Weight Loss Surgery Information Session

WFBH Bariatric Surgery Program
What makes us different?

- Center of Excellence (COE)
  - High volume center
    - > 1000 procedures since 2003
  - Less complications than non-COE centers
- Multi-disciplinary team approach
  - Pre- and Post-operatively
    - Psychological counseling
    - Exercise consultation
    - Nutritional guidance
- Message board for patient support
- Monthly Support Group meetings
What is Obesity?

• A progressive, life-threatening disease which results from the excess storage of fat with multiple co-morbidities.

• Morbid Obesity → Clinically severe obesity at which point serious medical conditions occur as a direct result of the obesity.

• Defined as:
  • ≥ 100 pounds over Ideal Body Weight (IBW)
  • Body Mass Index (BMI) ≥ 40

• Leading cause of preventable death (Smoking now # 2)

• Contributing Factors:
  1. Lifestyle (environment), dietary choices
  2. Genetic, metabolic
## What is BMI?

<table>
<thead>
<tr>
<th>BMI</th>
<th>Waist less than or equal to 40 in. (men) or 35 in. (women)</th>
<th>Waist greater than 40 in. (men) or 35 in. (women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.5 or less</td>
<td>Underweight</td>
<td>N/A</td>
</tr>
<tr>
<td>18.5 to 24.9</td>
<td>Normal</td>
<td>N/A</td>
</tr>
<tr>
<td>25.0 to 29.9</td>
<td>Overweight</td>
<td>High</td>
</tr>
<tr>
<td>30.0 to 34.9</td>
<td>Obese</td>
<td>Very High</td>
</tr>
<tr>
<td>35.0 to 39.9</td>
<td>Obese</td>
<td>Very High</td>
</tr>
</tbody>
</table>
| 40 or greater | Morbidly Obese                                          | Extremely High                                  | Extremely High

### Risks of Associated Disease According to BMI and Waist Size:

- **Underweight**: No increased risk.  
- **Normal**: No increased risk.  
- **Overweight**: Increased risk.  
- **Obese**: High risk.  
- **Morbidly Obese**: Extremely high risk.
Obesity Related Co-Morbidities

- Diabetes
- High Blood Pressure
- Heart Disease
- High Cholesterol
- Sleep Apnea
- Cancer
- Venous Stasis Disease
- Degenerative Joint Disease
- Acid Reflux Disease (GERD)
- Stress Urinary Incontinence
- Fatty Liver
- Depression
Who is the Ideal Surgical Candidate?

• Meets NIH criteria for Bariatric Surgery
  • BMI ≥ 40 OR BMI ≥ 35 with co-morbidities
  • Primary disease states complicated by obesity
  • History of weight loss attempts (5 yr weight history)
    • Diets (Weight Watcher’s, Atkins, Slim Fast, etc.)
    • Exercise
    • Medications (Phentermine, Xenical/Alli, Meridia)
  • No psychological contraindications
• Smoking cessation
• Dedicated to Lifestyle Change & Follow Up
Why Surgery?

- Non-Surgical treatment
  - ~10% weight loss
  - > 99% failure rate
  - Low risk

- Surgical treatment
  - 50-75% weight loss
  - ≤ 15% failure rate
  - Medical co-morbidities resolved or improved
  - Operative risk
Improvement of Co-Morbidities after Bariatric Surgery

- Diabetes: 88%
- High Cholesterol: 70%
- GERD: 90%
- High Blood Pressure: 81%
- Sleep Apnea: 80%
- Stress Incontinence: 87%
- Osteoarthritis: 75%
Surgical Treatment Options at Wake Forest Baptist Health

• **Restrictive**
  - Laparoscopic Adjustable Gastric Band (AGB)
  - Laparoscopic Sleeve Gastrectomy

• **Combination** (restrictive & malabsorptive)
  - Laparoscopic Roux-en-Y Gastric Bypass (RYGB)
Laparoscopic Adjustable Gastric Band

- Restrictive
- 40-50% excess weight loss
- US since 2001
- Long term results out of Europe and Australia
- Reversible
Laparoscopic Adjustable Gastric Band Animation

The LAP-BAND® System is inserted through one of the incisions and is wrapped around the stomach. This creates a small upper pouch and a narrowed outlet between the new upper pouch and lower stomach.
How does the Band work?

• Surgical Factors
  • Restriction of meal size
  • Decreased appetite
  • Adjustable:
    • fluid can be added or removed based on rate of weight loss and hunger level

• Patient Factors
  • Caloric intake
  • Exercise
  • Meal composition
Potential Risks with the LAGB

- Death → 1 in 2000
- DVT
- Pulmonary Embolus
- Erosion
- Bleeding
- “Slip”
- Pouch Dilatation
- Port site infection or malfunction
- Food Intolerances
- Weight Gain
Adjustable Gastric Band Hospital Course

• Surgery = 1 to 1 ½ hours
• Outpatient (~23 hours)
  • Same day discharge or overnight

- Sips & chips ➔ clear liquids
- Out of bed same day
- Walking
- Medications: liquid or crushed
Sleeve Gastrectomy

- Restrictive, stomach is 15% original size
- 40-60% EWL at 4 years
- Not reversible
  - Bridge procedure for patients too high risk for RYGB
Sleeve Gastrectomy
How does the VSG work?

- **Surgical Factors**
  - Restriction of meal size
  - Gut hormone alteration?
  - Decreased appetite

- **Patient Factors**
  - Caloric intake
  - Exercise
  - Meal composition
Potential Risks with Sleeve

- Death is << 1%
- DVT
- Pulmonary Embolus
- Leak
- Bleeding
- Gastric Stenosis
- GERD
- Food Intolerances
- Weight gain
Sleeve Gastrectomy
Hospital Course

• Surgery = 1 ½ to 2 hours
• Outpatient
  ~1 night stay

- Sips & chips → clear liquids
- Out of bed same day
- Walking
- Medications: liquid or crushed
Laparoscopic Roux-en-Y Gastric Bypass (RYGB)

- Combination
- Extensive research (1960’s)
- Not easily reversible
- 60-75% excess weight loss
Laparoscopic Roux-en-Y Gastric Bypass (RYGB)
How does the RYGB work?

• **Surgical Factors**
  - Restriction of meal size
  - Malabsorption
  - Decreased appetite

• **Patient Factors**
  - Caloric intake
  - Exercise
  - Meal composition
Potential Risks with RYGB

- Death → 1 in 300
- Pulmonary Embolus (PE)
- Deep Vein Thrombosis (DVT)
- Leaks – 1 to 5%
- Stomal stenosis (stricture) – 4 to 6%
- Ulcers – 5 to 15%
- Wound infection – 1 to 2%
- Bowel obstruction
- Hernias
- Vitamin/mineral deficiency
- Dumping Syndrome
- Weight Gain
Roux-en-Y Gastric Bypass
Hospital Course

• Surgery = 2 to 3 hours
• Inpatient
  ~ 2 night stay

  ■ Sips & chips → clear liquids
  ■ Out of bed same day
  ■ Walking
  ■ Medications: liquid or crushed
Long Term Lifestyle Changes

• Moderate to High Protein
  • Lean protein sources → chicken breast, fish, low fat dairy, lean beef, etc.

• Moderate carbohydrate intake (types)

• No high fat foods OR concentrated sweets

• Adequate fluid intake (no carbonated beverages or fluids with added sugar)

• Eat slowly, chew well

• Limit or avoid alcohol

• Maintain vitamin and mineral regimen

• Physical Activity/Exercise
# Head to Head Comparison

<table>
<thead>
<tr>
<th></th>
<th>BAND</th>
<th>SLEEVE</th>
<th>GASTRIC BYPASS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operative Risk</strong></td>
<td>Least</td>
<td>Least/Intermediate</td>
<td>Most</td>
</tr>
<tr>
<td><strong>Long Term Risk</strong></td>
<td>Most</td>
<td>Least</td>
<td>Intermediate</td>
</tr>
<tr>
<td><strong>Death Risk</strong></td>
<td>0.05%</td>
<td>0.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Weight Loss</strong></td>
<td>Least</td>
<td>Good/Best</td>
<td>Best</td>
</tr>
<tr>
<td><strong>Disease Improvement</strong></td>
<td>Good</td>
<td>Better</td>
<td>Best</td>
</tr>
</tbody>
</table>
## Bariatic Surgery Research Studies

<table>
<thead>
<tr>
<th>STUDY</th>
<th>GOAL</th>
<th>ELIGIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intestinally Targeted Therapies for Obesity</td>
<td>Study the effect of RYBG surgery on fat absorption and intestinal hormone levels</td>
<td>SLEVE RYBG</td>
</tr>
<tr>
<td>GIP in Human Obesity</td>
<td>Measure changes in blood levels of the intestinal hormone GIP-1 after surgery</td>
<td>RYGB</td>
</tr>
<tr>
<td>Pharmacologic Enhancement of LAGB</td>
<td>Study whether two FDA approved drugs can increase weight loss after LAGB</td>
<td>LAP BAND</td>
</tr>
<tr>
<td>Exercise Training following Weight Loss Surgery</td>
<td>Study how exercise training affects body composition after weight loss surgery</td>
<td>All types of surgery</td>
</tr>
</tbody>
</table>
Program Steps

• Weight Loss Surgery Information Session

• New patient packet
  • Complete “mini” packet tonight or call (336) 716-6099 option 1 to request a packet.

• Consultation with surgeon of choice:
  • Dr. Adolfo “Fuzz” Fernandez
  • Dr. Stephen McNatt
  • Dr. Myron Powell

• Once you have an appointment with the surgeon you can schedule:
  • Psychological Evaluation with Dr. Shenelle Edwards-Hampton or Dr. Jeffrey Smith
  • Nutrition Visits with Amber Norris, RD, LDN or Kerry Patrone, RD, LDN
  • Exercise Consultation with Erica Hale, MS or Julie Sorensen, MS
Insurance Authorization

“Each insurance plan has its own provisions and exclusions”

- Blue Cross Blue Shield (state specific)
  - NC – 6 month MD supervised diet (effective 9.10.13)
- Aetna
  - 3 month multi-disciplinary diet
- Cigna
  - 3 month RD supervised diet
- Medicare
  - 6 month MD supervised diet
- Medicaid & Medcost (WFBH employees)
  - 3 month multi-disciplinary diet with bariatric surgery program
- United Health Care (employer specific)

We encourage each patient to also verify their insurance benefits as coverage can change.
Additional Resources

• **Websites**
  • www.wakehealth.edu/weightlosssurgery
  • www.obesityhelp.com

• **Recommended Reading**
  • “Weight Loss Surgery for Dummies”
  • “The LapBand Solution”
  • “Before & After: Living and Eating Well After Weight Loss Surgery”
  • “EXODUS from OBESITY: The Guide to Long Term Success After Weight Loss Surgery”

• **Support Group** (schedule available on our website)
FAQ’s

• Return to work?

• What supplements do I need after surgery?

• When can I get pregnant after surgery?