BARIATRIC SURGERY GUIDE

THE SURGICAL WEIGHT LOSS PROGRAM
AT SEBASTIAN RIVER MEDICAL CENTER

Sebastian River Medical Center
A STEWARD FAMILY HOSPITAL

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SebastianRiverMedical.org/WeightLoss

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WELCOME

This patient handbook contains an overview of the bariatric surgery program for the laparoscopic sleeve gastrectomy, laparoscopic roux-en-y gastric bypass, laparoscopic biliopancreatic diversion with duodenal switch and options for revisional bariatric surgery offered at Sebastian River Medical Center. We also offer robotic assisted bariatric surgery in select patients. Our multidisciplinary team of bariatric surgeons, nurses, nutritionists, psychologists, exercise physiologists and plastic surgeons provides a comprehensive program of the highest standard. We believe that educating patients and preparing them for bariatric surgery is the foundation of patient success, and support after surgery is essential for successful long-term weight loss.

1097SRMCBKT (5/23)

MEET THE TEAM

MEDICAL DIRECTOR BARIATRIC SURGEON
Patrick Domkowski, MD, PhD, FACS, FASMBS

BARIATRIC SURGEON
Kevin Seeras, DO

BARIATRIC PROGRAM COORDINATOR
Jenny Rutledge, RN, MSN

BARIATRIC PROGRAM NUTRITIONIST
Diane Kingsley, RD

BARIATRIC ADMINISTRATIVE ASSISTANT
Mollie Jenks

BARIATRIC NURSE PRACTITIONER
Julia Fuller, APRN, FNP-BC

BARIATRIC OFFICE NURSE
Heidi Tucker, LPN

BARIATRIC PROGRAM INSURANCE COORDINATOR
Odilia Faria

BARIATRIC PATIENT NAVIGATOR
Haley King

FACTS ABOUT OBESITY

Obesity is the most prevalent nutritional disorder in the United States. More than two thirds of U.S. adults are overweight or obese, and the rate has steadily climbed since 1960. The obesity rate in America has doubled in less than 20 years. Obesity is a leading cause of preventable death among adults in the United States. Morbid obesity is a dangerous disease. Many primary care physicians mistakenly believe that obese patients can lose weight if they just change their life style by eating healthy and exercising. This is not true. Obesity is a disease not a choice. As a disease it must be dealt with directly and aggressively with the best tools available, whether they are surgical or medical treatments.

Currently, surgery is proven to be the most effective and sustained treatment to reverse obesity and keep it from coming back.

Obesity is actually defined by a standard weight per height measurement called Body Mass Index, or BMI. Generally, a man or woman would be considered overweight with a BMI of greater than or equal to 25kg/m^2. Obesity is defined as a BMI greater than or equal to 30kg/m^2. Any adult who is 30 pounds over their ideal body weight will likely meet obesity BMI. Extreme or "morbid" obesity is a BMI greater than or equal to 40kg/m^2. Adults, who are at least 100 pounds over ideal body weight, will likely meet morbid obesity BMI.

Obesity can contribute to many other chronic diseases or conditions also known as co-morbidities including:

- Diabetes (Type 2) – A disease in which blood sugar (glucose) levels are too high. More than 80% of people with type 2 diabetes are overweight.
- High Blood Pressure – Also called hypertension. Hypertension occurs when the force of the blood pushing against the walls of the arteries is too high. Your chances of having high blood pressure increases if you are overweight.
- Heart Disease – This condition occurs when a fatty material called plaque builds up on the inside walls of the coronary arteries (the arteries that supply blood and oxygen to your heart). Plaque narrows the coronary arteries which reduces blood flow to your heart. Your chances for developing heart disease and having a heart attack increase as your BMI increase.
- Metabolic Syndrome – A group of risk factors linked to obesity associated with heart disease, stroke, and diabetes. Metabolic Syndrome means having 3 or more of the following risk factors:
    - » A large waistline. This is also called abdominal obesity or having an apple shape. Having extra fat in the waist area is a greater risk factor for heart disease than having extra fat in other parts of the body such as the hips.
    - » Abnormal blood fat levels including high triglycerides and low HDL cholesterol.
    - » High blood pressure
    - » Higher than normal fasting blood sugar levels.

- Stroke – Being overweight or obese can increase your risk for buildup of fatty deposits in your arteries that form blood clots. If the clot is close to your brain it can block the flow of blood and oxygen and cause a stroke. Your risk for having a stroke increases as your BMI increases.
- Certain types of cancer (breast, uterine, colon) – Being overweight or obese raises the risk for colon, breast, endometrial, and gallbladder cancers.
- Osteoarthritis and mobility issues – Pain and mobility problems in the knees, hips and lower back occur when the tissue that protects the joints wears away. Extra weight can put more pressure and wear on joints causing pain.
- Respiratory problems Including Sleep Apnea and Asthma – Respiratory problems can be alarming particularly sleep apnea. Sleep apnea causes a person to stop breathing during sleep. A person with sleep apnea may have more fat stored around the neck area. This makes the breathing airway smaller and more difficult to breath.
- Digestive disorders including gallbladder disease and gastrointestinal reflux – There are several problems that arise in your gastrointestinal tract as a result of being overweight. Stomach acid can escape into the esophagus through a weak or overloaded valve causing burning or acid indigestion. This can also lead to a condition known as Barrett's esophagus, a pre-cancerous change in the lining of the esophagus. In addition, people who are overweight or obese have a greater chance of developing gallstones. The stones are mostly made of cholesterol and can cause back and abdominal pain. The gallbladder does not work the way it should and may become enlarged requiring removal.
- Infertility – Obesity can cause menstrual irregularity and infertility in women.

Quality of life for the obese person is diminished in many ways. Frequently the obese person struggles with depression, hopelessness, and despair. Typically, obese people have tried dozens of weight loss methods including diets and medications, only to realize that no matter how hard they try they cannot lose the excess weight without taking drastic measures such as liquid diets. When they lose weight, they cannot keep the weight off long term. In general people think that obese individuals lack the will power to stop eating too much or simply do not care about their weight or their health. Doctors routinely tell their obese patients to lose weight to help reduce their health problems because they believe patients can be successful, but do not try hard enough. Most doctors do not understand (unless they too are obese) that chronic dieting in their obese patients has led to biochemical changes causing permanent resistance to weight loss. In the 1991 Consensus Statement, The National institutes of Health (NIH) stated the following: "Surgery is the only way to obtain consistent, permanent weight loss for the morbidly obese patient." Scientific studies show that only 5% of morbidly obese people can achieve permanent weight loss using conventional methods such as diet, exercise and behavior modification.

Diet, exercise, and medication have long been regarded as the conventional way to achieve weight loss. Sometimes, these efforts are successful in the short term but for people who are morbidly obese, the results rarely last. In fact, many primary care doctors believe that effective long term weight loss can be achieved through diet and exercise. However this is a myth. Obesity is a disease and often runs in families.

Unfortunately our culture discriminates against obese people resulting in a much lower quality of life than people of normal weight. Physical and social functioning are the most affected but bodily pain, vitality, general health, and emotional and mental health are also significantly impacted. Each day becomes a challenge for obese people particularly when health and quality of life are poor. Obese people may have poor self-image, and often face social isolation and discrimination. When you are obese, the normal day to day activities of living can be challenging. You may tire more easily or experience shortness of breath which can lead to restrictive movement. Travel often becomes an issue as modern airlines are willing to accommodate wheelchair passengers but make little attempt to provide comfortable seating for obese people. We understand that obesity is a disease and not a choice.

CALCULATING YOUR IDEAL BODY WEIGHT AND BODY MASS INDEX (BMI)

Your ideal body weight is the weight statistically determined on insurance actuarial tables to be associated with the lowest mortality for an average individual, adjusting for some combination of height, age, frame size, and gender. Which factors should be included and how ideal weight is determined remains controversial.

The BMI is a statistical measurement derived from your height and weight. Although it is considered to be a useful way to estimate healthy body weight, it does not measure the percentage of body fat. The BMI measurement can sometimes be misleading – a muscleman may have a high BMI but have much less fat than an unfit person whose BMI is lower. However, in general, the BMI measurement can be a useful indicator for the 'average person'.

The formula for calculating BMI is below. You can also go to the Sebastian River Medical Center Bariatric Program website at SebastianRiverMedical.org/WeightLoss and follow the links to calculate your BMI.

BMI = weight in pounds:_____ x 703
Height in inches x height in inches

Dozens of studies with more than a million adults have shown that a body mass index (BMI) above 25 increases the chances of dying early, mainly from heart disease or cancer, and that a body mass index above 30 dramatically increases the chances. By convention, overweight is defined as a body mass index of 25 to 29.9, and obesity is defined as a body mass index of 30 or higher.

Nothing magical happens when you cross from 24.9 to 25 or from 29.9 to 30. These are just convenient reference points. Instead, the chance of developing a weight-related health problem increases across the range of weights.

WHAT IS BARIATRIC SURGERY

Bariatrics is a branch of medicine that deals with the causes, prevention and treatment of obesity. The field of bariatric surgery is a specialty dedicated to the surgical treatment of people who are suffering from health consequences as a direct result of excess weight, when other measures have been unsuccessful.

While all operations have risks, bariatric procedures performed at accredited centers are safe and have a low risk for complications. Annually we perform 120-200 laparoscopic sleeve gastrectomies, 50-70 gastric bypass surgeries and 30-50 revisional surgeries. The biliopancreatic diversion with duodenal switch is not as common. Please discuss procedure rates with the surgeon.

MINIMALLY INVASIVE SURGERY, LAPAROSCROPIC SURGERY, AND ROBOTIC SURGERY

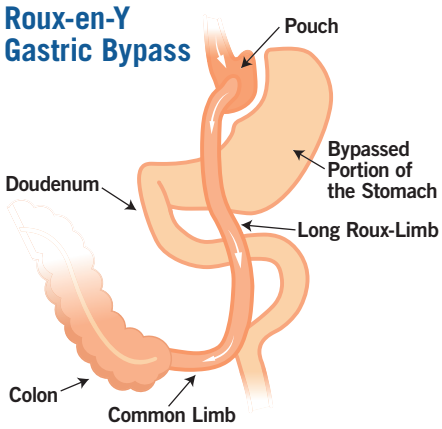
For the last decade, laparoscopic procedures have been used in a variety of general surgeries. Many people mistakenly believe that these techniques are still "experimental." In fact, laparoscopy has become the predominant technique in some areas of surgery and has been used for weight loss surgery for several years. Although few bariatric surgeons perform laparoscopic weight loss surgeries, more are offering patients this less invasive surgical option whenever possible.

When a laparoscopic operation is performed, a small video camera is inserted into the abdomen. The surgeon views the procedure on a separate video monitor. Most laparoscopic surgeons believe this gives them better visualization and access to key anatomical structures.

The camera and surgical instruments are inserted through small incisions made in the abdominal wall. This approach is considered less invasive because it replaces the need for one long incision to open the abdomen. A recent study shows that patients having had laparoscopic weight loss surgery experience less pain after surgery resulting in easier breathing, improved lung function and higher overall oxygen levels. Other realized benefits with laparoscopy have been fewer wound complications such as infection or hernia, and patients returning more quickly to pre-surgical levels of activity.

Laparoscopic procedures for weight loss surgery employ the same principles as their "open" counterparts and produce similar excess weight loss. Not all patients are candidates for this approach, just as all bariatric surgeons are not trained in the advanced techniques required to perform this less invasive method. The American Society for Bariatric Surgery recommends that laparoscopic weight loss surgery should only be performed by surgeons who are experienced in both laparoscopic and open bariatric procedures. Dr. Domkowski and Dr. Seeras are trained in open, laparoscopic and microscopic surgical techniques.

ROUX-EN-Y GASTRIC BYPASS



The most common operation for weight loss in North America is the Roux-en-Y Gastric Bypass. This procedure divides the stomach into two compartments, creating a small pouch (about 30ml or 1 ounce) that remains connected to the esophagus (food pipe). The larger portion of the stomach (excluded stomach) is left in its place and not removed. The two parts of the stomach are completely separated. The small intestine is divided downstream from the stomach and one of its ends is attached to the small stomach pouch. Ingested food goes into the small intestine and bypasses the stomach, hence the name of the procedure.

The intestine is then reconnected downstream from the pouch to receive the acid secretions made by the bypassed portion of the stomach. Absorption of food occurs in the common channel where ingested food meets the acid and bile from the bypassed stomach. Weight loss is achieved by two methods with this procedure. One way is a "restrictive" process where you feel full quickly and eat less due to small stomach pouch. The second way is through a "malabsorptive" process, where by limiting the length of the intestine that comes in contact with food, you limit the amount of food absorbed by the body. Expected weight loss following gastric bypass is 70-80% at 2 years.

Following bariatric surgery you will need to follow a specific diet that you will review with the nutritionist. Weight loss may be more rapid than other types of weight loss surgeries and as a result you may develop vitamin and mineral deficiencies. You will be asked to take nutritional supplements for the rest of your life. You also will need periodic laboratory tests to evaluate such deficiencies.

Research published in the New England Journal of Medicine showed a significant improvement in patients with type 2 diabetes mellitus following gastric bypass and sleeve gastrectomy when compared to those patients receiving intensive medical treatment for their diabetes. There was also improvement in cardiac risk factors allowing for modification in lipid-lowering agents and anti-hypertensive therapy.

The advantages of Roux-en-Y Gastric bypass are the following:

- Considered the gold standard and results in reliable and long lasting weight loss
- It has the most extensive long term outcome data of all bariatric surgeries
- Dramatically improves co-morbid conditions such as non-insulin dependent diabetes, sleep apnea, and hypertension

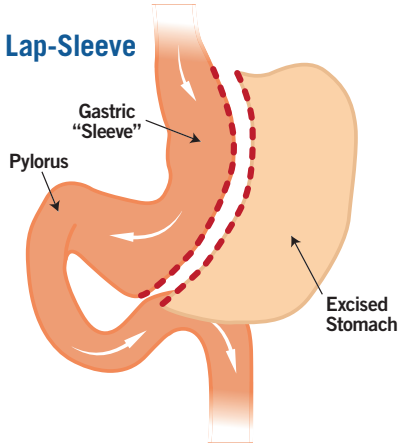
The adverse outcomes or disadvantages of Roux-en-Y Gastric bypass are the following:

- Dumping syndrome occurs when you eat sugar or fat after your surgery. Your body releases excess insulin as a result of the types of food you eat, however this problem is very infrequent
- Malabsorption of nutrients may occur due to the diversion of your small intestine. You will be required to take vitamins and minerals to prevent deficiencies.
- Gallstones following gastric bypass are common. If you still have your gallbladder and you currently have symptoms, your surgeon may recommend removing your gallbladder at the time of your surgery.
- There is a for small bowel complications and obstruction

THE LAP-SLEEVE

A highly effective weight loss surgery is the laparoscopic sleeve gastrectomy, (LSG) also known as the vertical sleeve gastrectomy. Through five small incisions (between 0.5 and 1 inch) 80% of the stomach is removed. This transforms your stomach into a long tube or a "sleeve" similar to your shirt sleeve. The new stomach has a total capacity between 90 and 120 mls. People undergoing the laparoscopic sleeve gastrectomy eat a small amount of food (1-3 ounces) and they are full or satisfied.

The laparoscopic sleeve gastrectomy is an excellent weight loss procedure that provides lasting resolution of comorbidities and long-term weight loss. There are several reasons for this. First, the normal course of flow of food through the gastrointestinal tract is not altered. Therefore there is no dumping syndrome and the risks of nutritional deficiencies are minimal. Secondly, Ghrelin, the hunger hormone, is reduced during the surgery when the outer portion of the stomach is removed. When Ghrelin levels are reduced the desire to eat is significantly diminished. Ghrelin levels have been found to be reduced 5 years following laparoscopic sleeve gastrectomy. Also the long term risks of gastric ulcers and internal hernias are eliminated with the sleeve, where they remain long term risks with gastric bypass patients.



Data recently presented at the International Sleeve Gastrectomy Summit demonstrate that weight loss with the laparoscopic sleeve gastrectomy is significant (60-70% of excess weight gone at 2 years) and is maintained long term. In a recent consensus article on laparoscopic sleeve gastrectomies, a review of over 12,000 cases found the sleeve gastrectomy to be a safe long-term solution to both morbid obesity disease and the metabolic complications it causes such as type II diabetes, hypertension and obstructive sleep apnea.

The advantages of the Lap-sleeve are the following:

- No intestinal bypass or foreign body
- No adjustments are needed
- Minimizes hunger/appetite hormone, Ghrelin
- No dumping syndrome

The adverse outcomes or disadvantages of the Lap-sleeve are the following:

- Soft calories such as ice cream, milk shakes, etc. can be absorbed and may slow weight loss
- Stomach stapling is involved and therefore leaks and other complications related to stapling may occur
- Because part of the stomach is removed, it is not reversible, but it can be converted to another weight loss procedure such as a gastric bypass
- Patients with pre-existing reflux disease may experience a worsening of their disease following surgery

BILIOPANCREATIC DIVERSION WITH DUODENAL SWITCH (BPD/DS)

The biliopancreatic diversion with duodenal switch (BPD/DS) is a combined surgery that makes your stomach smaller and bypasses part of your small intestine for the best-reported, long-term percentage of weight loss of 80-90% of excess body weight.

There are two parts to BPD/DS surgery:

The restrictive part uses a sleeve gastrectomy to make the stomach smaller while it works normally. The DS surgery keeps the pyloric valve intact, unlike other surgeries that bypass it. Keeping the pyloric valve intact lowers your risk of getting certain ulcers, or a blocked or narrowed opening (stoma).

The malabsorptive part of this surgery rearranges the small intestine to separate the flow of food from the flow of bile and pancreatic juices. This means you absorb fewer calories from most foods. Further down the digestive tract, the divided paths are rejoined. Food and digestive juices begin to mix, and some absorption happens in the common tract as the food continues on its path toward the large intestine.

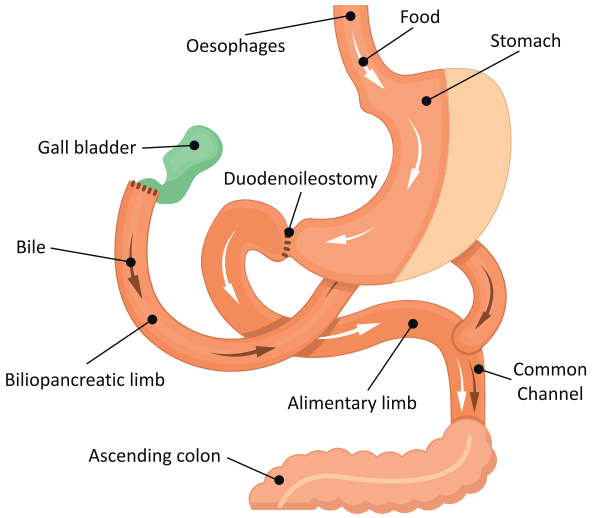
The advantages of BPD/DS:

- Larger, almost effortless weight loss
- Allows more normal eating habits
- Less hunger
- Ulcers less likely
- No Dumping Syndrome (when undigested food is “dumped” into small intestine too quickly, causing cramps and nausea
- Least chance of weight return

The adverse outcomes or disadvantages of the BDP/DS:

- BPD/DS has a higher risk of surgery complications and a longer recovery period than other bariatric surgeries
- Has the highest risk of nutritional deficiencies, mandatory to take nutritional supplements for life
- You may have more frequent, foul-smelling stools
- You will need life-long follow up care

BILIOPANCREATIC DIVERSION
WITH A DUODENAL SIWTCH **(BPD-DS)**



REVISIONAL SURGERY

Converting a lap band to a lap sleeve or lap gastric bypass

Sometimes after people undergo laparoscopic adjustable gastric banding (LAGB) surgery experience problems. These problems may include significant heartburn that does not seem to get better even with medication. They may also experience vomiting or difficulty eating despite being properly adjusted. This does not happen frequently but when it does occur it can be very frustrating. Alternatively, the esophagus (the tube above the stomach) may become dilated from the band being too tight for long periods of time. This is not a safe situation long term as it may lead to esophageal dysfunction or erosion of the band into the stomach.

Gastric Bypass Revision

If you have had a gastric bypass, either laparoscopic or open and you were initially successful, but now have experienced weight regain and are discouraged we are here to tell you there is hope for you and there are options. Often the gastric pouch and opening to your intestine can be surgically revised. This can be done laparoscopically even if your previous surgery was open. Both your pouch and opening to your intestine (stoma) can be reduced in size so that you can relose the weight and comorbidities. There are also other options for some patients such as modifying the length of intestines exposed to food absorption.

Both Dr. Domkowski and Dr. Seeras specialize in revising gastric bypasses. Before your surgery we will need to perform some tests to determine your previous surgery, but they are done on an outpatient basis.

PATIENT SELECTION

Each patient is evaluated on an individual basis. There are patient selection guidelines established by the American Society of Metabolic and Bariatric Surgery and the National Institutes for Health. There is no absolute rule as to which patient is accepted for surgery or not accepted for surgery. The option of surgical weight loss is offered to patients who are severely obese, well informed, motivated, and understand the surgical risks associated with the procedure.

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The following are factors considered during your evaluation process:

- Adult at least 18 years of age
- Have a BMI of 30 or greater with co-morbidities (health problems), or have a BMI greater than 40 with or without comorbidities
- Have failed at previous attempts to achieve lasting weight loss
- You do not have schizophrenia, or severe personality disorder
- You are physically able to undergo a surgical procedure
- You don't drink alcohol in excess
- You are motivated and willing to make the life-style changes necessary to be successful
- You are willing to continue working with Dr. Domkowski or Dr. Seeras, and the bariatric team after your surgery

Possible relative contradictions for weight loss surgery may include the following:

- You are under the age of 18
- If you have an inflammatory disease of the gastrointestinal tract like Crohn's disease, ulcerative colitis, or severe esophagitis
- You are a poor candidate for surgery if you have severe heart or lung disease
- If you have any other disease that would not clear you for anesthesia or surgery, you would be a poor candidate
- You have portal hypertension
- Have an autoimmune disease or connective tissue disease such as systemic lupus erythematosus or scleroderma
- You have cirrhosis
- You have chronic pancreatitis
- If you are currently pregnant
- If you take long-term chronic corticosteroids treatments
- Addiction to drugs or alcohol
- Infection anywhere (including dental) at the time of surgery
- You cannot or are not willing to make changes to your diet following surgery
- Tobacco/nicotine within the last 6 weeks

You will be asked to participate in a long-term follow-up program. This means effective management of life-style changes including physical activity, healthier eating and portion control. You will also need to have routine annual visits with your primary care physician for periodic blood work. Your ability to become motivated and stay motivated is critical to your success. The Bariatric Team will work with you every step of the way to empower you towards success.

1097SRMCBKT (5/23)

PATIENT INFORMATION WEBINAR

Our program requires that all patients attend the free informational surgical weight loss webinar.

The following topics are covered in the webinar:

- The anatomy and physiology of the surgeries (lap sleeve, lap gastric bypass, lap biliopancreatic diversion with duodenal switch (BPD/DS))
- Short-term and long-term patient results and outcomes, data and statistics
- Risks and complications

Please visit SebastianRiverMedical.org/WeightLoss and click the link to view the webinar. It is mandatory that you watch the webinar before surgery can be scheduled.

PATIENT CONSULTATION WITH THE BARIATRIC SURGEON/APRN

After viewing the webinar, if a person decides that surgical weight loss is the right choice for them they will need to see the bariatric surgeon for a consultation. This consultation is often covered by insurance. If it is not or you are paying for the surgery yourself, please check with our office coordinator for the current pricing.

Please bring the following items with you to the consultation:

- Documentation from you primary care physical of your health history especially pertaining to weight loss, asthma, sleep apnea, hypertension, high cholesterol, diabetes, and current medications
- Your insurance card
- A list of questions you have regarding the surgery, recovery etc.

At your visit, the bariatric surgeon will conduct a history and physical; review your weight history, and previous weight loss attempts. The surgeon will also determine from a surgical standpoint if you are a good candidate for weight loss surgery. If you are a candidate, he will discuss the specifics of the surgery, which surgery you desire and why. We will also discuss the benefits, risks and expected recovery of your surgery.

It is very important that if you have had a previous infection from a past surgery or for any reason at all that you inform the surgeon during your consultation. Your preparation for the surgery may be altered and you may be required to go on oral antibiotics for a period of time prior to your surgery.

Similarly, if you have ever experienced a blood clot from a prior surgery or for any other reason it is critical that you inform the surgeon and our team. This will also alter how we prepare you for your surgery.

Most patients make the decision to go forward with surgery at this time. They are then required to undergo a psychological evaluation and a nutritional consultation. The licensed psychologist will conduct your initial assessment as well as arrange for follow visits as needed after you have recovered from your surgery. Your nutritional evaluation will be conducted by our specially trained registered nutritionists at the outpatient dietician office or via telehealth.

After completing both the psychological and nutritional assessments you will return to the office to see the surgeon and set up a date for the surgery. Even before your visit our office will contact your insurance company to determine your benefits. We also encourage you to call your insurance company as well. You can often determine if bariatric surgery is a covered benefit. The CPT code for Sleeve Gastrectomy is 43775 and CPT code for gastric bypass is 43644. Please be sure to tell your insurance company this code as it will help them determine if this surgery is covered under your policy.

PRE-OPERATIVE PREPARATION

MEDICALLY SUPERVISED WEIGHT LOSS

Some insurance companies require patients to complete a "medically supervised weight loss program" for 3 or 6 months before they will approve you undergoing the surgery. Most patients are unsuccessful with sustainable weight loss after these programs. If you are required by your insurance company to complete a medically supervised weight loss program, you must do these monthly visits in our office. Our staff is familiar with insurance company requirements for these monthly consecutive visits. We include all of the pertinent information regarding your weight history and how that has impacted your health and quality of life. Frequently we are very successful at getting your surgery approved. Many patients will have some doctor notes or notes from a program supervised by nutritionists addressing weight management from previous visits. We encourage you to bring these with you to your consultation with the surgeon. If they are appropriate we will submit them along with our documents to your insurance company.

PSYCHOLOGIST

Following your consultation with the surgeon, you will be given instructions to arrange for your psychological evaluation. You will be required to make your appointment with a licensed bariatric psychologist. The psychologist will conduct an initial evaluation as a part of the preoperative preparation. Follow up with the psychologist is not required but is sometimes recommended to help support the patient on their weight loss journey.

NUTRITIONIST

You will also be required to meet with a nutritionist prior to the surgery and can follow up with dietician after surgery as needed. During your evaluation with the nutritionist, you will review the diet booklet that specifies your diet just prior to and following the surgery. The general expectation is a 2-week liver shrinking diet followed by a clear liquid diet for 2 days prior to surgery. There may be adjustments made to this plan at the surgeon's discretion.

SCHEDULING FOR SURGERY AND PRE-OP TESTING

Once we obtain approval from your insurance, our office will contact you with a tentative surgery date and schedule your pre-op labs and remaining visits to our office. Pre-op testing consists of: Lab work, other testing as needed: EKG, UGI, Stress test and chest x-ray.

1-2 WEEKS PRIOR TO SURGERY

When your surgery is scheduled you will have received a "start date" for beginning your liquid diet. You should have received your diet booklet and food scale. You should be completely comfortable with starting your liquid diet. If you are not, please contact the nutritionists or bariatric surgeon's office immediately.

In addition if you are a cigarette smoker or use other tobacco products, you will have to discontinue use these products for at least 4 weeks before surgery. Nicotine prevents wound healing, and smoking reduces lung capacity and stamina. Patients must be tobacco/nicotine free for a minimum of 4 weeks prior to surgery. This may include testing your urine prior to surgery to ensure you are tobacco free.

3 DAYS PRIOR TO SURGERY

You will have received from our office a bottle of antibacterial surgical soap. We want you to shower with this soap daily for three days prior to your surgery. This will help reduce the normal bacteria that all of us have on our skin.

In addition, one of the nurses from Ambulatory Care, our pre-op area, will contact you to obtain a medical history and to provide additional information on time of arrival to the hospital, where to go, eating/drinking instructions, and to answer any questions you may have.

DAY OF SURGERY

The day of your surgery you will go to the preoperative area, where you will be weighed. Family members (or significant others) may accompany you to Ambulatory Care. There you will be prepared for surgery, an IV will be started, and you will be given pre-op medications to enahnce your recovery and prevent complications. Your family may stay with you until you are transferred to the pre-surgery area.

While you are in surgery, your family will be advised to wait in the waiting room. Immediately after your surgery is completed, the surgeon will go to the surgery waiting area and talk with your family. The surgery itself generally takes anywhere from 1-3 hours – however, total time from the OR to the recovery room can take about 4-5 hours.

Sequential Compression Devices will remain on your legs to prevent blood clots. These function independently, do not cause discomfort, and are effective in reducing the incidence of blood clot formation in the legs. The single most effective way to prevent blood clots and pneumonia (the two most common complications after any surgery) at this critical post op period is get out of bed and walk. Once you have been evaluated by the nurse, you will be getting out of bed to a chair and then walk with assistance down the hall.

HOSPITAL STAY OVERNIGHT

This is a minimally invasive surgery. Therefore you can expect to spend one night in the hospital and go home the next day. However, there are some clinical conditions that may require a longer stay. Your surgeon will make that decision based on individual health history and progress.

BARIATRIC SURGERY POST-OP INSTRUCTIONS

SAFETY

- YOU MUST have a responsible person with you for the first 24 hours following discharge home!
- YOU MUST have someone available to drive you home from the hospital.
- General criteria to drive post-surgery is that you have been off pain medications for 24 hours and can check your blind spots without discomfort. Please confirm with the surgeon if you have any concerns about driving.

CALL THE OFFICE

- If you experience excessive abdominal pain, nausea/vomiting lasting 2 hours or more, rapid heart rate, shortness of breath, new onset swelling/pain in legs (especially if it is one-sided), temperature above 101, persistent low-grade temperature, or any other distressing symptoms not managed by conservative measures.

BOWEL FUNCTION

- It is important to avoid constipation especially while using pain medication.
- Start taking a stool softener twice a day at home. (i.e. Colace)
- If you have not had a bowel movement by day 2 upon returning home, start taking milk of magnesia 2-4 tbsp every 6 hours as needed until you have a bowel movement.
- Gas pain is common after surgery. The best way to get rid of gas is to walk often.
- Some foods may cause unusual bloating or heavy gas. Minimize or avoid these foods. You may take Gas-X or any anti-gas medication containing simethicone.

ACTIVITY

- It is important to be active and walk frequently after surgery. You should be on your feet at least every hour during the day.
- Avoid lifting anything greater than 15 pounds for 4 weeks and avoid repetitive bending, twisting.
- Incentive spirometer (IS): Continue to use your IS several times a day for 2 weeks after discharge.

MEDICATIONS

- When discharged from the hospital you will be given a written medication plan. Take your medications as prescribed by your surgeon. It is very important to follow-up with your primary care physician within 1-2 weeks to review changes and for ongoing health management.

WOUND CARE

- You may have Dermabond (glue) on your incisions that will fall off on its own.
- If you have cover dressings on your incisions, it is okay to remove them. Allow the Steri-Strips to remain in place.
- You may shower, but no tub baths or swimming.

NAUSEA/VOMITING

- Nausea and vomiting may occur following surgery. Do not be alarmed unless this persists.
- Vomiting can be caused by drinking or eating too quickly or too much at once. Remember to drink small amounts frequently, eat slowly, take small bites and chew well.
- If you are having persistent nausea/vomiting, lasting 2 hours, stop your pain medication and call your surgeon's office regardless of day or time

COMFORT

- Discomfort at the incision sites will significantly improve in 3-5 days after surgery. It is important to keep your pain under control, so you can get up, be active and do your deep breathing exercises.
- You may wear an abdominal binder as desired for comfort.
- Remember to hold (support) your abdomen when you cough or sneeze. You may have bruising around some of your incisions. You may want to try placing ice over these areas. Be sure to apply ice for no longer than 20 minutes at a time.
- If you are having excessive abdominal pain that is not relieved by your pain medication call your surgeon's office regardless of day or time.

DIET/HYDRATION:

- STAY HYDRATED. Sip on sugar free, low-calorie fluids throughout the day with a goal of 64 oz. per day.
- Follow the nutritional manual provided. DO NOT ADVANCE your diet more quickly than is outlined in your manual. You can advance slower if needed. Call your surgeon's office with any questions.

FOLLOW UP

- Please anticipate a follow up call after discharge. It is extremely important that we reach you.
- Plan to have a follow-up appointment with your primary care doctor within 1 to 2 weeks following surgery to review medication changes.
- You should already have your postoperative appointment scheduled at the time of discharge. If not call your surgeon's office within 2 business days of your discharge.
- You will meet with the bariatric team on a regular basis after your surgery. It is important for us to follow your progress and assist you through your weight loss journey.

SUPPORT GROUP

- Our support group meets regularly on the 4th Tuesday of every month at 6:00 pm in the dining room at Sebastian River Medical Center and virtually on Facebook live.

Date: _____ Signature: _____

PHYSICAL ACTIVITY FOR BARIATRIC PATIENTS

Physical activity is very important to the success of your surgery. We believe that surgery is only a small portion of the overall equation to succeeding at weight control. Making the lifestyle changes necessary for your success starts now. In addition to implementing good nutrition habits and smoking cessation, physical activity will be a critical part of your path to health and wellness.

There are several reasons to exercise:

- Achieving and maintaining your goal weight
- Build muscle tissue
- Increase strength & endurance
- Increase metabolism & burn fat
- Improve mobility
- Enhance mood
- Improve self-esteem
- Lower blood pressure and blood sugar
- Promote sleep
- Decrease stress, depression & anxiety
- Improve heart & lung function
- Promote healing & flexibility
- Improve skin elasticity & reduce joint stiffness

Unless you are physically unable, you should begin walking daily or doing some type of aerobic (cardiovascular) exercise activity. Some examples of aerobic activity are walking, biking, treadmill, and water exercise. Be sure to stretch before and after your exercise periods to maintain flexibility. You should try to achieve 30-40 minutes of cardiovascular activity daily prior to your surgery and resume your physical activity program gradually over the first 2-3 weeks as recommended by your doctor until you are back to 30-40 minutes of cardiovascular activity daily. Resistance training (lifting weights) can be added to your exercise activity after the second month following your surgery.

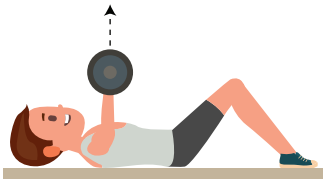
A home exercise program to strengthen and tone your muscles should be started prior to your surgery. This will assist in your recovery from surgery as well as develop an activity regimen that you can follow after surgery.

Home Exercise Program

1. Begin by performing 1 set of 10-15 repetitions for each exercise.
   Gradually increase to 3-5 sets of 10-15 repetitions over a 4-7 week period.
2. The speed of each movement should be 2 seconds up and 4 seconds down.
3. Begin with dumbell weight that you can easlily lift 10-15 times.
4. Wear shoes to prevent falls.

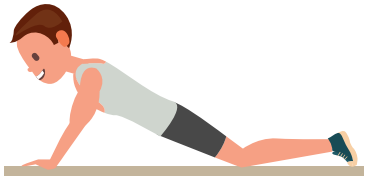
Abdominal Crunch

Lie on bed or floor with arms across chest. Raise the upper back slightly, keeping the neck in neutral position and eyes focused on the ceiling.



Chest Press on Bed/Floor

Lie on bed or floor. Grasp a dumbell in each hand. Begin with the dumbells at chest level and press the dumbells straight up until arms are fully extended.



Modified Push Up Chest Press

Lie on the floor with arms shoulder-width apart and knees on the floor. Begin by pressing the body up with arms fully-extended.

Tricept Kickback

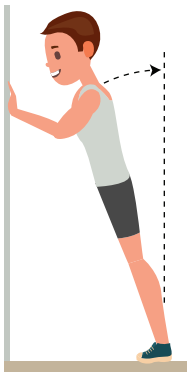
Sit in a chair. Grasp a dumbell in one hand. Begin with elbow bent and dumbell at side. Extend dumbell backwards, fully extending arm.

Squats

Stand in front of a chair with feet soulder-width apart. Sit down slowly, then stand up. Keep arms outstretched.

One Arm Roll

Stand with left foot forward, right foot back. Place hand on sturdy surface approximately 25 inches tall. Grasp dumbell with right hand. Start with dumbell aligned with left knee and pull up toward waistline. Reverse feet, and repeat with left hand

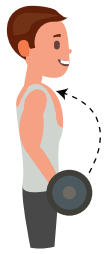


Chest Press on Wall

Stand in front of a wall. Begin by leaning back into the wall and press back.

Chest Press on Counter

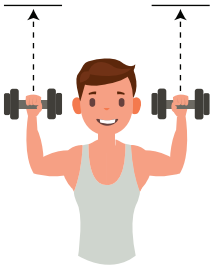
Stand in front of the kitchen counter with hands shoulder-width apart. begin by leaning into the counter and press back.



Bicep Curl

Sitting or Standing

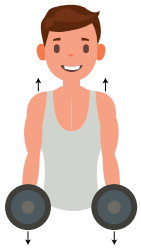
Grasp a dumbell in each hand, palms facing forward. Curl the dumbell up by flexing at the elbow.



Shoulder Press

Sitting or Standing

Grasp a dumbell in each hand, palms facing forward. Begin with the dumbells slightly above shoulder level and press them up overhead.



Shoulder Shrugs

Grasp a dumbell in each hand with arms at your side. Keep your elbows straight and shrug your shoulders up towards your ears.

NUTRITIONAL PLAN

As you will make lifestyle changes in your physical activity, you will also make changes in your diet. All of the changes you will need to make will be outlined in greater detail during your Pre-operative meeting with the Bariatric Nutritionist. It will be important that you FOLLOW THIS PLAN CAREFULLY. You will receive a nutrition book that you will review thoroughly during your Nutritionist appointment, but there are some general rules that must be followed regardless of your surgical procedure. Please refer to your nutritional manual for more details.

1. EAT SLOWLY AND CHEW THOROUGHLY
2. STOP EATING WHEN YOU FEEL FULL
3. DO NOT DRINK WHILE YOU ARE EATING
4. DO NOT DRINK 30 MINUTES BEFORE YOUR MEALS AND AT LEAST 30 MINUTES AFTER YOUR MEALS
5. DO NOT EAT BETWEEN MEALS
6. EAT ONLY GOOD QUALITY FOODS
7. AVOID FIBROUS FOODS
8. DRINK ENOUGH FLUIDS DURING THE DAY BUT THEY SHOULD BE LOW OR NO CALORIE ONLY – NO CARBONATED DRINKS OR JUICES
9. EXERCISE AT LEAST 30 MINUTES EACH DAY

FOODS TO AVOID

You will review a list of foods to avoid during your visit with the nutritionist. All of this information will also be included in the nutrition book you receive specific to your type of surgery. Past experiences tell us that there are some foods not well tolerated following weight loss surgery. Some of the foods you might want to avoid are potato skins, onion skins, fruit peelings, and the membranes between orange and grapefruit sections, the stringy portion of celery, asparagus, string beans, untoasted bread, and high caloric, high fat foods and beverages. Some patients have difficulty with chicken, steak and pork. Most patients have some difficulty with rice, pasta and tortillas. You will not be able to drink carbonated beverages after your surgery. This includes diet sodas and carbonated water and tonic water. The carbonation from these fluids regardless of calorie count increases the risk of expanding your new stomach pouch.

VITAMINS AND MINERALS

You have decided to make lifestyle changes. One of the changes you must make is to take daily vitamins and minerals. Since you are taking in smaller amounts of food and nutrition after your surgery, you will likely not get the minimum daily requirement of many nutrients, vitamins and minerals. You will need to take daily multivitamins, calcium with vitamin D and possibly vitamin B12.

SUPPORT GROUP

Bariatric patient support groups have proven to be an essential part of the recovery process for many patients. Research shows that patients who regularly attend support group meetings have better weight loss. All potential and post- operative patients and supportive family and friends are invited to join these meetings. Support groups offer a comfortable, secure forum for patients who have already had bariatric surgery, and for new patients considering or awaiting surgery. Patients can learn a tremendous amount when sharing their individual experiences with others. We think that support group attendance is so important to patient education and patient recovery that it is strongly recommended that new patients awaiting surgery attend at least one support group meeting prior to having surgery

Support groups are held twice a month:

- 4th Tuesday of every month, at 6 p.m. in the cafeteria at Sebastian River Medical Center.
- Please follow our Facebook page at Steward Bariatric and General Surgery to attend virtual support groups.

If you are interested in being added to our support group email list, please contact the office at 772-581-8003.

RISKS AND COMPLICATIONS

Bariatric surgery is considered a safe surgery, however with any surgery there is a risk of complications.

The risk of deep vein thrombosis and/or pulmonary embolus (blood clots) can occur with any surgical procedure, but the risk is increased when your BMI is increased. We take every precaution to prevent blood clots from occurring by giving adequate anti-coagulation (blood thinning medication) for your BMI and surgical procedure. You will also wear anti-embolism stockings while in bed to decrease risk of a blood clot and getting out of bed and walking frequently.

There is a low risk of infection anytime you have a surgical procedure. We take every precaution to prevent infectious complications from occurring. You will be given surgical soap to use prior to your surgery. This will decrease the bacteria that normally grow on your skin and decrease the risk of infection. We will also give you intravenous antibiotics prior to your surgery. Please contact us immediately if you have any signs of infection prior to your surgery. Your surgery may need to be postponed while your infection is treated with antibiotics.

A leak at the staple line is complication of the sleeve gastrectomy and gastric bypass procedures. .

The surgical complications described above carry a very low risk of less than 1%. We take every precaution to keep these complication rates low.

BENEFITS – EXPECTATIONS – OUTCOMES

Bariatric surgery is not a cure for obesity; it is a tool to help patients lose weight and keep it off long term. It is not automatic, and your behavior and commitment after surgery plays a very large part in the success of outcome. After bariatric surgery, you can expect to feel full on smaller meals; have less hunger, feel an improved sense of self-control, and will find it easier to avoid snacking between meals. To be successful, you will want to avoid snacking between meals, avoid foods high in sugar and carbohydrates, like alcohol or ice cream, avoid high calorie liquids, and avoid drinking fluids at least 30 minutes before and after meals. You will need to eat nutritious and healthy, be active and exercise, and make psychological adjustments.

Weight loss after bariatric surgery has been shown to dramatically improve medical conditions such as diabetes, high blood pressure, obstructive sleep apnea, reflux diseases (GERD), and joint pain. Type II diabetic patients obtain excellent results after surgery. Many physicians now believe that bariatric surgery may be the best treatment for type II diabetes in the obese patient.

Patients with asthma find that they have fewer and less severe attacks after surgery especially when attacks are triggered by episodes of gastric reflux. Other respiratory problems are improved after surgery. Patients who were unable to walk without getting short of breath prior to surgery, find that they can actually participate in most family activities and can begin more vigorous exercise within a few months after surgery. Sleep apnea decreases dramatically as patients lose weight.

ACHIEVING SUCCESS

One of the most essential keys to success after weight loss surgery is to thoroughly understand that the surgery is not magical. The new pouch that restricts your capacity to eat and gives you an early feeling of satiety (fullness), is a “tool” you put to work to help you control your weight for life. The pouch tool is one part of a larger process that requires you to put forth great effort to decrease your weight for life. In order for the pouch tool to work, the many rules of diet and exercise must be followed. The sooner you become completely familiar with the guidelines in this booklet, the better you will do and the greater success you will enjoy!

LONG-TERM FOLLOW-UP

Research has shown that patients who have achieved the greatest success in their weight loss journey are those that maintain a long-term relationship with their primary care physician and bariatric team. It is strongly recommended that you see your physician and your bariatric surgeon regularly for basic laboratory studies and physical examination.

INSURANCE AND FINANCIAL INFORMATION

Most bariatric surgeries are covered by insurance policies when it can be established that the patient is "morbidity obese", that the surgery is "medically necessary", and that the patient has attempted and failed at previous weight loss trials.

The process for getting coverage involves several steps, and in some cases different strategies, depending on the type of insurance, and the practices of individual insurance companies. Proof of medical necessity may also include the need for further medical testing to measure and clarify the degree of health risk of a given health problem. For example, a diagnosis of sleep apnea may need to be confirmed by a sleep study, when symptoms suggest that it is present.

Insurance carriers may want proof that you have dieted under the supervision of a physician – even though no study has ever shown scientifically that diets have long term therapeutic benefit in the obese person.

INDEMNITY AND PPO INSURANCE PLANS

We will prepare and submit a letter to your insurance carrier, requesting certification of your insurance coverage, and authorization for you to proceed with surgery. This letter will detail and specify each of the indications for surgery, and any corroborating information from other physicians. In addition, we will include the information you have personally submitted to us. It they issue an initial denial, you have the option of initiating an appeal.

HEALTH MAINTENANCE (HMO) AND MANAGED CARE ORGANIZATIONS

Managed care organization may not accept a letter or request from our program directly. You will most likely be required to see your primary care physician to get a referral for bariatric surgery. If you have not already visited your primary care physician for the purpose of a surgical referral, we can prepare a request letter, addressed to you which details the severity of your weight-related health problems, and the indication of surgery. If you cannot get a referral from one of the primary care physicians in your organization, you may have to pursue the grievance process provided through your carrier. If this is the case, do not give up hope. Continue to work through the process, and request a hearing if necessary. Most patients, who have valid indications for surgery, prevail in the end.

SELF-PAY / CASH-PAY

If you are interested in learning about the cash pay option available to patients, please contact us. Sebastian River Medical Center has a self pay fee schedule for patients that do not have coverage through their insurance company.

PATIENT CHECKLIST

BRING THIS LIST WITH YOU TO ALL YOUR VISITS

- ☐ Informational Webinar – Date: _____
- ☐ Financial approval for surgery – Date: _____
- ☐ Initial visit with Surgeon or APRN – Date: _____
- ☐ Start exercise program: Walking _____
- ☐ Nutritionist – Date: _____
- ☐ Psychologist – Dates: Pre-surgery _____ Post-surgery _____
- ☐ Attend Support Group Meeting (optional) – Date: _____
- ☐ Quit smoking – Date: _____
- ☐ Pre-operative Testing – Date: _____
- ☐ Pre-operative surgery visit with Dr. Domkowski/Dr. Seeras – Date: _____
- ☐ Start pre-op diet – Date: _____
- ☐ Start using antibacterial surgical soap – Date: _____
- ☐ SURGERY – DATE: _____
- ☐ Have I asked all my questions? And were they answered? _____
- ☐ Other testing: _____

_____

_____

_____

REFERENCES

The American Society for Metabolic and Bariatric Surgery – ASMBS.com

American Obesity Association – obesity.com

Sebastian River Medical Center Weightloss – sebastianrivermedical.org/weightloss

AACE/TOS/ASMBS Guidelines. Surgery for Obesity and Related Diseases. 4 (2008) S109-S184.

NOTES:

NOTES:

Sebastian River Medical Center

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