Disspelling the Myths Bariatric Surgery

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This is a very individual decision made between the patient and surgeon after a lengthy consultation and after multidisciplinary evaluation. Every member of the multi-disciplinary team can influence the decision regarding procedure choice WITH the patient. At a pre-op assessment, the bariatric team set realistic expectations with the patient. We will not operate on someone who has unrealistic expectations.

ICPO Reflections:

During ICPO Online Support Meetings many patients discuss their own experiences of surgery. This gives comfort and reassurance to others during a vulnerable time.
There are many who share their experiences on social media also, which many report they find useful.

However, it must be noted, these experiences may not always be following the recommendations of the multi-disciplinary team as best practise.

ALWAYS consult with your surgeon and multi-disciplinary team with any doubts, worries or concerns.

ALWAYS remember that everyone has their own individual medical history and reaction to bariatric surgery.

Disspelling the Myths Preparing for Surgery

Liver shrinkage diet (LRD) is a diet based on low energy (calorie) intake, in particular it is low in carbohydrate and fat, and high in protein.

This diet will vary slightly from service to service, it is recommended you follow the advice of your team.

Myth:

the LRD is to lose weight to prepare for surgery.

Facts:

The primary aim of this diet is to reduce the size of liver. By following the liver shrinkage diet, your body will be forced to use up the stored carbohydrate (glycogen) in the liver.

Glycogen and a quantity of water will leave the liver, therefore the liver will shrink and become smaller, firmer, and easier to move during surgery.

During laparoscopic (keyhole) surgery the liver has to be lifted out of the way to access the stomach lying beneath it.

Some people who have bariatric surgery can have a very large, fatty liver which makes keyhole surgery more difficult.

It makes it hard for the surgeon to see and gain access to the stomach underneath which can increase the duration of your surgery and therefore your time under general anaesthetic. It could increase the risk of bleeding during surgery. On rare occasions it can make the surgery impossible to do safely. Not adhering to the LRD in the days prior to surgery can undo much of this benefit and the preparation done following your Teams guidelines.

While bariatric surgery restricts your dietary intake post surgery, this does change over the coming years. Having bariatric surgery should not mean “mourning” the loss of certain foods and this is why preparation with the team psychologist is vital prior to surgery.

Disspelling the Myths Gastric Bypass

- More effective for inducing remission or improvement of Type 2 Diabetes
- Roux-en-Y gastric bypass is better for severe symptomatic reflux.
- Preferred for those who have specific dietary habits. Those who may not consume large volumes but want to avoid sugary, meltable foods. The bypass can act as a deterrent because of the possibility of dumping syndrome.

Myths:

- You don't simply "Shop" for which surgery you want.
- The bypass is not always the "gold standard" operation which is recommended for patients with higher BMI. The bypass may not be technically feasible/doable in patients with higher BMI or in patients with very large livers
- It is not a more "severe" operation.
- It is not one operation fits all.

Facts:

- The right surgery for you depends on your age, weight & height, health, medications, previous operations, dietary patterns and psychological health. it depends on a complete holistic assessment.
- From the psychological perspective, if some patients are on certain long-acting medications, they may not be well absorbed after a certain surgery so this will play a part in the decision.

Disspelling the Myths Gastric Sleeve

- **Preferred for those with a BMI over 55 as often it is not possible to move the bowel safely to perform a bypass.**
- **It can be the first of two operations. Can be converted to a bypass when it is safer to do so after some weight loss, but quite often it has not been needed as patients achieve their goals from the sleeve.**
- **Preferred if there is a lot of medical complications from obesity like heart and lung disease. The sleeve is a slightly less lengthy operation than the bypass and therefore is safer and carries less risk. If someone has had multiple previous abdominal surgeries and may have significant adhesions, the sleeve is preferred.**
- **Patients who have a very enlarged liver it is more feasible to do the sleeve than the bypass**

Myths:

- **You will "only lose 10 stone" with a gastric sleeve.**

Facts:

- The amount of weight a patient loses after surgery varies greatly and depends on a patients starting weight. It is proportional to the starting weight, and not a specific number of stones lost overall. There is very similar weight loss between the two operations (Sleeve and Bypass). In long term clinical trials (at 5 years and 10 years after surgery) there is no significant difference in weight loss between the two operations (possibly 2-5% difference)

Disspelling the Myths Gastric Band

- **The gastric band has largely become a historic procedure. Gastric banding is not frequently performed anymore.**
- **Not recommended as the long-term risks are high and it is not the best operation for treating the disease of obesity. It doesn't treat the underlying symptoms, signs or pathophysiology of obesity as effectively as other operations. The sleeve and bypass alter the gut anatomy which changes the signalling to the brain and therefore better treats the symptoms of obesity.**
- **They carry the highest complication rates in the long-term (e.g. weight regain, band slip, band erosion).**
- **it is a very safe procedure on the day of surgery, but approximately two-thirds of patients will have them removed within 10 years after band placement.**

Myth:

- **The band "is reversible".**

Facts:

- A gastric band can be removed, but it leaves a permanent scar on your stomach, and it could affect blood supply to the stomach, and it can cause irreversible damage to the movement of the oesophagus. It can make having further surgery on the stomach more complicated.
- It can lead to significant oesophageal dysmotility; once it gets to a certain point the movement to the oesophagus can become irreversibly damaged leaving trouble swallowing and worse quality of life.

Disspelling the Myths Post Bariatric Guidelines

- Lifting. light weight day to day objects only, immediately post operation. You can lift approximately a stone in weight (6kgs) safely, but no more than this to avoid risking a hernia at the wounds in the first 6 weeks. Examples shopping bag, new baby, small dog etc.
  Gradually lift heavier items after assessment by your surgeon or GP.

- Work depends on what you work at. The first month post op is chaotic. Learning to eat again and to ensure you get enough protein-rich foods and fluids in is time-consuming. People often don't give themselves enough time to get into good dietary habits. Recommended two weeks off regardless of one's job but expect to feel exhausted for another couple of weeks. Manual work involving heavy lifting - 6 weeks.

- Driving is controversial after any surgery. Insurance companies may say 6 weeks or to be deemed fit to drive must be signed off by a doctor sooner. I would only be comfortable to permit someone to drive once they can do an emergency stop safely. To do this, a patient must not have any residual abdominal pain, is not taking pain medication, and is fully mobile.

- Dietary Needs. You must be able to access food and water during your working day. You must be able to sip your fluids all day. We can provide a medical cert for employers to explain that this is necessary for you.
  Post op dietary guidelines can be different for each service. You should follow the guideline given to you. However, these are guidelines, and you should learn to listen to your body for when it is full and focus on your protein first.
  You should not drink fluids with your meals for approximately 20 minutes before and after. This can make it difficult to reach your water quota, so you must sip constantly throughout the day.

Vitamins

Vitamins are a lifelong commitment after bariatric surgery. If someone is not willing to take a vitamin for life, then I would not proceed with surgery as it indicates that they are not prepared for the lifelong change which comes with bariatric surgery.

Without vitamins, it is possible to develop malnutrition which is debilitating and can have serious consequences. You would have no energy, may be unable to go to work, or to look after your family, and can mean hospital visits for treatment. It can be difficult and slow to treat. Malnutrition is usually avoidable by taking the recommended diet and vitamins after surgery.

- **Recommended for both the sleeve and bypass are:**
- 2 multivitamin tablets/capsules Daily
- 1 Calci-chew D3 Forte Daily
- B12 injection, 3 monthly. B12 is best absorbed in the part of the stomach that has been bypassed or removed so to absorb it reliably it should be given by intramuscular injection (usually in the arm), or via a B12 spray under the tongue daily (which is more expensive in the long term).
- 1 Iron tablet Daily, if you have had a gastric bypass.
  Iron absorption is affected by some other medications. For absorption, ideally space the iron and calcium out by 30 mins or more, with the iron last.

Activity

Nothing for the first two weeks, other than household or leisurely walking.

Gentle walking to begin and possibly swimming.

You will be weaker compared to pre-op from the weight loss (some of which will be muscle loss)

You need to be assessed by your surgeon before resuming more strenuous activity

When you lose weight quickly, typically ¼ of that weight is muscle mass and you could injure yourself by going to the gym too quickly.

Optimum results post surgery= 150 mins a week of activity that increases the heart rate and makes you feel warm. Whatever you can do reliably, and something you enjoy.

Find something that is sustainable that can be worked into your daily routine.

Blood tests

Firstly, bloods to check ones baseline nutritional status should be done before the operation.

Then 3 months postop. Then at 6 months, 12 months and 18 months, and after that annually. Total of 5 times postop in first two years.

Bloods specific to bariatrics would include:

- Vitamin D
- Vitamin B12
- Folate
- Iron profile
- Thyroid Function

and other routine bloods (renal and liver function, bone profile, full blood count)

Postoperative concerns

Constipation. Many patients report this as a problem. Getting enough water helps (minimum 1.5 L per day) or you can be prescribed appropriate medication to help bowel movement.

Weight stalling. Many patients report this happens at various points after surgery. Reducing your calories or intake at this point and exercising excessively is not advised, sticking to your team's advice will see the weight loss resume in time.

Gallstones. This can arise from rapid weight loss. We usually prescribe a medication to prevent this happening

Hair loss. Patients report this happening frequently, from approximately 3 months after surgery, and it can last some weeks. There is no specific product that will prevent this happening. It is a consequence of rapid weight loss. Things that can help minimize it are reaching your recommended protein intake and taking your vitamins. Some patients report that taking high dose Biotin supplement can help hair regrowth. Normal hair growth will return once weight loss slows down.