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Metabolic Surgery

Metabolische Operationen

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Preface

Dear Patient!

You have decided to undergo an operation at the University Clinical Department of Visceral, Transplant and Thoracic Surgery in order to reduce your excess weight.

Please read this brochure carefully and also discuss its contents with your family and/or other persons you trust before you make a final decision concerning the operation.

If you have any questions, please contact the doctor who is treating you.

We wish you all the best!

The Team of the Interdisciplinary Workgroup for Bariatric Surgery

Introduction

Surgery that may reduce excess weight is called bariatric surgery or metabolic surgery. Various surgical methods are available, of which the most commonly used ones are the gastric bypass and the gastric sleeve techniques.

Bariatric/metabolic surgery is currently the most effective method to achieve a lasting reduction of morbid obesity and to cure or alleviate so-called comorbidities of obesity.

However, this surgery does not simply involve achieving the desired weight loss. A number of significant lifestyle changes are required and the side effects of metabolic surgery also have to be taken into account. A comprehensive assessment is necessary prior to surgery, which takes place during several outpatient appointments in our department. After the operation, regular check-ups and follow-up investigations are obligatory for the rest of your life.

This brochure is intended to provide you with an overview of the whole process, before, during and after metabolic surgery. It contains information about the surgical methods and their risks, the investigations required before the operation as well as the obligatory check-ups after the operation.

Pregnancy and contraception

A safe method of contraception is absolutely essential for women of childbearing potential during the first one to two years after bariatric surgery. Women wanting children after bariatric surgery need to ensure adequate supplementation with the relevant vitamins, trace elements and, if necessary, protein. Close supervision by a dietitian and by the metabolic medicine specialist and gynaecologist treating the patient.

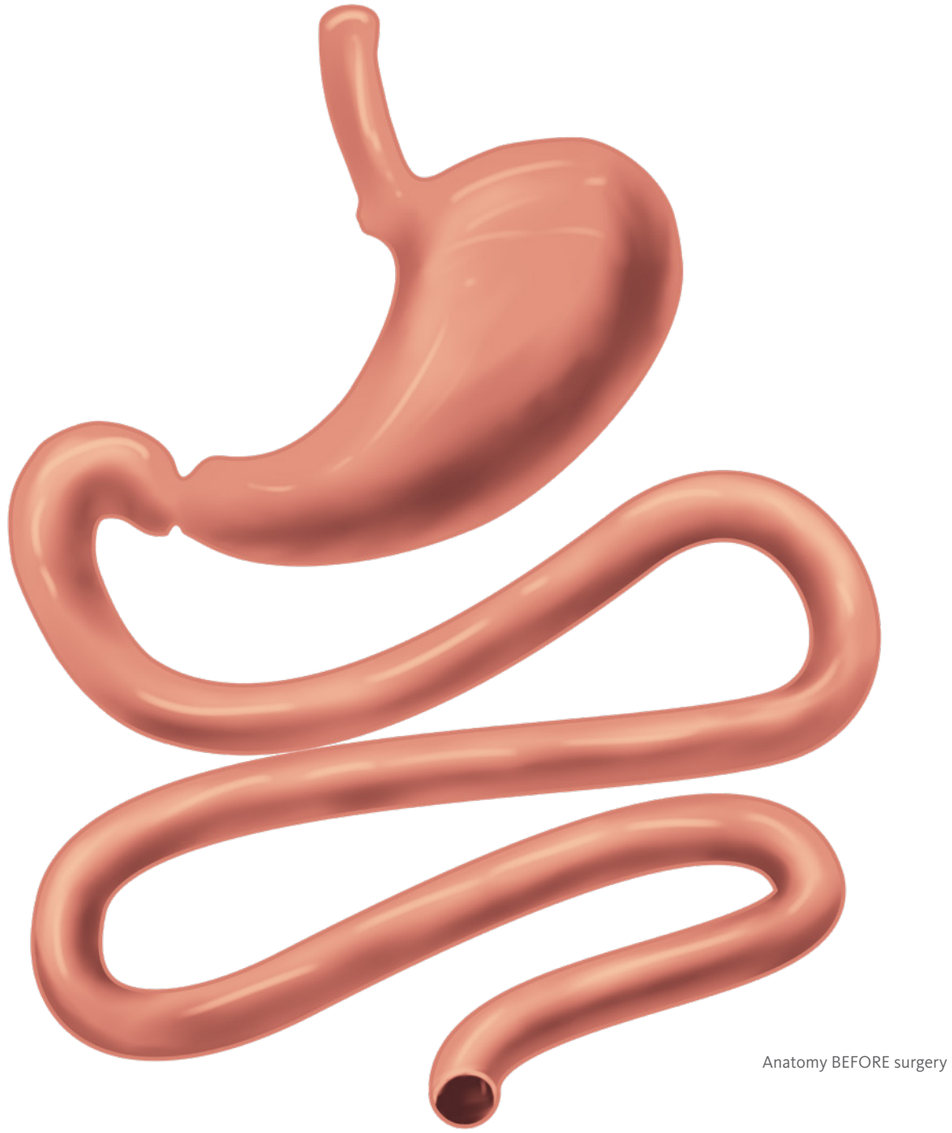
Gallstones

The rapid weight loss after bariatric surgery increases the risk of gallstone development. In order to reduce this risk, taking a medicine (Ursofalk®) for six months after the operation is recommended. After a gastric bypass, it is no longer possible to view the remnant of the stomach and the bile ducts using conventional gastroscopy.

Metabolic surgery – the methods

Bariatric or metabolic surgery is currently the most effective method to reduce morbid obesity and to either cure or relieve so-called comorbidities of obesity, such as diabetes, hypertension, hyperlipidaemia (increased levels of fat in the blood), obstructive sleep apnoea, backache, joint pain, depression, etc.

Metabolic surgery is performed under general anaesthesia. All procedures are primarily performed laparoscopically, i.e. using keyhole surgery. This means that about 5 small incisions (5 or 12 mm) will be made in your upper abdomen. Laparoscopic surgery is technically impossible only in exceptional cases, for example if extensive adhesions are present in the abdominal cavity as a result of previous surgery. In such a case, a larger incision may be necessary.



Anatomy BEFORE surgery

Roux-en-Y gastric bypass/ RYGB
(conventional gastric bypass)

In conventional gastric bypass surgery, the stomach is greatly reduced in size, and a so-called gastric pouch with a filling volume of only about 15 ml is created. This gastric pouch is connected directly to the small intestine. In this way, the rest of the stomach (remnant stomach), the duodenum and the upper 150 cm of the small intestine are separated off from the tract through which food passes. Digestive juices (bile, pancreatic juice) are only added to the gastric contents (chyme) by means of a further connection that is created between the loops of the small intestine (Fig. Roux-en-Y gastric bypass surgery).

Three mechanisms are responsible for weight loss after gastric bypass surgery: Because of the small filling volume of the gastric pouch, you are only able to eat very small amounts of food (restriction effect). Moreover, since the bypass avoids a large portion of the small intestine, it allows fewer nutrients to be absorbed from food into your body (malabsorption effect). In addition, a change in the release of so-called gastrointestinal hormones occurs in the course of gastric sleeve surgery. These hormones are responsible for feelings of hunger and satiety and they influence the metabolism of food components.

After conventional gastric bypass surgery, on average a loss of about 75 % of the excess weight can be expected at one year after the operation. After five years, the average excess weight lost is just under 70 %.

There is an 8 – 9 % risk of complications occurring after laparoscopic gastric bypass surgery.

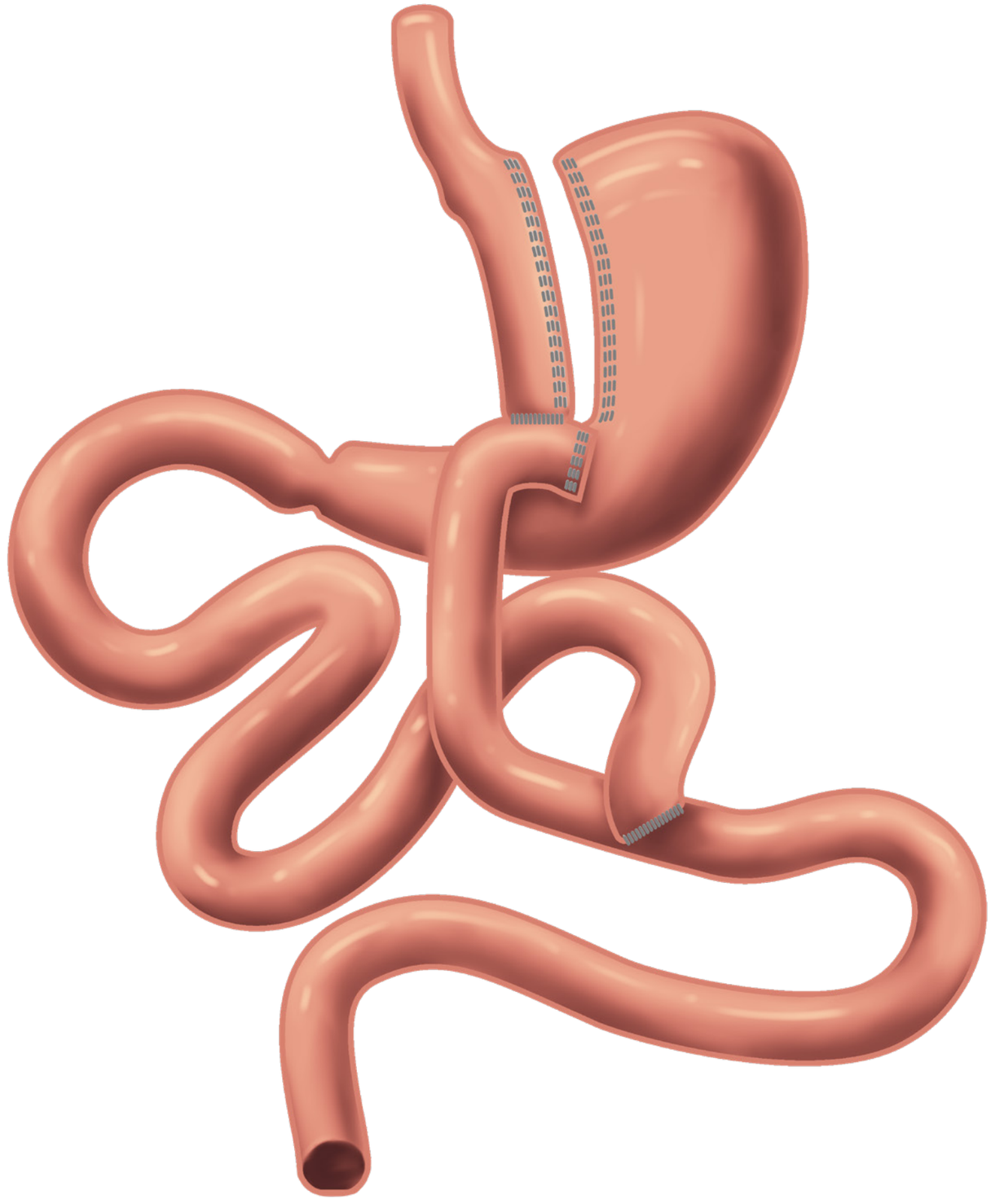
Possible surgical complications:

- Bleeding
- Leakage at the anastomosis (gastrointestinal suture) or staple line
- Intestinal obstruction due to narrowing

The following complications may occur over the medium and long term:

- Ulcer on the anastomosis (connection between the gastric pouch and intestine)
- Stenosis (narrowing) of the anastomosis (connection between the gastric pouch and intestine)
- Internal hernia (small intestine becomes trapped in the mesentery)
- Deficiency of protein, vitamins, trace elements and minerals is possible due to the complex changes in the digestive tract. For this reason, lifelong check-ups are necessary after surgery, as well as food supplementation if required.
- Consumption of rapidly digestible carbohydrates may cause so-called dumping syndrome with malaise, nausea/cramping/diarrhoea, palpitations, fall in blood pressure, sweating, tremor, dizziness and even collapse.

Anatomy BEFORE surgery



Anatomy AFTER Roux-en-Y gastric bypass surgery

Omega loop gastric bypass/ OLGB
(one-anastomosis gastric bypass/ OAGB, mini-bypass)

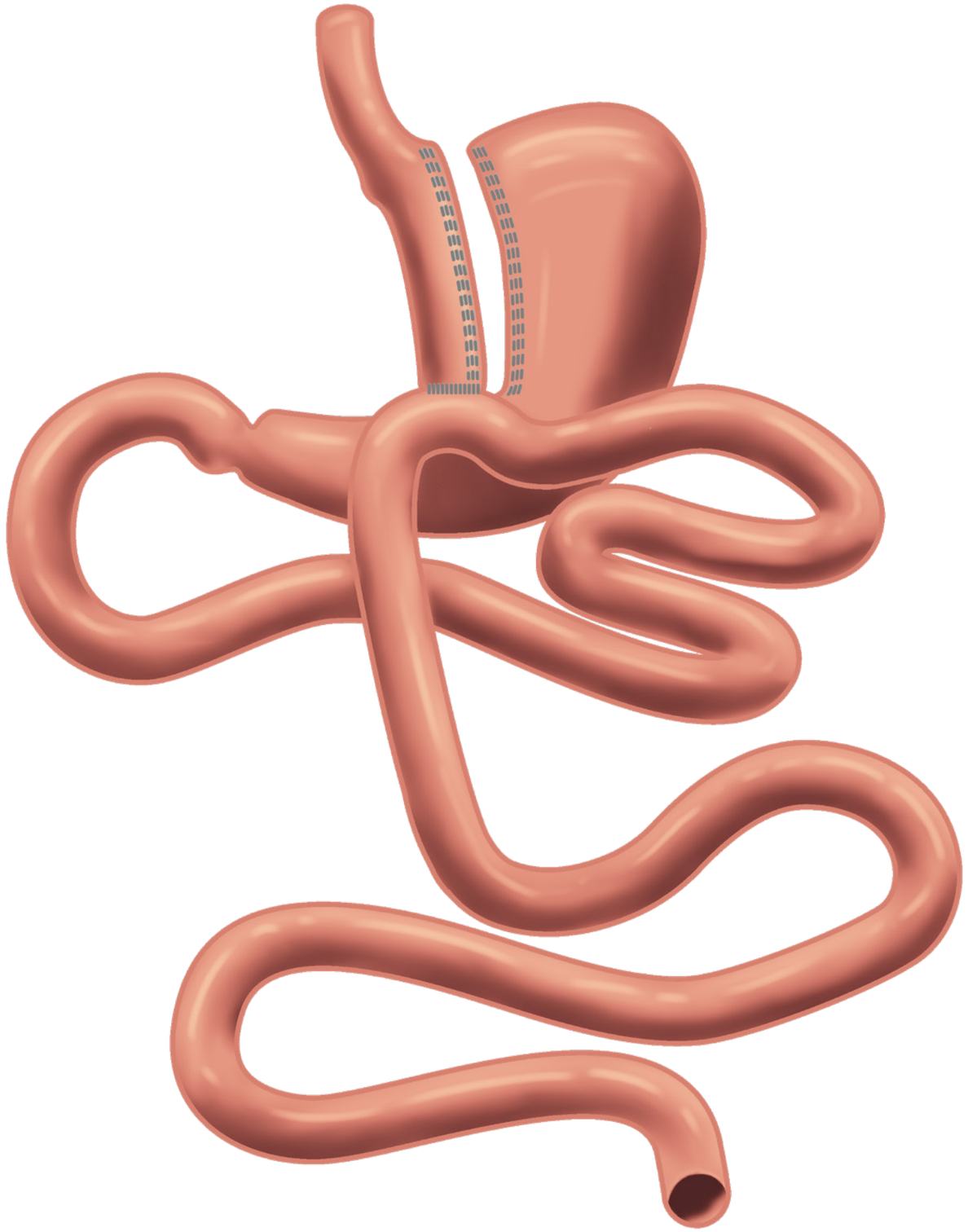
The omega loop gastric bypass is a variant of the conventional gastric bypass, in which only one anastomosis (= new connection) is necessary, namely the one between the gastric pouch and the small intestine.

In the omega loop gastric bypass, as in the conventional gastric bypass, the size of the stomach is drastically reduced and a gastric pouch with a filling volume of only 15 ml is created. The remaining stomach, the duodenum, and 180 to 200 cm of the small intestine are separated off from the tract through which food passes. Via the connection between the gastric pouch and the small intestine, the gastric contents come into delayed contact with the digestive juices (bile, pancreatic juice) (Fig. Omega loop gastric bypass surgery).

The mechanisms responsible for weight loss after an omega loop gastric bypass correspond to those after conventional gastric bypass surgery. The expected weight loss after an omega loop gastric bypass is comparable to that after conventional gastric bypass surgery and even tends to be somewhat greater.

The advantage of an omega loop gastric bypass is that the duration of the operation is shorter. The risk of surgical complications is 5 – 6 %, which is comparable, but with a tendency to be lower, to that with a conventional gastric bypass. Diarrhoea or fatty stools are somewhat more common after an omega loop gastric bypass than after conventional gastric bypass surgery.

Anatomy BEFORE surgery



Anatomy AFTER omega loop gastric bypass surgery

Sleeve
(Sleeve gastrectomy/SG, gastric sleeve, sleeve resection)

The size of the stomach is greatly reduced in gastric sleeve surgery. For this purpose, staplers are used to staple off and remove a large part of the stomach. The resulting shape of the remaining stomach is a long narrow tube with an inner diameter of about 1.5 cm (Fig. Sleeve resection).

Weight loss after gastric sleeve surgery is based on the fact that you can only take in very small quantities of food because the stomach filling volume is small. In addition, a change in the release of so-called gastrointestinal hormones occurs in the course of gastric sleeve surgery. These hormones are responsible for feelings of hunger and satiety and they influence the metabolism of food components.

About 70 % of the excess weight is lost on average at one year after gastric sleeve surgery. After five years, the loss is about 60 % of the excess weight.

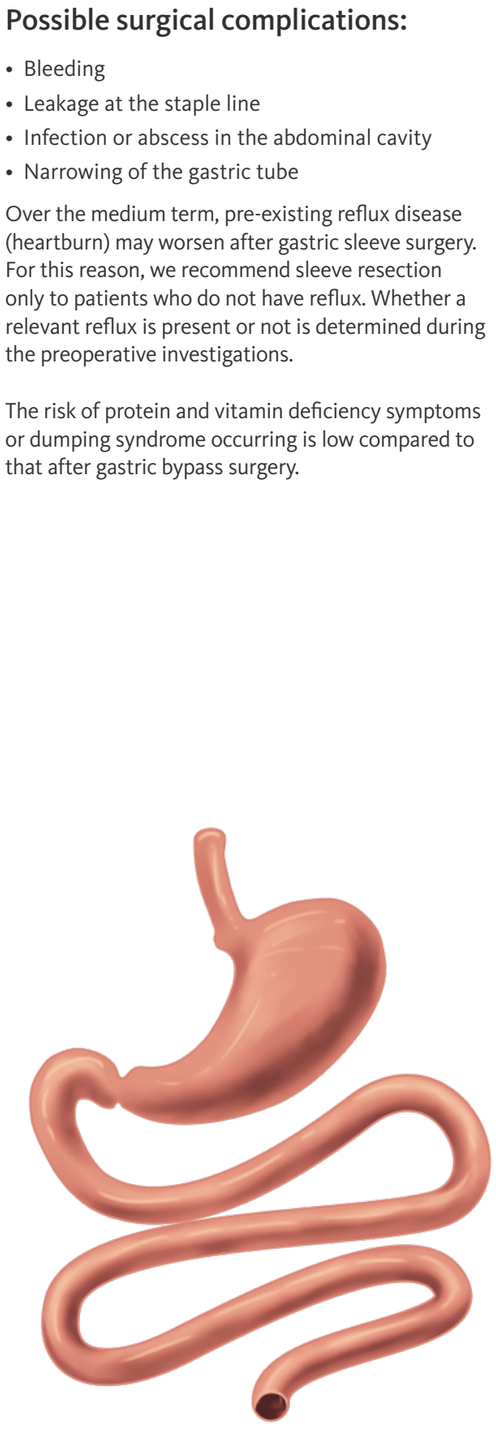
As with all surgery, laparoscopic sleeve resection is associated with a certain surgical risk. However, the overall risk of complications during surgery is low, about 5 %.

Possible surgical complications:

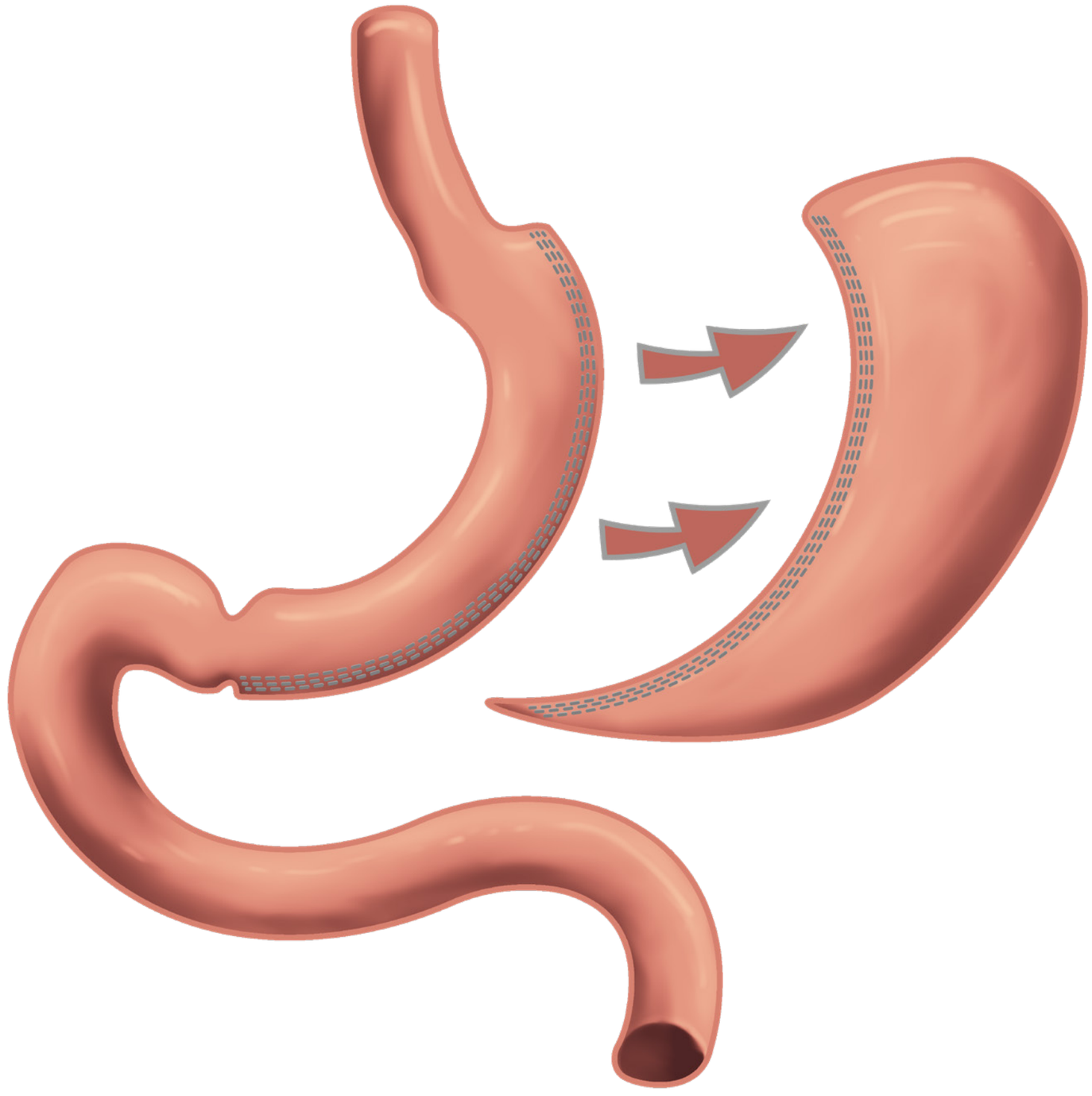
- Bleeding
- Leakage at the staple line
- Infection or abscess in the abdominal cavity
- Narrowing of the gastric tube

Over the medium term, pre-existing reflux disease (heartburn) may worsen after gastric sleeve surgery. For this reason, we recommend sleeve resection only to patients who do not have reflux. Whether a relevant reflux is present or not is determined during the preoperative investigations.

The risk of protein and vitamin deficiency symptoms or dumping syndrome occurring is low compared to that after gastric bypass surgery.



Anatomy BEFORE surgery



Anatomy AFTER sleeve resection

Metabolic surgery – the consequences

Changes in metabolism

The massive impact of bariatric surgery on digestion results in changes not only in body weight and appearance, but particularly also in metabolic parameters, i.e. in all the substances that can be measured in the blood.

These changes can affect blood glucose, blood lipids, vitamins, minerals and trace elements.

Blood glucose: It could be demonstrated in clinical studies that a reduction in excess weight resulting from the surgery is accompanied by an improvement in glucose metabolism. People who are severely obese run the risk of their body being unable to process glucose properly or of developing type 2 diabetes. This risk is particularly increased if, in addition to being severely obese, they have a poor diet and a sedentary lifestyle. Type 2 diabetes involves a deficiency of effective insulin, which is the substance that transports glucose from the blood into the cells of the body. This disease is characterised by increased blood glucose levels and long-term blood glucose levels (HbA1c). Bariatric surgery can cure type 2 diabetes in the majority (about 80 %) of patients.

Blood lipids: Elevated blood lipids (cholesterol, triglycerides, LDL-cholesterol) are common in severe obesity and are associated with an increased risk of heart or blood vessel disease. It was possible to demonstrate in clinical studies that, over time, bariatric surgery can have a positive effect on blood lipids and that the risk of heart disease (e.g. heart attack) decreases significantly.

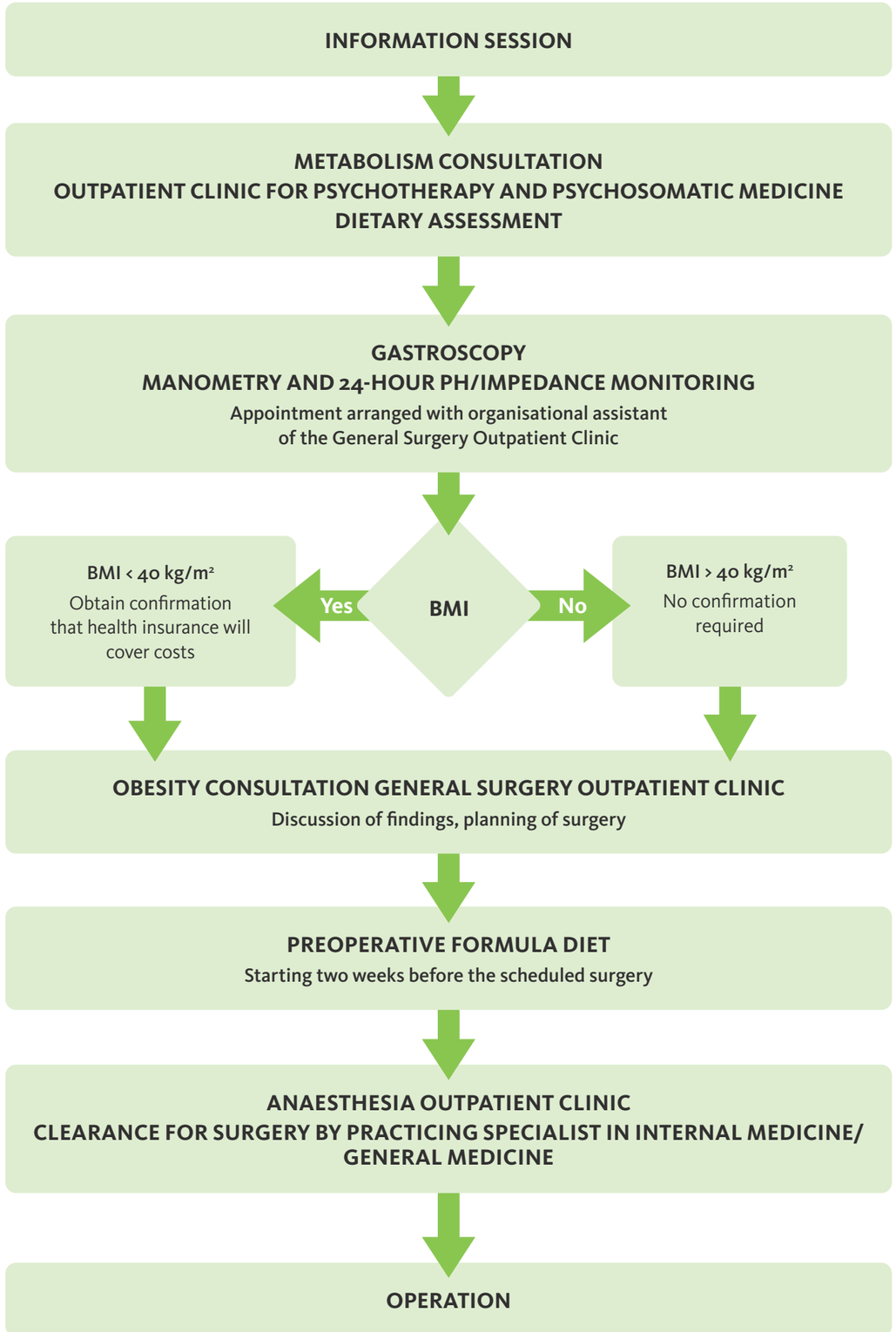
Vitamins: Since bariatric surgery deprives the intestine of valuable surface area through which it could absorb substances from food, the amount of vitamins entering the blood via the intestine also decreases. In particular, fat-soluble vitamins (A, D, E and K) are insufficiently absorbed. It is therefore recommended to integrate vitamins into the diet in a targeted manner or to take supplements. The following vitamins need to be supplemented:

- Vitamin A
- Vitamin D
- Vitamin E
- Vitamin K
- Vitamin B12
- Vitamin B1

Iron, minerals and trace elements:
Bariatric surgery also reduces the absorption of minerals, iron and trace elements. This can lead to anaemia or deterioration of the skin, nails and hair. Treatment with supplements as required may be necessary, especially with respect to iron, zinc, calcium and potassium.

Preoperative assessment

Before metabolic/bariatric surgery can be performed, you will have to undergo several investigations. These check whether surgery is suitable for you and whether the possible post-operative stresses and changes are acceptable for you.



Information session

During the information session you will receive comprehensive information about metabolic/ bariatric surgery. A representative of the treatment team will provide you with all relevant facts and information in the form of short presentations.

Metabolism consultation at the University Clinical Department I of Internal Medicine

Examination by a specialist during the metabolic consultation at the University Clinical Department I of Internal Medicine is an essential part of the assessment for metabolic/bariatric surgery. It will be determined whether any diseases or physical disorders are present that would prevent the surgery being performed. In addition, your blood glucose, blood lipids and blood pressure will be measured to determine whether and to what extent any other obesity-associated diseases (comorbidities) are also present. One or several blood samples will need to be taken and a physical examination will be performed for this purpose.

Outpatient Clinic for Psychotherapy and Psychosomatic Medicine of University Clinical Department II of Psychiatry

Your mental health will be investigated by means of questionnaires and a clinical interview. The goal is that you are not only physically fit for this surgery, but in a mentally stable and healthy state. The discussion will cover your current and past mental state, difficult life situations, your coping strategies, the importance of food and your body image and how you deal with them. You will be informed that the substantial weight loss from the surgery may not only have positive effects, but may possibly make you more sensitive and vulnerable, change the patterns of your relationships and might not always have a positive impact on how you perceive yourself. The aim of the psychosomatic examination is to assess how well you will be able to cope, in the context of your life, with the surgery and its consequences, which will demand a lot from you.

Dietary support

from Nutritional Medicine at the Dept. of Surgery of Innsbruck University Hospital

Metabolic surgery alone does not guarantee long-term weight loss. After metabolic surgery, a permanent change in drinking and eating habits is required together with regular meals. Unpleasant side effects may occur, particularly after gastric bypass surgery, such as fluctuations in blood glucose levels, digestive problems or deficiency symptoms. Several individual nutrition consultations will help you establish new eating habits.

Gastroscopy, manometry and 24-hour pH/impedance monitoring

at the University Clinical Department of Visceral, Transplant and Thoracic Surgery

The following investigations must be performed at the University Clinical Department of Visceral, Transplant and Thoracic Surgery in order to plan the surgery and select a suitable surgical method for you:

Gastroscopy

This refers to conventional examination of the stomach. A tube with a camera (endoscope) is inserted through your oesophagus into your stomach and the directly adjacent duodenum. This test allows a detailed examination of the oesophagus, stomach and duodenum. Any inflammation, ulcers or the presence of a diaphragmatic hernia can be assessed. In addition, samples of the mucous membrane can be collected and examined directly during the gastroscopy.

Manometry

This refers to measuring pressure in the oesophagus. A thin probe is inserted through your nose into your oesophagus and tests whether your oesophagus builds up orderly pressure waves, how strong these are and whether the oesophageal sphincter is functioning well. This examination provides information about the function and health of your oesophagus.

24-hour monitoring of impedance and pH

Similarly as for manometry, a thin probe is inserted through your nose into your oesophagus, where it is left for 24 hours. This probe measures whether and how often gastric juice flows from your stomach into your oesophagus and thus whether a so-called reflux is present.

You will receive appointments for the listed examinations from the organisation assistant at the General Surgery Outpatient Clinic.

Coverage of costs by health insurance

If your BMI (body mass index) is > 40 kg/m^2, the costs of bariatric/metabolic surgery are automatically covered by your health insurance fund. You do not need any confirmation from your health insurance fund.

If your BMI is between 35 and 40 kg/m^2 and you have an obesity-related comorbidity, your health insurance fund will also cover the costs of bariatric/metabolic surgery. However, in this case you must obtain written confirmation from your health insurance fund that it will cover the costs.

You apply for your health insurance fund to cover these costs by submitting the findings collected so far, particularly the doctor's letter from the metabolic consultation and also, if available, reports by specialistsmedical findings/expert opinions concerning your comorbidities (e.g. orthopaedics, pulmonology, gynaecology, psychiatry/psychology, etc.). Please bring the written confirmation of cost coverage to your appointment for an obesity consultation at the University Clinical Department of Visceral, Transplant and Thoracic Surgery.

Obesity consultation at the University Clinical Department of Visceral, Transplant and Thoracic Surgery

Once all investigations have been completed, we ask you to make an appointment for an obesity consultation at the University Clinical Department of Visceral, Transplant and Thoracic Surgery. We will discuss all the findings with you and together select the metabolic/bariatric surgery that is right for you. During a detailed discussion, we will answer any outstanding questions about the surgery and set a date for the operation.

Preoperative formula diet

Two weeks before the planned date of surgery, you will start nutritional therapy. For this, you will replace between one and a maximum three meals daily with a protein drink. This will shrink your liver (which is usually fatty if obesity is present), which will make the operation technically easier because the left lobe of the liver is located just in front of the stomach. This nutritional therapy also results in better medium and long-term outcomes of the surgery, with respect to both weight loss and comorbidities.

Anaesthesia Outpatient Clinic

One to two weeks before the planned date of surgery, your suitability for general anaesthesia will be investigated at the Anaesthesia Outpatient Clinic of the University Clinical Department of Anaesthesia and Intensive Medicine.

Clearance for surgery

One to two weeks before the planned date of surgery, you will have to make an appointment with a specialist in general or internal medicine to obtain clearance for surgery. This will usually involve a physical examination, collection of a blood sample, chest X-ray, ECG and lung function tests.

Metabolic surgery in adolescents and children

Morbid, i.e. pathological, obesity can occur already in childhood and adolescence. Metabolic surgery can be performed if the young people affected by this are extremely overweight, perhaps already have obesity-related comorbidities and have not managed to lose weight with conventional methods. The decision to perform gastric bypass or gastric sleeve surgery is made in close cooperation with the treating paediatrician. The involvement of parents or guardians in the treatment concept is of decisive importance for the success of metabolic surgery in adolescents.

Just as with adult patients, gastric bypass or gastric sleeve surgery requires changing eating habits and keeping to a diet plan. Lifelong regular check-ups are mandatory to ensure that there are no deficiencies of protein and certain vitamins and trace elements. Support and guidance from parents or guardians is particularly vital during childhood and adolescence.

Operation and hospital stay

You will be admitted to hospital on the day before the operation. The planned surgical procedure and associated risks will be discussed with you again during a detailed surgical briefing. It will be possible to clarify any outstanding questions. You must be in a fasting state from midnight in preparation for general anaesthesia.

On the day of surgery, you will be monitored in the ICU immediately after the operation. Depending on how quickly you recover from the anaesthesia and procedure, you will be transferred back to the regular ward on that same day or the next morning.

After the operation, you will first have to drink in sips. On the first day after the operation, you will receive liquid food, then on the second day you will receive mushy/pureed food. You will continue with this food for two weeks in total. While in hospital, you will also have another detailed nutritional/dietary consultation.

Discharge from hospital is usually possible three to five days after the operation.

Follow-up and aftercare

The first weeks at home

- The skin staples will be removed 10 days after the operation by a specialist in general medicine or at our outpatient clinic.
- You must go easy on physical activity during the first two weeks after the operation so that the wounds can heal properly. In particular, you must not lift or carry heavy things (> 5 kg).
- Thrombosis prophylaxis is necessary for a total of three weeks after the operation. You must self-administer the anti-thrombosis injections.
- You will have to take tablets (proton pump inhibitor) to protect your stomach lining for three months in total after the operation.
- In order to prevent gallstone formation, you will have to take a bile-thinning medicine for six months after the operation.
- In the first two weeks after the operation, you will have to eat only mushy/pureed food. After that, solid foods will again be possible.

Obligatory follow-up

Metabolic/bariatric surgery changes your life. These changes affect your weight, your blood test results, your comorbidities, your diet and your quality of life.

However, surgery alone does not guarantee success. Regular check-ups are necessary in order to achieve and maintain optimal weight loss and for the timely detection and treatment of potential malnutrition. These will continue for the rest of your life!

Aftercare after metabolic/bariatric surgery is therefore as least as important as the preoperative assessment and the operation itself.

Obesity consultation at the University Clinical Department of Visceral, Transplant and Thoracic Surgery

The first surgical check-up is planned to take place two months after the operation. Your food intake and digestive function will be discussed. The surgical wounds will be examined and any problems or pain will be addressed. Naturally we will also record the weight loss achieved so far.

The second surgical check-up will take place one year after the operation. Further or subsequent examinations may become necessary as required.

Metabolism consultation at the University Clinical Department I of Internal Medicine

Since metabolic/bariatric surgery may sometimes prevent you from being able to absorb all the substances present in food, deficiency diseases receive special attention. Therefore, your laboratory parameters must be checked regularly (blood glucose, blood lipids, proteins, vitamins and trace elements). Medical examinations are planned for three, six and twelve months after the operation. Annual check-ups are subsequently recommended for life. Depending on your laboratory test results and any deficiencies, additional tests may also be needed.

The dietary recommendations after metabolic/bariatric surgery and the associated drastic changes in eating habits are not always easy to implement. Dietary advice is also offered after surgery in order to ensure healthy eating habits, adequate fluid intake and an adequate supply of protein, vitamins and trace elements. Nutritional counselling will help you to become acquainted with the required diet plan.

Bariatric Aftercare Group

Three to six months after surgery, patients attend the aftercare group and meet with responsible persons from the Outpatient Clinic for Psychotherapy and Psychosomatic Medicine and the Dietetics Department. Doctors from the Department of Surgery and the Metabolism Clinic are also sometimes present. The purpose of this group is to let patients talk about their experiences after surgery: What goes well? What is difficult? Where are the problems? Since patients have in part the same experiences, there is usually a good exchange between patients (experiences and tips). If there are any questions, problems or complications, the team of doctors, psychologists and dietitians provide help or information.

Since most participants take much pride in their weight loss success, it is also a nice forum in which to talk about it to like-minded people. In addition, the treatment team obtains highly individualised information about the postoperative course, which enables the interdisciplinary care being offered to be constantly adjusted to the needs of patients.

Body-firming surgery

After massive weight loss, excess skin frequently remains on the abdomen, chest, upper arms, thighs, back and buttocks. Sagging skin in women can cause their breasts to lose substantial volume and become droopy. The massive quantity of excess skin can lead to recurrent skin irritation, mainly in the lower abdominal region. This saggy appearance usually is a source of psychological stress for patients. Our plastic surgeons can help by means of body-firming surgery.

In very severe cases, the health insurance fund will cover one operation in the upper body region and one in the lower body region. The decision on whether and what surgery can be covered rests ultimately with the treating doctors and requires approval from the chief medical officer at the health insurance fund.

The basic requirements for costs to be covered by health insurance funds is a body mass index below 30 or a loss of up to two thirds of the excess weight, as well as panniculus formation with recurrent symptoms or intertrigo (i.e. irritation and inflammation in skin folds). The weight that has been achieved must be maintained at a stable level for at least one year. After that, an initial appointment can take place at the Outpatient Clinic of the University Clinical Department for Plastic, Reconstructive and Aesthetic Surgery.

Many patients have lost weight after a gastric bypass or gastric reduction procedure. Before they undergo the operation, laboratory test results must be checked (in particular the blood count and levels of iron, minerals and vitamins) so as to allow for timely compensation of any potential deficiencies. These surgical procedures cannot be performed in heavy smokers or individuals with Hb levels below 10 g/dl.

Follow-up treatment

It is necessary to limit physical activity for six to eight weeks after body-firming surgery. Compression garments must be worn during this period. Heavy items must not be lifted. Sutures are usually removed two weeks after the operation. After that, the scars can come into contact with water again and need to be cared for through the application of fatty ointments. Sensitivity to touch may be reduced in the area where the skin has been tightened. The scars will show reddening in the first months and will need to be protected from the sun.

Interdisciplinary Workgroup for Bariatric Surgery

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Interdisciplinary Workgroup for Bariatric Surgery

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