



---

**Centre for Endoscopic, Bariatric  
and Laparoscopic Surgery  
(CEBLS)**

**Obesity Surgery Handbook**





---

**Table of Contents:**

**Introduction..... 4**

**Weight loss surgery (bariatric surgery) ..... 7**

**Background..... 8**

**Why treat obesity? ..... Error! Bookmark not defined.**

**What is a multi-disciplinary team (MDT)?Error! Bookmark not defined.**

**When can I be referred to the clinic?..... 11**

**Funding ..... 12**

**Specific Information on both types of surgery ..... 12**

*A. Gastric banding (LAGB) ..... 12*

        Advantages..... 13

        Disadvantages ..... 13

*B. Roux-en-Y Gastric Bypass (LRYGB) ..... 14*

        Advantages..... 15

        Disadvantages ..... 15

*C. Sleeve gastrectomy (LSG)..... 16*

**Which operation is right for me? ..... 17**

*Listed below are some factors you will need to consider in order to decide the right choice of operation for you: ..... 17*

**Appointments ..... 21**

*First appointment..... 21*

*Psychology/Eating disorder appointment**Error! Bookmark not defined.***

*Other specialist appointments to assess fitness:..... 22*

*Pre-surgery review appointment**Error! Bookmark not defined.***

*Appointment with the dietician..... 22*

*Physiological Accelerated Restorative Training (PART)**Error! Bookmark not defined.***

# Centre for Endoscopic, Bariatric and Laparoscopic Surgery (CEBLS)



---

<b>Surgery</b> .....	<b>22</b>
<i>When will I be put on the waiting list?</i> .....	22
<i>Pre-assessment appointment...</i> <b>Error! Bookmark not defined.</b>	
<i>Morbid Obesity Optimisation Service (MOOSE)</i> <b>Error! Bookmark not defined.</b>	
<i>The pre-operative liver shrinkage diet (PoLiSh)</i> .....	22
<i>Admission for surgery</i> .....	23
<i>What happens in hospital after surgery</i> .....	24
<i>Support available during early recuperation period after surgery</i> .....	<b>Error! Bookmark not defined.</b>
<i>Further follow up after surgery</i> .....	25
Roux-en-Y Bypass .....	25
Gastric Bands .....	25
Gastric band fills .....	25
<i>3-monthly follow up group sessions with the dietician</i> <b>Error! Bookmark not defined.</b>	
<b>Will further surgery be needed?</b> .....	<b>26</b>
<b>Patient support group</b> .....	<b>Error! Bookmark not defined.</b>
<i>National patient support networks</i> .....	26
<b>Patient testimonial</b> .....	<b>27</b>
<b>UK Websites</b> .....	<b>28</b>
<b>Booklist</b> .....	<b>28</b>
<b>Contact details</b> .....	<b>29</b>

## List of Tables

Table 1: Risk-benefit comparison of banding vs. bypass .....	10
Table 2: Health improvements after banding vs. bypass <b>Error! Bookmark not defined.</b>	
Table 3: Health implication in surgery vs. no surgery <b>Error! Bookmark not defined.</b>	
Table 4: CEBLS MDT members ... <b>Error! Bookmark not defined.</b>	
Table 5: Effect of band tightness .....	26



---

---

**List of Figures**

Figure 1: Gastric banding ..... 12  
Figure 2: Gastric bypass..... 14  
Figure 3: Sleeve gastrectomy ..... 16

**Introduction**

Welcome to the Centre for Endoscopic, Bariatric and Laparoscopic Surgery (CEBLS). We specialise in the surgical management of weight. Overweight and obesity is a significant problem worldwide. Obese individuals often develop complications like diabetes, blood pressure, arthritis, back pain, sleep apnoea, heart failure etc and survive about 9-13 years less on average than those with normal weight.

Most people will try many different ways to lose weight over many years. Unfortunately, most people struggle to maintain long term weight loss and put back weight on again very easily. We understand how difficult maintaining weight loss can be as you are not alone in experiencing this problem. We know that 80% of those who lose weight by dieting will regain weight within 2 years - this figure rises to 100% within 5 years. It is because your body vigorously defends it's weight.

Weight loss surgery can be the most effective solution to managing your weight problem and represents a major step forward. The aim of this is to ensure you lose weight safely and benefit from the improvements to your health that comes with this. A bariatric surgical procedure will be most effective and durable when combined with dietary measures and regular physical activity.

This booklet has been designed to provide you with an understanding of weight loss surgery and explain what it



---

involves. We hope that by the time you have finished reading this booklet you will be in a position to make an informed decision whether you should undergo surgery and what operation to have.

Effective weight loss surgery requires a partnership between the patient and the surgeon. We can offer you safe surgery and provide you with help and support before, during and after surgery. However, in order to obtain the very best results from surgery, you will need to make permanent changes to your lifestyle, especially your diet and the physical activity you will undertake daily.

## **What is obesity?**

The World Health Organisation defines obesity as a medical condition in which excess body fat has accumulated to the extent that it may have an adverse effect on your health, leading to reduced life expectancy. It is usually expressed as a figure, body mass index (BMI), obtained by dividing your weight by your height squared:

$$\text{BMI} = \frac{\text{weight}}{\text{height} \times \text{height}}$$

Your BMI is considered to be within normal range when it is between 20 to 25. You are overweight if you have a BMI above 25 and will be at risk of developing weight related health problems. Being overweight can also shorten your life.

## **Why treat obesity?**

The main concern regarding obesity is the impact it has on your health and life-expectancy. If your BMI is over 30 then you are obese and will have a greater risk to your health.



Obesity affects many body systems and can lead to a number of common health problems such as:

- High blood pressure
- Heart disease
- Type 2 Diabetes
- Joint pain, arthritis and backache
- Certain cancers e.g. breast cancer, colon cancer, endometrial cancer
- Cirrhosis of liver
- Sleep apnoea

Obesity now accounts for 30,000 deaths each year (6% of all deaths in the UK). On average, obese people are likely to die 9-13 years earlier than those who are not overweight, preventing many from reaching retirement age. The heavier you are and the longer you have been overweight the greater the risk. There can therefore be many benefits to health with weight loss, particularly after obesity surgery. Scientific research has demonstrated that obesity surgery can reduce health problems considerably, as shown in the table below:

**Table 1: Health improvements after banding vs. bypass**

<b>Health Problem</b>	<b>Gastric band</b>	<b>Gastric bypass</b>
Cured of diabetes (Off all medication)	48%	84%
Diabetes improved	80%	93%
High cholesterol improved	78%	95%
High blood pressure (Off all medication)	43%	68%
High blood pressure- improved	70%	87%
Sleep Apnoea- improved	68%	94%

One study, conducted in Sweden, demonstrated quite clearly the differences in health between a group of obese patients who underwent surgery and those that did not.



**Table 2: Health implication in surgery vs. no surgery**

	<b>Weight Reduction Surgery</b>	<b>No Surgery</b>
Arthritis	5%	12%
Cancer	2%	8%
Deaths	1%	6%
Diabetes and endocrine disease	9%	27%
Heart disease	5%	27%
Infectious diseases	9%	37%
Lung disease	3%	11%
Number of days in Hospital during a 5 year period	21 days	36 days

The costs linked with treating obesity and its related health conditions in England are enormous. It is thought that the direct medical costs alone in 1998 was approximately £500 million and it is projected to rise to 48 billion pounds by 2050.

## **Weight loss surgery (bariatric surgery)**

Greek baros means *weight*.

Weight loss surgery (bariatric surgery) consists of various operations designed to reduce weight. These operations may restrict the amount you are able to eat (restrictive operations such as the gastric band and sleeve gastrectomy) or reduce the amount of food you can absorb (bilo-pancreatic diversion). Other operations like gastric bypass or duodenal switch work by restricting the amount you can eat, reducing the amount you can absorb and diverting the flow of food. Procedures for surgical removal of body fat such as liposuction or abdominoplasty (tummy tuck) are not considered weight loss surgery - rather they are considered plastic surgery.



---

## Background

At CEBLS we commonly undertake gastric banding, Roux-en-Y bypass (gastric bypass) and sleeve gastrectomy. You will read more about these procedures shortly. All operations are performed laparoscopically (keyhole surgery), which will help you to get up and around and back to normal as soon as possible after surgery. We also perform gastric balloon endoscopically which can help in a smaller amount of weight loss. We ensure you are fully informed about weight loss surgery and that your operation is performed in the safest possible environment. Your safety is our first priority.

## History of bariatric surgery

In the earlier part of last century, patients commonly underwent operations for stomach ulcers and cancers. Some surgeons noticed that patients who had part or all of their stomach removed with diversion of the food stream, lost weight and were not overweight. **Gastric bypass** mimics this by forcing the food to bypass most of the stomach and the duodenum (proximal small bowel) to deliver food into the jejunum.

Almost all of our food and nutrients are absorbed through the small bowel. We could actually live quite happily with only a half or even a quarter of this bowel but as the amount of bowel we have reduces, our ability to absorb food reduces as well. People who have needed to have a significant part of their small bowel removed, such as those suffering from Crohn's disease and ischaemic bowel, lose weight and keep it off. An Italian surgeon called Scopinaro invented the **Scopinaro procedure (Bilopancreatic diversion)** - an operation that mimicked shortening of the small bowel by bypassing most of it. The food, instead of passing along the full length of the small bowel, went to the very end so that there was only a very short segment where food could be absorbed (about 50 cm or 20 inches). Patients lost weight rapidly and more importantly patients did not gain weight





---

again, no matter how much they ate. The disadvantage was many people suffered from loose motions, offensive smelling stools and developed a greater deficiency of vitamins, minerals and other nutrients. Hence, it is not common for patients in the UK to be offered this procedure.

**Gastric band** or the Lap Band was introduced more recently and has become very popular. This is probably because the operation is simpler to learn for most surgeons than that for gastric bypass and BPD and has less immediate risk associated with it. Fluid can be added or removed to the band to adjust the tightness. The band can also be removed completely and although one will put weight back on again, the patient is essentially “back to normal” after this has been done. However, this operation should not be contemplated if one is not committed to accept this as a lifelong choice. Long-term complication rate of band is probably no different from that of bypass and can sometimes be greater.

A **Sleeve gastrectomy** involves cutting away most of the stomach to leave a long thin tube. This new “sleeve” does not initially stretch as the original stomach did and therefore people feel full after small meals. It is not as involved as gastric bypass or BPD and produces more reliable and effective weight loss than a band. It is often offered as the first part of a two-stage operation for patients in whom a gastric bypass is considered too risky. Once the patient has lost a significant amount of weight and their health improved we can then go on to perform a gastric bypass. In recent years surgeons have offered this operation on its own. Unfortunately, there is evidence that 50% of patients may regain significant weight 5 year after surgery - this is because the “sleeve” stretches over time and can therefore hold more food. However, the operation can be repeated and extra stomach trimmed away or a gastric bypass / duodenal switch performed or a gastric band added to maintain long-term weight control.



A Gastric balloon is inserted into the stomach and works by reducing the stomach's capacity to hold food. It is inserted using an endoscope and left in place so that the patient feels full after a smaller meal. However, it has to be removed after about 3-6 months, though occasionally it can be left for longer. The balloon is only effective for the duration it remains within the stomach and patients will regain weight after removal. Therefore, it is suitable for people who are overweight but not obese or for very obese people in whom this can be the first of a number of procedures to obtain long-term weight control.

All of the above operations can and should be performed by "keyhole surgery" i.e. minimally invasive techniques (laparoscopically / endoscopically) in most patients. This means that the procedure is performed through the mouth or by small incisions or cuts in the belly wall instead of larger incisions needed in traditional "open" surgical procedures.

A comparison of the risks and benefits of gastric banding and bypass are shown in the table below.

**Table 3: Risk-benefit comparison of banding vs. bypass**

	<b>Gastric Band</b>	<b>Gastric Bypass</b>
Laparoscopic operation	Yes	Yes
Technical difficulty	Relatively straightforward	Requires advanced laparoscopic skills
Hospital stay	24 hrs	2-3 nights
Complications	Uncommon but increases with time	Uncommon but can be serious, especially with less experienced surgeons
Reversibility	Straightforward	Difficult
Start of weight loss	Minimum of 6 weeks	Starts immediately
Expected weight loss	30 – 60% of excess weight	70 – 80% of excess weight
Failure to loose weight	10%	<1%



---

It is important to remember that whilst people are often happy to have lost a significant amount of weight, the health risks remain as long as you are overweight. For this reason our aim is to get your weight as close to normal as possible.

## **When can I be referred for an operation in the NHS?**

Generally, most centres accept referrals if patients meet the NICE (National Institute of Clinical Excellence) 2006 guidelines. Mr Sufi leads the service at North London Obesity Surgery Service (NLOSS), one of the few accredited centres for performing these operations in the NHS.

In order for you to qualify for surgery in the NHS, you have to meet all of the following criteria:

- You must be willing to see various specialists that we recommend and follow our instructions.
- You are generally fit for anaesthesia and surgery.
- You commit yourself to the need for long-term follow-up.
- You belong to one of the following categories:
  - **Severely Obese** (BMI 35-39.9) with co-morbidity e.g. type 2 diabetes, high blood pressure, osteoarthritis, metabolic syndrome etc.
  - **Morbidly Obese** (BMI 40-50, no co-morbidity required)
- You would have tried non-surgical measures for at least 6 months and failed to achieve or maintain adequate clinically beneficial weight loss. However, if you are **Super Obese** (BMI > 50), then we waive this condition.

However, you should be aware that generally there is a long wait for these operations in the NHS.



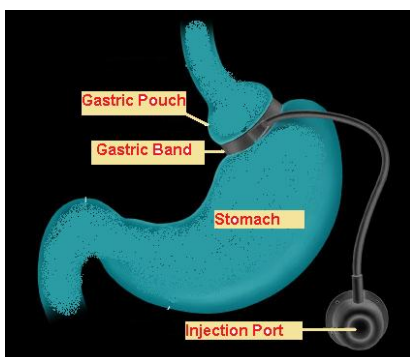
---

## Funding

Bariatric surgery is generally not funded by insurance companies. Therefore, you will have to fund your treatment from your own resources.

## Specific Information on both types of surgery

### A. Gastric banding (LAGB)



**Figure 1: Gastric banding**

Gastric Banding is a purely restrictive surgical procedure or in other words it restricts your ability to eat food. An inflatable band is placed around the uppermost part of your stomach and a tube connects this to a port in your abdominal wall. The band is inflated by injecting fluid into this port, resulting in the creation of a small stomach pouch above the band. The main stomach lies below this pouch and the inflated band guards the channel between these and restricts what can go from the pouch into the stomach and how fast. The pouch normally holds only a mouthful of food and therefore becomes easily distended leading to a early feeling of fullness. The speed at which the pouch empties will be determined by the tightness of the band and when just right will only allow you to eat a small meal (the equivalent of a starter in a restaurant) and make you feel satisfied after it. The band is not



---

inflated at the time of surgery. Your first band fill inflation will be at 4-6 weeks. You will need to have the band tightened from time to time as your weight loss progresses. With this procedure the structure of the stomach and intestines are not altered, so digestion and absorption remains normal.

### **Advantages**

- Helps improve health problems as shown in table 1 and 2 above (Page 6 and 7).
- You can expect to lose roughly 30-60 % of your excess weight, provided you follow the dietary advice.
- The amount of solid food that can be consumed at a meal is restricted.
- Food passes through the digestive tract in the usual order, allowing it to be absorbed fully by the body.
- The band can be adjusted to increase or decrease restriction via an access port in your belly wall.
- Surgery can be reversed (though you will most likely regain weight).

### **Disadvantages**

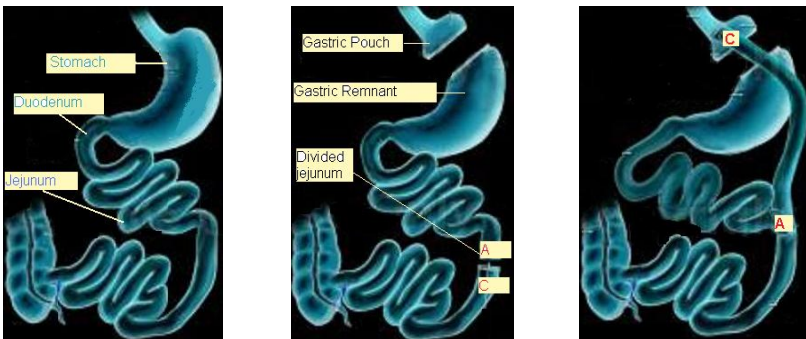
- Successful weight loss requires life-long adoption of healthy eating and self-control. The band will fail if you can not give up eating chocolates and sugary drinks.
- You may not be able to take tablets or capsules – all medication will have to be in liquid or injection form, at least initially.
- You may struggle to eat particular types of food, especially bread and meat.
- Weight loss is slower than that following Roux-en-Y gastric bypass surgery and may not start for a number of months after surgery until the band is filled or inflated.
- Surgery may not always provide the necessary feeling of fullness - 10% of people fail to lose weight with the band.
- The band may move or slip or erode into the stomach wall.
- The pouch or gullet above the band may dilate.



- The access port may leak or twist, which can require another operation to correct the problem.

### ***B. Roux-en-Y Gastric Bypass (LRYGB)***

In this procedure, the surgeon creates a small gastric pouch in the same position and the pouch is the same size as that seen with the gastric band. On this occasion though, the stomach is cut through so that the pouch is no longer attached to the rest of the stomach. The small bowel is then divided 50-80cm (20-30 inches) from its top and the cut end brought up to and attached to the gastric pouch. In this way, food enters the pouch, bypasses the initial part of the small bowel (duodenum) and enters further down than normal (into the Jejunum). The divided end of the bowel is re-attached 80 – 100 cm (30-40 inches) below where the other end is joined to the gastric pouch. This ensures that the food does not stimulate the secretion of certain hormones and the gastric and pancreatic juices required to digest the food properly enter the small bowel further downstream.



**Figure 2: Gastric bypass**

As with the gastric band the main effect will be that you will generally be able to eat small amounts only but there is no significant reduction in the amount of calories and protein you can absorb, even though most of your stomach and upper part of the small bowel is bypassed. However, there is a 30% chance



---

that you may develop vitamin and mineral deficiency unless you take daily supplements - you will therefore daily need to take tablets containing iron, calcium and certain vitamins, as well as, have 3-monthly vitamin B12 injections.

### **Advantages**

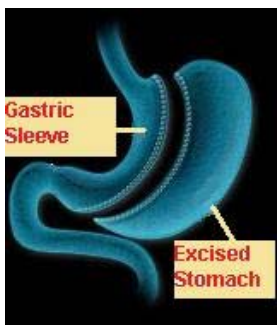
- Helps improve health problems as shown in table 1 and 2 (Page 6 and 7).
- The average excess weight loss after a gastric bypass procedure is generally higher than a purely restrictive procedure e.g. gastric band.
- You can expect to lose roughly 70 – 80 % of your excess weight after two years - it is unusual for a patient not to lose the expected amount of weight.
- Weight loss starts from the time of surgery.
- Studies show the large amount of weight loss helps to improve quality of life.

### **Disadvantages**

- It will be necessary to take regular iron, calcium multivitamin and B12 supplements.
- A condition known as dumping syndrome can occur from eating too much sugar or large amounts of food. While it isn't considered a serious health risk, the results can be very unpleasant. Symptoms can include vomiting, nausea, weakness, sweating, faintness, and, on occasion, diarrhoea. Some patients are unable to eat sugary foods after surgery.
- Whilst it is possible to reverse the procedure, it is technically very demanding.
- You may develop internal hernias.



### **C. Sleeve gastrectomy (LSG)**



**Figure 3: Sleeve gastrectomy**

In this procedure, the surgeon creates a narrow tube and removes the remainder of your stomach. Hence, the capacity of the new stomach is much smaller than the original. It is usual to offer this operation as a first stage procedure to super obese patients – a second stage bypass procedure is then offered after the patient has lost some of the excess weight to make this type of surgery safer. In a small number of patients, a sleeve gastrectomy may be the only operation that is required. Unfortunately, there is evidence that 50% of patients may regain significant weight 5 year after surgery - this is because the “sleeve” stretches over time and can therefore hold more food. However, the operation can be repeated and extra stomach trimmed away or a gastric bypass / duodenal switch performed or a gastric band added to maintain long-term weight control.

#### **Advantages**

- Helps improve health problems as shown in table 1 and 2 above (Page 6 and 7).
- You can expect to lose roughly 50-70 % of your excess weight, provided you follow the dietary advice.
- The amount of solid food that can be consumed at a meal is restricted.
- Food passes through the digestive tract in the usual order, allowing it to be absorbed fully by the body.





## **Disadvantages**

- Successful weight loss requires life-long adoption of healthy eating and self-control.
- The sleeve gastrectomy will eventually fail if you continue to force yourself to eat large meals.
- You may struggle to eat particular types of food, especially bread and meat.
- Weight loss is slower than that following Roux-en-Y gastric bypass surgery.
- The risk of a leak at the staple line is greater.

## **Which operation is right for me?**

It depends on your lifestyle and habits! It is likely that you will have your own ideas as to what is the right operation for you. We will provide you with information and experience to help you decide. It will be a joint decision between you and your surgeon. However, as a general rule band is suitable for those who have a BMI less than 40, have a greater control over their eating and will be happy with a lesser amount of weight loss. It is also suitable for those looking for a simpler operation. On the other hand, bypass may be more suitable for those with a poorer control over eating, an excessive sweet tooth, BMI greater than 50, those with type II diabetes and those looking for a larger amount of weight loss.

***Listed below are some factors you will need to consider in order to decide the right choice of operation for you:***

### **1. How much weight do you want to lose?**

You can expect to lose different amounts of your excess weight depending on the type of surgery you select. With a band you can lose between 30-60% of your excess weight



---

and with a bypass it is at least 70% of excess weight. If your Body Mass Index (BMI) greater than 50, you will have more weight to lose therefore you maybe better off with a bypass.

For example:

Start weight: 130kg (BMI 50)

Ideal weight (BMI 25): 64kg

Excess body weight: 66kg

Bypass (lose 70% excess wt): Lose 46kg,

New wt 84kg (BMI 32)

Band (lose average of 45% excess wt): Lose 30kg

New wt 100kg (BMI 39)

## **2. How quickly do you need to lose weight?**

This is also worth considering and the different types of surgery also make you lose weight over different time periods. With the bypass the weight loss is rapid, where most is lost within the first 6-12 months. After this it slows down. With a band there is a more steady weight loss over years, where you can expect to lose between 0.5-1kg/week.

## **3. What other health problems do you have?**

If you have other health problems linked to your weight such as diabetes, high cholesterol or high blood pressure, losing weight with surgery will help improve them. A bypass has a higher success rate in curing diabetes and maybe more suitable (table 2).

## **4. Are you planning to get pregnant?**

It is not advisable to get pregnant when rapidly losing weight such as with the bypass. This is because your body may not be getting all the essential nutrients. It is advised that you should wait for at least 1-2 years following surgery. It should also be noted that with the weight loss your body becomes more fertile and therefore you will have to take precautions.



---

**5. Does what you like to eat affect your choice of operation?**

If you tend to eat lots of sweets and chocolates and find it hard to get control of this, you maybe more suited to a bypass. Many people with a bypass experience unpleasant side effects when eating sugary foods. This leads to actually avoiding the foods all together.

Do you like to eat fatty or fried foods? These foods are high in energy and make it hard to lose weight if eaten regularly. When taken with a bypass they could give you diarrhoea or loose stools, putting many people off eating them all together. If you continue to eat them with a band, even in small quantities, they can still slow down the weight loss.

**6. What if you have problems with binge eating?**

Surgery will not stop binge or emotional eating. Therefore it is best to get treatment for these problems before having surgery. A band may not be suitable if binge eating continues, due to its restrictive nature. Trying to over eat with a band will cause you to be sick. Repeatedly being sick must be avoided as it can cause damage to a band and further surgery could be needed.

**7. Are you committed to work closely with your surgeon and attend regular hospital appointments?**

It is important to see your surgeon regularly (usually every 3 months) after a bypass surgery to ensure everything is going well and you are losing weight safely. If you choose a band, you should see your surgeon every 6 months. This is to make sure you are able to eat adequate nutrition. You will also need to have regular blood tests and vitamin injections.

**8. Is surgery dangerous?**

Patients are often worried about the complications of major surgery such as gastric bypass or sleeve gastrectomy. It is true that a leak from one of the joins in the stomach or bowel



---

is a major complication and can require a stay in hospital of 2 to 3 weeks where it occurs. If you are concerned about this, you may opt to choose the gastric band.

### **9. Is the procedure reversible?**

Many people want a procedure that is reversible. If this is important to you, then the gastric band is the best choice here as it can be removed more easily. However, you should not go into the operation with the intention to have it undone in the future – if the band is removed then your weight is likely to return to what it was before surgery.

### **10. Will you need a further operation if things go wrong?**

It is unlikely that a re-operation will be needed for either bypass and banding. However, generally with bypasses if you have not required one by the end of the first week then it is unlikely that you ever will. The opposite is true with bandings. Complications usually occur much later and are related to band slippage or erosion. Bands, like balloons, can also rupture.

### **11. Will my eating habits and lifestyle have to change after having surgery?**

It is commonly thought that this surgery will force you to follow healthy eating patterns and lifestyle, but this isn't true. This surgery will help you to lose weight but it won't make it happen without your hard work and determination.

Both the gastric band and bypass restrict how much food you can take at one time helping you to limit food intake, thus lose weight. However, surgical treatment will not physically stop you from eating your favourite energy dense snack foods e.g. crisps, chocolates, biscuits, cakes etc. You will need to use your will power to stop eating these. Even in smaller quantities they will still provide your body with unwanted energy and fat, slowing down your weight loss.



---

Many people find that once they have had the surgery and the weight is coming off, they feel better within themselves and feel more motivated to exercise more and stick to a healthy diet.

Eating to help you cope with stressful and emotional situations is very common – if this is your case then you may not lose weight despite surgery! It is best to start making healthy lifestyle changes before surgery, as it is unlikely that the operation will make you change habits. To help you achieve this you can get support from psychiatrists specialising in eating disorder. They can assist you to obtain behaviour therapy before surgery.

## **Appointments**

- These consultations will generally be in St Johns and St Elizabeth Hospital, unless you have been specifically informed otherwise.
- We are able to arrange an appointment with other specialists whose expertise is important in your care.
- Mr. Sufi's secretary can be contacted on the following number 07525 357 608.

### ***First appointment***

- Your surgeon will take a full medical history, finding out about your background and eating habits.
- Your surgeon will explain the obesity surgery assessment process and also outline the different types of surgery available, explaining the pros and cons of each.
- You may be informed of a weight loss target to achieve before surgery, to reduce your risks at surgery.



---

***Tests to assess fitness:***

Some patients are at a higher risk of developing complications during or after surgery due to pre-existing illness. You may be referred for

- Sleep studies – if you are at risk of stopping breathing when you are drowsy.
- Respiratory function – if you have breathing difficulty from lung diseases.
- ECHO, ECG, Stress study – if you are at risk of developing a heart attack, heart failure or other heart disease.
- Endoscopy – if you have a history of significant acid reflux or upper gastro-intestinal risk.
- Anaesthetic review – to assess your fitness for an anaesthetic.

***Appointment with a dietician:***

This will be arranged with a specialist bariatric dietician, if and when appropriate.

**Surgery**

***When will I have my surgery?***

You will get a date for your operation once:

- All assessments have been completed
- The appropriate surgical procedure has been agreed with you.

Usually, it will be 2-4 weeks after the initial consultation.

***Pre-operative liver shrinkage diet***

- Many people needing obesity surgery have a large fatty liver, which can cause difficulty for the laparoscopic surgery.



- 
- Therefore, before your operation, it is important to follow a special pre-op diet to help prepare your body for the surgery.
  - This diet is low in dietary carbohydrate and fat.
  - This diet will encourage your body to use up glycogen stores (carbohydrate that is stored in the liver), thus helping to shrink the size of your liver.
  - This diet should be strictly followed for at least 2 weeks prior to surgery. It is essential to follow this diet; otherwise the liver could bleed heavily during surgery or there could be injury to organs. If this happens, the surgeon may have to do open surgery, instead of a laparoscopic procedure or even postpone surgery.
  - You should use this period of time as a great opportunity to kick-start your weight loss and also to help get into the habit of eating a healthy diet.
  - If you continue to eat this way after the surgery you will manage to successfully reach your weight loss targets
  - Also the more weight you lose before the surgery the better, as it helps to reduce the risk related to surgery.

### ***Admission for surgery***

- You will be given tablets on the evening before surgery and on the morning of admission to reduce the likelihood of aspirating stomach acid.
- You will be given an injection on the morning of admission to reduce the risk of developing life-threatening clots in your veins or your lungs (thrombo-embolism and pulmonary embolism).
- The surgeon and the anaesthetist will see you prior to your operation. They will confirm that you are willing to undergo surgery, all preparations are complete and it is safe to proceed with your operation.
- They will confirm that an appropriate facility is available for you to recover after surgery.



---

### ***What happens in hospital after surgery***

- If you have undergone a Bypass or sleeve gastrectomy you may need an overnight stay in the High Dependency Unit. You will be receiving close attention. Other higher risk patients will need to stay overnight in the High Dependency Unit. A nurse will look after them on a 1:1 basis, with other duty doctors available on the unit.
- Otherwise you will go straight to the ward. Nurses on the general ward will look after all other patients. They will seek advice from doctors if there is a need to do so.
- The surgeon will visit you once you have recovered from your anaesthetic and in case of difficulties, as and when required.
- The anaesthetist will ensure that your pain control and breathing is satisfactory.
- You may be provided with a system that will allow you to self-administer effective painkillers safely (Patient Controlled Analgesia) – this involves setting up a pump to administer small amounts of morphine in to your vein when you press a button in your hand. Alternatively, you may be prescribed oral painkillers with injections for back up.
- Patients with sleep apnoea will be supported with CPAP (Continuous Positive Airway Pressure). If you use a machine at home then you must bring it in with you.
- Specialist 'heavy duty' equipment, beds, chairs etc are available to facilitate early mobilisation, which is crucial.
- Your length of hospital stay will depend on the type of surgery and your physical status; in general if you are having a Roux-en-Y bypass then you will stay in a bit longer. Below is a guide, however please note that this can vary if there are any post-operative complications
  - Gastric Bands – 1 nights stay; suitable patients can be done as a day case.
  - Roux-en-Y Bypass – 2-5 nights stay; 1<sup>st</sup> night in a High Dependency Unit.
- You will normally be allowed to drink sips of fluid overnight after surgery.





- 
- After surgery all medications will need to be crushed or taken in liquid form until you are eating normally. You will be given a supply of your tablets to go home with.
  - You will be expected to sit up and walk soon after your operation.
  - Initially, it will be necessary to confine yourself to liquids only for 2 weeks; then soft moist food can be introduced and after 4-6 weeks you can gradually progress towards normal food.

### ***Further follow up after surgery***

#### **Roux-en-Y Bypass**

People who have undergone a bypass will be followed up at 4-6 weeks following surgery. At this appointment you will undergo some blood tests. You will then be followed up every 3 months either by your surgeon or with your GP.

#### **Gastric Bands**

Your first appointment will be about 4-6 weeks after surgery, when you will have your first band-fill. You will be seen every 6 months either by your surgeon or with your GP.

#### **Gastric band fills**

- The 1st band fill is at 4 weeks following surgery, and subsequent band fills will depend on whether you have obtained adequate restriction.
- The band fill may be occasionally done in the x-ray department, so they can check that the band is in the correct position.
- We are guided by the table below in deciding whether further fluid is needed. One problem that can arise is if the band is too tight is that patients actually start to gain weight. This occurs because they start to take high calorie liquids.



**Table 4: Effect of band tightness**

<b><u>Band too loose</u></b>	<b><u>Band Just right</u></b>	<b><u>Band too tight</u></b>
Can eat large meals	Eats small meals: feels satisfied after food	Can't eat food because it sticks and will not go through
Seeking food between meals	Not seeking food between meals	Suffers from heartburn
Not losing weight or gaining weight	Losing 1 to 2 lbs in weight per week	Not losing weight

**Will further surgery be needed?**

The surgery you have undergone is intended to provide effective weight loss except for a small group of patients considered to be at a high risk of suffering a complication after the definitive operation. These patients (who will usually have had a sleeve gastrectomy) may then need to go on and have the second part of their procedure (usually a gastric bypass or a duodenal switch) after they have lost a significant amount of weight.

Occasionally, gastric banding may not prove an effective means of weight loss. There is no reason why these patients should not then go on to have a sleeve gastrectomy or gastric bypass, though there may be difficulty in getting your PCT to agree on funding.

Most patients are keen to undergo plastic surgery to trim excess skin. However, it is essential that this be not done too early i.e. until the period of rapid weight loss is completed. This is usually 18 to 24 months for gastric bypass and can be up to 4 years for patients with gastric bands.

**National patient support networks**

- British Obesity Surgery Patients Association



- 
- National Obesity Forum
  - Weight Loss Surgery Information – [www.wlsinfo.org.uk](http://www.wlsinfo.org.uk)
  - Weight Loss Surgery Information – Central London Support Group – meets third Saturday of each month, e-mail [central.london@wlsinfo.org.uk](mailto:central.london@wlsinfo.org.uk) or visit <http://wlsinfo.org.uk/forums/forumdisplay.php?f=114>

## **Patient testimonial**

“Since having my gastric band fitted in February 2007 my life has changed so much - for the better! To date I have lost more than 100lb and I just feel so great. I can now bend to tie my shoe laces, shop in regular shops for clothes and chose clothes that I like rather than just what will fit me, fit into an airplane seat, no longer have to worry about whether chairs have arms when I go to meetings, among so many other things. I am fitter than I have ever been and for the first time in my life I can see a bright and happy future ahead of me, all thanks to my wonderful gastric band and losing all of this weight. I still have a fair way to go to goal but I am certain that I will get there.

Perhaps the biggest change for me has been my approach to food. Immediately after surgery I moved from being totally obsessed with eating vast amounts of food to not wanting to eat at all. Partly because I just did not feel hungry but also because I had realised just what eating so much had done to me. It was at this time in particular that the support I received from the Dietician was most valuable to me. Ella was able to work with me on identifying my issues with food. She has continued to give me nutritional advice on the types and volumes of food I am eating and I always know that if things go wrong for a period, for example if I don't lose weight for a couple of weeks that I can talk through my food intake and she will advise me about realistic and liveable changes that I can make and help me decide whether I need a band fill.

I honestly don't believe that I will ever see food in the same way that I used to, but at least I can once again get enjoyment out of



---

my meals and try to make sensible, nutritional choices, which won't harm my weight loss. Without the support I have received from Ella and the rest of the Multi-Disciplinary Team at the Whittington as well as the many friends I have made through the WLS info website I really don't know how I would have managed. The support I have received from the Dietician and Clinical Nurse Specialist in particular had been very flexible. It has rarely been in the format of clinic appointments but instead by phone and e-mail, which is so convenient for me and in my opinion, a great use of hospital resources.

It can be so very lonely at times because unless you have had bariatric surgery or know many people who have, it is so difficult to understand the 'patients' perspective and so I would strongly encourage all who have had or who are thinking of having bariatric surgery to ensure they attend all of their aftercare appointments and utilise existing support structures. It has been a lot of hard work to get to where I am today but I do not regret one minute of it and wake every day looking forward to the challenges ahead and also the long and enjoyable life that I am certain I will now achieve having had my bariatric surgery."

***Christopher McDonnell – Gastric Band Patient***

***Start Weight/BMI (28/01/07): 31 stone 11 pound (202kg) – BMI 69.7***

***Current Weight/BMI (26/11/07): 23 stone 13 pound (152kg) – BMI 52.5***

**UK Websites**

1. British Obesity Surgery Patient Association – <http://bospa.org.uk/Information.aspx?Page=13>
2. Obesity Surgery Advice – [www.obesity-surgery-advice.co.uk](http://www.obesity-surgery-advice.co.uk)
3. Weight Loss Surgery Information- [www.wlsinfo.org.uk](http://www.wlsinfo.org.uk)
4. [www.Gastricbandservice.co.uk](http://www.Gastricbandservice.co.uk)

**Booklist**

- ***Calorie Counter.*** Collins Gem. 2006.



- 
- ***Calorie, Carb and fat bible.*** Juliette Kellow & Rebecca Walton. 2007. Weight Loss Resources
  - ***Eating Well After Weight Loss Surgery.*** Levine, Bentempo-Saray. 2004. Marlowe & Company Publishers
  - ***Living and Eating Well after Weight Loss Surgery. Before and After.*** Leach. 2007. Morrow Publishers
  - ***Overcoming Binge Eating.*** Dr CG Fairburn. 1995. The Guildford Press
  - ***The Emotional First Aid Kit. A practical Guide to Life after Bariatric Surgery.*** Cynthia L Alexander. 2006. Matrix Medical Communications
  - ***Weight loss surgery for dummies*** Kurian, Thompson, Davidson. 2005. Wiley Publisher

## **Contact details**

Secretary to Mr. P Sufi  
Lorna Antoine  
Tel: 07525 357 608  
E-mail: secretary@cebls.com

Specialist Nurse  
Kirsten McDougall  
E-mail: nurse@cebls.com

Specialist Dietician  
Lucy Jones  
E-mail: dietician@cebls.com