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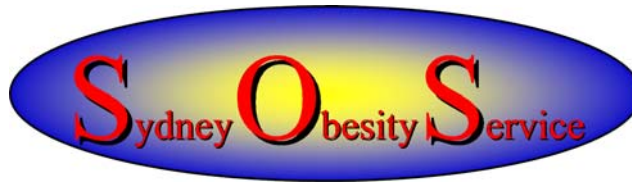
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INFORMATION FOR PEOPLE CONSIDERING SURGERY FOR WEIGHT LOSS.



Including details of the obesity epidemic and the range
of available surgical treatments.

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ESSENTIAL INFORMATION ABOUT THIS BOOKLET

This booklet is intended to explain issues involved in the surgical treatment of severe overweight or obesity. It is not supposed to replace medical advice given by your doctor but rather to add to it.

This booklet contains information across many obesity related topics. You may have questions that you should discuss with your surgeon before deciding to undergo obesity related surgery. There are spaces provided in the booklet for you to write down your questions for later discussion with your doctor. I have endeavoured to include the most up-to-date information on obesity surgery, with the majority of information in this booklet sourced from American, United Kingdom, and Australian Government Health Agency documents. A complete list of references is included in the appendix near the back of the booklet.

About Obesity and Obesity Surgery

Introduction.

Surgery is being increasingly recognised as the only consistently effective treatment for severe obesity however undergoing surgery involves lifelong change and varying degrees of risk. Reading this booklet is **essential** prior to having a consultation to discuss surgery. As there is more to surgery than “one size fits all”, the more information you can read the better.

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OBESITY IN AUSTRALIA: Most Australians have a weight problem!

Recent estimates are that 67 percent of adult men and 52 percent of women are overweight, equating to about 8 million Australians. About 1 in 5 Adults are **obese**. The increase in our weight is showing no sign of slowing and the proportion of people in the "obese" range has increased by almost 1% per year for the last 20 years. The costs, both social and economic, associated with obesity are enormous with hospital, medication, disability and "off work" payments costing billions per year.

OBESITY DEFINITIONS

The word "obesity" may have negative connotations but it is simply the medical diagnosis for patients in whom excess weight poses a health risk. Rather than focus on actual weight, doctors prefer to measure a person's weight in relationship to their height. This measurement, the **Body Mass Index (BMI)** is calculated by dividing Weight (kg) by Height (metres squared), or $BMI = \text{kg}/(\text{m}^2)$. This allows us to compare someone's weight with the weight of other people of a similar height in order to calculate how much they are overweight or their **excess weight**. We know that the risk of medical problems is related to how much excess weight someone carries so the BMI also allows us to estimate some of their risks. Using BMI also allows us to calculate an "ideal" weight for someone based upon their height.

For example: Someone who weighs **150 kg**, who is **180 cm** (5' 11") tall has a BMI = **46.3**
 Their theoretical "Ideal weight" = **81 kg** (calculated to BMI of 25)
 and they have an excess weight = **69 kg**

Every person being assessed for any type of weight treatment will generally have a calculation of their BMI, ideal weight, and excess weight performed, as this allows you to set treatment goals. In people who are moderately overweight the presence of a large abdomen is another significant risk factor for disease and helps distinguish heavy muscular people from those with excess fatty tissue (*Figure 1*).

	BMI (kg/m²)	Obesity Class	Risk of Disease. Waist > 102 cm (40inch) men, and 88 cm (35inch) women.
Underweight	<18.5		
Normal	18.5 – 24.9		
Overweight	25.0 – 29.9		High risk
Obesity	30.0 – 34.9	I	Very high risk
	35.0 – 39.9	II	Very high risk
Extreme Obesity	40.0+	III	Extremely high risk

Figure 1. Risk of medical problems related to BMI. In people who are moderately overweight an increased waist circumference indicates an increased risk of medical problems.

Notes: **What is my BMI?**
What is my waist circumference?

BMI = $\text{kg}/(\text{m}^2)$
BMI = Weight (kg) divided by the sum of height (metres) to the power of 2.

BMI =

Waist =

COMPLICATIONS OF OBESITY

Obesity is associated with a number of Medical and "Lifestyle" complications. The number and severity of these complications is directly proportional to the severity and duration of obesity and varies with the distribution of body fat (Figure 3).

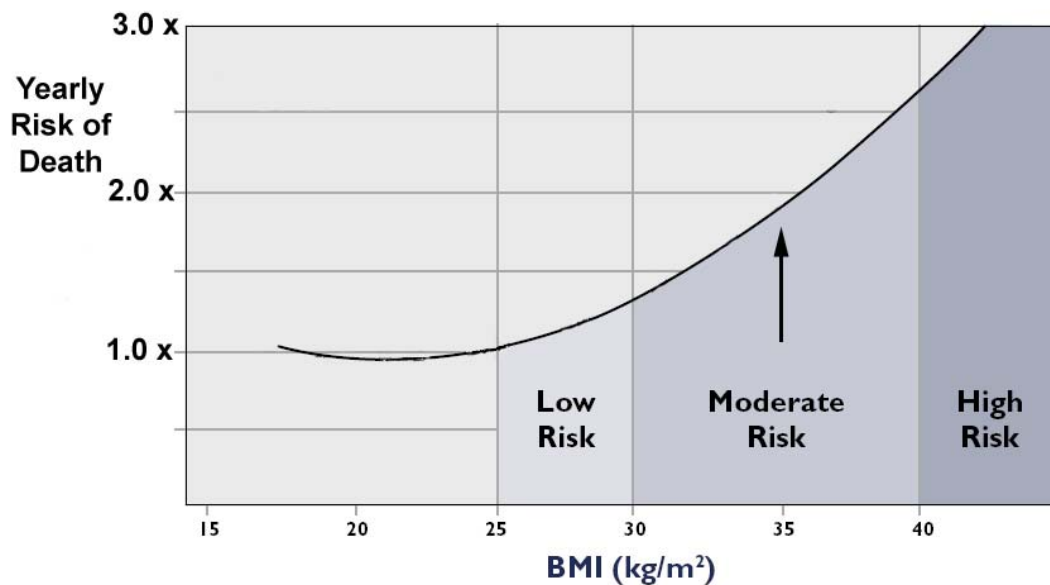


Figure 2. The yearly risk of death from all causes doubles at a BMI of 35 and rises considerably above this.

OBESITY ASSOCIATED CONDITIONS

Most patients with Morbid Obesity suffer from at least one of the following conditions. You should look at this list and think of the conditions here that you would wish to have removed from your life. You can expect some of these conditions to be alleviated or at least diminished as you lose weight, therefore you can use them as indicators to monitor your progress after surgery.

Medical Conditions

- 1) Diabetes
- 2) Hypertension
- 3) High Cholesterol
- 4) Gallbladder Disease
- 5) Gastrointestinal Disorders
- 6) Menstrual Irregularities/Infertility
- 7) Degenerative Arthritis/Joint Pain
- 8) Venous Stasis Ulcers/Lymphoedema
- 9) Intertrigo and other skin infections
- 10) Pulmonary Hypoventilation Syndrome, Sleep Apnoea, Snoring
- 11) Coronary Artery Disease and Arterial Sclerotic Disease
- 12) Increased Incidence of Malignancy in the ovaries, cervix, uterus, breasts, prostate, and gallbladder
- 13) Increased Risks with any Surgery
- 14) Accident Proneness
- 15) Pseudotumour Cerebri

Social Conditions

- 1) Clothing limitations
- 2) Limitation in performing activities of daily living, poor hygiene and sanitation
- 3) Limited access to chairs, seats & passage ways
- 4) Limitation in walking, climbing stairs, public transport
- 5) Social Withdrawal
- 6) Sexual limitations

Economic conditions

- 1) Cost of dieting
- 2) Cost of treating various medical conditions due to Obesity
- 3) Lack of Insurance coverage or increased premiums
- 4) Cost of special clothing and devices for activities of daily living.
- 5) High rate of school drop out
- 6) Difficulty obtaining good jobs
- 7) Cost of extra food consumed

Psychiatric Conditions

- 1) Depression
- 2) Neurotic disorders
- 3) Eating disorders

FIXING OBESITY IS GOOD FOR YOU

Loosing weight is the most effective treatment available for the medical conditions that obesity causes. The majority of the significant diseases that people undergo treatment for ie diabetes, hypertension, high cholesterol, sleep apnoea and depression are either cured or significantly improved by weight loss. Surgery is **the only treatment** that has been able to reliably allow morbidly obese patients to lose enough weight to treat their medical problems.

TREATMENT OPTIONS

The key to selecting a treatment for your weight problem depends on your goals. If you are a person who is overweight but not obese, there is no doubt that dieting and exercise will be able to help you to lose enough weight to help many medical problems and for the majority of people the 5-10 kg weight loss that this type of treatment gives is sufficient (see below). If you are a person who is obese, this may not be the case and you may be a candidate for surgery. Following consultation with your doctor, if you do decide on surgery then keeping focus on your goals will often help you determine which type of operation is suitable for you.

NON-SURGICAL TREATMENT: Summary of **average results > 2 years**

- 1) Diets (1.1- 2.7kg)
- 2) Supervised Modified Low Calorie Diets (4.1kg)
- 3) Meal replacement (6.5kg)
- 4) Behaviour Modification (2.8kg)
- 5) Pills and Pharmaceuticals (up to 6.9 kg)
- 6) Exercise Programs (1.3kg)

Non-surgical methods of weight loss eventually fail because they require daily compliance for the rest of your life. Our bodies are designed to fight weight loss so when someone diets their body becomes significantly more efficient and their brain sends stronger and stronger hunger signals. This explains the intolerable discomfort associated with dieting and the rapidity with which weight returns after a diet. The majority of people seeking surgery for long term weight control have had successful short term weight loss with diets in the past. **Regardless of the amount of weight lost your body will wish to return to the weight you were before the diet.**

Notes:What diets and other methods have I tried?

How much weight did I lose and for how long?



OBESITY (BARIATRIC) SURGERY

Obesity surgery is the only current treatment that can reliably provide effective long-term weight control in the majority of morbidly obese patients (>85% success). Cosmetic and reconstructive operations such as Abdominoplasty (tummy tuck) and liposuction are not weight loss operations and have no effect on long term weight. Obesity surgery is not cosmetic surgery, this is recognised by medical insurers and the majority of medical specialists. Obesity surgery has been recommended for morbidly obese individuals by the major health policy agencies in Australia, the United States of America and the United Kingdom.

WHAT CAN BE ACHIEVED WITH OBESITY SURGERY?

We know that a sustained 10-15% weight loss will significantly improve the long-term health of an obese person, but this is almost impossible to obtain without surgery. Patients (and their surgeons) want more than this so the definition of "success" with an operation is defined as loss of over 50% of excess weight (ie losing more than **half** of the extra weight you carry) or maintaining a BMI under 35. Most people after surgery will end up somewhere near their "ideal" weight as predicted by the BMI chart but will still carry some excess weight and loose skin (*Figure 3*).

There is a realistic possibility of cure of diabetes, high blood pressure, high cholesterol and sleep apnoea after surgery. Those patients in whom a cure is not obtained will in almost all circumstances be on significantly less medications, regardless of percentage weight lost.

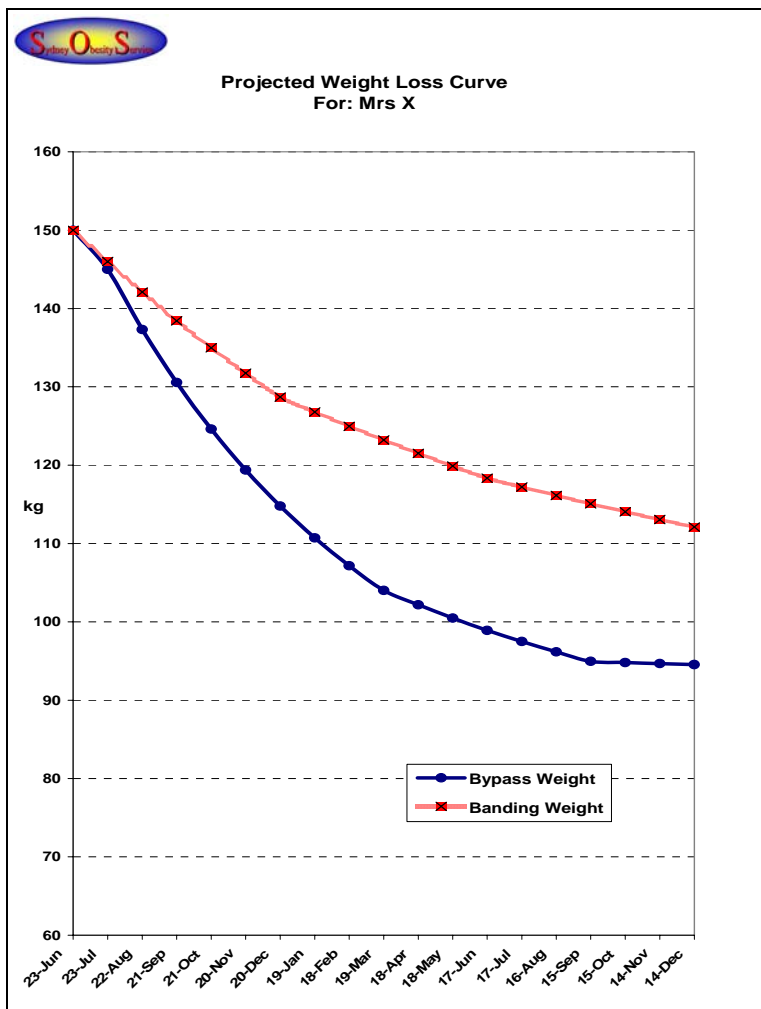
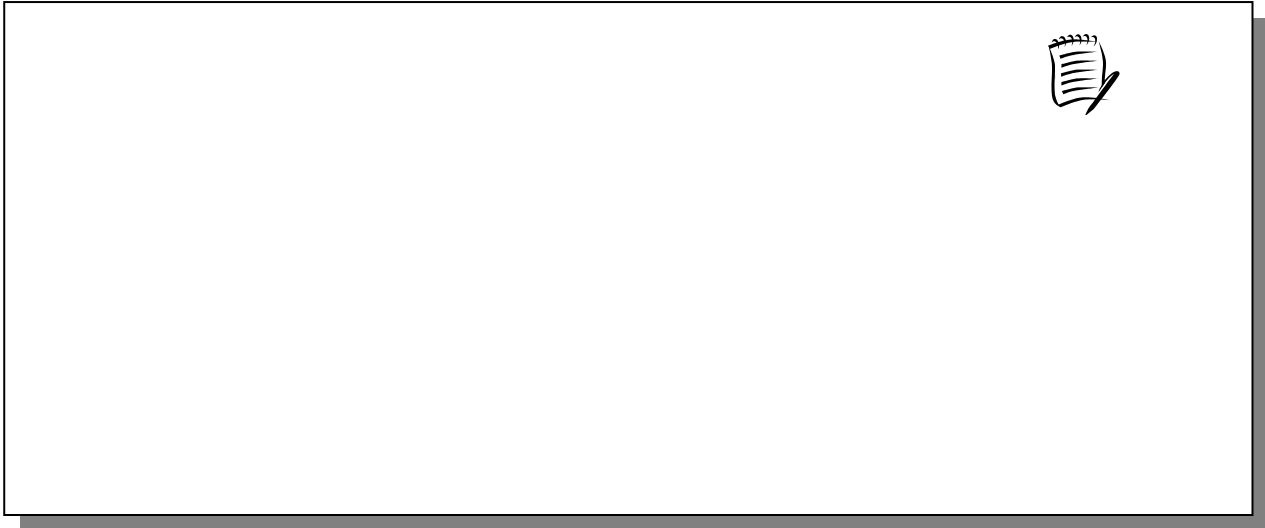


Figure 3. Projected post-operation weight loss over 18 months for a person weighing 150 kg at 180 cm (BMI 46).

The red line is the laparoscopic band estimate, and the blue line the gastric bypass estimate. The majority of patients will manage weight loss of a similar magnitude but individual weight loss will vary

What can obesity surgery achieve for you? **You need to have a list of obesity related problems that you wish to overcome, life goals you wish to meet, and an idea of what is the minimum weight loss you would wish to maintain long term.**

Notes: Which obesity conditions do I wish to lose? WHAT ARE MY GOALS?



TYPES OF OPERATION- Choosing an operation that suits

Not every operation and not every person is the same, you should have the opportunity given to you to choose the best treatment for you!

Operations for obesity are grouped into three categories: "Restrictive", "Malabsorptive", and "Combined". They have all been found to be successful, in that the least successful operation is still more effective with regard to weight loss than the most successful non-surgical options. Some operations have been found to be more effective than others and all have differing potential side effects. Most people, following consultation with their doctor, are able to choose which suits them the best. When choosing a surgeon you should ask what operations they perform as it may be difficult for them to offer an opinion on an operation that they may not have seen or done.

When choosing an operation it may be useful to speak to other people who have undergone similar procedures. Try to find out about as many of the options as possible, and as many support groups for post-operative patients are web-based these can be good forums for discussion. Remember that more than one option will exist for you!

Restrictive procedures: reduce stomach size/suppress appetite

Intra-gastric Balloon (Figure 4)

This is not a surgical procedure but it still requires an anaesthetic and a short admission to hospital. The Balloon is a relatively new procedure that works in a similar manner to other "restrictive" procedures by suppressing appetite and causing fullness after a few mouthfuls of food. Under a light anaesthetic the balloon is placed through the mouth into the stomach using a flexible endoscope, and inflated to fill up the mid-part of the stomach in the same way a large meal would fill it. The device is left in place for up to 6 months and is ideal for people who;

- 1) Are perhaps a little light to be considered for regular weight-loss surgery, or
- 2) Need to lose weight quickly for medical reasons (such as for a Hip or Knee replacement) but find it hard to do so, or
- 3) Are heavy enough to undergo regular weight-loss surgery but do not wish to commit to something more permanent, or
- 4) Are wanting to have standard weightloss surgery but need to lose weight prior to the operation in order to improve their health

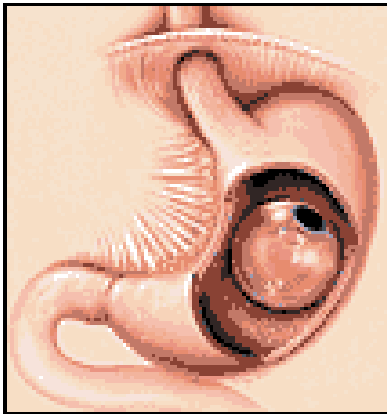


Figure 4. **Bioenterics Intra-gastric Balloon.** The device "floats" in the stomach and causes a feeling of fullness.
Diagram courtesy of Allergan Health.

As the balloon is removed at six months, its effect is not permanent, but it is hoped that the intensive "retraining" that occurs after Balloon placement can help people keep weight off long term.

Advantages: Very low risk of long term complications. Rapid initial weight loss for most patients. Rapid return to normal activities.

Disadvantages: 2-3% of people do not tolerate the balloon and need to have it removed before it has had any useful effect. Nausea common for the first few days. Average weight loss is less than surgery (20 kg), and risk of weight gain is high unless significant lifestyle changes can be maintained after Balloon removal. > 75% will have weight regain by 3-5 years post-procedure. Heavier people can find it especially hard to maintain weight loss after Balloon has been removed.

Laparoscopic Adjustable Gastric Band (Figure 5). This procedure has evolved from lessons learned from patients undergoing stapling operations in the 1980's. The location of the band at the upper part of the stomach allows people to feel satisfied after eating only a small amount of food, and as the size of the inlet to the stomach can be adjusted food is slowed down on its journey, allowing you to eat small quantities of food over the same time that others will eat a large meal. Vomiting and heartburn can be minimised if this device is used correctly. The easy adjustability of the band is the key to allowing weight loss without affecting the enjoyment of a reasonable range of foods. Worldwide the band accounts for at least 25% of obesity surgery, but is the most common procedure in Australia. Most obesity surgeons in Australia are trained in this operation only.

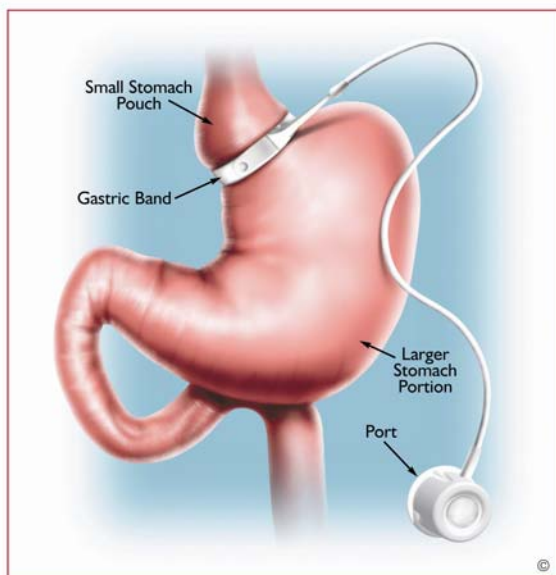


Figure 5. Laparoscopic Band (Diagram courtesy of Johnson & Johnson Medical).

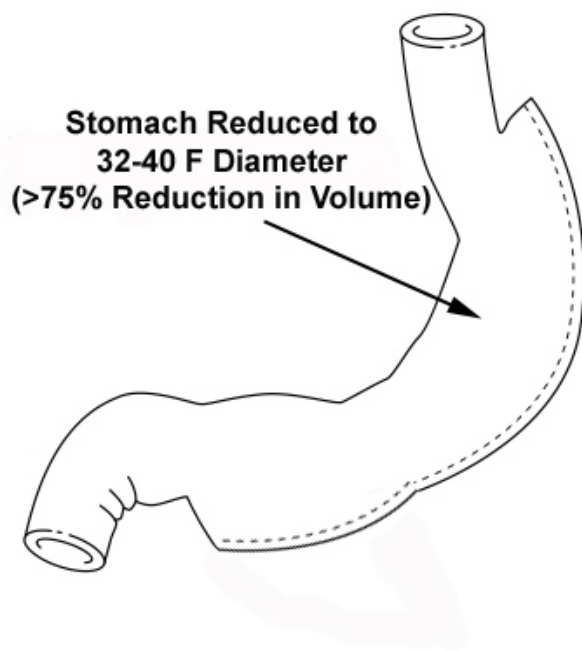
Advantages: Minimal vitamin deficiencies as no part of the bowel is bypassed. Lap banding is probably no more risky than elective gallbladder surgery (risk to life between 1 in 1000 and 1 in 3000), and is a very good operation in women of childbearing age.

Disadvantages: Some people cannot tolerate the restricted diet, and while the majority cannot eat white bread and chicken, sometimes the restriction interferes with the ability to eat other foods that are components of a normal diet (some fruits, vegetables and salad). It is possible to "beat" the operation by eating sweets/chocolate/ice cream and some people develop a preference for these foods leading to failure. These operations do not work so well for older, larger patients with diabetes. Due to the fact that banding is a relatively new procedure we do not know the long term (ie 10 year or longer) results but it is widely acknowledged that while the operation seems "easy" to perform there is a significantly higher failure rate in some hospitals than others.

Laparoscopic Sleeve Gastrectomy(Figure 6), has some resemblance to the old fashioned "stomach stapling" procedures of the 1980's and 90's (the Vertical Banded Gastroplasty) and has probably replaced them worldwide. It involves removing the outer part of the stomach therefore significantly reducing your capacity to store food and generate hunger signals. People who undergo this operation become "full" after a small meal and cannot overeat. Their stomach is turned into a narrow tube with a volume >75% less than before. Their maximum meal size reduces to less than a cup full of food but the restriction in volume of food that can be eaten occurs without significant restriction of the types of food that can be eaten. Vomiting is uncommon. Although the side effects of this gastroplasty are far less than "stomach stapling" the long term results are not as well known as for other types of operations.

The weight loss is quite rapid initially, and seems greater than that obtained by Gastric Banding. The Sleeve Gastrectomy can be used along the path towards a Gastric Bypass (see later) for patients wanting to consider some of the benefits of the Bypass (ease of weight-loss, minimal vomiting), without the negatives (potential Calcium, Iron and B12 problems, and the small risk of small bowel blockages). If the weight loss is not sufficient long term the Sleeve can be then converted to a Bypass laparoscopically without undue difficulty.

This particular operation may be ideal for people who would like to avoid the risk of device failure or vomiting with a Gastric Band, people who do not wish to have the vitamin supplements of a Gastric Bypass, or people who may be too unwell initially to tolerate a Bypass but probably require it due to significant weight and metabolic problems (as stage one of two stage surgery). Because part of the stomach is removed it **is therefore permanent**.



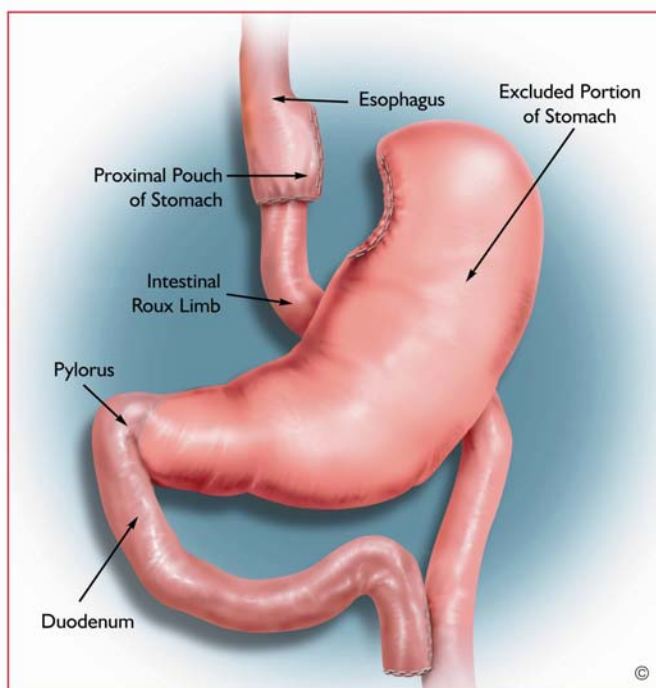
*Figure 6. **Sleeve or Tube Gastrectomy.** A narrow Stomach Tube is created and the outer part of the stomach discarded. This can be done as a "stand alone" operation or it can be "made stronger" with more weight loss by changing it to a bypass months or years later.*

Combination procedures: make stomach smaller/very strong hunger suppression

Laparoscopic Gastric Bypass (Figure 7), There are several forms of this procedure that have been performed over the last 20 years or so. It is based on an operation used to treat stomach ulcers and cancers for almost 100 years. The current operation involves a restrictive element (by considerably reducing the size of the stomach) with early passage of food into the intestine. These two factors give the strongest possible appetite suppression which makes the process of weight loss relatively straightforward in the large majority of people. This operation has a very good combination of both effectiveness (how much weight is lost) and durability (how long it lasts) of weight loss. This is without some of the dietary limitations of restrictive operations and the nutritional deficiencies of intestinal bypass operations. **Accounts for 65% of obesity surgery worldwide.**

Most of the published evidence leading to the worldwide acceptance of obesity surgery by Government Health Agencies in Australia, America, and the United States is based on Gastric Bypass Surgery which is the "Gold Standard" against which other weight loss methods should be judged.

Banded Gastric Bypass. In larger patients, or those who are habitual large meal eaters, a ring can be placed around the gastric pouch to prevent it softening due to forceful eating. Pouch softening may otherwise lead to increased capacity and late weight regain.



*Figure 7. **Gastric Bypass.** Has a small volume gastric pouch, a narrow outlet from the divided stomach, and bypass of part of the small bowel. A ring can be placed around the stomach pouch during the operation in some people to limit the risk of weight regain. (Diagram courtesy of Johnson & Johnson Medical).*

Advantages: Effective, long lasting weight loss in >85 % of cases. There are different versions of the operation (such as the mini-Gastric Bypass) which allows for a bit of flexibility during the operation

Disadvantages: Vitamin supplements should be taken daily. Some menstruating women will need iron tablets. Calcium tablets probably should be taken by post-menopausal women. This operation is more risky than the Gastric Band or Sleeve, the

risks being equivalent in magnitude to elective hip or knee surgery (1 in 200 to 1 in 1000 risk to life). There is a 2-3 % chance of bowel blockage in the years after surgery. People who have previous complex abdominal surgery can have adhesions that make laparoscopic bypass difficult and those people may therefore require open surgery or consideration of other options.

Malabsorptive procedures: Stop you absorbing the food you eat

**** This description is provided for illustrative purposes only. I do not perform, or endorse this operation****

Intestinal Bypass, "Duodenal switch" (Figure 8), "Biliopancreatic Bypass", "Scopinaro procedure". These operations work primarily by bypassing large amounts of the small bowel so that food eaten is poorly absorbed (especially fats), and passed out in bowel motions (some current diet pills work in a similar manner). Patients may suffer from vitamin and nutrient deficiencies which can be a significant problem. Worldwide intestinal bypass accounts for 5% of obesity surgery.

This is not a Gastric Bypass, but confusion between the two procedures is very common and this leads to frequent misunderstandings.

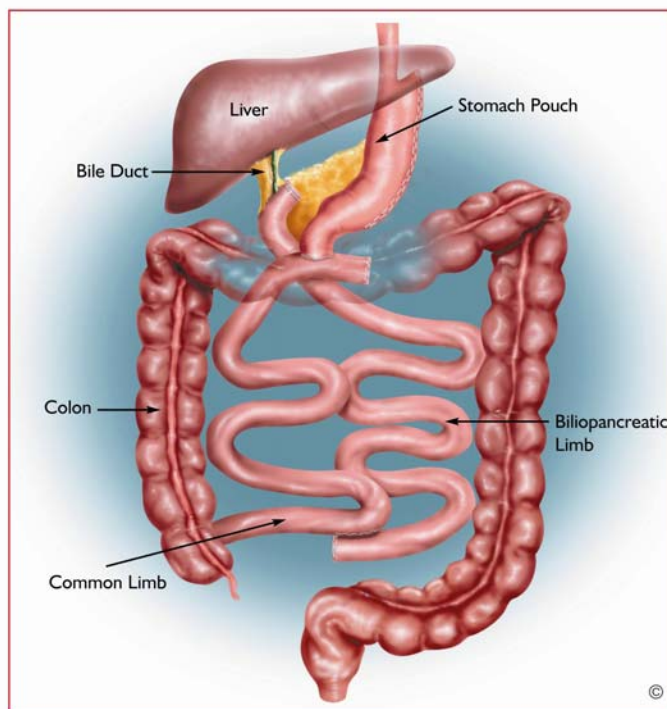


Figure 8. Duodenal switch operation allows food without digestive juices to travel down part of the bowel, while the digestive juices travel down the other part of the bowel. A small amount of food can be digested in the final 50-100cm where the food and digestive juices mix (Diagram courtesy of Johnson & Johnson Medical).

Advantages: The operation results in consistent weight loss that people are able to maintain for years or decades.

Disadvantages: Long term adequacy of nutritional supplements not known, some people have severe nutrient deficiencies. Diarrhoea, cramps, offensive motions, odd body odour. Many patients need separate toilet facilities due to odour problems. I do not do this operation but is happy to refer you to someone who does if it is appropriate for you.

Notes: Do I know anyone who has had a weight loss operation?

What operation did they have?

Were they happy with their result?

What are my own weight loss goals?

What questions should I ask?



WHY IS OBESITY SURGERY UNCOMMON?

Obesity surgery has been established internationally as the only proven method for sustained weight loss in the severely obese for over 15 years. Despite this, surgery is offered very infrequently to overweight patients with an obvious need for it. There are a number of potential explanations for this:

- 1) Although Medicare pays for surgery to be done on privately insured patients there is extremely limited access to surgery in the public hospital system. As surgery is therefore not freely available it is therefore not considered as a treatment option by many physicians.
- 2) Obesity is not perceived as a disease by some people despite the significant medical illnesses it causes. The erroneous belief that morbid obesity is a lifestyle affliction caused by a lack of willpower may lead to treatment not being offered.
- 3) There can be a tendency to refuse obese people surgical treatment saying that it is "too risky" and this (unfounded) belief has affected the decision making of both doctors and patients. Probably > 15 000 people die in Australia from their weight, but death after weight-loss surgery is extremely rare despite > 6-7000 procedures being done yearly.
- 4) Some Doctors are unaware of the results of surgery and who may benefit from it. There are published recommendations available that recommend appropriate surgical treatments which can be freely obtained from the Australian Governments health policy advisors (the NH&MRC – see references).
- 5) Even if surgery is offered it entails the prospect of risk taking and substantial change, these are things that we are all very resistant too. These issues need to be examined closely.

CHANGE

Eating is a central part of our existence and what drives us to eat is more complex than just the feeling of hunger. The only way to lose weight is to eat less, and the operations described reduce appetite and the amount that can be eaten. Eating is a soothing, enjoyable activity that everyone uses as a way of coping with stress and socialising with others. Obesity surgery changes this permanently and the realisation that this coping mechanism may be removed can be a daunting prospect for anyone considering surgery.

The prospect of losing a lot of weight forces people to evaluate their body image and how other people see them. As overweight people may feel shame and blame themselves for their problem they can find it difficult to seek assistance.

RISK- HOW SAFE IS THIS SURGERY?

Obesity surgery is **major surgery** requiring a general anaesthetic and as such carries a risk of complications or significant problems happening. These are not common but deaths have occurred.

The risks can be broken down into a number of categories:

- 1) **Anaesthetic risks.** Anaesthesia is very safe in this country and despite peoples fears, patients do not die "on the table" except in extremely unusual circumstances. The risk is so low it is very hard to measure, but is about 1 in 40 000.
- 2) **General risks.** Operations involve incisions which may become infected or heal poorly. Hernias and other wound complications are the most common problems after surgery. Operations also involve changes in bodily functions that put people at risk of chest infections (pneumonia), urine infections and blood clots (like the so called "economy class syndrome"). These are the risks that pose the greatest threats to life after major surgery. The risk of bleeding during the operation or immediately following it is also present, and this means that occasionally patients may require transfusions or even re-operation to get them well.
- 3) **Specific risks.** These risks are different depending on which operation you have and may occur early or late following the procedure. For example, the most feared complication in operations which involve the bowel is a leak from where the bowel is divided or joined. Although these joins are all made in a standard way which is repeated again and again from operation to operation, in about 1% of people they fail to heal, allowing the contents of the gut to spill out. This causes infection and almost always requires another operation and always significantly prolongs the recovery time. Other risks may be more relevant to some people than others so part of the process prior to surgery involves discussion of what is most relevant to the person having the procedure. Although we can tell you about the more likely risks, the list of rare complications is so long it would be almost impossible to tell you them all but it should be possible to discuss the risks that are most relevant to you. Prior to making a decision to have an operation these issues are best approached at an individual level.

- 4) **Death.** We all know that even driving to work involves the risk of accidents that can be fatal and that an operation will also carry a small risk. Most people go into operations with this expectation and accept the possibility that things may not go as planned. The risks depend on the type of surgery you are having and your age, weight and health and so your overall risk of death may vary from 1 in 200 to 1 in 3000.
- 5) **Disability.** Someone is effectively disabled while recovering from an operation and if they have complications then the duration of their disability can be prolonged. Some disabilities may be permanent and some permanent disabilities occur even if no or only minor complications or have arisen. This is because the effects of any operation vary from person to person and as these operations affect the way the body functions, if this affects quality of life, it may be a difficult problem to remedy. Disability may take the form of prolonged tiredness, abdominal pain, difficulty in eating, vomiting, or nutritional deficiencies. All of these operations are to some extent reversible, but reversing the operation may not fix an established problem. **What makes these risks acceptable is the fact that obesity causes disability, psychological distress and risk to life.**

WHO SHOULD CONSIDER SURGERY

The requirements for people wishing to undergo surgery for a weight problem are listed below. The most important determinant of eventual success, regardless of the operation performed is the realisation that an operation while facilitating weight loss, will not create weight loss “magically”, rather it will help the individual to eat less. We are able to lend support to help make this happen, but the ability of the person undergoing surgery to work with the operation is the key to successful ongoing weight loss.

BMI > 40. BMI > 35 with medical complications. No hormonal cause for obesity. Obesity must have been present for 5 years and persisted despite adequate attempts with other weight loss measures. No alcohol or drug abuse. Absence of “major” untreated psychiatric conditions. Ability to comply with long term vitamin supplements and follow-up after surgery. Actively supportive General Practitioner.

Table 1: People suitable for surgery

WHO SHOULD BE DETERRED FROM SURGERY?

There is no good answer to this question, other than to say that the decision to go ahead should not be taken impulsively. An operation is just the beginning of a lifelong change that will lead to permanent weight reduction, but in order to maximise results a person needs to work with, rather than against their surgery. A desire to eat whatever you wish is probably not compatible with the desire to lose weight. Focusing on short term goals is also not ideal, as people can allow themselves to get into bad habits once they have lost weight (by snacking) as they can feel that they have achieved what they wanted to.

Before Surgery

At least two consultations with your Surgeon will be required. It is very important that we have the opportunity to assess both your risks and your desired outcomes from surgery. In order for you to make the best decision regarding which operation will suit you best a good understanding of how the different procedures may work for you will be needed. This will allow you to make decisions that best suit your circumstances. If possible you should bring a support person to your consultations, as they may be able to ask questions that you forget.

After Surgery

Everyone is different regarding their requirements after surgery. The majority manage very well with simple verbal and written advice. Some people need more intensive support from our dietician, and may need advice about exercise programmes etc also. As weight loss can trigger significant life changes it is not uncommon for people to require professional psychological support. Feeling down or confused should not be taken as a sign of failure.

WHAT TO DO NOW?

Think about things, discuss your thoughts with your family. A large number of people having weight loss surgery do not even discuss it with their spouse and although this simply reflects the belief that others may not take their problem seriously, it also robs them of a significant source of support.

Anyone perusing the web for information regarding obesity management would be well advised to consider avoiding websites with obvious commercial intent. There are good sources of information that can be obtained from neutral government agencies, such as the American National Institute of Health (NIH), the British National Institute of Clinical Excellence (NICE) and the Australian National Health & Medical Research Council (NH&MRC). If you visit internet chat sites consider visiting those discussing more than one operation. As most obesity surgery in Australia is relatively limited in scope it may be worth visiting overseas sites to canvas a broader range of options before making a decision.

Discuss your options with your GP, they will be aware of your previous medical history and they, like ourselves will prefer you to have had sustained attempts at losing weight by other methods before considering surgery. Your GP will also have a central role in supervising your health following surgery should you go ahead. As a large number of your current medications will be ceased post-operatively you will need ongoing contact with someone who will be able to do this in a sensible manner. Take this booklet to your next visit with your GP, it will remind you of any questions you mean to ask him or her.

If you are considering surgery and would like to make an appointment, please keep this booklet and bring it to your appointment. Again it will serve as a useful reference point for discussion.

Appendix and References

The majority of the data and references for the above document can be found at the Government agency websites of the NIH (America), NICE (UK), and NH&MRC (Australia). These sites contain vast collections of the published data, and the NIH site especially provides a lot of practical information for laypeople.

Weblinks for references.

- 1) The Australian NH&MRC guidelines for management of obesity, including recommendations for surgery are at; <http://www.obesityguidelines.gov.au>
- 2) National Institute of Health, National Heart, Lung and Blood Institute guidelines are available at; www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm
- 3) The National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health guidelines are at; www.niddk.nih.gov/health/nutrit/pubs/unders.htm
- 4) The UK based National Institute of Clinical Excellence has a number of documents for patients and Doctors that can be found by searching at; www.nice.org.uk. Specific documents relating to Obesity Surgery are at; <http://www.nice.org.uk/cat.asp?c=34789>.
- 5) Mini-gastric bypass, not used as reference material, but an interesting site: <http://www.clos.net/>
- 6) Australian Institute of Health. Cost of obesity in the National Health Strategy. Inaugural Scientific Meeting, Australasian Society for the Study of Obesity. Sydney, 1992. Sourced from <http://www.phaa.net.au/policy/obesity.htm>
- 7) Difficulties in provision of bariatric surgical services to the morbidly obese. Michael L Talbot et al. The Medical Journal of Australia 2005; 182 (7): 344-347. http://www.mja.com.au/public/issues/182_07_040405/tal10771_fm.html