42 Summary Discussion	(publication bias): First sentence was confusing.	Corrected
Page 42 Summary Discussion	'publication bias – should this read 'since we did NOT do A quantitative… '	Corrected.
Summary Discussion	Please generalize the conclusion to include the need to better understand these issues in all populations and not just veterans. I recognize that this report was commissioned by the VA but it relied mostly on non-VA data. This reflects that the vast majority of bariatric surgery occurs outside the VA. To be useful, the report should call for more research in both VA and non-VA populations.	Changed as suggested.
References to Check		
References to Check	Zimmerman M1, Francione-Witt C, Chelminski I, Young D, Boerescu D, Attiullah N, Pohl D, Roye GD, Harrington DT. Presurgical psychiatric evaluations of candidates for bariatric surgery, part 1: reliability and reasons for and frequency of exclusion. J Clin Psychiatry. 2007 Oct;68(10):1557-62.	This citation was excluded for its small sample size.
References to Check	de Zwaan M, Enderle J, Wagner S, et al. Anxiety and depression in bariatric surgery patients: a prospective, follow-up study using structured clinical interviews. Journal of affective disorders. Sep 2011;133(1-2):61-68	This citation was excluded for its small sample size.
References	Kalarchian MA, Marcus MD, Levine MD, Soulakova JN, Courcoulas AP, Wisinski MS.	This citation was excluded for its small

to Check	Relationship of psychiatric disorders to 6-month outcomes after gastric bypass. Surg Obes Relat Dis. Jul-Aug 2008;4(4):544-549	sample size.
References to Check	Odom J, Zalesin KC, Washington TL, et al. Behavioral predictors of weight regain after bariatric surgery. Obes Surg. Mar 2010;20(3):349-356	This article is now included in Key Question 2 after we reduced the sample size restriction on consecutive or random samples to 200.
References to Check	Legenbauer T, Petrak F, de Zwaan M, Herpertz S. Influence of depressive and eating disorders on short- and long-term course of weight after surgical and nonsurgical weight loss treatment. Comprehensive psychiatry. May-Jun 2011;52(3):301-311	This reference was included in the report.
References to Check	Dixon JB, Dixon ME, O'Brien PE. Depression in association with severe obesity: changes with weight loss. Arch Intern Med. Sep 22 2003;163(17):2058-2065	This article is now included in Key Questions 1 and 2 after we reduced the sample size restriction on consecutive or random samples to 200.
References to Check	Heinberg LJ, Ashton K. History of substance abuse relates to improved postbariatric body mass index outcomes. Surg Obes Relat Dis. Jul-Aug 2010;6(4):417-421	This citation was excluded for its small sample size.
References to Check	Consider the following as possible additional information concerning binge eating in bariatric population. I believe this review cites a number of additional studies beyond those cited in the current synthesis. Niego SH, Kofman MD, Weiss JJ, Geliebter A. Binge eating in thebariatric surgery population: a review of the literature. Int J Eat Disord 2007;40(4):349–59.	This article was mined for references, but because it is a review, it was not included.
References to Check	Larsen, F. (1990) Psychosocial function before and after gastric banding surgery for morbid obesity: a prospective psychiatric study. Acta Psychiatr Scand Suppl359: 1–57.	This citation was excluded for its small sample size.
References to Check	Valley, V., Grace, D. M. (1987) Psychosocial risk factors in gastric surgery for obesity: identifying guidelines for screening. Int J Obes11: 105–113.	This citation was excluded for its small sample size.
General		
General	While the objectives, scope and methods are clearly described, it would be quite helpful to differentiate in Key Question 3 mental health interventions prior to bariatric surgery from mental health presurgical clearance evaluations, if possible. An additional concern is whether or not these evaluations help with improving long term surgical outcomes.	We have reworded KQ3 to clarify this point. We have also added language regarding the lack of data on long-term outcomes in these intervention trials.
General	However, it may be helpful to reference the literature related to encouragement to complete psychological pre-clearance evaluations in the report.	We reviewed and considered this literature, but found it to be outside the scope of our review.
Page 1 General	On line 9 on page 1 and throughout the document, it would be beneficial to reference “mental health disorders” rather than “psychiatric disorders.”	Changed as suggested. We have replaced “psychiatric disorders” with “mental health conditions” where appropriate throughout the report.
General	Consider change in the title to better reflect the actual scope of the ESP from “Psychiatric Clearance for Bariatric Surgery” to “Psychiatric Assessment and Psychosocial Interventions for Bariatric Surgery”	Changed as suggested.
General	Recommend changing “morbid obesity” references to “class III obesity” on line 6, 7, 15, 19 and paragraph 1 of page 42.	Changed as suggested from “morbid obesity” to “severely obese” or “severe obesity” throughout the report.
General	I am not sure whether PsycINFO would have been the best search engine to have used for this	The part about cutting out studies is true but

	topic. I also found the other aspects of the search strategy to be a bit unusual. In addition, although the strict criteria that were used for inclusion of studies in the review are laudable, and the rationale for these criteria is understandable, the bariatric literature comprises mostly lower-quality studies, so the ones they examined are not really representative of the body of existing literature. Further, by leaving out the vast, vast majority of studies on this topic, the authors missed the opportunity to pick up on themes that are suggested over and over again, albeit in less-rigorous studies. They may be of poorer quality, but the consistency of some of the themes among the findings from those studies is convincing in its own right.	I think it makes sense that we cut out lower quality studies. Again we can address this with a mention in the limitations/ research gaps. Professional library selected these search strategies. Given the goal of
General	However, I think there is a very serious bigger-picture issue here. I am concerned that the "key questions" asked were not necessarily the most relevant ones. I am particularly concerned about the narrow focus on "psychiatric disorders" (and, to a lesser extent, eating pathology) in this review. As the authors found in their literature search, the existing literature does not contain strong evidence that any specific disorder affects WLS outcomes (in various domains). However, what the authors are not addressing in their lit review and report is that there are many, many psychosocial factors that may potentially affect various domains of WLS outcome, both directly and indirectly, and though I happen to know the research on these non-diagnosis factors is also pretty sparse, it's actually a bit more convincing than studies looking at diagnosis alone. Just for some small concrete examples, there are papers looking at cognitive functioning (and other factors like various dimensions of temperament) and post-op adherence, papers looking at factors (including but not limited to psych Dx) that influence attendance at follow-up visits, *etc* I am concerned that this document, especially given its 'authoritative' role, will perpetuate what I see as a major problem in the way bariatric psychology gets practiced, which is to focus only on diagnoses, rather than a comprehensive look at all psychosocial factors that may affect the various domains of outcome. I am also concerned that the narrow focus on psych Dx in this document will have the effect of making it less likely that bariatric patients at the VA will receive any psych input – whether it is for evaluation, preparation, or follow-up. It is true that no studies have looked at the relationship between psych input/support and bariatric outcomes, but the fact that nearly every surgical program in the US includes these components suggests that it is widely thought (and anecdotally observed) that psych input/support is likely to enhance outcomes, at least for a subset of patients. The fact that we have not yet found a way to identify that subset a priori is a strong argument FOR providing such input/support as a standard part of the bariatric protocol. I understand that the remit of this report was to only examine the existing empirical literature, but I am concerned that this report will substitute for a broader discussion that takes more than just these few identified studies into account.	We added 'Other' section to limitations. Added sentences: We limited the scope of our evaluation to particular mental health conditions. However, other factors, such as cognitive functioning, temperament, socioeconomic status and personality traits may also play a role in patient safety and success with bariatric surgery.
General	Another point that seems small but is not: The title of the report mentions "Psychiatric Clearance", which is a very problematic term. Firstly, it implies that only psychiatrists have a role here, while if anything, psychologists are much better-suited to this task since they are trained to base their practice on empirical knowledge and to examine factors other than diagnoses and symptoms. Second, the word "clearance" is very problematic. Given the state of the existing empirical literature, a dichotomous "clearance/no clearance" decision is probably the absolutely least useful aim of the pre-surgical psychosocial evaluation. Ideally the role of the evaluation is to identify	We have changed the title of the report and refocused the implications of our results.

	factors (usually in a non-dichotomous fashion) that may affect the domains of WLS outcome and to formulate recommendations for interventions to ameliorate those that are identified.	
General	At the very least, the authors may consider looking at studies examining non-diagnostic psychosocial factors and various domains of WLS outcome, or considering relaxing their inclusion criteria so that themes that emerge repeatedly in lower-quality studies are included in the report. I would also really like to see the authors include some paragraphs that acknowledge that there are dimensions that fell outside of their specific brief (those dimensions I note above) that are still likely quite important in the evaluation and care of bariatric patients, to minimize the chances that this report will have an adverse impact on the standard of care in this arena for VA patients.	While potentially important, we believe that psychosocial factors and additional outcome domains are outside the scope of our report. We have added language to explicitly acknowledge this in the limitations section.
General	This report does not include a clear definition of psychiatric disorders and blends the concepts of disorders, diagnoses and symptoms. The definition presented on page 7 does not include sufficient rationale for the categorization and selection of these disorders: depression, anxiety, post-traumatic stress disorder (which is one type of anxiety disorder), personality disorders, substance abuse disorders, or suicidality (which is not a disorder per se)?	Clarified as noted above.
General	The report would also benefit from a clearer distinction between the predictors of interest (psychiatric disorders, focus of question 1) and the postoperative outcome domains of interest (not only psychiatric disorders, but also a range of other factors including quality of life, *etc*, focus of question 2). For example, p. 34, the table column labeled "Psychiatric Diagnoses Assessed" includes entries that are not psychiatric diagnoses (*eg*, Adams, quality of life).	Clarified as noted above.
General	I recommend checking all of the studies included in Tables 1-2. For example, references 54 and 59 do not appear to meet inclusion criteria, nor do they address report questions.	We have clarified our inclusion criteria in the methods section, and re-checked these references against our criteria.
General	As highlighted earlier, the tables seem to include a mix of pre- and postoperative psychiatric disorders, symptoms, and other factors. For example, on page 17, the Hood study includes "maladaptive eating." However, bottom of page 7 states that "eating behaviors that are not classified as disorders are not included." Therefore, I would think that a report on maladaptive eating would not fall in the scope of Question 1, which pertains to the prevalence of psychiatric disorders; possibly maladaptive eating would be a postoperative outcome of interest and could fall under Question 2. Additionally, throughout the tables, some cells seem to be filled with lengthy descriptions adapted from the publications or abstracts, whereas others include more concise summaries. Inconsistencies were also noted in the reference formatting.	We have clarified which pre-operative mental health conditions were included in the report, and the methods used to assess them. This information is included in Table 2.
General	I commend the VA and the investigators for conducting a systematic review to shed light on clearance procedures for bariatric surgery. It makes sense to be cautious about routinely requiring a potentially expensive and time consuming preoperative psychological evaluation that will not predict success. Although this report has culled a large amount of information, overall, it does not provide a balanced, clear picture of the evidence "for or against" routine preoperative mental health evaluations as posed on page 7. At a minimum, the inclusion of studies should be double checked, the text edited for clarity, and the tables organized for consistency and better alignment with the questions. Finally, because the initial question was broken into smaller questions due to lack of data (p. 7, line 13), it might be helpful to reference current clinical guidelines or expert consensus relevant to the initial question. Some suggestions:	We have edited and reorganized the text to more directly answer our key questions. We have also added references to updated clinical guidelines.

	• Clinical practice guidelines for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient (Mechanic et al., 2013) • Expert Panel on Weight Loss Surgery: Executive report update (Blackburn et al., 2009) • Behavioral and psychological care in weight loss surgery: best practice update (Greenberg, Sogg, & Perna, 2009) • Best practice updates for multidisciplinary care in weight loss surgery (Apovian et al., 2009)	
General	The term morbid obesity is no longer preferred. Consider using clinically severe obesity.	Changed as mentioned above.
General	It would be useful to outline the types of non-randomized studies that might be useful to fill in important gaps here, because RCTs aren't going to be feasible for all questions for which there is limited evidence. For full disclosure, such detail would serve me well because I have developed (with HSR&D funding) matched cohorts of veterans undergoing surgery and non-surgical controls with which I intend to address some of these questions in a December 2014 IIR submission. I suggested several additional studies above to include in this review, because I recently (independently) reviewed much of this literature in preparation for this IIR and an Oct 2014 R01 in response to the NIDDK & NIDA RFA.	This information has been added to the future research section.
General	Binge eating as a psychiatric disorder did not exist formally until DSM-5 in 2013/2014. Therefore, prior papers on binge eating behavior likely defined this condition in somewhat different ways than in the DSM-5 (*eg*, perhaps just basing it on binge eating alone as in the San Diego VA study with the outlier eating disorder value [this study measured only self-reported binge eating] without the perceived loss of control element). Given the new disorder criteria, it is an area in need of future research incorporating the DSM-5 standards	We have added language to clarify how binge eating disorder was diagnosed and the potential limitations due to changes in criteria over time.
General	As the reports states in various places, one of the difficulties in answering the Key Questions resulted from the many different measurement tools utilized in studies to measure psychosocial factors. Although developing consensus guidelines for the use of certain measures for measuring psychosocial factors may be beyond the scope of this review but could be a recommendation for future research in order to facilitate greater reliability across new studies. For example, VA centers could develop and utilize a standardized psychological instrument battery for bariatric patients that would allow for a rapid increase in the state of knowledge about Veterans participating in bariatric procedures.	We have added language to the discussion regarding the need for consensus in the measurement of mental health conditions across sites.
General	Perhaps looking at the mere presence of psychiatric disorders in not predictive of bariatric outcomes, but it might be worthwhile to expand the review to determine whether severity and chronicity of psychiatric disorders are predictive of bariatric outcomes. If there are only a few, low quality studies on severity and chronicity of psychiatric disorders as predictors of outcome, this might be mentioned in the section on limitations.	We have added this as a potential avenue for future research.
General	I think that when we talked before we discussed that there were limits to the validity and reliability of psychosocial assessment for patients prior to bariatric surgery, given the fact that these patients wish to be perceived as healthy and well adjusted. I believe I sent you a couple of articles that address this directly. I can send them again if you wish. I think at some point this issue needs to be raised, since it addresses the quality of the data.	We added a sentence and the suggested reference reporting that confidential assessment of mental health conditions resulted in higher reported prevalence. We did assess each article whether or not it reported that the mental health assessment

		was confidential (included in Tables 1 and 2). Unfortunately, so few studies reported this that no sensitivity analysis was possible.
General	Terminology is not well defined. For example, is the anxiety diagnosis made using a structured system such as the DSM? Which anxiety diagnosis are included? What does depression include? It appears that you included bipolar disorder, which really is an affective disorder and not a form of depression. It isn't clear what systems you used for eating disorder diagnosis, which were primarily binge eating disorder (DSM-IV or some other variant of DSM?). Which system was used for personality disorders or was it just accepted what was written in the articles? Psychosis is a very broad term, I assume that most of this is schizophrenia; however, depression can be psychotic, as can be manic depressive illness. At some point it might be useful to define these terms and also to stipulate what is included. For example, if an article commented on "clinical depression" but didn't refer to any diagnostic nomenclature would that be considered a depressive diagnosis?	We have added language to clarify which mental health conditions were asses and included the individual metrics in Tables 1 and 2. Our discussion sections also notes that the use of different tools to measure and diagnose mental health conditions limited our ability to draw conclusions.
General	A major limitation of all this literature is the lack of long-term follow-up in most of these studies. Again I don't know how much you can be critical of this literature in your review but this seems to be a very key variable. Another key variable is the lack of consistency as to what constitutes the psychosocial evaluation. As far as I know there is no standardization employed, which is part of the problem, and again this should probably be cited as a difficulty in interpreting the literature.	Both limited follow-up and lack of consistency in measurement are included in our limitations section.
General	Question number 3 regarding the role of required pre-operative assessment with appropriate intervention prior to operation could not be answered by this review.	Based on our results, we agree with this statement, and have clarified our findings in the text.
General	The clinical questions are complex and not quite simple as the wording of the questions would suggest. In clinical practice, presumably including the VA, all bariatric surgery candidates are interviewed with variable degrees of psychological assessment. Selected formal or specialized psychological assessment and highly selective intervention may well be beneficial/crucial in certain cases. All bariatric surgery programs encounter patients whose psychopathology renders them unsuitable candidates for bariatric surgery. These candidates can be identified by the surgical and/or medical bariatric team without routine specialized psychological assessment having been required. It is unlikely that adequately powered trials of routine psychological assessment as well as intervention protocols will be conducted in the near future to guide clinical decision making and coverage policy. This reviewer understands that such disclaimers of statements of limitations of the methodology are not a standard part of these evidence based reviews. Nevertheless, a comment regarding the limitations of the evidence based program in formulating clinical decisions as well as policy should be considered.	We have added language regarding the many ways in which bariatric surgery patients are assessed prior to surgery, both formally and informally. As suggested by the comment and in our introduction, there is insufficient evidence to explicitly evaluate pre-operative psychiatric clearance for bariatric surgery. Instead we chose to focus on determining the prevalence and potential implications of mental health conditions prior to bariatric surgery, and have framed our results with these goals in mind rather than using them to comment on the process of psychological assessment.
General	This report will serve to call attention to the lack of evidence supporting mandatory preoperative formal psychological assessment among bariatric surgery candidates. As noted above this report should not be taken as indicating selective preoperative psychological screening and intervention should not be done.	We have clarified the implications of the report in its conclusion.