Mercy

Mercy Bariatric Surgery Patient Guidebook

Surgical Treatment of Morbid Obesity:

A Patient Choice

SPR_22911 (4/6/12)

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Welcome

The information in this packet is offered to provide information on surgical management of Morbid Obesity. It is important for patients who are considering weight loss surgery to be well informed regarding indications for surgery and benefits and risks of surgery. This packet will give you information to help you decide, along with our health care professionals, if surgery for weight loss is right for you. Mercy has a team of health care professionals that will help give the greatest chance for long-term success with weight loss surgery. The surgeons at Mercy have had extensive training and experience in bariatric surgery, both open and laparoscopic. In preparation for the journey, a group of health care professionals has been assembled with expertise in many fields that will assist you as you make life changes to improve your overall health.

WELCOME
- Preparation
- Path to Success

The path to a successful surgery will involve many steps. We will help you through these steps in a timely fashion. The instructions below should help you become more informed as well as provide us with essential information to start you on your way.

The Beginning

We believe patient education is the foundation for a long-term, successful, healthy patient. Surgery is a serious step and should be considered only after all other methods have not resulted in maintained weight loss, the patient has done considerable research, discussed other options with his/her family physician, attended an educational lecture, and has spoken with other patients who have undergone bariatric surgery.

PATIENT EDUCATION
- Study
- Written Exam

Please study this material carefully! You will be asked to complete a written exam to ensure full understanding of the risks, benefits, and potential complications as well as the level of lifetime commitment involved.

Returning Your Patient Packet

Carefully read this packet. The criteria establishing approved guidelines for this program are the result of many years of extensive research performed in the field of bariatric surgery. *Each requirement has been included with your safety and success as our number one priority!*

PATIENT PACKET

- Preparation
- Path to Success

- □ Check for insurance coverage for the procedure with your carrier. Our staff can assist you with checking for insurance coverage if you have questions.

- □ Please include a copy of the front and back of your insurance card(s) with the returned materials.

- □ Obtain health records **for the last five years** from your primary care physician and other treating physicians. **Your packet will be processed when we receive records**. Please mail them with your packet or ask the doctor's office to fax them to 417-820-9586. Please work to get all of your records – the information is important regarding your approval and insurance coverage.

- □ Completely fill out the Patient History/Profile Section.

- □ Complete Registration form: Provide the name and address of your primary care physician to ensure we are able to communicate with your physician and expedite your care.

- □ **Medicare Patients**: We must have the **letter of medical necessity** from your primary care physician before your packet can be processed. A sample letter has been included in your packet (see "ATTENTION MEDICARE PATIENTS" handout in your packet.)

- □ Return the completed paperwork and copies of your insurance card(s) to our office in the envelope provided so that we may review it and schedule your initial evaluation appointment with a bariatric surgeon.

Morbid Obesity

Morbid obesity is a disease process connected to increased morbidity and mortality. Associated co-morbid conditions as outlined in the 1985 National Institutes of Health (NIH) Consensus Conference include: elevated blood pressure, hypertrophic cardiomyopathy, elevated cholesterol, diabetes, gallstones, obstructive sleep apnea, hypoventilation, degenerative arthritis, and psychosocial impairments. Other risk factors include urinary stress incontinence, increased breast and uterine cancer, gastroesophageal reflux disease (GERD), infertility, varicose veins.

DISEASE PROCESS
• Co-morbidity
• Complex

Simply put, obesity is a complex disease with many contributing factors. Clinically, obesity is not a simple disorder of willpower, but a complex disease. Contributing causes include heredity, environmental, cultural, socioeconomic, and psychological factors.

Other factors include total calorie intake, total energy used, and proportions of proteins, fats, and carbohydrates in one's diet. Frequency and duration of physical activity and exercise, patterns of sedentary activity, and the amount of lean muscle mass are factors that determine one's likelihood to develop morbid obesity.

Bariatric Surgery: A Choice

For those patients who meet specific criteria, bariatric surgery may be recommended. The option of surgical treatment should be offered to patients who are morbidly obese, well informed, motivated, and have acceptable operative risks. Each patient must commit to participate in treatment and long-term follow-up. Patients whose BMI is 40 or above (or with BMI 30 to 40 with associated life-threatening conditions) are **potential** candidates for surgery. Each patient must clearly and realistically understand how life will change after the operation.

CHOICE
• Option
• Last resort

Choosing bariatric surgery requires careful consideration. Surgery should be a last resort! You must be able to make a commitment to participate in a lifestyle with focuses on your nutrition, exercise, and long-term healthy living. The decision to choose surgical treatment requires an assessment of the risks of non-treatment, the low complication rate of operative treatment, and the benefits in each case.

While image may be improved, this is a major surgery, not a cosmetic procedure. The goals are improved quality of daily living, living longer, improvement of medical problems, and the benefit of feeling good about yourself with improved confidence and self-esteem.

Non-Surgical Options

NIH studies reveal that weight loss attempts fail an average of 95% of the time. The downfall of many programs is the lack of a team of health care professionals that work together to assist in weight management. The treatment goal for obesity should be more than just pounds lost on a scale. The focus should be on changing your environment and behaviors that help lead to improvements in health. This can be achieved with a team of professionals leading you to reduce life threatening risk factors and improving your ability to perform activities of daily living.

NIH
• Success
• Mercy Services

Mercy Weight Management Services

New Images is a medically supervised, lifestyle management program designed to help you lose weight, and even more importantly, to maintain your loss. New Images is a physician-referred program managed by dietitians, exercise physiologists and psychologists. New Images helps you achieve significant weight loss goals by offering a program that provides a sensible alternative to rigid and unrealistic diet plans. New Images is an excellent option for patients required to attend a medically supervised weight loss program prior to surgery.

Our professional staff provides one-on-one expert guidance you need to manage your weight in a positive way without adverse side effects. Your New Images program includes:

- individualized exercise and nutrition plans
- body composition analysis
- resting metabolic assessment
- medical management and long-term support

Our staff helps you make informed decisions regarding your weight loss journey.

Are You A Candidate?

Surgical management of the disease process of morbid obesity is intended to alter the body functions as little as possible while allowing the patient to enjoy the improved quality and length of life. The NIH set criteria for surgical treatment of Morbid Obesity in 1991. These guidelines, considered the standard of care, are followed by most major insurance plans. The criteria for our program are listed below:

CRITERIA

- Guidelines

□ Patients must have made documented attempts at weight loss. Bariatric surgery is an excellent tool to attain weight loss and resolution of medical problems associated with obesity; it is not the primary treatment for obesity.

□ BMI 35-40 with one or more co-morbidities directly related to your weight, **OR** BMI >40 with or without a weight-related co-morbidity (unless your *insurance* requires presence of a co-morbidity for coverage). See Body Mass Index Chart next page.

□ Lap-Band surgery: patients with BMI of 30-35 with one health-related comorbidity are eligible for Lap-Band placement by our program. **Currently this BMI is below insurance criteria requirements and will not have coverage.**

□ You must **meet weight/size restrictions for essential diagnostic equipment** at Mercy Hospital. While the capability to perform surgery is possible at 500 lbs, the ability to treat any post-operative complications may be limited. We evaluate patients on an individual basis and work to accommodate individual safety. Your surgeon may ask you to lose a specific amount of weight before surgery for your safety.

You will be guided through these steps:

□ Participate in a **psychological evaluation**.

□ Participate in **behavioral health counseling** as recommended by the bariatric team.

□ **Participate in group education**. Mercy is proud to have a comprehensive behavioral health program designed specifically for bariatric surgery patients. Prior to surgery, all patients attend a full-day group seminar to equip you with tools that will help you maximize your success after surgery.

□ Attend **nutritional counseling** with a registered dietician who will educate you about the dietary changes that must take place in order to successfully maximize short and long-term weight reduction/maintenance.

□ Attend **exercise and activity counseling** with an exercise specialist who will tailor your exercise and activity progression with your individual abilities and needs considered.

□ Commit to continue with surgical **post-operative follow up care**. Long-term follow up is necessary to make sure your success remains permanent.

□ Achieve **Tobacco Cessation** prior to ALL surgeries, confirmed by lab testing.

□ Evaluation for **Sleep Apnea** as recommended by the bariatric team.

Body Mass Index Chart

Weight (pounds)	Height (Inches)																		
	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78
180	**35**	**34**	**33**	**32**	**31**	**30**	**29**	**28**	**27**	**27**	**26**	**25**	**24**	**24**	**23**	**23**	**22**	**21**	**21**
200	**39**	**38**	**37**	**36**	**34**	**33**	**32**	**31**	**30**	**30**	**29**	**28**	**27**	**26**	**26**	**25**	**24**	**24**	**23**
220	**43**	**42**	**40**	**39**	**38**	**37**	**36**	**35**	**34**	**33**	**32**	**31**	**30**	**29**	**28**	**28**	**27**	**26**	**25**
240	**47**	**45**	**44**	**43**	**41**	**40**	**39**	**38**	**37**	**36**	**35**	**34**	**33**	**32**	**31**	**30**	**29**	**29**	**28**
260	**51**	**49**	**48**	**46**	**45**	**43**	**42**	**41**	**40**	**38**	**37**	**36**	**35**	**34**	**33**	**33**	**32**	**31**	**30**
280	**55**	**53**	**51**	**50**	**48**	**47**	**45**	**44**	**43**	**41**	**40**	**39**	**38**	**37**	**36**	**35**	**34**	**33**	**32**
300	**59**	**57**	**55**	**53**	**52**	**50**	**49**	**47**	**46**	**44**	**43**	**42**	**41**	**40**	**39**	**38**	**37**	**36**	**35**
320	**63**	**61**	**59**	**57**	**55**	**53**	**52**	**50**	**49**	**47**	**46**	**45**	**43**	**42**	**41**	**40**	**39**	**38**	**37**
340	**66**	**64**	**62**	**60**	**58**	**57**	**55**	**53**	**52**	**50**	**49**	**47**	**46**	**45**	**44**	**43**	**41**	**40**	**39**
360	**70**	**68**	**66**	**64**	**62**	**60**	**58**	**56**	**55**	**53**	**52**	**50**	**49**	**48**	**46**	**45**	**44**	**43**	**42**
380	**74**	**72**	**70**	**67**	**65**	**63**	**61**	**60**	**58**	**56**	**55**	**53**	**52**	**50**	**49**	**48**	**46**	**45**	**44**
400	**78**	**76**	**73**	**71**	**69**	**67**	**65**	**63**	**61**	**59**	**57**	**56**	**54**	**53**	**51**	**50**	**49**	**47**	**46**
420	**82**	**79**	**77**	**74**	**72**	**70**	**68**	**66**	**64**	**62**	**60**	**59**	**57**	**55**	**54**	**53**	**51**	**50**	**49**
440	**86**	**83**	**81**	**78**	**76**	**73**	**71**	**69**	**67**	**65**	**63**	**62**	**60**	**58**	**57**	**55**	**54**	**52**	**51**
460	**90**	**87**	**84**	**82**	**79**	**77**	**74**	**72**	**70**	**68**	**66**	**64**	**62**	**61**	**59**	**58**	**56**	**55**	**53**
480	**94**	**91**	**88**	**85**	**83**	**80**	**78**	**75**	**73**	**71**	**69**	**67**	**65**	**63**	**62**	**60**	**58**	**57**	**56**
500	**98**	**95**	**91**	**89**	**86**	**83**	**81**	**78**	**76**	**74**	**72**	**70**	**68**	**66**	**64**	**63**	**61**	**59**	**58**

Is Surgery Always Indicated?

Special consideration is used if it is determined that the surgical treatment presents an unacceptable risk or if you meet any of the following conditions. These risks may include, but may not be limited to:

CANDIDATES
• Considerations
• Risks

- Active alcoholism or drug abuse
- Active tobacco use
- Peptic ulcer disease
- Hepatic cirrhosis with impaired liver function tests
- Not prepared to make lifestyle and/or behavior changes
- Serious psychiatric disability - Careful consideration will be given to patients
- Previous blood clots
- 65 years of age for gastric bypass and Sleeve; 70 years of age for Lap-Band

Normal Digestion Function

Food passes from the mouth through the esophagus and stomach to the small and large intestine, along which nutrients and water are absorbed. Residue then passes to the rectum where it is excreted.

DIGESTION
• Stomach
• Intestine

The esophagus is a channel that guides food from the mouth to the stomach for storage. A stomach may hold as much as 1 1/2 quarts of ingested food. While the stomach does not absorb food, it does produce gastric acid necessary for digestion. Food empties from the stomach through muscle contractions, passing gradually into the duodenum which is the first part of the small intestine.

There are three parts to the small intestine: the duodenum, jejunum, and ileum. Digestive secretions are mixed with food in each part which allows nutrients to be absorbed into the bloodstream.

In the duodenum, the food is mixed with bile from the liver and enzymes from the pancreas. Food, bile, enzymes, and liquids are brought together in the duodenum and passed into the jejunum.

The jejunum is about 10 feet in length. This section of the small intestine continues breaking down food.

The third portion of the small intestine is the ileum and is also about 10 feet in length. Here, the major part of the absorption of food & liquids occurs. Waste products of this process pass into the large intestine (also called the colon). The primary function of the colon is to reabsorb water from waste products of the digestive process prior to excretion.

Understanding the Surgeries

It is important to study the anatomy and different approaches to the surgical treatment of Morbid Obesity. There are two definitions that must be understood:

SURGERIES
• Restrictive
• Malabsorptive

"Restrictive" procedures decrease or limit the intake of food, with only small amounts of food intake needed to feel satisfied after a meal. Mercy performs two restrictive procedures: Laproscopic Adjustable Gastric Banding and Vertical Sleeve Gastrectomy.

"Malabsorptive" procedures cause incomplete absorption of food intake. The function of the small intestine is to absorb nutrients from the food you eat. Mercy performs on malabsorptive procedures: Roux-en-Y Gastric Bypass.

Restrictive Procedures

Restrictive procedures reduce the stomach size without change to the small intestine anatomy. Typically, restrictive surgery patients can only eat 1/2 to 1 cup of well-chewed food. This leads to an overall reduction in calorie intake. While restrictive operations typically lead to weight reduction, long-term studies show they are less effective than malabsorptive surgeries in sustaining this weight loss. Lasting weight reduction always depends upon your capability or motivation to adopt a long-term lifestyle of healthy eating and exercise.

RESTRICTIVE
• Sleeve
• Gastric Banding

Vertical Sleeve Gastrectomy: A restrictive operation where a small stomach pouch is created along the inner curve of the stomach, reducing the amount of food needed to feel satisfied and allowing a person to feel satisfied for a longer period of time after a meal. In this procedure, a thin, vertical sleeve of stomach is created and the rest of the stomach is removed. The sleeve is about the size of a banana.

Laparoscopic Adjustable Gastric Banding: A simple restrictive operation where a band of synthetic material is placed around the stomach near the upper end, creating a small pouch. This pouch serves as the "new, smaller stomach," reducing the amount of food needed to feel satisfied and allowing a person to feel satisfied for a longer period of time after a meal.

Malabsorptive Procedures

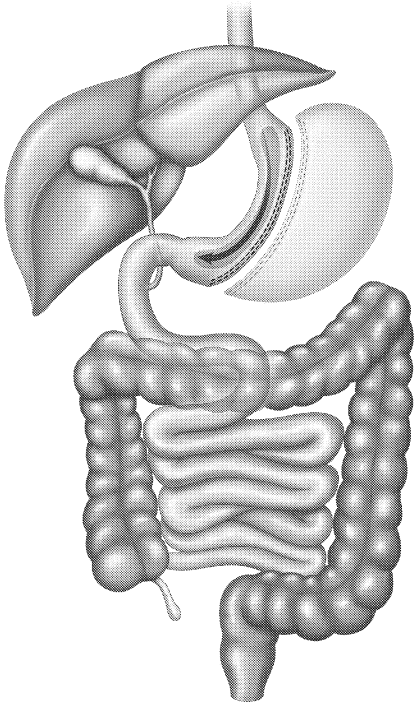
While combining meal size restriction and reducing stomach size, the small intestine anatomy is also changed in these procedures. Malabsorptive procedures bypass a large amount of small intestine reducing the absorption of nutrients and calories.

MALABSORTIVE
• Malabsorption
• Restrictive

Close monitoring, nutritional supplements, vitamins and lifelong medical surveillance are crucial in maintaining health. Lasting weight reduction always depends upon your capability or motivation to adopt a long-term lifestyle of healthy eating and exercise.

Roux-en-Y Gastric Bypass: This procedure changes the original shape of the stomach, the capacity to hold food, time emptying the stomach of food, and re-routes the direction of food leaving the "new" stomach. The gastric bypass combines gastric restriction with malabsorption.

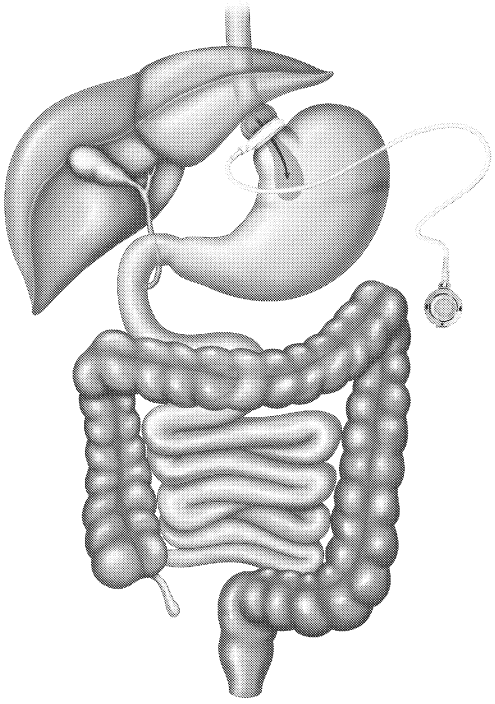
Sleeve Gastrectomy



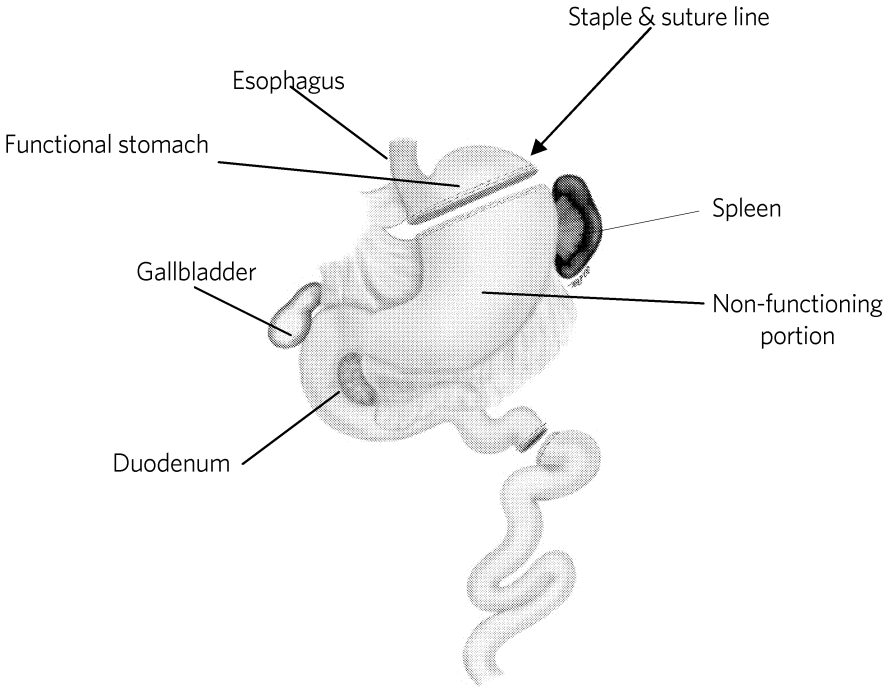
The sleeve gastrectomy consists of separating the stomach into two sections. The small inner segment connected to the esophagus and small intestine remains the functional portion of the stomach, while the large lower segment is removed.

Laparoscopic Adjustable Gastric Banding

The laparoscopic adjustable gastric banding consists of creating a small pouch in the upper portion of the stomach. This pouch serves as the "new, smaller stomach," and increases the length of time fullness is felt. With banding, both portions of the stomach remain functional.



Roux-en-Y Gastric Bypass



The divided gastric bypass with Roux-en-Y gastro-jejunostomy consists of separating the stomach into two sections. The small upper segment connected to esophagus remains the functional portion of the stomach, while the large lower segment connected to the duodenum becomes the non-functioning portion of the stomach.

The small intestine (upper jejunum) is separated, and the lower end is brought up to the small gastric pouch, then connected by making an opening about the size of a dime. This allows the food to pass directly into the intestine where it is digested.

The other end of the jejunum is then reconnected in the shape of a "Y" (Roux-en-Y) by means of another opening below the first. Secretions from the lower segment of the stomach and duodenum empty into the jejunum well below the opening where food ingested through the small upper pouch mixes with secretions from the lower stomach and duodenum. From there on, digestion and absorption of food nutrients occur through the normal process.

Complications and Risks

When considering any type of surgery, a patient needs to understand the risks versus the benefits of the procedure. Clearly, the benefits of any procedure should outweigh the risks. As part of our educational process, it is important for us to describe potential complications to you. These include:

COMPLICATIONS	
• Early	• infections, excessive vomiting/dehydration, acid reflux, narrowing or stretching of the outlet to the stomach, ulcers, bowel obstruction, psychological reactions including anxiety and depression while adjusting to a new life style.
• Late	

- Other risks and complications during surgery may include perforation of the stomach or intestine, leak, internal bleeding, infection, injury to the spleen or potential removal of the spleen.
- Gallbladder disease is common in association with Morbid Obesity. The gallbladder will be removed if recommended during preoperative studies or if disease is noted during surgery.
- All surgeries have a risk of stomach ulcers; causes include tobacco use, overeating or large portions, and the use of aspirin or non-steroidal anti-inflammatory drugs. Cortisone use in the postoperative period may also lead to a higher incidence of ulcers.
- Vitamin and mineral deficiencies (Vitamin D, B12, and iron) should be closely monitored post surgery.
- Pulmonary complications include blood clots, post-operative pneumonia, collapse of lung tissue, fluid in the chest or other breathing problems. As with all surgeries, bariatric surgery carries the risks of general anesthesia and potential complications which are more common with increased weight.
- Also standard with any major surgery is the risk of heart attack, heart failure, irregular heartbeat, stroke, liver problems, or kidney problems.
- Specific Lap-Band complications may include band slippage, pouch or esophagus dilatation, and port sight complications and infections.
- Specific Roux-en-Y complications may include ulcers at the site of the stomach or intestinal opening or ulcers in the non-functional large stomach pouch.
- Specific Sleeve complications may include leakage, strictures/narrowing of the pouch, bleeding, esophageal dilation, and reflux.

When considering surgery, it is important to check complication rates as well as technique. Our surgeons are happy to discuss potential complications with you.

Dumping Syndrome

Following gastric bypass, some patients experience intolerance to certain food types - usually sweets, dairy, and/or fatty foods. This intolerance is called Dumping Syndrome. This syndrome may be described as a side effect of the gastric bypass surgery. Dumping syndrome does not occur with the Lap-Band or Sleeve Gastrectomy surgery because the small intestine is not rerouted.

DUMPING
• After effect
• Proper diet

Dumping Syndrome is characterized by unpleasant symptoms including: sweating, nausea, and shaking which may last from a few minutes to a few hours. We consider this an "after effect", as it is useful in reinforcing good dietary choices.

Upon re-admittance to a hospital for any reason, please inform staff of your bariatric surgery. This will ensure a proper diet during your hospitalization.

Long-Term

Bariatric surgeries have been performed in this country for over 20-years. Published statistics reveal excellent, sustainable weight loss and improved health. Surgery by itself will not guarantee long-term success. ***It is possible to defeat the surgery*** if you ignore program guidelines by drinking high calorie liquids, continual snacking, and lack of physical activity. What this operation *will* do is provide a **tool** that allows you to feel satisfied, while eating less and helps you choose a healthy lifestyle.

LONG-TERM
• Participation
• Tool

Support Groups

Our support groups are formed to assist patients with any problems or challenges they may face as lifestyle and health change. Change is inevitable, and we offer these meetings as an avenue to meet and discuss solutions with other patients. Family and friends may attend.

SUPPORT
• Topic
• Change

While varied in topic and style, you will usually find a specific "topic of the month". Meetings are held at Mercy with participation by the bariatric team members at scheduled meetings. We feel the support group is an important part of your recovery process. You will enjoy the unique commitment by our entire team to the long-term health and success of our patients.

Pre Surgery Documentation

We offer a valuable tool for primary care physicians who supervise pre surgical weight management programs. Some insurance companies require you to have a physician-supervised weight loss program for a specific period before surgery. The pre-surgery Physician-Supervised Weight Loss Packet we provide will give guidance to your primary care physician helping your physician meet most insurance company requirements during your care. Ask a staff member for a packet to take with you to your primary care physician appointment(s).

DOCUMENTATION
• Pre Surgical
• PCP

Before Surgery

The following list will help prepare you for the surgery.

□ Weight loss of 5% to 7% is strongly recommended before surgery. This will make the operation much safer, assist in recovery, and decrease the chance of blood clots or infection. Further information regarding a personalized pre-surgical weight-loss plan is provided for you at the time of your initial dietary and exercise consultations.

GUIDELINES
• Pre-operative
• Checklist

□ Increase activity daily to improve cardiovascular function and to strengthen and build muscles and lean mass.

□ Our surgeons **require** tobacco cessation prior to **all** surgeries. Tobacco cessation will be confirmed through lab testing. (Tobacco cessation assistance is available through our program.)

□ Before surgery, you will continue to follow the liquid diet as instructed during your consultations before surgery.

□ Use of aspirin and/or non-steroidal medications before surgery will be discussed during your consultation visit.

The Team

Our team knows bariatric surgery does not stand alone for weight management. We work to help provide you the tools to maintain successful weight management. The team approach is important due to the multiple factors that contribute to obesity and the management of potential comorbidities. Due to these many factors, we choose to provide you with an NIH designed bariatric team who provide state-of-the-art disease management consisting of:

TEAM APPROACH

- NIH Design
- Professional

- ☐ Surgeon fully trained in bariatric medicine
- ☐ Behavior management professionals
- ☐ Registered Dietitians and Exercise Specialists
- ☐ Nurse practitioner
- ☐ Nurse coordinator certified in bariatric medicine
- ☐ Patient advocate

Psychiatric/psychosocial evaluation(s) include:

- ☐ evaluation of potential conditions that might delay post-operative recovery and long-term success
- ☐ assessment of realistic expectations
- ☐ appropriate psychological readiness
- ☐ risk of post-operative depression
- ☐ ability to comprehend and carry out required post-operative lifestyle changes
- ☐ commitment to long-term follow-up care

Nutritional evaluation(s) include:

- ☐ assessment of your nutritional status pre and post surgery
- ☐ evaluate readiness to change dietary behaviors
- ☐ create individualized care plans for patient success
- ☐ nutritional exam pre and post surgery
- ☐ teach strategies for making healthy food choices, cooking and meal planning

Exercise evaluation(s) include:

- ☐ assessment of your physical fitness status pre and post surgery
- ☐ assessment of your readiness to change exercise/physical activity behaviors
- ☐ create an individualized exercise and activity plan
- ☐ educate the importance of exercise for the successful treatment of obesity
- ☐ review the fundamentals of good health and weight maintenance

Tobacco Cessation:

- ☐ **Required** for all patients
- ☐ tobacco cessation means minimum of 6-weeks completely tobacco free
- ☐ cessation determined by lab tests
- ☐ counseling to assist in tobacco session is available through our program

A team of health care professionals, as outlined above, is required to maximize the opportunity for our patients to achieve long-term success and experience the same quality and length of life enjoyed by the person who does not suffer from morbid obesity.

The Hospital Stay

We are devoted to quality patient care with emphasis on dignity and support for our patients. We provide state-of-the-art medical equipment with emphasis on the special needs of the bariatric patient. We are proudly designated as a Bariatric Center of Excellence.

HOSPITAL
• State of the art
• Center of Excellence

The operation usually takes from ninety (90) to one hundred twenty (120) minutes. If the procedure is performed by the "open" technique, a vertical incision will vary from four to eight inches in the upper abdomen area. The "laparoscopic" approach requires five to seven ½ inch incisions. Your surgeon will discuss options prior to surgery.

Using our advanced technique, the hospital stay is usually one to two days. An important requirement of your immediate postoperative care involves moving, walking, coughing, and deep breathing. Use of a breathing device may help prevent pulmonary complications. Patients may use an abdominal binder, which supports the abdominal muscles and incision. You will be given further instructions on this before and after your operation.

Remember, the more you move and walk, the risk of forming blood clots or developing pneumonia decreases, and your energy will return much quicker.

You will be discharged from the hospital when your surgeon determines it is safe for you to return home. Out-of-area patients may be required to stay in Springfield a few days after discharge from the hospital. This is determined on a patient-by-patient basis; the surgeon will discuss this with each patient. When traveling home after surgery, stopping to walk every hour is required to reduce the risk of blood clots. You will want to plan for rest breaks accordingly.

After Surgery

You will be given specific instructions on important nutritional and physical activity guidelines prior to leaving the hospital. Changes must be made to prevent pain and vomiting and to preserve the new anatomy created by surgery. We encourage physical movement to increase circulation and prevent complications. As previously discussed, you will find the need to make changes in your menu and eating patterns. Nutritional instructions will be given at the time of your dietary consultation(s). Continuing the appropriate eating habits learned before surgery aid in the prevention of early swelling and/or stretching of the new pouch and opening.

GUIDELINES
• Nutrition
• Behavior/Exercise

The following requirements will help you during this process:

- ☐ Take 20-30 minutes to eat a meal
- ☐ Take small bites of food and eat slowly
- ☐ Drink slowly – avoid "gulping"
- ☐ Sip water throughout the day
- ☐ Eat quality protein
- ☐ Chew foods to an "applesauce" consistency before swallowing
- ☐ Properly fitting dentures are required for patients who have no teeth
- ☐ Learn when to stop; listen to your body
- ☐ Learn the feeling of "satisfied" instead of "full"
- ☐ "Fullness" may be a feeling of pressure in the center of your abdomen
- ☐ No liquids 30 minutes before meals and wait 30-60 minutes after meals
- ☐ Do not lie down immediately after a meal
- ☐ Eat 3 meals a day with 1-2 snacks if needed
- ☐ Take your daily vitamins/minerals as suggested by team
- ☐ NO aspirin/non-steroidal anti-inflammatory drugs; you may take TYLENOL
- ☐ Be active daily with planned exercise at least 3 days per week

As you recover, you may find that certain foods are not tolerated and vomiting may occur. Your chances of vomiting are more likely to occur if you do not follow the recommendations above. Every patient will be different regarding these statements. Discuss concerns with the bariatric team.

Further Along

Frequent initial follow-up is important for your recovery and success. We strongly encourage everyone to keep post-operative visits. We will ask your commitment to a minimum of the following:

FOLLOW-UP
• Commitment
• Frequent

- Immediate post-op visit with your surgeon
- One month after surgery
- 3 months after surgery
- 6 months after surgery
- 12 months after surgery
- Annually

Whenever possible, **we ask out-of-area patients to bring your lab results to the follow-up clinic appointments**.

Because our bariatric program is certified as a Center of Excellence, information regarding your care will be collected and reported to the Bariatric Outcomes Longitudinal Database. Please be assured that your confidentiality is preserved during this process. Any information reported as a result of your surgical treatment will be not include your demographic information.

Conclusion

Our entire Bariatric Surgery Team is committed to the highest level of medical care and surgical expertise. We feel the well-educated, well-informed patient is the successful patient. We continually strive towards our mission of providing education and information for our patients. Questions, comments, suggestions, and your participation are encouraged as you travel the road to improved health, longevity, and quality of life.

While the criteria are designed to be applied to all patients, we do consider each patient as an individual and will evaluate you in this way.

Bariatric Services: 417-820-3282. Our staff will be glad to answer your questions and assist you as you prepare for weight loss surgery.

We look forward to partnering with you as make lifestyle changes to improve your health!

Frequent Questions

1. ***When do I begin vitamins?***

   Answer: We recommend vitamins on the day of discharge. Chewable or liquid forms are preferred. Your dietitian will discuss the recommended vitamins for you.

2. ***Can I take my regular medication right after surgery?***

   Answer: All medications are reviewed by your surgeon. During the first 4 weeks, large pills are closely evaluated. Smaller pills may be taken on discharge.

3. ***What happens if I have a complication?***

   Answer: You and your family will be kept informed of any problems that have occurred, and any further treatment necessary will be discussed thoroughly.

4. ***When can I return to exercise?***

   Answer: We recommend that you return to light physical activity immediately after surgery to improve healing. We will ask you to avoid heavy exercise or lifting more than 20-pounds for at least four weeks or until released by your surgeon.

5. ***Is diarrhea normal after surgery?***

   Answer: Patients may experience either constipation or diarrhea as the body adjusts to the new anatomy. Diarrhea is not considered a long-term side effect of surgery.

6. ***Is it true that I can expect to have gallbladder problems after surgery?***

   Answer: There is a higher incidence of gallbladder removal in the first year following gastric bypass. Your surgeon will remove your gallbladder during surgery if there are signs of disease.

7. ***What is the likelihood of blood clots?***

   Answer: All patients who are morbidly obese are at increased risk for blood clots. We guide patients through participation in a pre and post-operative exercise to reduce the risk. We also recommend frequent movement post surgery to improve circulation.

8. ***How about anemia?***

   Answer: Women are at higher risk of long-term anemia. We ask all patients to commit to life-time follow-up to monitor health status.

9. ***Will I have to fast before and after the surgery until my stomach heals?***

   Answer: Patients are required to have special diet two weeks prior to surgery, with nothing by mouth (no food, no drink) after midnight the night before the surgery. The nutritional packet is part of the education provided to you by your dietitian at the nutritional consult.

10. ***Can I eat what I want after surgery as long as I take small bites and eat often?***

    Answer: Your diet will change dramatically after surgery. The nutritional guidelines provided for you will assist you in choosing the right foods after surgery.

NOTES: