Weight Loss Surgery

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INTRODUCTION
The fact that you are reading this means that either you or someone you know is considering the life-altering decision to undergo weight loss surgery. This is an important decision and should not be made without considering all the facts.

This booklet has been designed to help you understand the following:
• The health problems associated with obesity
• Advantages and disadvantages of weight loss surgery
• Descriptions of the common surgical procedures
• Risks associated with weight loss surgery
• The next steps to take

Please bear in mind that the information provided here is not a substitute for the opinion and advice of a qualified doctor or surgeon. Your best source of information is an experienced surgeon.

THE TEAM
We are committed to providing multidisciplinary expert management of your weight problem. The team includes a specialist surgeon, an assistant surgeon, an anaesthetist, a nutritionist, nurses and our friendly office staff.

We are located at:

Central Sydney: Royal Prince Alfred Hospital Medical Centre in Newtown

And

North Sydney: The Mater Clinic in Crows Nest

The surgery is performed at the Mater Hospital in North Sydney, backed by a great team of nurses and clinicians.
Obesity is associated with poor health.

Associated health risks
There are many medical conditions that have a direct association with obesity. These include type 2 diabetes, hypertension, fatty liver disease, respiratory problems, and female infertility. Patients who are obese are also more likely to suffer from coronary heart disease, stroke, kidney issues and cancer!

There is clear evidence that obesity is associated with reduced life expectancy. Those who are morbidly obese face a risk of dying that is twice that of others of the same age.

In addition to the diseases mentioned above, obesity has a number of immeasurable negative effects. Morbidly obese people often have a low sense of self-esteem and it is common for them to suffer from depression and to withdraw from social interactions at many levels.

Dieting
Those people who can maintain a healthy low-calorie diet will be able to lose weight and keep it off in the long term. Unfortunately for most people who have become obese, dieting will only produce temporary weight loss with the weight (and more) coming back after a diet stops.

Irrefutable evidence has shown that surgery results in far greater weight loss than diets. Furthermore, weight loss is maintained over the long-term.

Importantly, studies have shown that mortality (risk of dying) is significantly reduced in patients who undergo surgery for weight loss when compared with those who don’t.

WHY SURGERY?
Weight loss surgery should be considered if you:
- Are unable to achieve a healthy body weight for a sustained period, despite dieting and exercise.
- Have a Body Mass Index (BMI) of over 40.
- Have a BMI of over 35 and are experiencing negative health effects
- Weigh more than 45 kg above your ideal body weight.
- Are highly motivated and committed to long term lifestyle changes

BMI calculators are available online and at my website www.bariatricsurgeon.online

WHERE TO BEGIN?
This information booklet has been designed to give you a better understanding of the risks and benefits of weight loss surgery. In the end though, your best source of information is an experienced laparoscopic surgeon who knows how to handle your special needs before, during and after weight loss surgery.
The Importance of Support
The changes in your diet and lifestyle after obesity surgery can last a lifetime. And you'll have a greater chance of long-term success if the people around you understand and support your goals. There are things you can do, such as:
• Help your friends and family members understand why you've chosen a surgical weight loss solution.

Discuss your reasons for having surgery; you will be counting on them to help you during and after weight loss surgery.

WEIGHT LOSS SURGERY
Surgery for obesity has been carried out for over 50 years and numerous advances have been made during this time. In the past, surgery for weight loss was associated with high risks of side effects and complications. Advanced laparoscopic (keyhole) techniques have allowed this to become a safe and reliable means of achieving and maintaining weight loss.
Nonetheless surgical treatment of obesity is a major undertaking. It means undergoing major surgery and requires a lifelong commitment and compliance with post-operative advice. It is not a cosmetic procedure for those who are unhappy with their body image, but rather a medically proven treatment for an established health problem.

Types of surgical procedures
Bariatric surgery is typically described as one of the following

1. Restrictive procedures that decrease food intake. This includes Sleeve Gastrectomy (and gastric banding). These lead to a sense of fullness and satiety

2. Malabsorptive procedures that alter digestion, and cause changes in the gut hormones that decreases appetite. Some food may be poorly digested so that it is eliminated in the stool.

3. Combined procedures have a component of restriction and malabsorption. Both types of Gastric bypass are examples of combined procedures. All bariatric procedures work primarily through a decreased appetite and decreased intake

PRIOR TO SURGERY.
In order to shrink some of the fat out of the liver, you will need to be on an 'Very-low Calorie Diet' (Optifast) for 2 weeks before surgery. If you have something else, then it needs to contain very few calories. Check with the nutritionist.

Hospital Stay
You will be admitted the day of the surgery. The usual stay in hospital is 2-3 post-operative nights.
SLEEVE GASTRECTOMY

Sleeve Gastrectomy is the most commonly performed operation. Laparoscopic (keyhole) techniques are used to remove a large segment of the stomach (up to 80% of the total volume), whilst maintaining the normal passage of food anatomically. The capacity of the stomach is reduced from about 1.5 litres of food and liquid to approximately 300mls, and this provides the brain feedback via stretch receptors that signal a feeling of fullness and satiety. Severe hunger is reduced. Despite being smaller, the remaining digestive system functions normally.

GASTRIC BYPASS

1) Roux en Y Gastric Bypass

The stomach is divided into a small pouch just after the oesophagus. The small intestine is divided, and one end is joined to the small stomach pouch. The other end is sewn to the intestine further down. Food travels through the pouch into the small intestine joined there, while digestive juices travel down the other limb until they meet at the intestinal join. The operation leads to strong appetite suppression and best diabetic control without the risk of severe heartburn.

2) Mini-Gastric Bypass (omega or Single anastomosis)

With this modification, a long thin pouch of stomach is made. After this, a single join around 2 meters down the small bowel is made. Digestive juices pass through the first part of the intestine without food and mixing with absorption happens only after the join to the stomach. In some ways this gives the best of the Gastric Sleeve and the Roux en Y Bypass but is not recommended if there is Acid Reflux.

No matter what surgery, smokers should cease smoking for at least 4 weeks before surgery

Roux en Y is best for people with severe reflux. Either bypass operation may be superior to the Sleeve for Super Obesity or Severe Diabetes but not for smokers.

Sleeve gives the best Quality of Life and is the least complex surgery.

Dr Crawford will review your needs and advise you which is best suited to you.

A video explaining the differences is available at www.bariatricsurgeon.online
## Comparing Operations

<table>
<thead>
<tr>
<th></th>
<th>Roux Y Gastric Bypass</th>
<th>Mini Gastric Bypass</th>
<th>Laparoscopic Sleeve Gastrectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety</strong></td>
<td>Complications in up to 5%</td>
<td>Around 3%</td>
<td>Safe (around 1% major complication rate)</td>
</tr>
<tr>
<td><strong>Adjustability</strong></td>
<td>Set once at Surgery</td>
<td>Set once at surgery</td>
<td>Set once at surgery</td>
</tr>
<tr>
<td><strong>Success</strong></td>
<td>Highly Successful</td>
<td>Highly Successful</td>
<td>Highly Successful</td>
</tr>
<tr>
<td><strong>Need for more procedures</strong></td>
<td>Low chance</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td><strong>Frequency of doctor appointments</strong></td>
<td>Moderate</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td><strong>Restrictions of certain foods</strong></td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td><strong>Reflux Symptoms</strong></td>
<td>Less likely</td>
<td>Unlikely</td>
<td>Unlikely</td>
</tr>
<tr>
<td><strong>Long-term Satisfaction</strong></td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Diabetes Control</strong></td>
<td>Best</td>
<td>Best</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Reversibility</strong></td>
<td>Yes (but big surgery)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Convert to another procedure later</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Hospital stay</strong></td>
<td>2-3 Nights</td>
<td>2-3 Nights</td>
<td>2-3 Nights</td>
</tr>
<tr>
<td><strong>Return to solid food</strong></td>
<td>3-4 weeks</td>
<td>3-4 weeks</td>
<td>Up to 6 weeks</td>
</tr>
<tr>
<td><strong>Long term nutritional issues</strong></td>
<td>Yes</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td><strong>Ulcers</strong></td>
<td>Rare (smokers)</td>
<td>Rare (smokers)</td>
<td>No</td>
</tr>
<tr>
<td><strong>Bowel obstructions</strong></td>
<td>Can Occur</td>
<td>Can Occur</td>
<td>No</td>
</tr>
<tr>
<td><strong>Length of Surgery</strong></td>
<td>2-3 Hours</td>
<td>1.5-2.5 Hours</td>
<td>1-2 Hours</td>
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## Diet Following Surgery

Day of Surgery: Ice to suck only.
Day 2-7: Fluids that could be sucked through a thin straw.
Day 7 to week 3: Pureed food.*
Week 3-5: Sloppy/soft foods.
Week 4+: Slow introduction of some more solid foodstuffs thereafter, as guided by the team.

* Progress from thin to thick only after the thinner fluids are easily tolerated
Reflux/heatburn is occasionally experienced early after surgery, you will therefore have an anti-acid tablet for 30 days. In sleeve patients; it sometimes persists long-term, and an anti-acid treatment might be required.

**Time away from work**
Plan for two weeks off work. Pop some soups in the freezer before surgery. Avoid heavy lifting for 6 weeks.

See your dietitian around 1 week after surgery

Plan a check-up with Dr Crawford at 4-6 weeks post-op.

**Weight Loss Surgery is a Tool**
Think of the surgery like a nicotine patch for smokers; taking away the strong hunger that prevents you from sustaining weight loss without it. Use the tool to eat less and eat healthier. Work with your dietitian to achieve the best results

**Regular exercise** should be a part of your weight loss program and you should aim to exercise for at least 20 to 30 minutes every day.

**CONTACT US**
This information is intended as a guide only. Please bear in mind that the information provided here is not a substitute for the opinion and advice of your surgeon. Your best source of information is an experienced surgeon who specialises in the management or control of obesity.

You will need a referral from your local doctor.

Please call (02) 9565 4854 for an appointment with Dr Michael Crawford.

Dr Crawford sees patients at:

**Suite 314, RPAH Medical Centre 100 Carillon Avenue, Newtown**

and

**The Mater Clinic, 198 Pacific Hwy, North Sydney**

Much more information is available at my bariatric surgery website including videos and downloadable information booklets

[www.bariatricsurgeon.online](http://www.bariatricsurgeon.online)
Gastric Sleeve

Roux en Y Gastric Bypass

Mini Gastric Bypass