NEA BAPTIST®

HEALTH SYSTEM

Bariatric Patient Education

NEA BAPTIST HEALTH SYSTEM

MY CHECKLIST

___1. Call your insurance company and ask the following:

A. Is weight loss surgery a covered benefit? Yes or No

B. If yes, what are the requirements? (please list these and decide if you meet their criteria. If so, begin gathering any required documents)

_____
_____
_____

C. Where do we need to send the Letter of Necessity and required documents? *It is not necessarily the address on your card! It may be a fax# Please ask!

_____
_____
_____

___2. **Complete** all health history papers from Dr. Jones office, (*before the day of your visit the coordinator*), both front and back (they are stapled together).

___3. Obtain copies of any testing you have had done recently, example– heart or lung tests, test for sleep apnea, thyroid lab work.

___4. Please be sure to bring the above information/documents as well as your insurance card with you to your appointment with the coordinator.

IMPORTANT

Address or Fax Number for the Letter of Medical Necessity to be sent to your insurance company.

_____
_____
_____
_____
_____
_____

This is your responsibility to obtain. We will *NOT* submit a letter of medical necessity to your insurance company until this slip is turned into the bariatric coordinator.

NEA BAPTIST CLINIC

NEA BAPTIST MEMORIAL HOSPITAL

Dr. K. Bruce Jones
Phone: 870-932-4875
800 S. Church Ste 104
Jonesboro, AR72401

3024 Stadium Blvd.
Jonesboro, AR 72401

Date: _____

Name: _____

Address: _____

Phone: _____ *Date of Birth:* _____

Social Security Number: _____

Height: _____ *Weight:* _____

Insurance: _____ *ID#* _____

Group# _____

Employer providing Insurance: _____

Effective Date: _____ *Deductible:* _____

Letter of Medical Necessity Fax Number: _____

Email: _____

Referral Source: _____

Procedure: _____

K. Bruce Jones, MD

NEA Baptist Clinic– General Surgery
800 S. Church, Ste. 104
(870) 932-4875

- Has performed bariatric surgery since 1989
- Graduate of Vanderbilt Medical School
- Certified in Surgery by the American Board of Surgery
- Fellow of the American College of Surgeons
- Member of the American Society of Metabolic and Bariatric Surgeons
- Member of the Society of American Gastrointestinal and Endoscopic Surgeons
- Participant of a Bariatric database that records bariatric outcomes.

Meet the NEA Baptist Weight Loss Surgery Coordinator

Kristen Brewer, RN
NEA Baptist Weight Loss Surgery Coordinator

I would like to take a moment to introduce myself. My name is Kristen Brewer. I am NEA Baptist Memorial Hospital's Bariatric Coordinator.

I have spent the last 18 years as a nurse; 13 years of cardiac experience and 5 years in the Intensive Care Unit. I've also served as the Occupational Medicine Coordinator for Doctors Health Group and NEA Clinic. I graduated from Arkansas State University with a nursing degree. I am married with two children.

As we work towards our goal of becoming a Center of Excellence in Bariatrics, there are many requirements that must be met.

Our clients are the most important part of this journey. I will be working with clients interested in Bariatric Surgery for weight loss. When a client has made the decision for surgery, I will be working closely with Dr. Jones to ensure that the patient is educated in the process and what to expect.

As a part of this new and very exciting program, we are proud to announce that we have a monthly support group. Monthly support group meetings are a very important part of your success. My plan is to follow you throughout your journey to ensure that all of your needs are met.

NEA BAPTIST HEALTH SYSTEM

Is this Surgery for Me?

Congratulations on making the decision to explore the option of bariatric or weight loss surgery! This packet will be your resource for information and is designed to answer your questions about surgery for Obesity.

Understanding Obesity

According to the National Institutes of Health (NIH) consensus report and numerous other scientific reports, morbid or clinically severe obesity is a serious disease and must be treated as such. Perhaps no other medical condition has been more misunderstood.

Genetic factors clearly play a role in this disease. Many obese people do not seem to need as many calories to maintain weight as non-obese people do.

In the 1991 Consensus Report of the (NIH) the following conclusions were presented:

>Clinically severe obesity is defined as:

- Weight in **excess of 100 pounds over** the ideal calculated weight or Body Mass Index of approximately 40
- Somewhat **less** than 100 pounds if there is a serious associated condition
- Success in most cases of non-surgical treatment is only temporary
- Most patients with clinically severe obesity have an organic, genetically based disease
- Clinically severe obesity results in mortality rate greater than that of the general population in the same age group
- Clinically severe obesity results in many serious medical, psychological, social and economic problems
- Dietary regimens fail to provide long-term weight control in severely obese patients

>People who are *at least 100 pounds over their ideal body weight* suffer severe health risks, not to mention discrimination, ridicule and misunderstanding.

To be eligible for weight loss surgery for obesity you must:

☑ Be willing to cooperate with the follow-up program

☑ Have no emotional or medical problems which would make surgery unsuccessful

☑ Have no glandular cause for your obesity including hypothyroidism or hyperadrenalism (these are very rare)

Please understand that we consider surgical treatment to be a very serious undertaking and should be considered only after other conservative methods have failed. You must weigh the risks of the operation against the risks associated with remaining massively obese. We make a long-term commitment to our patients, and in turn, expect that they make a long term commitment to their health and this program. You must understand that the surgery is only a part of the total treatment for obesity

Dangers of Obesity

There is considerable evidence that massive obesity shortens life. Obesity is also related to many other diseases. Many obese patients suffer from:

◊ Diabetes Mellitus

◊ High Blood Pressure

◊ Restrictive Lung disease

◊ Pickwickian Syndrome (falling asleep while sitting up)

◊ Degenerative arthritis

◊ Gallbladder disease

◊ Sleep apnea

◊ Esophageal reflux

◊ Infertility

◊ Varicose Veins and stasis ulcers

◊ Increased risk of cancer of the breast, uterus, and others

Morbid obesity is a medical disease with serious economic, social and psychological impact. Physical co-morbidities that affect the morbidly obese include:

◊ Limited clothing choices and price

◊ Furniture incapacity (seating in theaters, planes, buses, restaurant booths)

◊ Personal hygiene (due to reach limitations)

◊ Inability to tie shoe laces

Obese people also suffer from social and economic discrimination from family and friends. They also endure this at school, from healthcare providers and in the workplace.

Definition of Obesity

Two of the most common methods for determining obesity are :

1. *Ideal Calculated Weight*-The calculation for ideal calculated weight is:
   - For Men: 106 pounds for first five feet plus six pounds for each inch in height over five feet.
   - For Women: 100 pounds for first five feet plus five pounds for each inch over five feet.
2. *Body Mass Index* (BMI)- the person's weight in kilograms divided by his height in meters squared. To determine your own BMI:
   - Find your weight on the left side of the provided table (on next page) and move to The right until you find your height.

     Example: Weight 300 lbs/Height 5'5" = BMI of 50

*A (BMI) of 40 is equal to approximately 100 pounds over ideal body weight, this is considered Morbidly Obese and represents a level for which weight loss surgery should be considered. When co-morbid conditions are present, a BMI of 35 or greater also indicates surgery should be considered.

Note: Some insurance companies and third party payers define obesity differently and insurance funding for bariatric surgery is not always available. For those whose insurance will not cover the procedure or those without insurance, pre-payment is sometimes an option.

Height in feet/inches

Weight in Pounds

	4'9"	4'11"	5"1"	5'3"	5'5"	5'7"	5'9"	5'11"	6'1"	6'3"
154	33	31	29	27	26	24	23	22	20	19
165	36	33	31	29	28	26	24	23	22	21
176	38	36	33	31	29	28	26	25	23	22
187	40	38	35	33	31	29	28	26	25	24
198	43	40	37	35	33	31	29	28	26	25
209	45	42	40	37	35	33	31	29	28	26
220	48	44	42	39	37	35	33	31	29	28
231	50	47	44	41	39	36	34	32	31	29
243	52	49	46	43	40	38	36	34	32	30
254	55	51	48	45	42	40	38	35	34	32
265	57	53	50	47	44	42	39	37	35	33
276	59	56	52	49	46	43	41	39	37	35
287	62	58	54	51	48	45	42	40	38	36
298	64	60	56	53	50	47	44	42	39	37
309	67	62	58	55	51	48	46	43	41	39
320	69	64	60	57	53	50	47	45	42	40
331	71	67	62	59	55	52	49	46	44	42
342	74	69	65	61	57	54	51	48	45	43
353	76	71	67	63	59	55	52	49	47	44
364	78	73	69	64	61	57	54	51	48	46
375	81	76	71	66	62	59	56	52	50	47
386	83	78	73	68	64	61	57	54	51	48
397	86	80	75	70	66	62	59	56	53	50
408	88	82	77	72	68	64	60	57	54	51
419	90	84	79	74	70	66	62	59	56	53
430	93	87	81	76	72	67	64	60	57	54
441	95	89	83	78	73	69	65	62	58	55
452	98	91	85	80	75	71	67	63	60	57
463	100	93	87	82	77	73	69	65	61	58

Weight Category	***BMI***
Normal Weight	**18.5-24.9**
Overweight	**25-29.9**
Obesity	**30-34.9**
Severe Obesity	**35-39.9**
Morbid Obesity	**≥40**

Anatomy and Function of The Gastrointestinal Tract

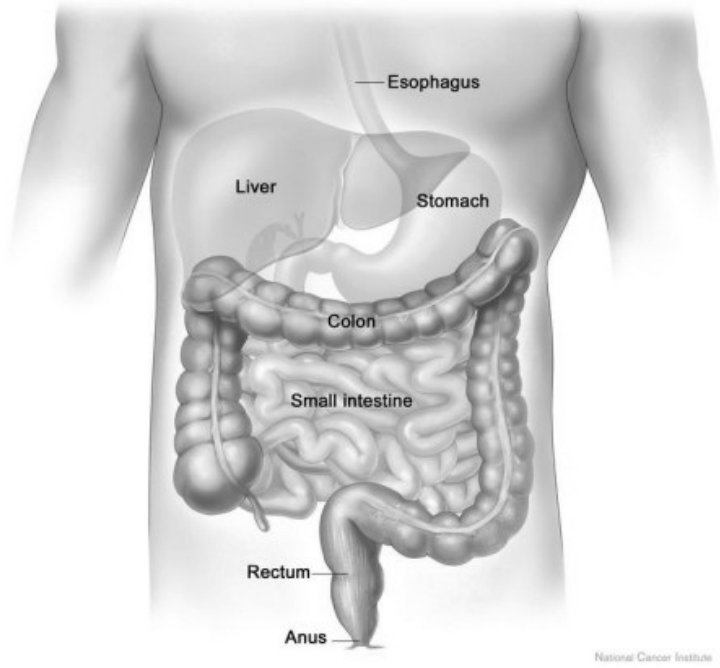
We want anyone considering gastric bypass surgery, sleeve gastrectomy, and LAP-BAND surgery to have a basic understanding of gastrointestinal (GI) anatomy and physiology. In this section, we explain the structure and functions of various parts of the gastrointestinal tract involved in the specialized surgery for the treatment of clinically severe obesity.

The GI tract is the pathway food travels from the mouth, through the esophagus, stomach, small and large intestine where eventually the nutrients are absorbed for the needs of the body. What is not absorbed passes to the colon and rectum to be eliminated.

The first part of the GI tract pathway is the esophagus, a conduit that guides food from the mouth to the stomach where it is stored. The stomach is both a storage space, holding as much as a quart and a half of ingested food, and a secretory organ that produces the gastric acid necessary for digestion. It does not absorb food. When food enters the stomach from the esophagus, it remains there for a short period while it is mixed with gastric acid. The stomach then, by involuntary muscle contractions (peristalsis), empties the food gradually into the first part of the small intestine (duodenum).

The small intestine consists of three parts: the duodenum, the jejunum and the ileum. In these three parts, certain digestive secretions are mixed with food, and the nutrients the body needs for energy are absorbed into the blood stream.

The duodenum treats the food it receives with bile from the liver and enzymes from the pancreas. It also adds fluid that comes from the wall of the duodenum itself. The food, bile, enzymes, and liquids brought together in the duodenum are then passed into the jejunum.

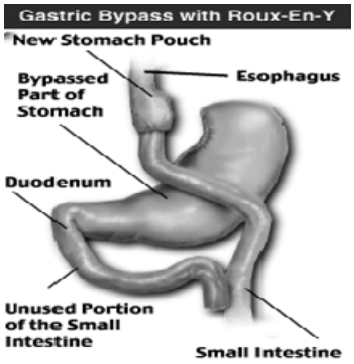


The jejunum, or second portion of the small intestine, is approximately five feet long. It lies immediately behind the duodenum and continues the process of digestion, breaking down food into essential elements.

The ileum, or third portion of the small intestine, like the jejunum, is about five feet long. It is here that the major portion of food and liquid absorption occurs. Waste products from the digestive process are passed from the small intestine into the large intestine, also known as the colon. The colon begins in the right lower quadrant of the abdomen near the appendix. It is about 8 feet in length. The colon moves waste products by the continuing process of undulating contractions or peristalsis, which is common to all parts of the gastrointestinal tract. The primary function for the colon is to store digested waste products prior to elimination. The colon also reabsorbs small amounts of water and electrolytes.

Biliopancreatic Diversion (BPD) and Duodenal Switch mild restriction with more malabsorption. Despite having average higher weight loss than other Bariatric operations, the complications of the malabsorption are high enough that this operation is done in relatively few Centers.

Vertical Banded Gastroplasty is one of the two major types of operations initially recognized by the NIH for the treatment of clinically severe obesity. It is a purely restrictive procedure with no malabsorption effect. This operation was once the most commonly performed Bariatric procedure. The goal of this procedure is to severely restrict the stomach's capacity to store certain foods. The limitation of this operation is the unpredictability of the weight loss. In addition, it may require difficult surgical modifications. For these reasons this operation has been mostly abandoned.



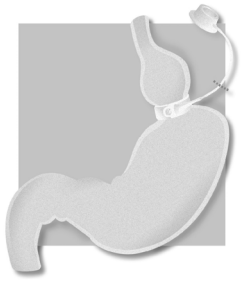
Roux-en-Y Divided Gastric Bypass (RYDGB) is recognized by the NIH Consensus Report for the effective treatment of clinically severe obesity. **This is the most common Bariatric Procedure in the United States due to the low complication rate and long-term proven results in achieving weight loss.** This procedure combines a gastric restrictive operation with slow gastric emptying and reduced food absorption to provide lifelong help for clinically severe obesity. Most RYDGB procedures can be performed laparoscopically or with minimally invasive surgery. Laparoscopic procedures produce smaller incisions, allow for a shorter hospital stay, and provide a quicker recovery. The RYDGB offers a high average long term success rate with low rates of mortality, complications, and failures.

The operation divides the stomach into a small and large portion. When the small, functioning upper stomach pouch is full (after only a few bites), patients will feel full and satisfied. In this way, the intake of food is dramatically limited and appetite is reduced. The rerouting of the small intestine slows food passage and mildly reduces absorption.

Most average patients will lose as much as 100 pounds or about two thirds of their excess weight in one year. Some will lose a little more, some a little less. Weight loss may continue slowly during the second year.

The Divided Gastric Bypass with Roux-en-Y gastrojejunostomy consists of separating the stomach into two sections using parallel rows of titanium staples, with the staples additionally secured with sutures as needed. The staples remain fixed and do not migrate. The larger distal segment connected to the duodenum no longer comes in contact with ingested food. In the next phase, the surgeon disconnects the continuity of the part of the small intestine (upper jejunum) and brings the lower end up to the small gastric pouch. The intestine is connected to this small stomach pouch by means of an opening a little larger than a dime. This allows food to pass directly into the intestine where it is digested. This is called the gastrojejunostomy.

Following the gastrojejunostomy anastomosis (connection of jejunum to the stomach pouch), the free end of the small bowel is then reconnected in the shape of a “Y” (hence, the name Roux-en-Y) by means of another anastomosis below the first. Secretions from the lower segment of the stomach and duodenum empty into the jejunum well below the upper (gastrojejunostomy) anastomosis. Thus, food passing through the small upper stomach pouch will mix with secretions from the lower stomach pouch and duodenum at this Y junction. From here on, digestion and absorption of food nutrients are carried on in a completely normal fashion.



ADJUSTABLE GASTRIC BAND or LAP-BAND is a gastric restrictive operation with slow gastric emptying. The word Lap-Band is the abbreviated and trademarked combination of two words (LAP from laparoscopic and BAND from gastric band). The LAP-BAND is made of a silicone elastomer band and placed around the upper part of the stomach to create a small stomach pouch, which can hold only a small amount of food. The lower, larger part of the stomach is below the band. The small outlet created by the band connects the two stomach parts. Food will pass through the outlet (“stoma” in medical terms) from the upper stomach pouch to the lower part more slowly, and you will feel full longer.

The band is placed laparoscopically, or with minimally invasive surgery, under general anesthesia. A small tunnel is made behind the top of the stomach. Then the band is pulled around the stomach to form a ring. The band has a locking part which securely holds the band in a circle around the stomach. The Band is held in position by the connective tissue around the tunnel and by stitches used to create a tunnel anterior to the stomach.

Beginning 6 weeks after placement of the band, you will go for your first “fill” or “adjustment”. This is when fluid will be placed in your band to further reduce the size of the opening between the two parts of your stomach. The band is connected by a tube to an access port placed beneath the skin during surgery. Saline fluid is placed into the port up to your band to make you eat less, get full sooner and make the full feeling last longer.

You may require several “fills” the first year to get the proper amount of restriction to obtain maximum weight loss.

You must commit to coming for “fills” as necessary. This is the key for optimal restriction and good weight loss.

The band is an excellent “tool” to help you lose weight, but you must be very motivated and committed to changing your lifestyle and eating habits. You must control your portion size and exercise to achieve optimal weight loss.

Although the band may be removed, it should be considered a permanent procedure. Unless you develop a complication the band should not be removed. If the Band is removed you may soon go back to your original weight and you may gain more.

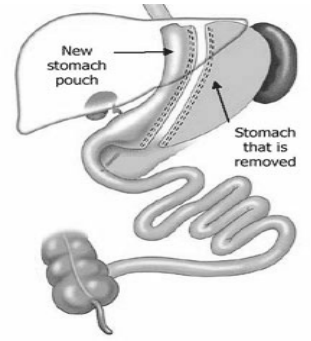
original shape. However, you may soon go back to your original weight and you may gain more.

Weight loss with the LAP-BAND is gradual and slower than other types of weight loss surgeries. Typical weight loss is 1-3 pounds a week the first year. Remember that your main goal is to have a weight loss that prevents, improves, or resolves health problems related to your obesity.

BAND and BYPASS

The Roux-en-Y Divided Gastric Bypass is currently the "gold standard" for the surgical treatment of clinically severe obesity. This procedure carries a national mortality rate of less than ½ percent, an operative morbidity (complication) rate of five to ten percent, and an effective reduction on average of 50 to 70 percent of excess weight. In most cases, this is enough weight loss to reduce the life threatening diseases which come with co-morbid obesity conditions.

The Laparoscopic Adjustable Band reported average weight losses of 40-55 percent of excess weight. The complication rate is about 10 percent, but usually these complications are not life-threatening. The mortality rate is extremely low at less than 0.1 percent.



Sleeve Gastrectomy or Laparoscopic Gastric Sleeve. The "Lap-Sleeve" is the newest weight loss operation. The first Lap-Sleeve was done in 2002. Some 5 year results are now reported and complete 3 year results are available. This operation is restrictive only, like the BAND, but uses no foreign body. The pouch is larger than with either the Band or the Bypass. The pouch is a long narrow tube between the esophagogastric junction and the distal part of the stomach. So far, complication rates with this operation have been very low. Death rate and weight loss results have been somewhere between the BAND and the Bypass. The Sleeve can be more easily converted to a Bypass should that be necessary for more weight loss in the future. (The BAND is difficult to convert). The Lap-Sleeve appears to be a very promising operation.

Risks of Surgery

Bariatric surgery is a major operation. Although mortality and serious complications are very uncommon, you must be aware of the risks of surgery. The immediate risks of the operation are quite similar to those of any major abdominal operation. The list of complications listed below is not complete as it is impossible to include every event that could happen in a surgical setting. However, the more common complications of abdominal surgery in general and surgery for obesity specifically are listed below.

Potential Early Complications

◊Thrombophlebitis or blood clots in the legs. These clots may sometimes travel to the lungs. When this occurs, this life-threatening problem is called pulmonary embolism. ✷Early walking, beginning the evening after surgery and pneumatic intermittent leg compression hose make this complication very rare. Low dose blood thinner is also given to help prevent this problem.

◊Atelectasis (lung collapse) and/or pneumonia. These problems are lessened by discontinuance of cigarettes, frequent deep breathing exercise and coughing postoperatively. Use of an Incentive Spirometer device to encourage deep breathing and early ambulation the evening after surgery also help prevent these complications.

◊Wound infection and wound separation. Perioperative antibiotics help prevent this.

◊Peritonitis following leakage from the stomach pouch or intestine. This is an extremely unusual but very serious complication which would require a secondary operation and a prolonged hospital course up to several weeks.

◊Obstruction of the new stomach pouch outlet. Occasionally the new stomach a gastroscope or in very rare incidence, a re-operation. Sometimes edema or swelling of the anastomosis or stitch lines occur in the early postoperative period. This may result in the need for one to stay on liquids or blended foods or intravenous feeding for a prolonged period, until the edema resolves.

◊ Enlargement of the pouch or enlargement of the outlet channel. The stomach pouch and channel are made very small in order to limit your consumed calories. However, with consistent overeating to the point of pain or vomiting, the pouch may gradually enlarge, allowing one to eat more and have weight gain, after an initial weight loss. It is theorized that prolonged drinking of carbonated beverages may cause the pouch to gradually enlarge over time and thus allow the patient to eat more and regain weight.

◊Small Bowel Obstruction for adhesions. This is unusual, but if it occurs, it may require an operation for correction.

◊Spleen injury. Repair of the splenic injury or a splenectomy is a very rare complication, but sometimes does occur because the spleen is located in the immediate area where the operation is done. Some patients develop an increased vulnerability to infection such as pneumonia, after the splenectomy. Certain precautions should be taken by anyone requiring a splenectomy, including vaccination every 5 years.

◊Death. Any operation carries with it the possibility of postoperative death.

◊Skin Sag. In the very obese, especially those over 40, the skin of the abdomen, breasts, underarms, legs, and buttocks may sag after the patient has lost a considerable amount of weight.

◊Family members have difficulty adjusting to the patients new appearance.

◊Ulceration

◊Gastritis (irritated stomach tissue)

◊Gastroesophageal reflux or heartburn

◊Dysphagia (difficulty swallowing)

◊Band slippage

◊Obstruction of the stomach outlet

◊Port leak

◊Port infection

◊Excessive vomiting

◊Band erosion

◊Polyneuritis. This can occur from vitamin B1 (thiamine) deficiency. Taking your recommended vitamins and eating a balanced diet should prevent this from occurring.

◊Anemia, usually after Bypass only. This can occur from iron deficiency, B12 deficiency, or folic acid deficiency. You **must** have an annual blood count to check for this problem. A balanced diet and taking the appropriate vitamins can help prevent this.

Please feel free to discuss any of these complications and the expected results from surgery with your surgeon or any other member of our staff. We want you to understand as thoroughly as possible what to expect from the operation and all potential risks. You must make an informed judgment as to whether this surgery is for you.

Postoperative Eating Habits

Behavior patterns must be modified simultaneously to achieve the desired weight loss and to maintain the lower weight. It is important to eat three meals daily. Most of your fluids should be consumed between meals and these should be low-calorie fluids such as water, skim milk, coffee, and tea. Diet soda is not recommended anymore but probably can be consumed in small amounts without any long-term consequences as long as the soda is allowed to sit open for a while prior to drinking, in order that some of the carbonation will fizz away. Alcohol (a source of calories) should certainly be avoided until your goal weight has been reached. If you must drink alcohol, then certainly it should only then be taken in modest, well-diluted quantities. Food should be cut small, chewed well, and if necessary, prepared in a blender. You should stop eating as soon as you feel full. The primary foods to avoid are apple peelings, orange pulp, raw coconut, grape peelings, and raw carrots, for the first few months after surgery, as these can plug up the small opening at the gastric outlet. Large leafy vegetables should be avoided. Lettuce should only be taken if it is shredded or chopped finely. During the first six months, raw fruits and vegetables should be eaten especially carefully. The diet should consist mostly of protein foods, and to a lesser extent, carbohydrates and fat. Good sources of protein are fish, cottage cheese, eggs, skim milk, beans, peanut butter, and of course, various meats. Some meats are tolerated better than others, and you simply have to find out which ones work best for you. You will receive more specific dietary instruction for the first days, weeks, and months following your surgery.

Please continue to take your vitamin long term. Deficiencies in iron, B12, folic acid, and calcium usually do not occur until after the first or second year. Therefore, patients may think they are doing well without taking their vitamin supplements only to suddenly become ill and find that they are deficient.

Eat Slowly & Chew Food Until it is of a Mushy Consistency

Swallowing food in chunks may block the opening of the gastric pouch. To help you eat more slowly, set aside 30 to 45 minutes for each meal. Some find benefit in counting the number of times you chew each bite. Aim for 30 chews. Make a sign which says EAT SLOWLY and place it in front of you. Explain to family members why you must eat slowly, so they will not urge you to eat faster. Take small bites of food. You may want to try eating with a baby spoon. Pay attention to taste. Notice the food's flavor, texture, and consistency. Chew well. Ground or very soft foods will be necessary if you have dentures.

Stop Eating as Soon as You are Full

Besides causing you to vomit, extra food over a long period of time may stretch your stomach or pouch. Indications of fullness include a feeling of pressure or fullness in the center just below your rib cage, feelings of nausea, and pain in your shoulder or the upper portion of your chest.

Set Aside Three Mealtimes Per Day
And Eat Solid Foods Only At These Times

It is important to eat nourishing foods and not snack. If you eat often throughout the day you may not lose weight or you may regain your weight. Individuals who continuously munch on crackers, potato chips, and other foods not only have failed to lose weight but have even gained weight. If you have the strong urge to snack, air-popped popcorn is an excellent very low-calorie snack. This can be seasoned with Pam and remain very low calorie.

Fluid Intake

Liquids are needed to replace normal body water losses and, thus, prevent dehydration. Again, water, skim milk, coffee, and tea are recommended. Initially, you should separate your solids and liquids in order that you can get enough solids at mealtime to sustain your nutrition. Later on, you will need to separate solids and liquids to help maintain your weight loss. Drinking fluids during mealtime will wash the food from your small pouch, causing you to become hungry again sooner. Therefore, after you become accustomed to your operation, you should drink your fluid requirements right before consuming solid foods at mealtime. You should drink four to six cups of liquid per day between meals. Remember early on that you will need to spread out this fluid intake during the several hours between meals in order that you can consume enough fluid to prevent dehydration. Later on, you will want to take most of your fluid volume shortly before mealtime. This will help you not to have the urge to drink during meals or immediately after meals and will also help you to eat less during mealtime. Your small pouch will be filled with food, and this will remain in your pouch for a long time, and you will not be hungry and can continue to maintain a good weight loss. Remember to avoid high-calorie drinks such as milk shakes, soda, beer, other alcoholic beverages, and whole milk.

Eat a Balanced Diet

Since the quantity of food you can consume at a meal is reduced, it is important that what you do eat is of good nutritional value. You should eat foods from each of the four food groups every day – milk group, meat group, fruit and vegetable group, and grain group.

Progression of the Diet During Hospitalization

As you begin to eat after surgery, you will be offered water and clear liquids. Clear liquids include jello, juice, and broth. Remember that at each meal you will be able to only eat a couple of small spoonfuls of each item sent on the tray. It is better to eat some of all the items rather than just one of them. After a short period, you will be advanced to a soft or chopped diet. Sometimes specific foods may cause discomfort or vomiting; however, because there are many reasons one may vomit, you should be careful not to avoid a food just because you vomited once after eating it. You may wait a while and then try the same food again.

The Diet At Home

For the first three weeks after surgery, you will be on a full liquid or blended diet. For protein you may eat cottage cheese, yogurt, sliced cheese, cheese dishes, eggs and egg dishes. After three you may carefully eat meats that are ground or very thinly sliced after cooking. You may also eat canned fruits and vegetables, baked potatoes without the skin, mashed potatoes, rice, macaroni, noodles, crackers, and cooked or ready-to-eat non-bran cereals. If you are tolerating the foods listed above during the first four or five weeks after surgery, you may want to experiment with some more foods. Well-cooked meats, raw fruits, raw vegetables, and even salads may be tried (as long as the lettuce is shredded or chopped). When starting a new food, eat only a bite or two the first time. Remember to chew well. Never swallow anything that is not chewed completely. Spit out the food if it cannot be completely chewed.

Remember Your Vitamins

Gastric Bypass
Multivitamin
Iron
B12
Calcium
Protein—rarely

Lap Band
Multivitamin with iron
Calcium

Lap Gastric Sleeve
Multivitamin with iron
B12
Calcium

Certain Foods May Be Difficult to Tolerate

Through trial and error, you may find that you are able to tolerate some foods and not others. Tough meats may always be difficult. Even hamburger sometimes contains gristle and is difficult to eat. Remember that foods with membranes, skins, and strings should be avoided. Milk is hard for some to tolerate, but is important. If you cannot tolerate skim milk in your diet, then you should incorporate the milk through foods such as soups, yogurt, and cheese. Sweets, especially if concentrated or liquid, such as ice cream, may cause dumping. This is the unpleasant effect of concentrated sugars emptying too quickly into the small intestine. Symptoms include weakness, sweating, and a heavy feeling. In some cases, there may be diarrhea. Dumping actually acts as a deterrent to eating sweet foods and therefore may be helpful to you.

Remember, the operation alone is not a cure. The operation is not magical. You will not be able to lose as much weight as you would like if you eat either continuously or if you stretch your stomach by eating large amounts of food at one time. You will lose weight only if you are willing to control what you eat and the way in which you eat it.

Remember that it is important to eat slowly, chew food well, stop eating when you are full, eat three meals a day, avoid snacking, avoid sipping high-calorie beverages, select a balanced diet, exercise regularly, and after you have become accustomed to your operation, take fluids before, not during or immediately after meals.

How Much Weight Will I Lose?

It is impossible to predict how much weight you will lose with your operation. In general, people lose between 40% and 75% of their excess weight, depending on many factors, including choice of operation, compliance with instructions and exercise. The excess weight is

how much you weigh above and beyond your ideal weight, as determined by Metropolitan Life Insurance tables. For example, a 200-pound person who should weigh 100 pounds according to the Metropolitan Life Insurance tables would have 100 pounds of excess weight. With careful follow-up and adherence to guidelines, this 200-pound patient could expect to lose and maintain a weight loss of 50-70 pounds of those 100 excess pounds. Some people lose almost to their ideal weight. Most patients should select a goal weight which is between 10 and 40 pounds over their ideal weight as the end point for their weight loss. For most people, this is more realistic and just as healthy as trying to reach an ideal weight. The operation will do 75% of the job for you, but 25% is your responsibility, and this includes restricting high-calorie fluids and snacking. If you are a heavy soda or beer drinker, you must prove that you can control this habit before surgery, because if you cannot stop drinking soda or beer, you will not achieve a good result no matter how well your operation is done. Compulsive eaters who cannot control snacking on high sugar foods and high-calorie liquids should become actively involved in a support group such as Overeaters Anonymous for additional help.

Exercise such as walking, swimming, bicycling, or any kind of sustained physical exertion, will help you lose additional weight and help keep weight off and also increase your overall sense of well being. When you feel strong enough after surgery (usually in about six to eight weeks after the operation), you should start on a graduated exercise program.

Activity and Exercise

Gradually increase your exercise as you get stronger. Walking is a good form of exercise. You may begin walking immediately after surgery. Increase your walking with a goal of two to three miles per day. In inclement weather, shopping malls are a good place to walk.

Do not drive for ten days unless approved by your surgeon. Early after the operation, do not sit with your legs cramped for more than ½ hour to deter blood clot formation. Therefore, limit car trips even with someone else driving in the early weeks after surgery.

After three weeks you may start a graduated program of sports, exercise, physical work and sex as tolerated. The length of absence from work is very individual and varies depending on your job.

Follow up

You will be seen in the office very soon after you are discharged from the hospital. Visits thereafter will be scheduled at progressively longer intervals. If you move out of town or are unable to come to our office, please let us know. We need to see you on an annual basis to determine any problems and keep track of your progress. Please remember you must have a blood count every year. If you are anemic, additional blood studies will be done to determine if you are deficient of iron or B12.

Support Group

A support group consisting of patients who have had a weight loss surgery has been formed and will be very helpful to you. It is important for those considering surgery to attend as well as those that have had the surgery. It will be very helpful for you to talk with those who have already experienced the surgery and discuss any problems or concerns. They have already worked through many issues and found solutions either through group discussion, on their own, or through their surgeon. Support group meetings are fun as well as informational. A variety of topics will be discussed with frequent guest speakers. Patients who share their experience and have the support of others tend to have better long term results! You will always receive notification of group meetings. Please know that you are always **welcome** and we strongly encourage you to come!

Other Considerations

- ✸You may not have as many bowel movements as before surgery because you will be eating less food. Therefore, you may wish to use a stool softener or a bulk producing laxative, such as Metamucil. For those that may have more frequent bowel movements, this problem will correct itself over time.
- ✸Avoid aspirin-containing products, NSAIDS or non-steroidal anti-inflammatory drugs
- ✸You may ask our office secretaries for the contact information of patients who have had the operation that will be glad to speak with you about their experience.
- ✸Please ask any questions that you may have that are not covered in this information.
- ✸Please discuss this operation with your family. You will need their support and understanding. We want you to have an excellent result from your operation and achieve your goal of better health and quality of life.

Lifelong Commitment

Those deciding to proceed with weight loss surgery after attending seminar and reading this information can expect the following.

- ☑We will obtain your insurance/payment information
- ☑You will be contacted for an appointment with our office for an initial interview and health assessment. **Please bring the health history forms that you received in the mail and/ or in the back of this book with you to this appointment. Please have these forms completed.**
- ☑We will begin communicating with your insurance company to determine coverage. **We are not taking Medicare primary insurance at this time.** Please note that if you have Qual Choice or Health Advantage through the state or school program, this is a non-covered procedure and you will be considered self pay.

All other Health Advantage groups should contact your human resources department to determine if this is a covered service. **Medicaid patients** please see the Coverage requirements on the separate page in this packet.

☑An appointment will be made for you with Dr. Jones. Please note the charge for your initial office visit is **$270.00.** If you have insurance, all deductibles and co-pays will be expected at time of service. If you are self-pay, payment in full is expected.

☑All necessary blood tests, X-rays, electrocardiogram, etc… will be done prior to your operation.

☑If necessary, a pulmonologist (lung specialist), cardiologist (heart specialist), or other needed specialists will be consulted before surgery.

☑You will be given an operative consent form to read and sign. Please read it carefully as you are acknowledging that you understand and accept the potential complications and side effects.

☑You will be scheduled for a Pre-Admission Testing (PAT) visit. This will be done 2-3 days prior to surgery.

☑You will be expected to attend a support group meeting prior to surgery.

☑Please be prepared to make the lifelong commitment to the lifestyle changes that are necessary to assure success.

☑Make the commitment to attend support group regularly after surgery

☑Make the commitment to attend all scheduled follow-up office visits including yearly follow up and blood-work.

What Will Happen Now?

Weight Loss Surgery Patient Flow Sheet

Getting Started: -You made an inquiry about the surgery to Dr. Jones office. You are registered for Dr. Jones' next informational seminar.

Seminar: -Attend Dr. Jones informational seminar
-Provide Insurance and contact information
-After the seminar, if you wish to pursue weight loss surgery, sign the appointment list and our bariatric coordinator will contact you for an evaluation.

Insurance: -After your appointment with the coordinator, we will provide your insurance company with the necessary information to determine if they will cover this operation for you.
-Confirmation of coverage may take 4-6 weeks. We will contact you if additional information is needed.
-Please be aware that ***all co-pays must be paid in full two weeks prior to your scheduled surgery date.*** If you will be a ***self-pay, the full amount must be paid by two weeks prior to your surgery date. *This includes both the surgeon and the hospital fees.***

*****For LAP-Bands the first 3 months following surgery are included in the Lap-Band price. (Usually 2 adjustments are done during this time)***

Your appointment: -Dr. Jones' office will call you to schedule your first appointment. Please ***be sure your checklist and Patient information forms are completed.*** Bring all appropriate documents with you to your appointment.

Your office visit: -Please note the charge for your office visit is **$270.00**. If you have insurance, all deductibles and co-pays will be expected. If you are self-pay, payment in full is expected.

-Dr. Jones will do a thorough exam, explain the risks and benefits of the operation and answer any questions you may have.

Lab Work/Tests: -Dr. Jones will determine what test are necessary for you and if a consult with a specialist is needed, the necessary appointments will be made.

Setting a Date: -Once all the reports are received and reviewed, a surgery date will be determined and your operation will be scheduled.

PAT visit:
Education Class: -When your operation is scheduled, we will also schedule a date and time for you to go for your Pre-Admission Testing (PAT) visit.

Pre-op diet: Also about 2 weeks before surgery, you may meet with Dr. Jones' nurse and receive instruction regarding your pre-surgery diet. It is very important that you follow this diet as instructed.

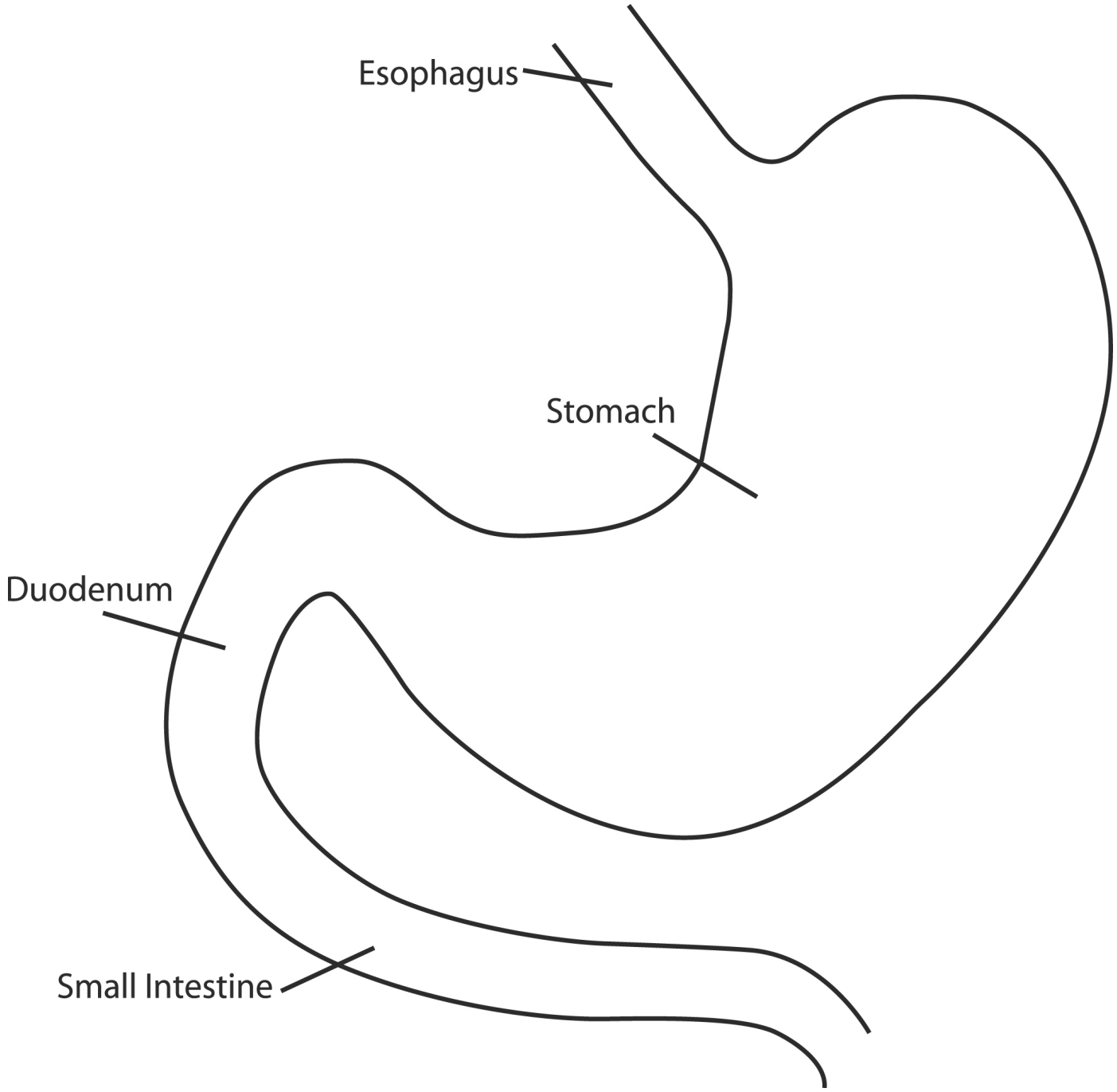
Support group: If you haven't already done so, please make plans to attend a support group meeting before you surgery if at all possible. It will be very helpful to you to talk with others that have had weight loss surgery before your operation.

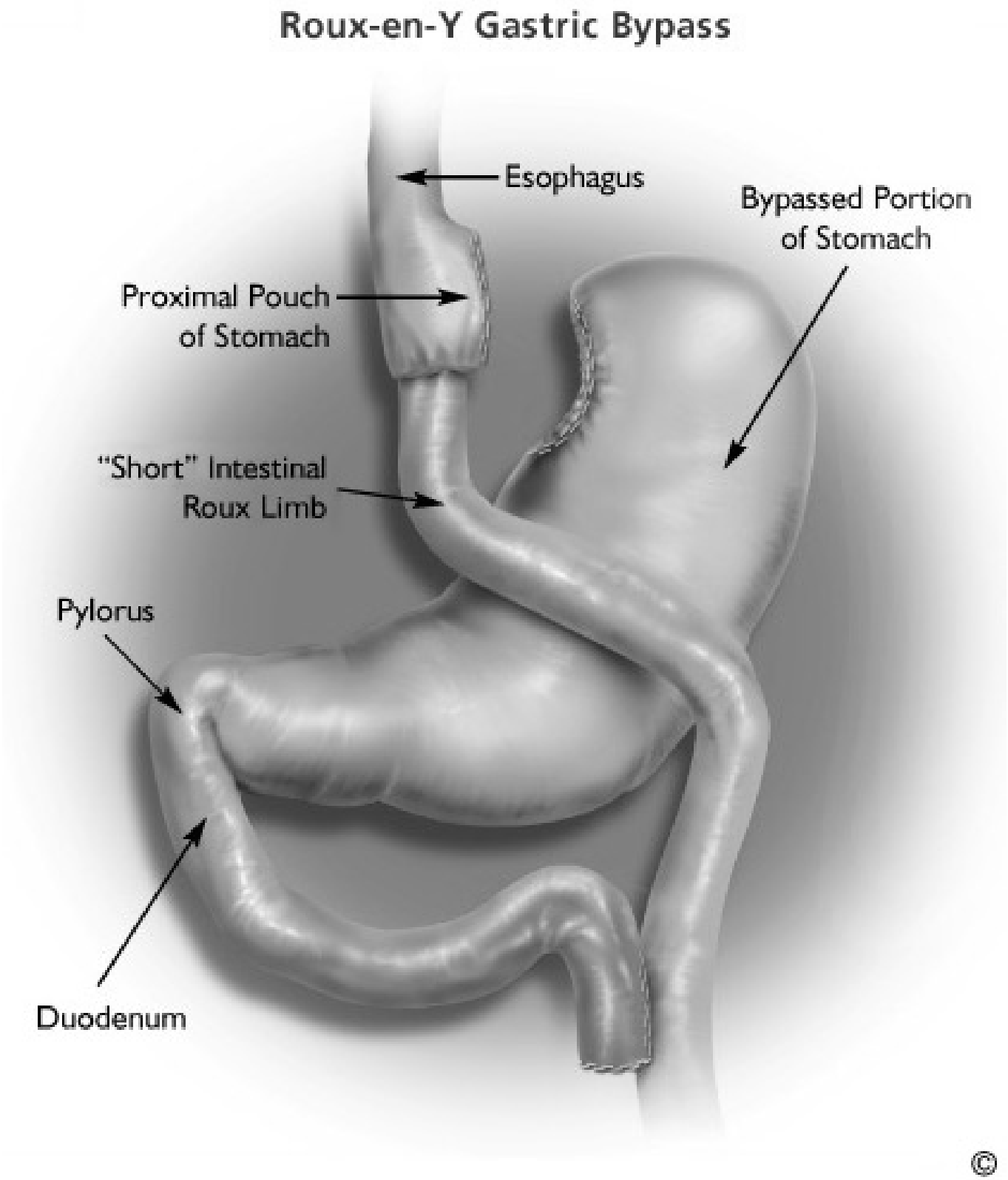
The Big Day: Your surgery is performed. You will be well prepared and know what to expect. You can expect to be in the hospital 2-3 days with Gastric Bypass and Sleeve Gastrectomy, 23 hours or less with the LAP-BAND.

Follow-up: You will be scheduled for an appointment with Dr. Jones upon discharge from the hospital. Attending all follow-up appointments is very important to your health and well-being. You will be scheduled for a check up every year or as needed. It is very important that he see you and follow how well you are doing.

Support: Please make plans to attend support group meetings monthly. Continued support is very important to your weight loss success. Please call your weight loss coordinator if you need additional support.

Normal Upper Gastrointestinal Tract




Roux-en-Y Gastric Bypass
Esophagus
Bypassed Portion of Stomach
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"Short" Intestinal Roux Limb
Pylorus
Duodenum
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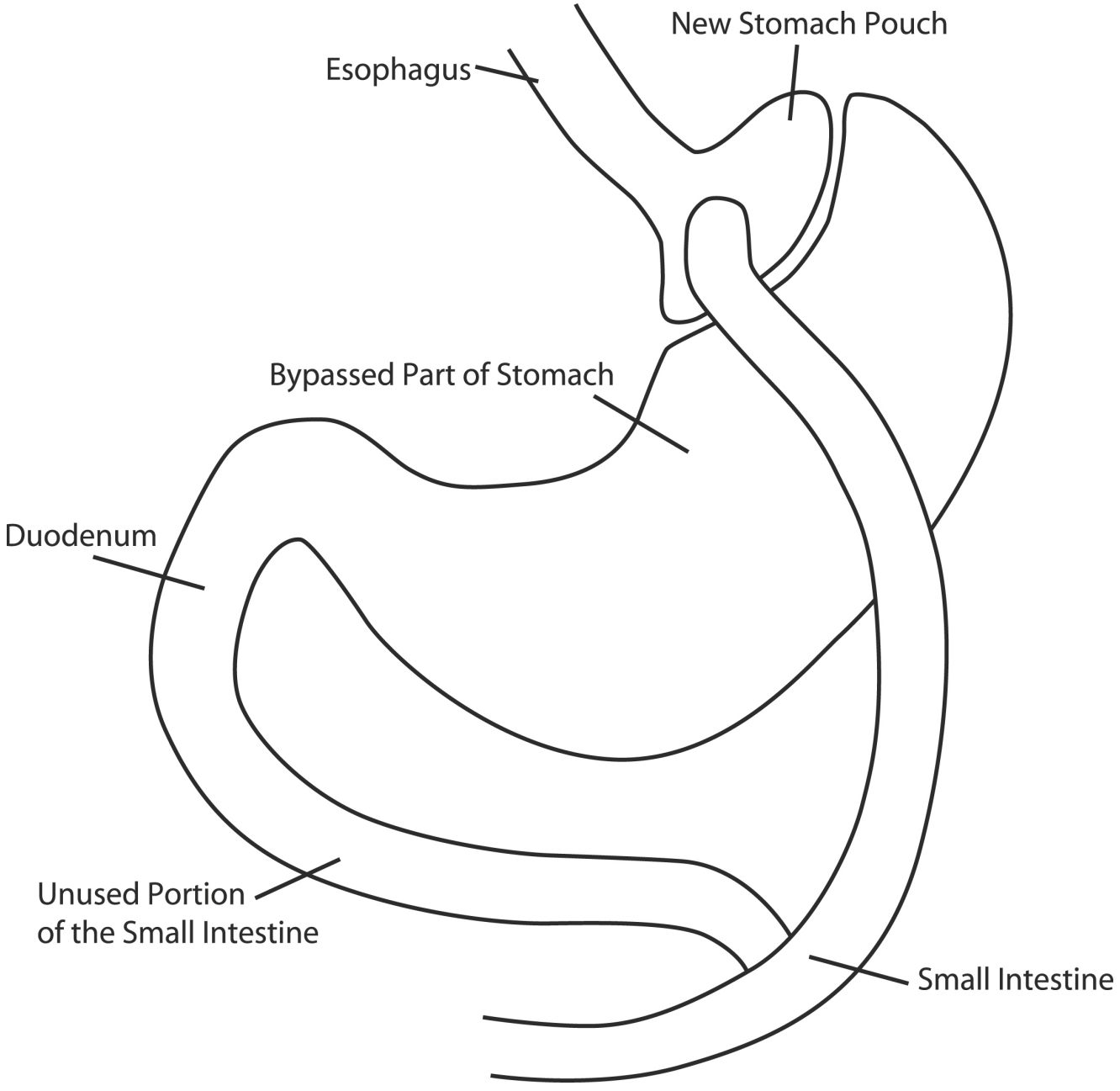
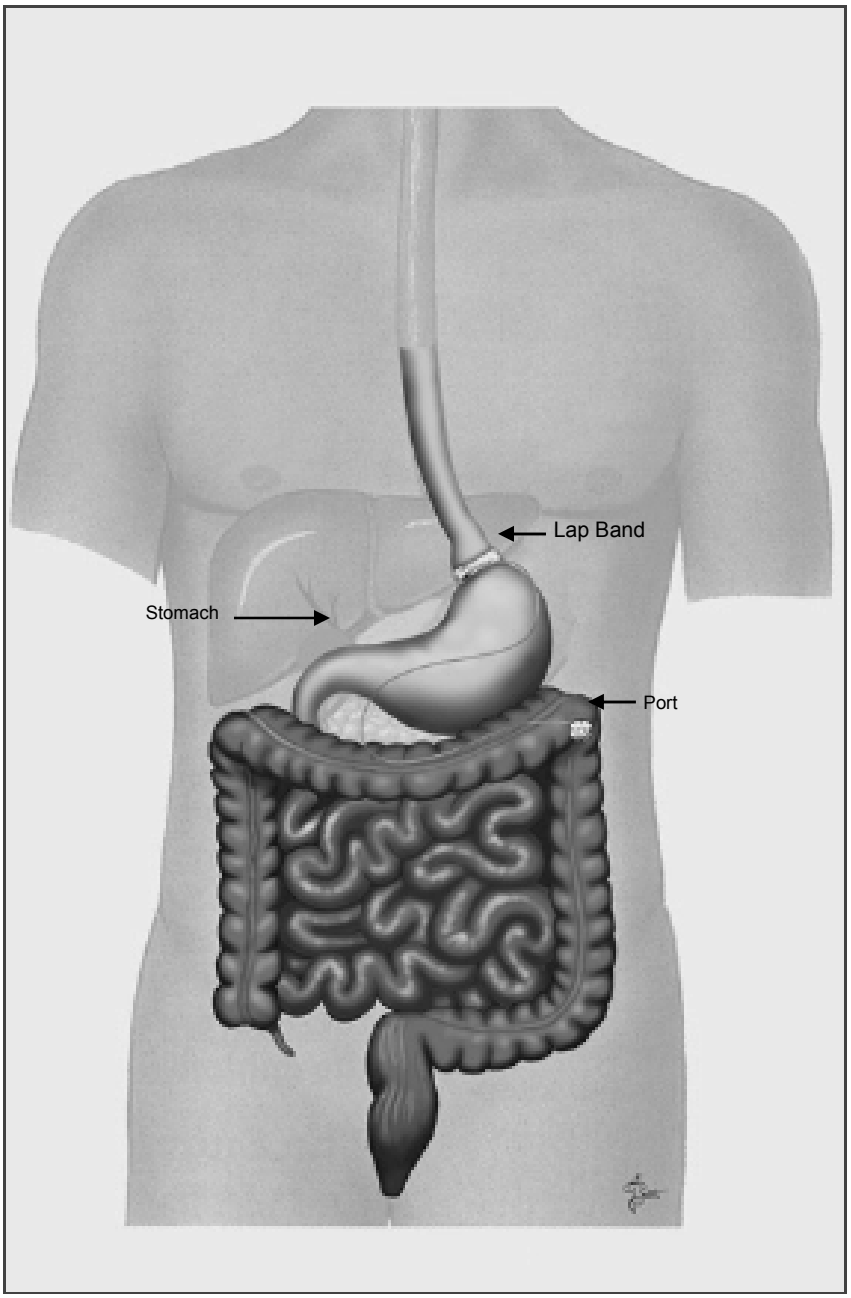
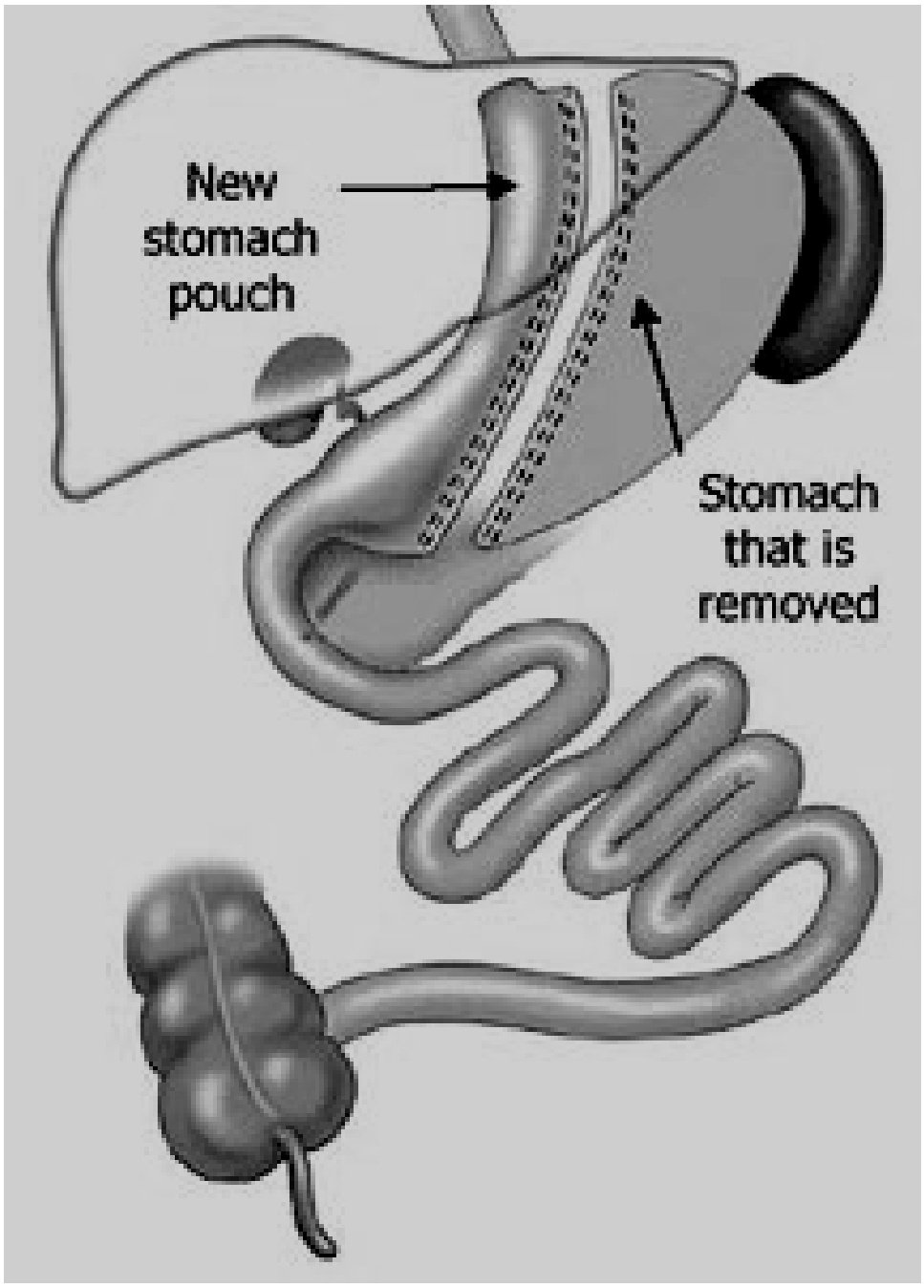
Gastric Bypass With Roux-En-Y



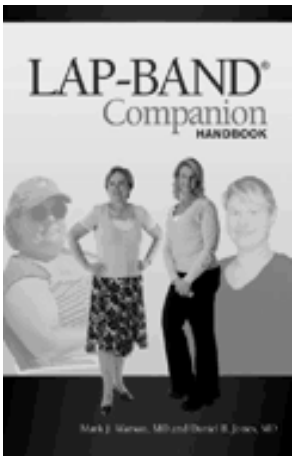
LAP-BAND System on Stomach



Sleeve Gastrectomy



Lap Band Companion Book and Websites



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