

NEW DIMENSIONS WEIGHT LOSS SURGERY

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OPERATIVE PERMIT FOR ROUX-EN-Y GASTRIC BYPASS

Expected outcomes and patient commitments

The planned weight loss operation will partition (cut across and separate) your stomach using surgical staples made of stainless steel or titanium, creating a tiny stomach pouch that empties into a segment of your small intestine called the jejunum. The size of the pouch is intended to be 1 ounce or less, and the outlet into the intestine is about 1 cm in diameter. The surgical changes should make it difficult or impossible to eat “normal” amounts of food, and should create symptoms of illness when too much food is eaten, or if sugar or other concentrated calories are consumed.

The operation does not guarantee weight loss, and does not cure the underlying cause of obesity. The procedure only works well when coupled with an active effort on the part of the patients to adapt their eating habits toward infrequent small volume meals in concert with the surgical changes – the Gastric Bypass is best viewed as a “tool” to assist in reduction of calorie intake and it cannot serve as a substitute for the patient’s mental effort in dieting and exercise. The amount of weight lost depends on the patient’s starting weight (heavier patients tend to lose more weight, but end up further above ideal body weight), the patient’s age (younger patients tend to get closer to ideal body weight), and motivation. Thus there is no guaranteed amount of weight loss, though it is reasonable to expect that the overwhelming majority of surgical patients will lose enough weight to have a significant positive impact on their medical condition.

In the first 6-8 weeks after surgery, you should be able to drink liquids but tolerate only very small amounts of food. In the subsequent 3-6 months (as the new stomach heals) you should progress to eating enough food for adequate nutrition over time. It is our experience that patients must use this recovery phase after surgery to re-learn and choose optimal habits of diet and exercise that will promote the best health and weight control over time. Patients must also begin taking the recommended vitamin and mineral supplements (usually vitamins with Iron, and supplemental Calcium) and should continue taking these supplements for life.

The stomach can never be returned to normal after this operation. Furthermore, you should understand that the gastric bypass should never be “taken down” or “reversed” because you are likely to regain weight if this is done.

Patients who have undergone any type of Weight Loss Surgery may develop deficiency of Iron (may result in anemia), Vitamin B₁₂, Calcium (may result in osteoporosis, “weak bones”), or other nutrients. Your surgeons believe the risk of nutritional problems is much lower if you have follow-up and screening blood work checked by a physician experienced in bariatric surgery, periodically for life. Patients should also take basic mineral supplements as instructed by the surgeon (usually vitamins, Iron, supplemental Calcium, and possibly B₁₂) for life.

Risks of the Operation

Risks of the Gastric Bypass operation include risks that are physically related to the surgical procedure, and the risks caused by the stress that any major surgical procedure would impose on your body and vital organs. One or more of the following adverse events can occur in any patient, and some patients die as a result of undergoing the gastric bypass operation. The risk of death from this procedure ranges from a low of 1 in 1000 for the best risk patients, up to 1 in 4 or worse for patients who are severely ill before surgery. Another way to describe the risk of death is as a percentage: from 0.1% chance of death (“low risk”) up to or greater than 25% chance of death. By the time you read this, your surgeon should have discussed your own estimated level of risk.

Physical risks that are related to the surgical procedure include: leak from an anastomosis (bowel hookup) or the stomach, bowel obstruction, bleeding inside the bowel or inside the abdominal cavity, rupture of abdominal closure (dehiscence), injury to nearby structures such as the spleen (may require removal of spleen), esophagus, liver, pancreas, or intestine, ventral (incisional) hernia, infection in the wound or inside the abdomen, chronic stomach or intestinal function problems, and need for later procedures to repair or revise a part of the surgery that is not working correctly. These procedures may include IV fluids, CT scans, endoscopic procedures, or repeat operation(s).

Risks that arise from the systemic stress effects of major surgery include: lung failure, heart failure or heart attack, kidney failure, pneumonia, and Deep Venous Thrombosis with possible Pulmonary Embolus (blood clot forms in legs and floats into vessels of lungs). Your significant obesity increases the risk of all these problems, and unfortunately also makes diagnosis & treatment of most problems more difficult (obviously, the obesity is the reason you are considering this surgery, so there is no way out of this dilemma).

Other undesirable outcomes

Your surgeon may encounter a situation in the operating room that requires a change in the operative plan. In particular, if a laparoscopic approach is planned, we find it is necessary in a very small percentage of cases to change the approach to a traditional open incision. Findings such as an unexpected tumor or massive enlargement of the liver, or cirrhosis of the liver, might make it medically sensible to stop the operation without performing the gastric bypass.

Not all patients lose all the weight they hope to. Inadequate weight loss may arise from a surgically correctable problem, but more commonly weight loss fails when patients fail to work *with* the surgery to dramatically reduce their calorie intake and establish a regular exercise program. The latter problem cannot be altered surgically.

Most patients will be left with excess skin on the abdomen, arms, legs, and other areas. This skin may be unattractive, and may cause pain or hygiene problems. Unfortunately, the excess skin usually does not “snap back” with exercise or time – if it is to be treated it must be removed by additional surgery. Most patients find they have tremendously improved energy after recovering from surgery, but a few find that they fatigue easily and have difficulty holding physically demanding jobs. Some minerals or other nutrients may tend to be low after gastric bypass, and additional prescription medications or injections may be required. As a result of weight loss, patients may experience internal or external psychological distress – divorce, depression, and/or need for counseling are commonly seen.

Possible removal of the Gallbladder

Many patients who undergo gastric bypass have previously had their gallbladders removed. Of patients who still have their gallbladders at the time of surgery, many will have gallstones or gallbladder inflammation identified prior to surgery or at the time of gastric bypass. When a diseased gallbladder is identified before or during surgery, your surgeon recommends removal of the gallbladder. This is proposed because there is a real chance that the diseased gallbladder will progress to cause clinically significant problems in the setting of rapid weight loss. On the other hand, if the gallbladder is normal, the surgeons will leave it alone because of the small but real risks of gallbladder removal (injury to main bile duct, or liver, leak from bile duct closure, or stones retained in main bile duct). If you still have your gallbladder after surgery, you will be prescribed a bile thinning medicine (Actigall) to take for 6 months – this should reduce but not eliminate the chance of gallstone formation.

Summary

You are being offered the gastric bypass procedure because your surgeon believes it is a medically reasonable option in your case. Your part of the decision to undergo surgery is more complex and more important. Before choosing to undergo gastric bypass surgery, you must:

- 1) believe that your weight is a medically significant problem
- 2) believe that you have exhausted all non-surgical options for weight loss
- 3) understand the expected outcomes and the risks of the gastric bypass
- 4) believe that the tradeoffs and risks associated with gastric bypass are worth the risks of surgery for you
- 5) pledge to comply with recommended followup visits with your surgeon, or to work with your surgeon to make other arrangements if you move, and
- 6) pledge to keep Dr. Pilcher/Dr. Reiss/Dr. Duperier/Dr. Stegemann/Dr. Seger/Cavazos /future associates informed of your address/phone numbers. If all of the above are true, please sign below:

Patient signature

Witness signature

Date

Date