

Mercy Bariatrics

Morbid Obesity Surgery Information

Patient information Sheet Version 3.0

Leon Cohen FRACS (Medical Director)

Arif Valibhoy FRACS

Adam Boyt FRACS

Introduction

By the time you have considered surgery for your obesity, you will probably have been battling with a weight problem most of your life. You may have tried all manner of diets, joined Weight Watchers or Jenny Craig's and even tried acupuncture or hypnotherapy. Perhaps you have been prescribed appetite suppressants, antidepressants, Xenical or stimulants.

If you are like most patients, any limited success you will have had with these techniques has been temporary and any lost weight rapidly regained and then exceeded!

The simple truth is that the reason you suffer from morbid obesity is not that you are greedy, or lazy or slothful or any of the other negative misconceptions that a lot of people have about obesity. The main factor in morbid obesity is that your metabolism is genetically programmed to very efficiently lay down extra calories as fat. In the days of the caveman this was a distinct survival advantage..... In our world, with such free access to food rich in calories and a toxic mixture of carbohydrates and fat, it results in a severe weight problem.

A very few people, with the discipline of Gandhi and the endurance of Anna Meares (Olympic cyclist) might be able to overcome this programming by rigidly sticking to a diet. Most of us cannot.

Morbid obesity surgery is designed principally to make it easier for you to sufficiently modify your food intake to bring your weight down to a safer and more comfortable range.

Why perform surgery for morbid obesity?

Morbid obesity surgery is not cosmetic surgery. All doctors recognize that once a patient's weight exceeds a certain range they are more likely to suffer from a wide range of illnesses such as diabetes, sleep apnoea, asthma, hypertension, arthritis, infertility and skin problems. Their chances of dying at a premature age, is also greatly increased. Their employment prospects, mobility and social acceptance also suffer. Depression is much more common in the morbidly obese. The main aim of this surgery is to bring your weight down to a safer range where most of these associated conditions are reduced in severity and many completely reversed. Along the way most people find an improvement in their mobility, body image, self-esteem and enjoyment of life.

Who is a candidate for this surgery?

There are a number of widely accepted criteria which make a patient suitable for this operation:

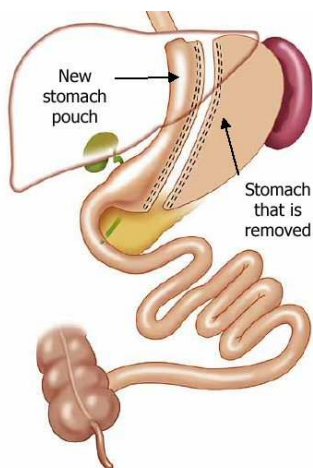
- BMI (Body mass index = wt (kg) / height (m)²) > 40 by itself, or >35 if there is an associated obesity illness, such as diabetes or sleep apnoea.
- Sometimes, under special circumstances, we will accept people for surgery with BMI 30-35.
- Reasonable attempts at other weight loss approaches
- Obesity related health problems
- No unstable psychiatric or drug dependency problems
- A capacity to understand the risks and commitment associated with the surgery.

What type of surgery is done?

Obesity surgery has been refined over several decades by a trial and error process. There are dozens of different operations and most bariatric surgeons concentrate on one or two varieties, which they have confidence in. Basically, most of these operations involve the following principles:

A. Laparoscopic Sleeve Gastrectomy (Gastric Reductive operation)

A “reductive operation” : The stomach is reduced in size from a 1000mls bag to a 100 ml tube.



Advantages:

- Keyhole operation: 2-3 days in hospital. Back at work 1-2 weeks
- Simply reduces the amount of food not the type of food
- Normal stomach emptying therefore no vomiting
- No malabsorption
- No adjustments required
- Ideal for patients in remote areas
- Reduces hunger hormone Ghrelin
- A good revision option in failed lap band

Disadvantages:

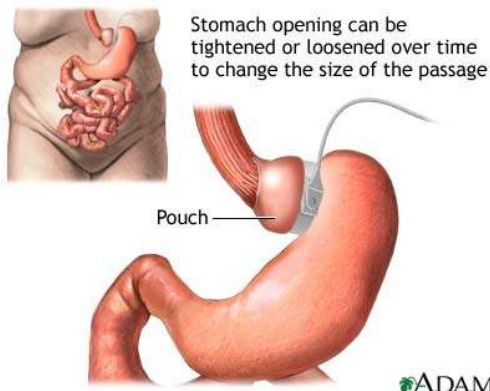
- Risk of bleeding or staple line leak immediately after operation
- Possible long term weight regain if tube stretches up

Ideal Gastric capacity 100 mls

Predicted Excess Weight Loss (EWL) 70-80% over 2yrs

B. Gastric Restrictional Surgery (Stomach banding) Rarely performed at Mercy Bariatrics now.

LAGB (Gastric Band)



Advantages:

- Keyhole approach less scarring or wound problems
- 2 days in hospital
- Earlier return to work (1-2 weeks)
- Adjustable : by filling port the outlet size can be reduced
- Reversible: by removing fluid or the band.
- No malabsorption
- Lowest risk 1:2500 surgical mortality

Disadvantages:

- Easy to cheat if chocolates or sweets taken.
- Some foods can get stuck e.g. steak and bread
- Mechanical problems: prolapse, pouch dilatation,
- Erosion, infection of the band or port leak.
- Need for regular adjustments

Revision rate? 20 -40%

Ideal Gastric Pouch capacity 30mls

Predicted EWL 40-60% over 2 yrs.

C. Combined Gastric Reductive and Intestinal Bypass. e.g. Scopinaro procedure and Duodenal Switch operation and Gastric Bypass. These are more difficult surgeries and are usually

reserved as revision operation for patients who have failed the lap band or sleeve. We do not generally offer them to first time patients.

At Mercy Bariatrics we have concentrated on Sleeve Gastrectomy as the principle operation for new patients and as a revision option for those with a LAGB that has failed.

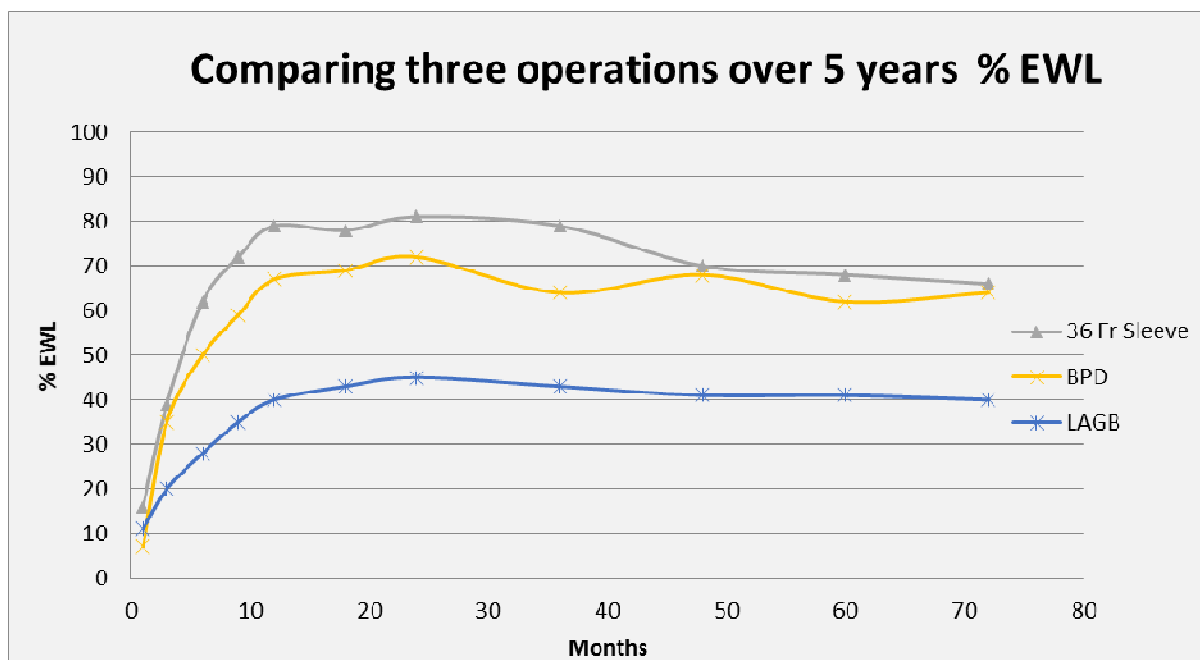
- **The most important thing to understand is that all of these operations will result in a dramatic reduction in the amount and rate at which you can eat. On average about a tea saucer full of food will leave you feeling satisfied for several hours. Any more than this and you may vomit or feel uncomfortable.**
- **Although it is possible to undo or reverse some of these operations it is very difficult and most of the lost weight will be regained in six months. It is best to consider these operations as not reversible. The sleeve gastrectomy is not reversible.**
- **Surgery only provides part of the cure. You must still be prepared to follow a sensible diet and exercise program. Most people find this becomes easier as their weight is shed.**

Is this surgery effective?

In properly chosen patients, the purely restrictive operations (e.g. lap band) have a long-term success rate of about 60% to 70%. This means losing at least 50% of your excess weight and keeping it off for at least five years. The average excess weight loss with the restrictive operations is about 40-50% depending on the initial degree of obesity.

The Gastric Sleeve is achieving on average 65-80% EWL measured over 5 years. The more conservative combined procedures (such as the Roux-en-Y gastric bypass) have a long-term success rate approaching 80% and an average excess weight loss of between 60-70%. The Duodenal Switch has similar results to the sleeve loss with most people losing 70-80% of their excess weight over two years.

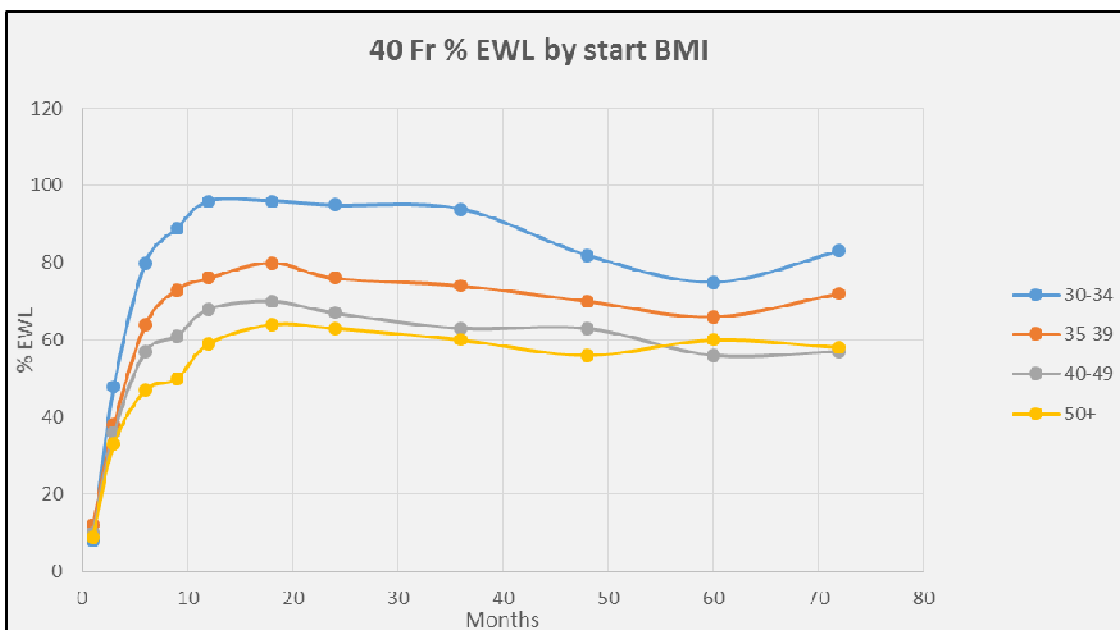
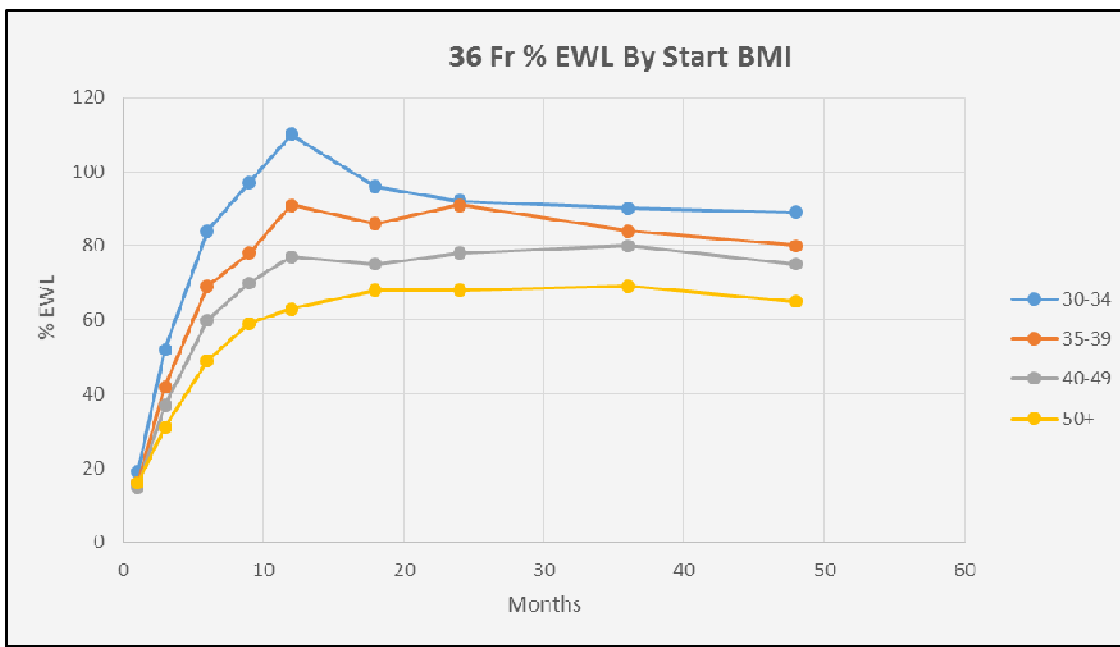
This is a graph of Mercy Bariatrics results for each operation over a 5 year period.. It is shown as the percentage of excess weight lost over time (Excess weight = Start weight – Ideal weight)



The expected weight loss outcome for sleeve is also influenced by:

- Your starting BMI or weight
- The size of the bougie (36Fr slim or 40 Fr mid size) used to calibrate the width and therefore the volume of your sleeve
- Primary vs revisional surgery

Our Sleeve gastrectomy results at Mercy Bariatrics:



This means if your starting BMI is 50-59 and a 36 Fr bougie is selected we are seeing a 68 % EWL at 2 years and 64 % at 4 years.

If your start BMI is 35-40 it is closer to 90% EWL at 2 years and 80% by 4 years.

Most people are now offered the slim 36Fr bougie but if you work in a hot environment or have a BMI below 35 we may offer you the mid size 40Fr bougie which will be better tolerated.

Late weight regain.

Some degree of late weight regain is anticipated for all bariatric surgery patients after 2-3 years.

Most failures are due to poor dietary choices on the patient's part (high calorie liquids and/or fried, salty snacks), although a significant percentage of failures are due to a mechanical failure of the surgical procedure itself, such as stretching of the sleeve or pouch above the band. If the sleeve does stretch up sufficient to produce significant weight regain it can be reduced in size by further surgery.

Bariatric surgery should be thought of as “buying you a second chance”. It’s what you do with that chance that determines long term success.

It’s why we concentrate on postoperative follow-up and our Success Habits™ postoperative training program to teach you to get the best outcome from your surgery.

What are the risks of the surgery?

- All surgery carries some risks and these sorts of operations are technically difficult and demanding.
- The risk of dying from the procedure is less than 1:2500 for the lap band and Lap tube but closer to 1:250 for the open bypass operations.
- There is a risk of bleeding, stomach or bowel injury or other organ injury from the laparoscopic instruments or ports leading to peritonitis. This may require a blood transfusion or further surgery.
- There is a risk of leak from the staple lines or joins immediately after surgery. If this occurs you can become very sick very quickly, you will require further surgery to correct the problem **and spend many weeks in hospital recovering and many months before you are well again.**
- **Very rarely this leak can persist as a chronic fistula to the skin or another organ such as the colon or lung requiring further surgery and interventions.**
- Sometimes transfer to another hospital then becomes necessary for reasons of funding or the requirement for ICU. The leak rate for Primary Sleeve Gastrectomy in our unit is now less than 0.5%. For revisional surgery e.g. band to sleeve it is as high as 1%.
- Other serious complications of this sort of surgery are deep venous thrombosis and pulmonary embolism (blood clots to the legs and lungs or liver). Any of these complications can be fatal, but fortunately they are uncommon. These complications occur early after surgery and require immediate attention and anticoagulation therapy.
- The spleen may be injured and may need to be removed.
- Minor complications include wound infection and hernias, collapse of the lung bases and bladder infections.
- Late complications include staple line disruption, stretching of the gastric tube, reflux, bowel obstruction from adhesions and nutritional deficiency including osteoporosis and iron deficiency if supplements are not taken; these are rare and can be corrected.
- Reflux can become worse after surgery

- If you choose a malabsorptive operation like duodenal switch you will need to take at least two multivitamins, two calcium tablets and often two iron Tablets (if still menstruating) for the rest of your life.
- Risks pertaining more to the LAGB (Laparoscopic Adjustable Gastric Band) are slippage of the band, stretching of the gastric pouch above the band. Disconnection of the tubing from the port and leakage of the tubing or band. Infection of the band or port and erosion of the band into the stomach. These risks are uncommon but may require repositioning, replacement or removal of your band or port.

These risks will be discussed with you during your consultations and we encourage you to ask questions or seek clarification on areas that concern you.

What happens if I decide to proceed?

This is a major decision you are making that will radically affect your life. We will need to meet on more than one occasion to explain the procedures and consequences carefully, assess your health risks and eating behavior and make sure that you have made an informed decision to proceed.

You will need to complete our pre-operative program prior to your surgery. This involves additional appointments with other members of the bariatric team including a Bariatric Medical Assessor, dietitian, exercise physiologist and anaesthetist.

If your BMI is greater than 40, we will usually ask you to undertake a 2-4 week preoperative Very Low Calorie Diet (VLCD) using Clinical/ Optifast to kick start your weight loss and shrink the size of your fatty liver.

In some cases an examination of the stomach by endoscopy will be required.

Costs:

In most cases the Hospital and theatre costs including purchase of the LAGB will be covered by your health fund if you have been a member for more than one year. However you must also make sure that your health fund will cover bariatric surgery for your level of policy. The Item number they will request for sleeve is 31575

Without private insurance the total cost of the procedure is in excess of \$20,000.00, and it may be even more if a complication was to develop which required a prolonged hospital stay. If uninsured, full payment is required prior to surgery.

The program and surgeon's fees depends on which procedure you choose and ranges between \$5000. - \$6000. **Your health fund will only cover a small portion of this.** There will also be an out of pocket expense for the Anaesthetist and Surgical Assistant. Full payment, to cover the surgeon's fee, is required prior to all surgery.

The out of pocket costs for this surgery are significant, and there are several payment options available to you. There are companies who provide credit for surgical procedures, and **accessing your superannuation is another alternative.** Our business manager will be very happy to answer any queries you have regarding these options.

If you decide to proceed, we will provide you with a complete estimate for the surgical fee and bariatric program.

More information can be obtained from the Internet on:

www.mercybariatrics.com.au

<http://www.ossanz.com.au/>

There is a complete Video feed of a public information evening held in Jan 2007 on our website.

www.mercybariatrics.com.au

Key words to search:

Lap Band

Sleeve gastrectomy

Lap tube gastrectomy

Biliopancreatic bypass

Duodenal switch

BPD-DS

Mr Leon Cohen. MBBS FRACS FRCS

Nov 2015

Telephone: 9272 0420

Fax: 9272 0450

Email: info@mercybariatrics.com.au

Mercy Bariatrics

Level 2, Suite 1A, SJOG Mt Lawley Med Centre , Ellesmere Road, Mount Lawley, WA 6050

Obesity information confirmation sheet 3.0 (Nov. 2015)

- I confirm that I have received and have read the obesity information sheet version 3.0 provided by Mr Leon Cohen, Mr Arif Valibhoy and Mr Adam Boyt.
- I have had the opportunity to ask, and have had answered questions arising from this information sheet.
- I understand that bariatric surgery is potentially risky and dangerous and complications and side effects can be experienced. There is a risk of death from these procedures or complications which may require hospitalisation for many weeks and further surgery. Transfer to another hospital may then be required.
- I have been warned that the operations do not always work, and I will still need to modify my eating behaviour for maximum benefit.
- I understand that for the best results and safety, I must commit to regular follow-up and surveillance after surgery, and may require long term vitamin and mineral supplements.
- I understand that I must complete the Bariatric Program prior to surgery.
- I agree to have my data, relating to my surgery and follow-up treatment, included in future medical research and publications. I understand that my data will not be associated with my name, address or any other personally identifying information in the research. Only authorised Mercy Bariatrics personnel will have access to my data.

Questions arising from this sheet:

(Please bring this with you on your next consultation)

Signed: _____ **Date:** _____

PRINT NAME: _____

Witnessed: _____ Date: _____

PRINT NAME: _____

Mr Leon Cohen
MBBS., FRCS.(Glas), FRACS

Mr Arif Valibhoy
MB BCh. FRACS BAO

Mr Adam Boyt
MBBS BSc. (Hons) FRACS PhD