An unexpected finding across numerous studies of patients after bariatric surgical procedure highlights a troubling association; those who receive bariatric surgery go on to develop alcohol use disorders at a rate higher than would be expected compared with the general population.\textsuperscript{1-3} If this association cannot be explained by other factors, the clinical implications are vast and suggest that new alcohol-related problems are an iatrogenic complication of bariatric surgery. However, considerable debate regarding the veracity of past data persists because of the methodological limitations of cohort studies, which may simply capture preexisting, undetected risk factors in the patient population. Additional research using well-matched control patients could further clarify the magnitude and timing of alcohol-related risks already observed in noncontrolled cohort and laboratory studies.\textsuperscript{3} Maciejewski and colleagues\textsuperscript{4} present a well-designed study of change in alcohol use over time among patients who underwent a bariatric surgery compared with matched nonsurgical control patients. Using a large administrative database from the US Department of Veterans Affairs, this study examined preoperative to postoperative change in unhealthy alcohol use across an 8-year follow-up period among those who received a laparoscopic sleeve gastrectomy (LSG) and a Roux-en-Y gastric bypass (RYGB). Findings indicated that patients who underwent an LSG and an RYGB had a higher probability of developing unhealthy alcohol use across all postoperative years. Eight years after the surgical procedure, the probability of developing unhealthy alcohol use was higher among surgical patients compared with the nonsurgical control patients. Specifically, 7.9% of patients vs 4.5% control patients in the LSG cohort and 9.2% patients vs 4.4% control patients in the RYGB cohort developed unhealthy alcohol use. The probability that patients abstained from alcohol use decreased in the 8 years after both LSG and RYGB.

Maciejewski and colleagues\textsuperscript{4} also compared a smaller sample of surgical patients with nonsurgical patients who were already drinking at unhealthy levels at preoperative baseline. Overall, patients in the RYGB cohort reported greater reduction in alcohol use compared with control patients after a bariatric surgery, suggesting a potential exacerbation of preexisting alcohol problems in this group. This association did not reach significance among patients in the LSG cohort; however, the comparison lacked robust statistical power. Interestingly, this research highlighted a sizable decrease in alcohol use among those who underwent LSG or RYGB in the 2 years leading up to the surgical procedure. The sample included predominantly male patients, which limits the study's generalizability but contributes unique findings to the bariatric literature that is characterized by female-skewed cohorts. Another limitation of this study is the reliance on screening data from electronic health records that likely underestimated the prevalence of alcohol problems.

Unhealthy alcohol use represents an important but overlooked end point in surgical bariatric research. By definition, unhealthy alcohol use includes any pattern of drinking that is associated with adverse health outcomes, including but not limited to alcohol use disorders. Unhealthy alcohol use drains hundreds of billions of dollars from the US economy and leads to substantial alcohol-associated morbidity and mortality.\textsuperscript{5} In tandem, obesity-related morbidity, mortality, and health care costs represent an ongoing national health crisis.\textsuperscript{6} Thus, bariatric surgical procedures represent a crossroad whereby a subset of patients transition from one pervasive and high-risk behavior to another, an iatrogenic outcome that affects patients, families, and society alike. In fact, the behaviors underlying obesity and unhealthy alcohol use (ie, physical inactivity, bad diet, and alcohol use) represent the leading causes of preventable death in the United States.\textsuperscript{7} Bariatric surgical
intervention is a potentially life-saving procedure; however, the benefits must be weighed against the risks of new or increasing postoperative alcohol problems.

These findings warrant a more strident effort to improve preoperative alcohol education, counseling, and problem prevention provided by surgical health care teams. Given that Maciejewski and colleagues4 found alcohol use decreased as the surgical date approached, preoperative alcohol screening will not be particularly helpful in identifying patients at risk for new or recurring alcohol problems. Thus, multidisciplinary teams should provide universal alcohol education and prevention messaging for patients before the surgical procedure, regardless of past alcohol use. Clear evidence of unhealthy alcohol use should lead to brief intervention and/or treatment referral and may also negate surgical candidacy depending on the severity of the problem. Maciejewski and colleagues4 reported that postoperative unhealthy alcohol use emerged or increased over an 8-year time span, suggesting that patient monitoring and screening need to take place at distal time points. Monitoring and screening may require creative solutions, such as placing flags and reminders in patients' electronic health records after a bariatric surgical procedure. In addition, primary care physicians and other nonsurgical health professionals who encounter patients after bariatric surgery should receive education about postoperative alcohol risks in this patient group to ensure that proper screening and monitoring take place.

Overall, this study by Maciejewski and colleagues4 bolsters our understanding of the timing and magnitude of the association of RYGB and LSG procedures with unhealthy alcohol use. The use of matched nonsurgical control patients and a validated alcohol screening tool strengthens the validity of findings and advances the field in critical ways. The findings echo those reported in numerous, noncontrolled cohort studies that found postoperative increases in alcohol use disorder diagnoses. Although this observational study cannot infer causality, its results complement those of laboratory studies that suggested potential causal mechanisms that may account for the observed associations, such as changes in alcohol metabolism, pharmacokinetics, and reward processing after bariatric surgical procedures.3 This body of coalescing evidence supports the conclusion that unhealthy alcohol use is an iatrogenic complication of bariatric surgical procedures, a finding that is of substantial clinical concern and warrants further inquiry.
