Utah Surgical
Weight Loss Center

AMERICAN COLLEGE OF SURGEONS
MBSAQIP
ACCREDITED CENTER
QUALITY PROGRAM
AMERICAN SOCIETY FOR METABOLIC AND BARIATRIC SURGERY

(435) 628-1641

UTAHSURGICAL.COM

Introduction to Utah Surgical Associates

The surgeons at Utah Surgical Associates are committed to the care of patients who are struggling with their weight. Since January of 2004, we have provided surgical care and follow-up for patients undergoing weight loss surgery. We have successfully partnered with St. George Regional Hospital (SGRH) to provide an integrated multidisciplinary team approach to patient care.

Laparoscopic gastric bypass has been performed since the onset of this program. As different surgical approaches have been developed, we have incorporated those procedures that we feel have shown significant success in the treatment of this illness. With this in mind, sleeve gastrectomy has been added to our program.

With a team approach and careful post-operative care our patients have been able to achieve remarkable success. We hope this manual will help you to understand the issues involved in this important and life changing event. We are committed to helping you achieve your goals.

Introduction to Obesity Surgery

Basic definitions used for obesity surgery

Surgery for weight loss is becoming a common method for treatment of severe obesity and its associated illnesses. This document is to educate the patient considering surgical weight loss about different types of surgery available, the risks of the procedure, the benefits of surgical weight loss and the requirements for a successful outcome.

Certain words are commonly used in discussing these surgical procedures. For better understanding the following definitions are provided:

· **BMI (body mass index)**- a measure of an adults weight in relation to their height. Used to compare the obesity of patients with different heights. If a patient's height were 6'3" and they weighed 200lbs then that would be a normal weight, but if the same patient were 5'0'' then they would be severely obese (BMI of 25 compared to 39 respectively). The BMI is calculated as weight in kilograms divided by height in meters squared (kg/m2). This is number can be obtained using BMI calculators that are available on the internet or using the tables we have provided.

· **Obesity**- defined as having a high amount of body fat in comparison to lean body mass. Specifically, a BMI of 30 or greater.

· **Bariatrics**- the branch of medicine dealing all aspects of obesity.

· **Comorbidities**- diseases caused by specific underlying conditions. In this particular case, the illnesses and problems caused by obesity.

The obesity epidemic

Surgical weight loss has been around in various forms for more than thirty years. Recently, a lot of attention has been focused on these procedures because of an explosion in obesity rates around the country and indeed around the world. In certain states in this country more than 25% of the population are obese having BMI's greater than 30. Three in five Americans are either overweight or obese. In the past 20 years, adult obesity has doubled. It is estimated that more than 300,000 premature deaths occur annually because of obesity. The death rate from obesity is rapidly approaching that of smoking.

Causes of the obesity epidemic

Genetic predisposition: Obesity tends to run in families. Studies of children from "overweight" parents adopted into "thin" families show that the children's weight mirrors their biologic parents. The search is on for the "obesity gene".

Physiologic: Complex hormonal interactions exist that are not completely understood, but are an important area of active research and possible future therapy. These interactions have developed over many generations of human history and have been important for human survival throughout our history. Unfortunately, food is plentiful today and these factors are contributing to the explosion of obesity.

Behavioral: Food is intimately intertwined into our behaviors and family traditions. Many of the pleasurable moments in our lives are associated with eating. Food addictions are common. Food is a comfort and pleasure that is difficult to replace.

Gender: Women have a higher incidence of obesity.

Socioeconomic: High fat/calorie food is inexpensive and readily available. It costs more to eat healthy. Exercise can also be an expensive hobby.

Psychosocial: Food can be a mechanism for coping with stress and abuse.

Societal: Modern society is filled with labor saving devices. Exercise and activity have become optional. Technology has contributed greatly to our high quality of living, but also has been a major contributor to our high obesity rates.

Energy Imbalance

The basic cause of obesity is an energy imbalance. If you think about it, less than 100 years ago people lived very different lives. Most people worked hard to make a living and episodes of famine were common. The human race has lived for many thousands of years in this fashion. Those people who could absorb and store energy efficiently survived the famines and were able to pass along their genes.

We now live in a completely different society, but our genes haven't changed. We are basically living in a modern society with Stone Age genes. There is a huge supply of food that is low in cost, always available, attractive, tasty, and hygienic. In addition, labor-saving technologies have virtually eliminated the need for physical activity in everyday life. Activity is now optional. This is a very simple equation:

Increased Caloric Intake+ Decreased Energy Expenditure= Energy Storage/Fat Deposition

We are literally eating so much and storing so much fat that our bodies and organs are unable to handle the consequences. This problem is not just a cosmetic issue. The weight is not just unsightly, its dangerous. The body is impacted on almost every level and the most important organ systems in our body are compromised. We call these consequences of obesity *comorbidities*. Below is a list of the most common illnesses associated with obesity.

Obesity related illness (Comorbidities)

Obesity increases the incidence of these specific diseases:

Diabetes	GERD/Heartburn
Hypertension (high blood pressure)	Depression
High triglycerides/cholesterol	Liver failure/Cirrhosis
Heart disease/Stroke	Gallstones
Obstructive Sleep Apnea	Infertility
Pulmonary Hypertension	Urinary incontinence
Heart Failure	Blood clots/DVT's
Degenerative Joint Disease	Gout
Cancer (endometrial, breast,prostate, colorectal)	and others....

Psychological Impact of Obesity

In addition to the adverse impact obesity has on the body, there is an impact on the mind and psyche. People with obesity are frequently depressed and feelings of social isolation are common. Social phobias are also very common. Even without the phobias patients find it difficult to cope with the consequences of their size. Fitting through turnstiles, sitting in theaters, finding a seat on an airplane, finding stylish clothes, etc., can be challenging and embarrassing.

Society has not come to terms with this epidemic and the obese are frequently the target of discrimination. Discrimination in the workplace is rampant. Comedians and movies frequently use overweight people as the butt of their jokes. Obesity is the last bastion of discrimination.

Criteria for Weight Loss Surgery

National Institutes of Health Consensus Statement

In 1991, the National Institutes of Health convened an panel of experts to evaluate the available treatments for obesity. All the research on the medical and surgical options for weight loss were evaluated. The panel then generated a statement explaining their findings.

The panel found no evidence to support the effectiveness of medical weight loss. Specifically, it stated that the available diets, exercise, and medications were ineffective at long term weight loss for the “morbidly obese”. They found the weight loss with dieting to be small and the weight was regained in almost every patient.

The panel also found clear evidence of the effectiveness of surgical weight loss in the treatment of these same patients. A majority of the excess weight was lost with surgery and the weight loss was maintained when following patients out 10 years.

The consensus panel also made recommendations regarding who would benefit from surgery. These guidelines are followed by most weight loss programs. These criteria are based on a patients BMI and the illnesses they have developed as a consequence of their excess weight.

Criteria for Weight Loss Surgery

The NIH Consensus Panel recommends that a patient is a candidate for surgery if:

1. Patients have a Body Mass Index > 40 kg/m_2.
2. Patients have a Body Mass Index between 35 and 40 kg/m_2 with obesity related illnesses.

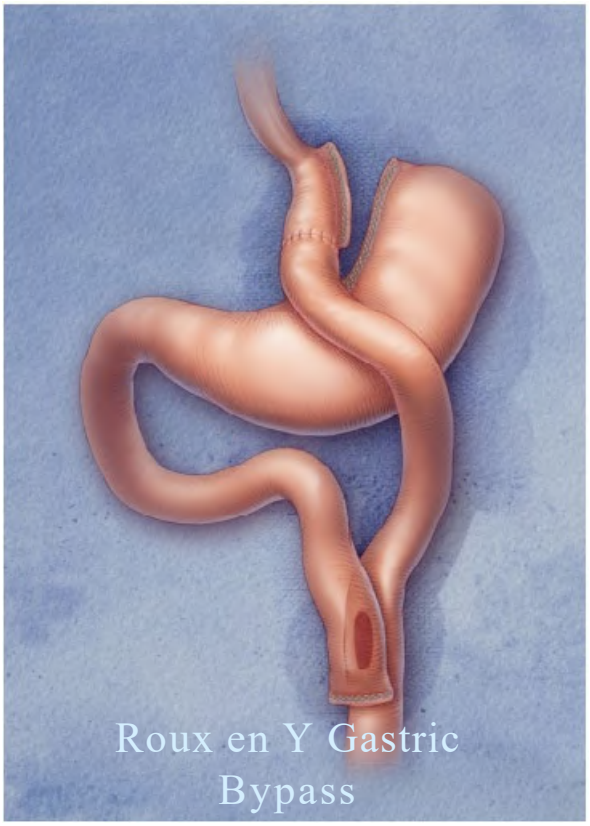
http://consensus.nih.gov/1991/1991GISurgeryObesity084html.htm

Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity														
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	Body Weight (pounds)																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Weight Loss Surgery Options

Roux-en-Y Gastric Bypass



The gastric bypass is considered by many the gold standard obesity operation. We compare other weight loss surgery outcomes to this surgery to compare effectiveness. It has been studied for many years and long term outcomes are well known.

A small pouch, approximately 1 ounce in size, is created at the top of the stomach.

The small bowel is divided. The biliopancreatic limb is reattached to the small bowel.

The other end is connected to the pouch, creating the Roux limb.

The small pouch releases food slowly, causing a sensation of fullness with very little food.

The biliopancreatic limb preserves the action of the digestive tract by allowing bile and pancreatic fluids to mix with the food from the pouch. These substances are necessary for normal absorption of nutrients.

Risks of gastric bypass

All surgical procedures are associated with risk. With appropriate patient selection and preparation these risks are relatively low. We want all patients considering surgical weight loss to understand the risks prior to surgery. Below is a list of some common risks associated with gastric bypass surgery.

Bleeding, infection, spleen or liver injury, blood clots (DVT's), pulmonary embolus (blood clots traveling to the heart/lungs), pneumonia, heart attack/arrhythmia, anastamotic leak (leak at the bowel connections), conversion from a laparoscopic approach (small incisions) to an open approach, and death (approximately 1/200 or 0.5%)

Late Complications: Hernias (more common with open surgery), ulcers, intestinal obstruction, outlet stenosis (narrowing of the connection between stomach and bowel), anemia/nutritional deficiencies (all patients are required to take vitamin/mineral supplements), osteoporosis (all patients should take calcium citrate supplements, and dumping (usually only occurs when wrong food choices are made, therefore is helpful for weight loss).

Advantages/Disadvantages of Gastric Bypass

Advantages:

· Rapid intial weight loss

· Minimally invasive approach is possible

· Longer experience in USA with longer follow-up

· Minimal diet restrictions

· <1% need for repeat surgery

Disadvantages:

· Cutting, stapling and rerouting of the bowel is required

· More operative complications than sleeve

· Duodenum (first part of small intestine) is bypassed (this is where much of the iron and calcium is absorbed)

· Technically less complex if preformed laparoscopically

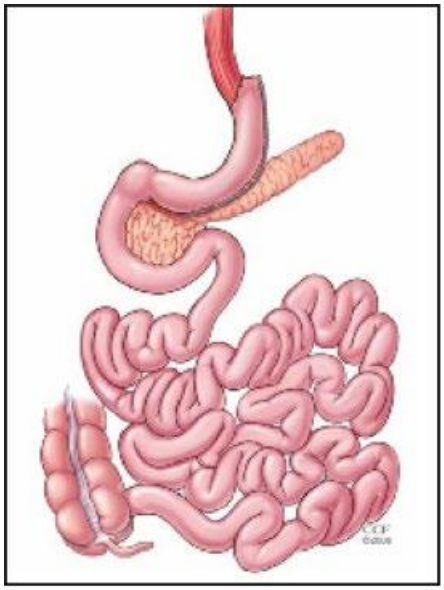
· Difficult to reverse

Weight Loss Surgery Options

Sleeve Gastrectomy

Sleeve gastrectomy is a relatively new procedure. It has been used for many years in conjunction with a malabsorptive procedure such as a duodenal switch/ biliopancreatic diversion. It is currently being used as a stand alone procedure that combines some of the benefits of the gastric bypass and the gastric band procedures.

The procedure is performed laparoscopically. It usually entails an overnight stay in the hospital.



A tube is placed down the esophagus into the stomach and used to guide a stapler that cuts and seals the stomach. All the stomach, except that which is around the tube, is removed creating a narrow tube of the stomach.

The procedure effectively restricts calorie intake. It has the advantages of letting food enter the digestive tract normally like a gastric band, but the problems associated with the foreign body/band are solved.

Risks of sleeve gastrectomy

All surgical procedures are associated with risk. With appropriate patient selection and preparation these risks are relatively low. We want all patients considering surgical weight loss to understand the risks prior to surgery. Below is a list of some common risks associated with a sleeve gastrectomy.

Bleeding, infection, spleen injury, liver injury, blood clots, pulmonary embolus (clots that travel to the lungs), heart attack/arrhythmia, bowel injury, conversion to open surgery from laparoscopy, staple line leak, stomach obstruction, weight regain (can happen with all weight loss operations), and death (0.02%).

Advantages/Disadvantages of Sleeve Gastrectomy

Advantages:

- No intestinal rerouting
- No bypass of the duodenum (where much of the calcium and iron is absorbed)
- No dumping syndrome
- Less risk of ulcer
- Little risk of internal hernias and bowel obstructions

Disadvantages:

- Staple line complications
- No dumping syndrome (this can help motivate patients to avoid "sweets")
- Slightly less weight loss compared to a Gastric Bypass
- Increased acid reflux in some patients and tendency to develop hiatal hernia

What are my Next Steps for Weight Loss?

Step towards surgery	Date
1) **Determine if you meet the criteria** for surgery (See p. 4 for criteria) *Must be over 18. Ages 70-75 are evaluated on case by case basis and may need additional clearances. Patients weighing greater than 450lbs/70+ BMI will need to be referred to another program. 2) **Watch weight loss seminar** https://utahsurgical.com/procedures/bariatric-weight-loss-surgery/ 3) After watching weight loss seminar video, **email lhiner@utahsurgical.com or jenny.thompson@imail.org to get credit for first criteria**. Please include name, DOB, contact info, BMI, obesity related illnesses, referring physician and insurance. We will then send you a detailed overview of our program.	Date completed seminar:
1) **Call your insurance for bariatric specific requirements**. If you have two insurances, please contact both. Insurance companies may need a procedure code- Laparoscopic sleeve gastrectomy 43775/Laparoscopic Roux-en-Y gastric bypass 43644	
2) If you have insurance questions, please call Lorraine Hiner (435) 625-0220 to coordinate insurance information and to verify benefits.	
3) **Start medically supervised diet with physician of choice (PCP or dietician).** Record dates of each visit. **Insurance requires that you not skip a month or you will be asked to start over**. Your first visit initiates the diet, therefore, the date of your second visit counts as the completion of 1 month. For example: If your insurance requires you to complete a 3-month diet. Typically, you will need 4 visits over at least a 90-day period. **(* If you are self-pay you do not need to do this step.)**	Month 1: Month 2: Month 3: Month 4: Month 5: Month 6: Month 7:
4) **Set up nutrition and psych evaluation** (See p.13 for phone #'s for providers) Ask providers to fax notes to Lorraine Hiner at (877) 588-3498 if not an intermountain healthcare physician. ***Note steps 4 and 5 can be done at the same time**	Dietician name & appointment date: Psych provider and appointment date:
5) **Call Lorraine Hiner (435) 625-0220 approximately 1 month prior to completing your requirements to set up your surgical consult**. Ask your physician to fax supervised diet and exercise clinical notes to Attn: Lorraine Hiner (877) 588-3498 if physician is not an intermountain healthcare provider.	Surgeon: Date of Consult:
6) **Contact Jenny Thompson (435) 251-1632/jenny.thompson@imail.org** 7) **to register for a pre-op class** after you have received your surgeon consult appointment. *Virtual Pre-op Classes are 2/4th Tuesdays of each month 10-12.	Date of pre-op class:
8) **Go to surgeon consult and schedule surgery during your visit**. Additional clearances may be requested by your surgeon dependent on medical history. Medical clearances will need to be received before going ahead with surgery.	Provider Name: Date of surgery:
9) **Complete pre-operative labs and tests required a week prior to surgery date.** Labs will be ordered at your surgeons consult and electronically sent to an intermountain facility. When you arrive at the facility the lab will be in the computer system waiting for you.	
10) **Join our virtual support group**. It is highly suggested. Studies show individuals who attend support group have better outcomes. Please contact Jenny Thompson at 435-251-1632/jenny.thompson@imail.org to register. DRMC New Beginnings virtual support group class via Web Ex is scheduled 3rd Wednesday of every month 5:30-6:30 PM.	

11) **2 weeks prior to surgery date start your liquid protein diet.**	Date to start pre-op diet:

Jenny Thompson MSN RN
Bariatric Coordinator
Specialty Care Coordinator II-Bariatrics
Associates
Intermountain Healthcare | St. George Regional Hospital
Dr. #200
1380 E Medical Center Drive (2nd floor Program Specialist Office)
84790
St. George, Utah 84790
877-588-3498
Office: 435.251.1632 | *jenny.thompson@imail.org*

Lorraine Hiner
Bariatric Coordinator
Utah Surgical Associates
1490 E Foremaster Dr. Ste 200
St. George, UT 84790
Ph. 435-625-0220/Fax
lhiner@utahsurgical.com

Frequently Asked Questions

1. ***Why do I need a dietary consult?***

   This is to teach you the skills to choose the right food and nutrients to nourish your body and help with overall success in sustainable weight loss that is permanent. https://intermountainhealthcare.org/services/wellness-preventive-medicine/live-well-centers/st-george-live-well/?utm_campaign=gmb-website&utm_medium=organic&utm_source=google

2. ***How recent does my supervised diet need to be as I have tried many diets over the years?***

   In general, most insurance companies require supervised diets to be within the last year. Please contact your insurance company to get your specific guidelines.

3. ***What happens if I am at a 35 BMI, but I go under during my supervised diet?***

   This depends on your insurance company some will look at your previous weights over the last year and use it as a baseline. Other insurances require that you stay above 35 BMI no matter what. Contact your insurance for specifics.

4. ***What if I fall just under BMI or I don't have obesity related illness?***

   Intermountain offers several programs by the Live Well Center such as the weight to health program, nutrition consults, and various wellness and fitness classes. https://intermountainhealthcare.org/services/wellness-preventive-medicine/live-well-centers/st-george-live-well/ or call (435) 251-3793.

5. ***I see the age requirement cut off is 70 but I am 73. What can I do?***

   If you are between 70-75 the doctors will evaluate you on a case by case basis. Please have medical records sent to Utah Surgical Associates for review. Fax (435)628-1660 or email to lhiner@utahsurgical.com. The doctor will review your records and access your risk level. Then the office will contact you with the decision. Additional clearances may be requested.

6. ***Why do I need to have a psychiatric evaluation?***

   The intent is to make sure there is no untreated psychological illnesses that might compromise the outcome of your surgery. Weight loss surgery is a stressful event that can cause worsening of underlying psychiatric diseases. Having a resource available that you feel comfortable with prior to surgery can be valuable in managing psychological symptoms post-operatively and help with behavioral modification needed to be successful life-long.

7. ***If I am already seeing a psychiatrist can I use them for the psych evaluation?***

   Yes, you can use your own psychiatrist. Please contact Utah Surgical Associates for specific topics that needs to be addressed and documented in this visit.

8. ***Are the suggested providers the only ones that I can see?***

   No, you can choose your own provider. These are just recommendations.

Frequently Asked Questions

9. ***How quickly can I get in to have surgery?***

   Self-pay patients typically can be seen within a couple months as they do not have to complete a medically supervised diet. Patients that are following insurance guidelines have to complete the medically supervised diet, nutrition consult and psychiatric assessment. Insurance patients can take anywhere from 3-6 months on average depending on how long the insurance company dictates for the supervised diet. We recommend you schedule your dietician consult and psych evaluation concurrently while you are completing your medically supervised diet. Then upon completion you will be ready to schedule your consult and pre-op class.

10. ***What if my insurance company doesn't have bariatric benefits is their funding available?***

    You can look into funding through a bank or contact Prosper Healthcare Lending (prosperhealthcare.com or 866-602-6066). I also recommend rechecking your specific insurance benefits at the beginning of each calendar year to see if benefits have changed. It may be that bariatric benefits aren't available this calendar year but the following year it has been added as a benefit.

11. ***Is payment expected in full to the doctor, hospital and anesthesia before I have surgery?***

    Self pay patients must pay the entire amount prior to their surgery to each individual department. Payment is expected at least 7 day prior to surgery to avoid possible cancellation of your surgery. In general, for patient's that are using insurance, the surgeon's office and the hospital will request a $500.00 to $1000.00 pre-surgery payment if your yearly deductible has not been met. For payment at SGRH, please contact Katie Hansen (801) 442-9647 or Larry (801) 357-0806. For payment at Utah Surgical Associates, please contact Lorraine Hiner at (435) 767-9405 or Audry (435) 767-9423. For payment at Mountain West Anesthesia, please contact Keeley at (801) 432-2624.

12. ***Why are you more expensive than other surgeons out of the country?***

    Our price includes a comprehensive program with providers available 24/7. This includes resources such as ER, anesthesia, imaging, IV infusion clinics, ICU etc. Therefore, if complications were to arise we are able to offer many service lines to evaluate your problem. Our program is an accredited center which means our program meets the highest standards in safety, quality and reliability. These standards come with regulations that dictate best practice from how to disinfect instrumentation properly, to best surgical technique, to pre and post-operative protocols which allow for better outcomes. Our prices also include the manpower and hours to make sure that you have the safest, best quality outcome. Self-pay prices are all inclusive which means they include the surgeon consult, post op appts and life-time bariatric follow-ups.

Frequently Asked Questions

13. Why should I choose your program over medical tourism where the fees are cheaper?

All surgeries come with risk; however, it is proven that accredited centers have lower risks associated with them than non-accredited center. This is because being accredited means the program follows national standards for bariatric surgery. MBSAQIP (Metabolic Bariatric Surgeons Accreditation Quality Improvement Program) is a governing body that follows ASMBS (American Society for Metabolic and Bariatric Surgeons) guidelines. These are specific standards that are researched and proven to be best practice. This allows for the advancement of safe and high-quality care. These guidelines dictate that certain physical and human resources be available at all times to allow for the best outcome possible. I would advise if you are seeking treatment outside of the US that you thoroughly research the facility. Complication risk reporting may be skewed and misleading from these facilities as they don't always include post-operative complications that are treated in the US. If complications were to arise from your surgery once you are back in the US your insurance can deny all charges associated with the procedure making all payments out of pocket for you. Recently, Utah has seen an increase in an antibiotic resistant bug known as pseudomonas aeruginosa associated with medical tourism and bariatric surgeries. Please refer to the Utah Health Department link and the CDC for facts on this life-threatening illness.
https://www.cdc.gov/hai/outbreaks/pseudomonas-aeruginosa.html

https://health.utah.gov/featured-news/utah-resident-dies-following-surgical-procedure-in-tijuana-mexico

BARIATRIC SURGERY
Pre-Operative Liquid Diet

Purpose: The Pre-Operative Liquid Diet is a method used to reduce the amount of fat around the liver. This makes the liver more pliable, allowing the surgeon easier access to the stomach. The diet is to be started 2 weeks prior to surgery. This liquid diet is high in protein, minimal in carbohydrate, and 900-1200 calories.

Guidelines:

1. The main component of the diet is a liquid protein supplement (see list).
2. Caloric intake ranges 900-1200, depending on which and how many supplements are consumed.
3. More than one brand and/or flavor of supplement can be consumed to increase variety.
4. Hydration can be accomplished with water and sugar free/calorie free beverages such as Crystal Light (including store brands and Mio drops), sugar free gelatin, low sodium broth, sugar free Popsicles, coffee, tea, and diet carbonated beverages, such as Diet Coke (no sugar or fat added).
5. The multi-vitamin/mineral supplement can be started during the pre-operative liquid diet.

Please direct questions regarding diet to the Outpatient Dietitian: 435-251-3789

Golden Rules of Successful Weight Loss

Golden Rules

If you are seriously considering weight loss surgery, you need to carefully examine this list of rules. These rules, if followed, will allow you to meet your goals of weight loss and better health. All of the operations, described previously, are tools. To be effective a tool has to be used appropriately. A list of instructions typically accompanies a tool that is purchased. These acquaint the new owner with the appropriate use of the equipment to achieve the desired goal. Without these instructions the completion of the task is much more difficult and in some cases more dangerous.

The following is a list of instructions for weight loss surgery. If you look at this list and feel you would be unable or unwilling to follow all of the instructions, then it would be best to reconsider your decision. You should wait to have surgery until you have made the commitment to follow all these guidelines.

· **Two to three small meals per day**. Patients who fail to lose the expected weight after surgery ,or regain weight later on, tend to do so because they are eating many small meals or snacking. With snacking it is easy to get enough calories into your digestive system to fail to achieve your weight loss goals.

· **High protein meals**. Patients are instructed to eat a diet that consists of about 70% protein and the rest vegetables. The protein fills the stomach pouch and produces a sensation of satisfaction and fullness that lasts for hours. In addition, the body needs a certain amount of protein to be healthy and thereby avoid protein malnutrition.

· **No snacking**. As mentioned above, this is a frequent cause of weight gain.

· **Avoid liquids with calories**. Liquids empty quickly from the stomach pouch allowing a lot of calories to be consumed and producing no long lasting fullness. We encourage our patients to stay well hydrated with liquids that contain no calories, but to avoid liquids with calories after the early post-op period. This includes soups, soda drinks, ice cream and shakes, protein shakes, alcohol, etc.

· **Stop eating when satisfied**. The operation will help you understand this concept. Usually, if one bite to much is taken, pain and vomiting can result. If a patient persists at overeating, it is possible to stretch the pouch and eventually sabotage their operation.

· **Exercise daily**. Exercise impacts the energy output portion of the energy equation. Surgery decreases energy intake. Exercise burns energy and strengthens muscles that burn energy all day long.

· **Be active**. A sedentary lifestyle causes obesity. Find ways to be active in addition to exercise.

· **Follow-up with physicians**. Regular follow-up is also critical for success. This allows your surgeon to monitor your progress and regularly check for signs of problems. A weight loss clinic has been set up that has all the components to help you achieve your goals.

· **Daily multivitamin and calcium citrate**. Because the post op diet lacks certain food groups and because some operations cause malabsorption of certain nutrients, it is important to supplement the diet with a multivitamin high in iron and B vitamins. Calcium supplementation is also important.

· **Support Group**. A great support group experience is available to all patients. Studies have shown that those patients who regularly attend support group have much better weight loss

Resources

· Nutritionist or Registered Dietician

St. George Livewell Center	**435-251-3793**
Cedar City Hospital	**435-359-3687**
Garfield Memorial Hospital	**435-359-3687**
Sanpete Valley Hospital	**435-462-4631**
Sevier Valley Hospital	**435-893-0569**

· Psychology/Psychiatry

Amy Brotherson MSW, LCSW	**435-669-7109**
Tim Kockler Ph. D	**435-632-1445**
Aubree Sullivan LCSW	**435-862-4767**
Therapy Associates	**435-862-8273**
Kristi Shaw MS, LCMHC	**435-429-1055**
Melyssa Myers LMFT	**435-214-1783**

***You may choose any licensed psychologist or psychiatrist to perform your pre-op evaluation.**
***You may want to check with your insurance company for preferred providers.**

· DRMC Specialty Care Coordinator II - Bariatrics

Jenny Thompson, RN MSN **435-251-1632**

jenny.thompson@imail.org

· Bariatric Coordinator @ Utah Surgical Associates

Lorraine Hiner **435-628-1641 or 435-625-0220**

Fax: **877-588-3498**

lhiner@utahsurgical.com

· Website: **utahsurgical.com**