



OAC News

The Obesity Action Coalition's Quarterly Newsletter

Weight-Loss Surgery — Treatment Options —

In this issue of *OAC News*, the Cover Story provides you with an in-depth explanation of the three most commonly selected weight-loss surgeries:

- **Roux-en-Y Gastric Bypass**
- **Laparoscopic Adjustable Gastric Banding**
- **Biliopancreatic Diversion with Duodenal Switch**

Weight-loss surgery, also commonly known as bariatric surgery, is a safe and effective treatment option for those affected by morbid obesity. Morbid obesity is de-

defined as having a body mass index (BMI) greater than 40, or weighing more than 100 pounds over ideal body weight. In addition, a patient with a BMI greater than 35 with one or more obesity-related diseases is classified as morbidly obese.

There is a great amount of importance and responsibility associated with choosing a weight-loss treatment option. Weight-loss surgery is one of the most commonly chosen and performed treatment options for morbid obesity; however, choosing which surgery is right for you can be a difficult task. This article will provide you with the education needed for you and your physician to make the appropriate treatment selection. Consult your physician and insurance provider to see if you are a candidate.

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Remember, weight-loss surgery is not the “easy way out.” This treatment option is a tool that you will continually use to lose weight. Surgery is a resource to help you reduce

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A Message from President and CEO, Joseph Nadglowski, Jr.

This, the fourth issue of *OAC News*, marks the one year anniversary of the Obesity Action Coalition. It was only a short time ago that a

legislator pointed out the need for a group that represents those affected by obesity and I am proud to say the OAC exists today to fill that role.

As we step into our second year of operation, I would like to take the opportunity to thank all of those who have made the OAC a reality. The OAC exists and flourishes today because of the hard work and support of our Board members, volunteers, sponsors, staff and members.

If you are reading this message and have not yet joined as a member, I strongly encourage you to do so. Not only will you receive access to our educational and advocacy materials, but you will also lend your support to our efforts. If you are already a member, help spread the word by encouraging others to join. Remember, the larger our numbers the stronger our voice.

One major issue that the OAC continues to receive questions about is Medicare's new rules regarding bariatric surgery. If you have been impacted by the new rules, either positively or negatively, I strongly urge

you to contact the OAC to share your experience. More information on this request can be found on page 18.

As always, if you have any questions about any of the OAC's activities, please do not hesitate to contact our National office at (800) 717-3117 or info@obesityaction.org. Thank you!

Sincerely,

MEMBERSHIP

Membership in the OAC is important in helping those affected by obesity educate themselves about obesity and advocate for access to treatment. Whether a patient, family member, friend, professional or organization, the greater our membership the stronger our voice!

To join, please see page 23 for a membership application. For more information, call (800) 717-3117.



a National Board of Directors. Members of the OAC Board of Directors include: Robin Blackstone, MD, Jim Fivecoat, Julie M. Hill-Janeway, Georgeann Mallory, RD, Paulette Massari, LCSW, CAP, CS, Melissa Parish, Christopher Still, DO, FACN, FACP and Barbara Thompson, MLS.

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Obesity Action Coalition
4511 North Himes Avenue, Suite 250
Tampa, FL 33614
(800) 717-3117
Fax: (813) 873-7838
www.obesityaction.org
info@obesityaction.org

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If you are interested in contributing to this publication, or for reprint requests, please contact the OAC National Office.

The **Obesity Action Coalition (OAC)** is an independent national non-profit patient organization dedicated to educating and advocating for those affected by obesity.

The mission of the OAC is to elevate and empower those affected by obesity through education, advocacy and support.

The OAC is governed under the authority of

Cardiovascular Disease

Obesity and the Heart

By John A. Batsis, MD

According to the most recent National Health and Nutrition Examination survey (NHANES III), the prevalence of obesity in the American population increased from 23 percent in 1976-1980, to 30 percent in 1999-2000. The risk of both medical and surgical illnesses increases with the magnitude of body mass index (BMI), a measurement of weight in relation to height. As BMI increases, the risk of cardiovascular diseases increases as well.

Obesity – the “New” Cardiovascular Risk Factor

In 1997, the American Heart Association (AHA) acknowledged that obesity was an independent modifiable cardiovascular risk factor [1]. Studies suggest, patients with BMIs greater than 30 have significantly shorter life spans than those who are not obese [2,3]. Excess weight, especially central or abdominal obesity, significantly increases the risk for heart disease.

Other Cardiovascular Risk Factors

The association of obesity with cardiovascular risk factors, such as high blood pressure, high cholesterol and diabetes, has been well established. These modifiable risk factors are influenced by the amount of weight gained and lost. Each risk factor independently increases the likelihood of developing coronary artery disease, and subsequent chance of suffering a heart attack, stroke or peripheral vascular disease.

Lifestyle modifications, including diet and exercise, along with medications in some cases, are known to control such factors. Other modifiable cardiovascular risk factors include smoking and physical inactivity. Smoking has been implicated in a variety of disease states. It is especially important for obese patients who smoke to find a means to quit, as their cardiac

risk is often escalated beyond that of a non-obese patient.

Non-modifiable risk factors are ones that patients cannot change, including age, family history or race. The AHA places males at higher risk for heart disease who are 45 years of age and older, and females who are 55 years of age and older. Family history may be important, especially in younger patients. Those with family members who have had a history of an early heart attack (before age 50) would be at a higher risk.

Obesity and the Effect on the Heart

Obesity can lead to a variety of other cardiac problems. In a sub-analysis of the Framingham data, the risk of developing heart failure was twice as high in patients with a BMI greater than 30 as compared to non-obese patients, independent of other co-morbidities. This may be due to a variety of physiological changes occurring in the heart, including an increase in the circulating blood volume and flow, which may lead to fluid retention. This can subsequently cause the heart to undergo volume overload, putting further strains on its capacity to work.

Excess weight causes an increased strain on the body requiring a greater cardiac workload at a given level of activity compared to non-obese individuals. When coupled with hypertension, left ventricular enlargement and hypertrophy may occur, a condition where the left side of the heart is thickened and enlarged. This is also known to increase patients' risk of heart failure, produce irregular and fatal heart rhythms and lead to heart attacks or sudden death.

Adipose tissue (loose connective tissue) pro-

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Obesity-Related Diseases

Cardiovascular continued from page 3

motes the development of atherosclerosis. This is a hardening of the arteries believed to be an inflammatory disorder. Leptin is a hormone produced from excessive adipose tissue and “turns-on” inflammatory systems, accelerating coronary atherosclerosis, and inducing insulin resistance. This process can damage heart cells, inevitably leading to replacement of healthy heart cells by fatty cells. The implications of this are profound, leading to deadly rhythm disturbances.

Another well documented complication of obesity is sleep apnea. Symptoms include a complaint of daytime sleepiness, snoring at night and instances where patients may “stop” breathing. This disease has significant consequences to the heart and places patients at higher risk for heart failure, high blood pressure and sudden rhythm disturbances.

Bariatric Surgery and Cardiovascular Risk

The American College of Cardiology (ACC) and AHA have outlined that weight-loss is of paramount importance in the prevention of heart disease, but also in those who have suffered a cardiac event. Bariatric surgery is

known to induce a profound weight-loss, which itself will lead to decreased resting metabolic demand and blood volume. As such, blood pressure is likely to fall, and the work exerted by the heart is likely to be reduced. Weight-loss can reduce the progression of left ventricular hypertrophy and size, and perhaps even promote its regression.

Most studies examining outcomes of weight-loss surgeries concentrate on surgical outcomes and very few examine the observed changes in cardiovascular risk factors. The largest prospective study, the Swedish Obesity Study (SOS), has shown significant improvements in hypertension, hyperlipidemia and diabetes amongst patients treated with gastric banding procedures or biliopancreatic diversion. Our group has recently presented results showing significant improvements of weight, blood pressure, lipid profiles and diabetes, with a decreased usage of medications, in obese patients treated with a Roux-en-Y procedure, compared to patients managed in a traditional weight-reduction program. Although follow-up lasted approximately three and a half years, further follow-up is required to better characterize the stability of the improvement of such factors [6].

Benefits of Weight-Loss on Cardiovascular Health

There have been a multitude of studies that have determined that weight-loss can provide a beneficial effect on a number of cardiovascular risk factors.

Although there is little if any literature available which demonstrates that voluntary weight-loss affects total mortality or cardiovascular disease, control of such variables will have beneficial effects on long-term outcomes.

Behavioral modification in the form of diet and exercise is required in all obese patients. Die-

tary modification leading to weight reduction has been well established in reducing the LDL (bad cholesterol), with related increases in HDL (good cholesterol). Furthermore, weight-loss can be sustained by regular exercise.

Small degrees of weight-loss of five to 10 percent have remarkable effects on lowering blood pressure improving lipid profiles. Substantial weight-loss is known to improve insulin sensitivity and leads to improvement in diabetes.

Even in patients with pre-existing heart disease, bariatric surgery has been shown to be a relatively safe and effective procedure. In a study published by our group in 2005, there were no differences in mortality or cardiac events between patients who were classified as having coronary artery disease (CAD) and those who were free of CAD [7]. This has profound implications for obese patients, who are inherently at a higher pre-operative risk to begin with, who may in turn have been candidates for bariatric surgery but may have not been identified early enough. There is very little long-term data examining the outcomes of bariatric surgery on patients with pre-existing heart disease.

With reduction in cardiovascular risk factors, one would expect improvements of cardiovascular risk; how-

ever, there is no data presently examining prospective cardiovascular events in patients who have undergone surgery. Further data is still needed prior to concluding that bariatric surgery would definitively improve long-term cardiovascular outcomes.

Conclusions

There appears to be an explosion of clinical research in examining the outcomes following bariatric surgery in the past few years. It is well established that obese patients are at significantly higher risk for heart disease and will inevitably have a shorter life expectancy than non-obese individuals. Studies have shown that medication costs, outpatient and hospital visits are higher in those with a higher BMI. This has profound implications on our society as a whole. Current estimates predict that obesity accounts for roughly \$140 billion / year.

In patients who meet appropriate criteria, bariatric surgery leads to sustained long-term weight reduction, with improvements in the management of high blood pressure, diabetes and high cholesterol. These near-resolutions in patients' cardiovascular risk factors are likely to result in a significant reduction in patients' predicted cardiac risk, with a decline in health-care utilization. However, prospective long-term studies examining the Roux-en-Y procedure are needed to determine if resolution of such factors persist and whether the number of cardiac events and deaths actually correspond to those projected in risk-estimates.

About the Author:

John A. Batsis, MD, is a researcher at the Mayo Clinic in Rochester, Minnesota.

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About the OAC Chairman's Council:

The Chairman's Council is the OAC's most prestigious membership level. The Chairman's Council is designed to allow individuals, companies and organizations to join at a higher level of commitment and is accompanied with several exclusive benefits.

A minimum annual gift of \$1,000 automatically entitles you to membership in the Council. To learn more, please contact the OAC National Office at (800) 717-3117.



If you become a candidate for bariatric surgery, you will likely be referred for evaluation and consultation with a psychologist. Although this may seem surprising to you, it has become a routine part of your preparation for surgery. Your follow-up care will be provided by a team of professionals and each of them, including a dietitian, exercise therapist and psychologist, will need to become more familiar with you and your individual situation and needs.

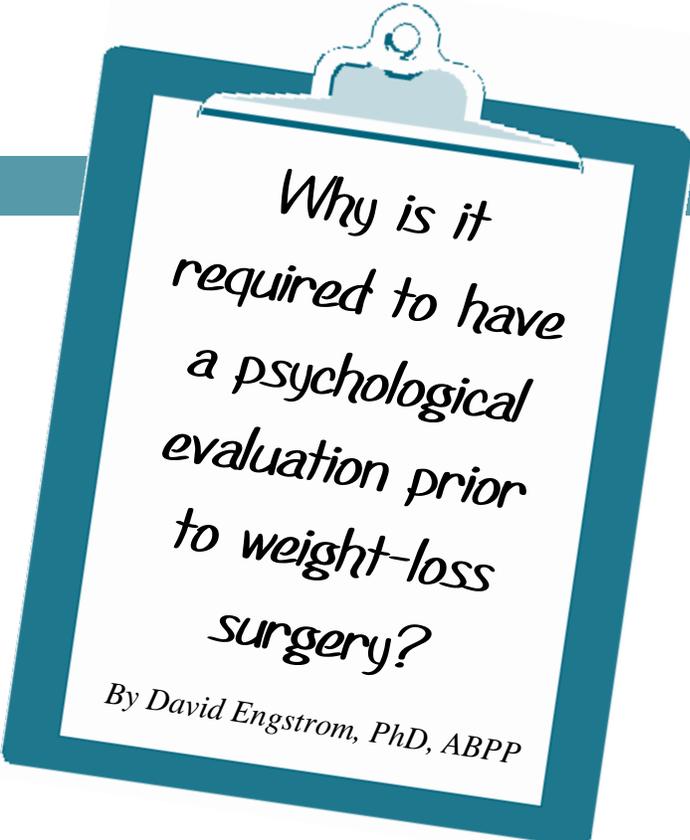
People sometimes say, “Why do I have to see a psychologist?”

There are two very good reasons for this evaluation. First, many insurance companies realize its importance and require a psychological evaluation before they will approve bariatric surgery. More importantly, your entire surgery team of physicians, nurses and dietitians want you to maximize your success – to lose excess body weight, become a healthier person and improve the quality of your life to the greatest possible extent.

The psychological evaluation can help identify your strengths, such as a strong motivation to exercise as your weight is coming off, a complete understanding of the effects of surgery or a supportive marital relationship. It can also help find areas where you might need support after surgery, such as depression or mood swings, lack of family support or triggers for past emotional eating.

The thought enters some people’s minds, “Do they think I’m crazy?”

It is important for you to understand that people with obesity are usually psychologically normal and do not fit any specific psychological profile. The psychologist’s main purpose is not to find underlying problems and



*Why is it
required to have
a psychological
evaluation prior
to weight-loss
surgery?*

By David Engstrom, PhD, ABPP

conflicts that might have caused you to become obese. Most psychologists who perform these evaluations specialize in health psychology, and as such, are looking for ways to help you prevent disease and promote health in the future. The psychologist’s purpose is never to “fail” people and exclude them from surgery. In fact, studies have shown that a very small number (perhaps four percent) of individuals are found to be poor candidates based on their psychological evaluation results.

Weight-loss surgery is by far the most successful treatment method for people with morbid obesity, where the body mass index (BMI) approaches 40 or greater. There is really no specific personality pattern that predicts success or failure after surgery. Many studies have examined depression, bipolar illness, history of childhood sexual abuse and even severe mental illness or eating disorder as potential predictors of failure to reach weight-loss goals after surgery.

Results have shown no clear-cut predictors of failure. As an example, about 40 percent of candidates for bariatric surgery have a history of depression. Often, the depression is being treated with medication and/or counseling and is well controlled. This situation almost never presents a problem after surgery.

There are, however, behavior patterns which suggest greater need for follow-up after your surgery. For example, grazing, or non-mindful snacking and nibbling on

high-calorie foods between meals can be a problem if not identified and stopped once you have had surgery. It is a pattern that significantly reduces your chances of success.

Your evaluation will probably include psychological testing, such as personality tests, mood inventories and other questionnaires. This paperwork is often completed before meeting with the psychologist. You will also have a face-to-face interview, usually scheduled for about an hour.

It is often suggested that you bring a family member or close friend along to the interview if possible, since it is important to know that you have good family and social support. Results of the testing are usually discussed during this time, and the psychologist will want to know about your family and social history, any medical or psychological concerns you may have and your reasons and motivation for seeking the surgery. You will also be asked about your past and present eating patterns, your level of activity and exercise and your current family and social situation.

The psychologist can often answer questions you might have. For instance, some people are fearful of the surgery itself and may be able to benefit from stress management techniques. There is evidence that people who are relaxed prior to many types of surgery not only heal faster, but also have less post-operative pain. The psychologist may be able to guide you toward techniques which may help with this.



The psychological evaluation can help identify your strengths, such as a strong motivation to exercise as your weight is coming off, a complete understanding of the effects of surgery or a supportive marital relationship.

Others may be concerned about future feelings of “deprivation,” such as not being able to eat their favorite rich, high-calorie foods after surgery. The psychologist will help you to understand that these feelings, if they occur at all, will usually be short-lived. And, if you feel the need for a referral for counseling, please feel free to ask. Just remember, the psychologist is part of your “safety net” after your surgery whose primary focus is your ultimate success.

About the Author:

David Engstrom, PhD, ABPP, is a clinical health psychologist, board certified in Clinical Psychology. He practices in Scottsdale, Arizona and is a psychologist at Scottsdale Bariatric Center. An active member of the American Society for Bariatric Surgery and is a specialist in applying mindfulness techniques to long-term weight management. Dr. Engstrom currently serves on the OAC Advisory Board.

Calling all Walkers! Participate in the Annual Walk from Obesity

This year on Saturday, September 30, the American Society for Bariatric Surgery (ASBS) Foundation will host a walk across the United States benefiting those affected by obesity. The walk, titled “**Walk from Obesity**,” will raise funds for research, educate the public about obesity, address legislators about access to care issues and much more.

According to the ASBS, the walk was established to give hope to those needing it most. Walkers raise money by asking friends, family and co-workers to sponsor them. In addition to walker income, funds are raised through sponsorship, matching gifts, corporate

contributions and other fund-raising activities.

The funds raised through this event will support the ASBS Foundation's educational mission by:

- Increasing research funding specifically for morbid obesity
- Improving obesity awareness and reducing its associated discrimination



Walk from Obesity continued on page 23

Support Groups



Educating, Motivating and Celebrating Weight-Loss Surgery Patients

By Colleen Cook

From the “Do I have to go?” to the “I can’t wait until next month” attitude, feelings about bariatric support groups are as diverse as the groups themselves. At any one of the thousands of bariatric support group meetings held each month, you will find that those in attendance include:

- Weight-loss surgery investigators seeking information and the “real story”
- Anxious pre-op patients waiting for surgery
- Early post-op patients or “newbies”
- Long-term veteran patients checking in
- Back on trackers seeking to re-lose pounds
- Friends and family members
- Volunteers
- Professionals

Each person is there for a different reason, with different needs and doesn’t it make you wonder, “What is it that draws these people together? Why do they come?”

Our experience with thousands of weight-loss surgery patients and hundreds of support groups has provided us some valuable insight into why people attend support groups, how they are benefiting and why those who are not attending should. Here are just a few of the benefits that we identified:

Validation: From my own experience, I recall the weeks prior to my surgery were a time of great trepidation; a time full of questions.

For instance, I remember thinking:

- “Am I doing the right thing?”
- “Will I be ok?”
- “Will I succeed?”
- “Is it worth the risk?”

As many do, I turned to a bariatric support group to find not only answers to my practical questions, but also for validation for my decision to have weight-loss surgery. While each must find his or her answers to these questions and come to feel good about their choices, support groups can help provide insight, perspective and real world experiences from those who have been there and now are able to share their perspective.

Education: Quality support groups provide more than just social and emotional support. They provide a wonderful opportunity for learning. Some groups provide a more structured agenda, featuring scheduled topic presentations and discussions. Others enjoy participatory activities designed to reinforce key principles of success and help patients learn concepts sometimes difficult for lay people to grasp.

Many groups often invite guest speakers. Some are bariatric professionals like dietitians, psychologists and fitness instructors. Other guests provide presentations on topics like grooming, dating and cooking. All are designed to educate, inform and provide a well-rounded foundation of knowledge for long-term success.

Motivation: There is a wonderful story told of a young mother wanting to have her little boy learn to play the piano. He was taking lessons and she was just sure that he would become a famous pianist. She made arrangements for him to go to Carnegie Hall to see the Master Ignacy Paderewski play.

She dressed-up her son in his little suit and took him to the concert. They found their seats, settled down real close to the stage, and the mother turned around and saw a friend of hers and started talking. When she turned back around the little boy was gone, and she panicked immediately. “Where did he go? Oh, no!” Moments later, she noticed her son up on the stage, at the grand piano on Carnegie Hall, playing “Twinkle, Twinkle Little Star.” He had just learned the song. The audience was aghast – “Somebody stop him!” “That is awful!” “Somebody get him down from there!”

From the back of the room came the Master Ignacy Paderewski at a dead run, down through the aisle, up onto the stage, and behind the little boy. He began playing an accompanying melody to the little boy’s song and as he did, he encouraged, saying, “Don’t stop, keep going, you’re doing fine.”

As weight-loss surgery patients, we sometimes feel alone and misunderstood in the real world. It is so very important to surround ourselves with people who understand our decision to have weight-loss surgery and what it is like to deal with the many physical, emotional and relationship changes that we experience throughout our journey.

Support groups are a place to find people who provide

us with understanding, compassion and encouragement.

Celebration: As pounds come off, health is restored and dreams come true. It is a wonderful thing to have an opportunity to share successes with others. Support groups provide just such a place. Whether formally or informally, comments like these abound: “I am half the woman I used to be!” “I can cross my legs!” “They didn’t even recognize me!”

What an exciting time for weight-loss surgery patients. Support groups provide patients a time to share their success; to have a moment in the sun, to be queen or king of the prom, to graduate, or to receive a personal recognition for their achievement with a pin, photo or certificate.

Rededication: The first few years following weight-loss surgery are awesome, but there comes a time when we reach what I call, “the end of invincible.” It is not uncommon for patients to slip back into old habits, regain a few pounds and become discouraged. When and if that happens, support groups become an even more important connection to help stay focused, in control and successful. A monthly weigh-in or check-in at a support group meeting provides an important element of accountability and an opportunity to reconnect and rededicate ones self to long-term goals.

So, if you need to be educated, motivated, celebrated or rededicated, you will find it all at a quality support group meeting. For meetings in your area, refer to the International Support Group Registry online at www.bariatricsupportcenter.com, in WLS Lifestyles Magazine Publications, or on the OAC Web site at www.obesityaction.org.



About the Author:

Colleen Cook is a speaker, author and President of Bariatric Support Center International (BSCI), a company that specializes in providing long-term education and support for weight-loss surgery patients and professionals. For more information on BSCI or for the International Support Group Registry visit www.bariatricsupportcenter.com.

A FAMILY EFFORT

By James Zervios, OAC Director of Communications

"ΤΡΟΦΙΜΑ ΕΤΟΙΜΟ."

"ΕΛΛΑ ΝΑ ΦΑΜΑΙ."

If you can read the words above, then you know that "the food is ready" and "let's eat."

You would also be able to read Greek.

For Eva Samartzis, these are words that she heard growing up. Now, I know what most of you are thinking, "Hey, we all heard that growing up," but in certain cultures there is a greater emphasis on those simple statements.

In Eva's culture, these words were often said at any time of the day. In fact, they're said in the morning, afternoon, evening, when friends or family visit, when the kids do something rewarding, just because, etc.

It is not uncommon for the Mediterranean culture to center everything, especially family, around food. Coming from a time when not eating all the food on your plate was a bad thing, instead of stopping when you were full, Eva and her family knew they had to change their ways.

For 20 years, Eva said she dieted with little or no results. "I tried Medi-Fast, Weight Watchers, you know

all the popular ones, but I never saw any weight come off," said Eva. Here and there she would lose some weight. At times, maybe she would lose 15 pounds, but then she said she would just put 20 back on again.

In 2005, depressed and down on herself, Eva knew she had to do something about the weight. "I felt that inside I was sad. I was depressed. I would go to Europe for a vacation and people would say, 'You live in America. Why are you fat? You have the best doctors and medicine.' They never took the time to realize they were hurting me with the comments," said Eva.

In addition to the emotional stress and comments, Eva was also experiencing physical pain from arthritis. "My knees really hurt me. In 2005, I had a knee replacement, but my feet still hurt me. Also, my blood pressure was very high," said Eva.

Between the hurtful remarks, arthritis and high blood pressure, Eva was about to make a change in her life. Not too far back, a relative of hers had gastric bypass surgery to lose weight. "I went to my cousin's wife and asked her about the surgery. She said she was doing well with it and it made me curious," laughed Eva.

After attending a weight-loss surgery seminar in White-stone, NY, Eva made an appointment with a bariatric surgeon to see if this was right for her.

On January 10, 2006, Eva underwent gastric bypass surgery. "I decided to do it. My insurance covered it and I knew this would be best for me," said Eva.

"I was never a big eater, but I guess what I ate, Spanakopita (Greek spinach pie), Baklava (Greek pastry), etc. was not good for me. I am not a big meat eater. I like vegetables, cheeses and soups," said Eva.

Today, Eva feels that she really hasn't had to adjust too much to new eating habits. She watches what she eats, but says that having to be on a liquid diet for the first few weeks was difficult.

Not long after her surgery, Eva's daughter, Pauline, also decided to have gastric bypass surgery. "My daughter said she wanted the surgery, and I told her that it's been great for me. She felt confident in me and decided to have it done," said Eva. Her surgery was successful; however, she did have heart palpitations due to rapid weight-loss. Pauline was losing up to 20 pounds per-week. "She's doing great and it's a big help for her and I both to have each other," said Eva.

You could hear a sense of comfort in Eva's voice. One of the biggest parts of post-operative care is support.

Coming from a time when not eating all the food on your plate was a bad thing, instead of stopping when you were full, Eva and her family knew they had to change their ways.

Many patients join support groups and find them extremely beneficial. For Eva and Pauline, this was the perfect form of support.

"I like having her there for me. We both share tips on foods to eat and help each other if we need it. For one month, I didn't lose any weight and it bothered me. It was nice to have that support system there. Along with Pauline, my husband Tony has also been great to me. He always helps me," said Eva.

Today, Eva has lost more than 50 pounds and continues to be successful with her surgery. "I feel great. I have more energy and if anyone asked me if they should do this, I would say definitely YES," proudly said Eva.

For Eva, Pauline and Tony, it truly is a "Family Effort," or "Oikogeneia Prospatheia."



Above, Eva (pre-op) poses with her daughter, Pauline, while celebrating

Right, Eva (5 months post-op) smiles for the camera at a Greek festival



Cover Story continued from page 1

your weight. Behavioral, physical and psychological changes are required for you to maintain a healthy quality of life. Continued positive weight-loss relies upon your desire and dedication to change your lifestyle with a proactive approach.

In the Cover Story, you will see terms, such as “Malabsorptive” and “Open,” that you may not be familiar with. Prior to reading about the different surgeries, we have provided you with a brief description of some of the most commonly used terms.

Open vs. Laparoscopic

In each section, you will see the surgeries described as being performed “Open” or “Laparoscopic.” Although laparoscopic has increasingly gained in popularity and frequency, “Open” is also still commonly used in practice today.

“Open” – The Open approach procedure involves a long incision that opens the abdomen, which provides the surgeon access.

“Laparoscopic” – In Laparoscopic surgery, a small video camera is inserted into the abdomen allowing the surgeon to conduct and view the process on a video monitor. Both camera and surgical instruments are inserted through small incisions made in the abdominal wall.

Malabsorptive vs. Restrictive

Throughout the Cover Story, the surgeries will be described as “Malabsorptive” or “Restrictive.” Depending on the type of procedure that is determined to be best for your needs, each form requires different lifestyle changes.

“Malabsorptive” – Malabsorptive procedures alter digestion, thus causing the food to be poorly digested and incompletely absorbed.

“Restrictive” – Restrictive procedures decrease food intake by creating a small upper stomach pouch to limit food intake.

In addition to these terms, there may be other words, topics or descriptions that you might not understand. If so, make sure to speak with your physician further to gain a better understanding. Also, feel free to visit the OAC Web site at www.obesityaction.org for more information on weight-loss surgery.

Weight-Loss Treatment Options

As you begin reading, remember, weight-loss surgery is a tool to help you lose weight. As weight-loss surgery is a commitment for life, it is imperative that you educate yourself about your treatment choice and have the appropriate support system in place to help you with your journey ahead.

About the Authors of the Cover Story:

Robin Blackstone, MD, FACS, is a practicing bariatric surgeon from Scottsdale, Arizona. Dr. Blackstone established the Scottsdale Bariatric Center. She is also the Vice Chairman of the Surgical Review Corporation, Center Review Committee. Dr. Blackstone is a member of the OAC Board of Directors.

Melissa Davis, RN MSN, APRN, BC, NP-C, CNS, is a nurse practitioner, clinical nurse specialist, and registered nurse first assistant at the Scottsdale Bariatric Center, Scottsdale Arizona.

Lloyd Stegemann, MD, is a private practice bariatric surgeon with New Dimensions Weight Loss Surgery/Weight Wise in San Antonio, TX. He was the driving force behind the Texas

Weight Loss Surgery Summit and in the formation of the Texas Association of Bariatric Surgeons (TABS) where he currently serves as President. He has been very active in the Texas state legislature trying to increase patient access to weight-loss surgery. Dr. Stegemann is a member of the American Society of Bariatric Surgery (ASBS) and the OAC Advisory Board.

Debra Salvatore, RN, BS, CNOR, CFN, is the Director of Bariatric Services at North Oakland Medical Centers in Pontiac, Michigan. She continues to work in both fields of nursing. She was the Surgical Education Coordinator for six years at NOMC prior to becoming an administrator. She is a member of the OAC Advisory Board.

Gastric Bypass Roux-en-Y

By Robin Blackstone, MD, FACS, and
Melissa Davis, RN, MSN, ANP, APRN-BC, CNS

Worldwide, the gastric bypass Roux-en-Y is the most frequently performed obesity operation and accounts for 85 percent of all bariatric surgery in the United States.

It is unique in that it is the first of the gastric procedures for morbid obesity to combine restriction with malabsorption. Also, there is an element of intolerance for many patients. These three elements are what make the gastric bypass Roux-en-Y so popular and effective in creating a tool for successful, long-term weight-loss, and resolution of the co-morbidities associated with morbid obesity.

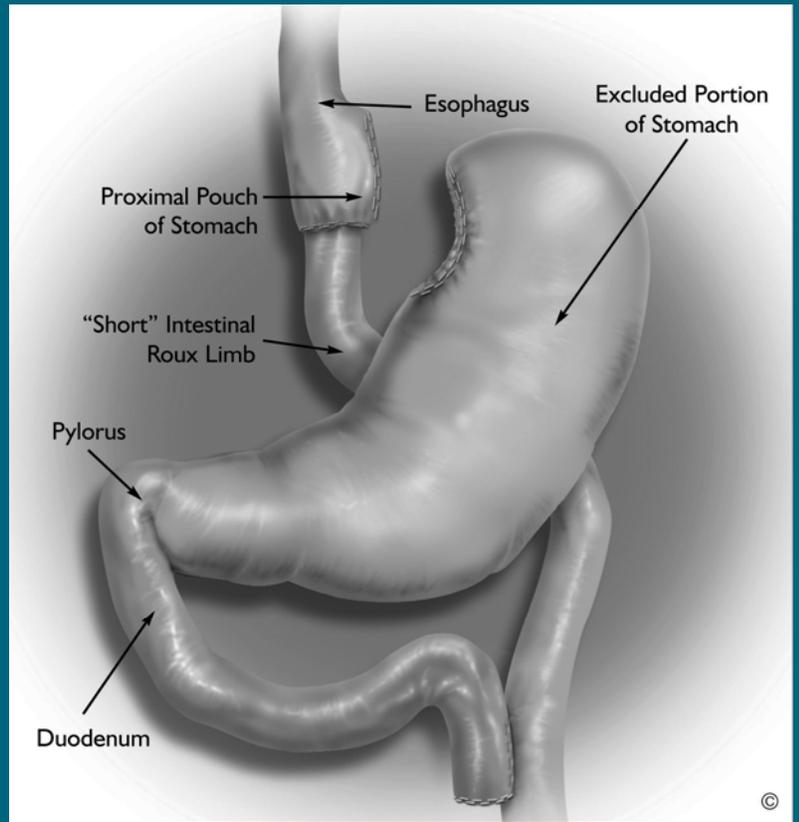
The gastric bypass Roux-en-Y can be performed by both open and laparoscopic techniques. It has been argued that there are advantages to both approaches, but these advantages seem to be related to the surgeon's capabilities and skill sets, and not the patient's recovery, surgical outcomes or resolution of co-morbidities. In the U.S., the laparoscopic technique has become the more popular approach by patients and competent surgeons, as recovery is quicker and post-operative wound healing complications are significantly reduced.

The gastric bypass Roux-en-Y surgery itself can be described in three significant steps. Each of these steps can be related directly to either restriction, malabsorption or intolerance.

- 1) creation of the pouch
- 2) creation of the jejunostomy
- 3) and the anastomosis of the jejunum to the pouch (the gastro-jejunostomy)

Often, the first step in the gastric bypass Roux-en-Y is the creation of the pouch. Restriction is produced because of the pouch. Restriction is one of the most significant outcomes of the surgery and is only related to volume of food able to be ingested at one sitting. This is what is achieved after the creation of a small gastric

Gastrointestinal Tract after Gastric Bypass Roux-en-Y



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pouch with a small outlet that, with distention from eating food, causes the sensation of fullness.

The pouch can be created either horizontally or vertically, and is generally an average of 15 ml (one half of a shot glass) in capacity. This 15 ml is the size of the pouch initially, but because of the nature of stomach tissue, will eventually stretch to approximately the size of a small egg. Also, this is the size of the pouch at rest, which means that it is not the only amount of food that can be eaten at one time. The nature and texture of the food eaten at the time will determine volume of food eaten at each sitting. Although this initial small size of the pouch can create some challenges for the newly recovered gastric bypass patient, it's creation is necessary in order to avoid a pouch that is later too large, preventing a patient

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from either reaching goal weight or being able to maintain long-term weight-loss.

The next step is the creation of jejunostomy, causing malabsorption. The malabsorptive element is created from the bypassing of the distal stomach, the entire duodenum and a distance of approximately 100 to 150 cm of the jejunum. A connection and opening are also made so that that food can be passed through the intestine and still receive the same digestive enzymes from the pancreas and liver. This connection is called the jejuno-jejunosomy. The malabsorptive element is significant to the bariatric patient, requiring vitamin supplementation; however, this element does not seem to be as significant in regard to long term weight-loss as the element of restriction.

The third step in the gastric bypass Roux-en-Y is the creation of the gastro-jejunosomy. During this step, the second part of the small intestine, the jejunum, is connected to the pouch. This connection is called the gastro-jejunosomy, and it is because of this connection between the pouch and the jejunum that a patient can experience intolerance.

This intolerance is in relation to certain foods, and is often referred to as “dumping” or “dumping syndrome.” This intolerance is a direct result of the food, usually higher in sugars and starches, entering directly into the jejunum having only mixed with saliva and not stomach acid. The symptoms of dumping syndrome may vary from person to person, but can include the following:

- Sweating
- Rapid heartbeat
- Flushing skin
- Vomiting
- Shakiness
- Low blood pressure
- Dizziness
- Shortness of breath
- Diarrhea
- Fainting

Although dumping syndrome may not seem desirable, it can be. For the gastric bypass patient, it can be a strong motivator to eat healthier, protein-dense foods and to avoid junk food. This has been referred to as “forced behavior modification.”

Many patients wonder what happens to their old stomach or if the rest of it was removed. What they are referring to is the distal portion of the stomach, or the part of the stomach tissue that was separated from the tissue used to create the pouch. The “old” or “distal” stomach is not removed, as this would not be in a patient’s best

interest. First of all, it is still well connected to other organs in the body, and separating or removing it would provide an added risk.

Secondly, although the distal stomach will no longer receive food, it does continue to serve an important function. After gastric bypass, it still continues to receive digestive enzymes from the pancreas and liver, which are very necessary for digestion and absorption of nutrients. These enzymes continue to drain into the distal stomach, and flow through the duodenum, later mixing with food at the point where the food drains from the pouch and flows through the jejunum (jejuno-jejunosomy).

Weight-loss

Weight-loss after gastric bypass surgery usually exceeds 100 pounds, or can be anywhere from 65 percent to 100 percent of excess body weight. Weight-loss generally levels off after approximately one to two years, and a weight gain of up to 20 pounds is common. Long-term follow-up with a multidisciplinary program can usually provide the best weight-loss results.

Complications

Short term complications include pulmonary emboli, anastomotic leak, bleeding and wound infection. Operative (30 day post-op) mortality is about 0.5 percent. This means that approximately one out of every 200 patients who have gastric bypass will die within 30 days of their surgery. Patients need to remember that this number is what is reported nationally, and they should inquire with their individual practice as to their own mortality rate. Laparoscopic approach provides a shorter hospitalization stay, lower wound complication rate and a higher rate of postoperative patient comfort.

Long term complications can include stricture (generally the gastro-jejunosomy), ulcers, staple line disruption and internal hernia. Nutritional complications are few, and can generally be avoided with life-long supplementation of a multivitamin, iron, calcium and B12. Peripheral neuropathy is also a rare complication, and can mostly be avoided with vitamin supplementation and adequate protein intake. Also, ventral hernia rates are significant with open gastric bypass Roux-en-Y, just as for any open abdominal procedure.

Conclusion

All surgeries contain a certain level of risk. Be sure to speak with your physician to determine which weight-loss treatment option best fits your needs.

Laparoscopic Adjustable Gastric Banding

By Lloyd Stegemann, MD

Obesity rates in the United States continue to rise. It is estimated that approximately 30 percent of Americans are obese and recent data suggests that we may actually be underestimating this number. As body weight rises, so does the incidence of serious medical problems related to the weight, such as diabetes, high blood pressure and sleep apnea.

The good news is that with weight-loss many of these medical problems improve or go away completely. The bad news is that this weight-loss is often difficult to achieve, especially for those who are significantly overweight. For many people, weight-loss surgery provides the best opportunity to achieve meaningful, sustained weight-loss. This article will focus on one of the most commonly selected weight-loss surgeries, the adjustable gastric band.

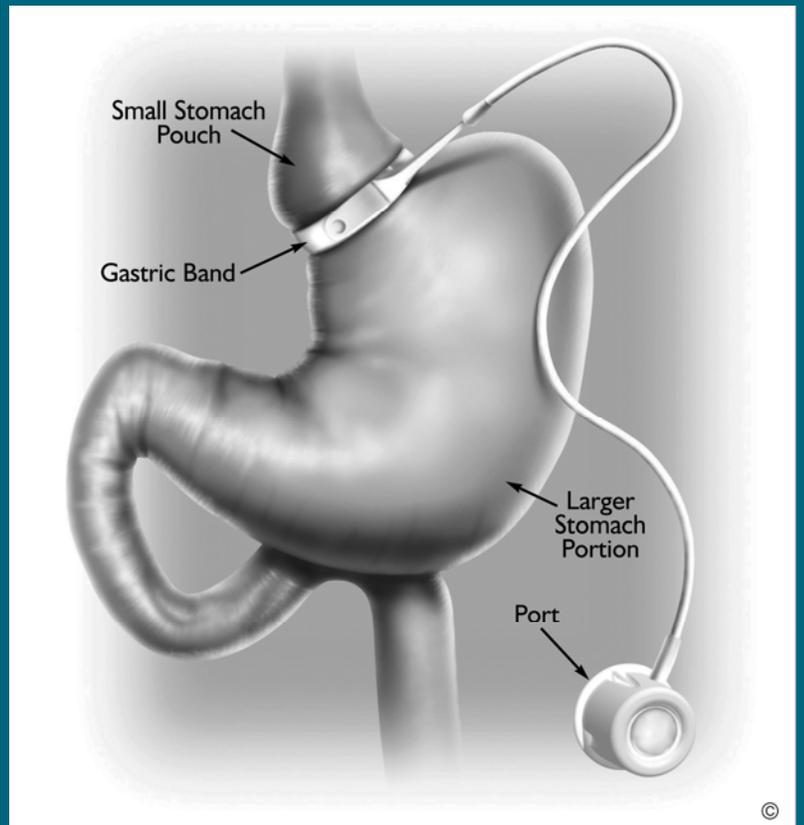
General Information

Currently, in the U.S., there is only one adjustable gastric band on the market (LAP-BAND[®]) although several different types of bands are available worldwide. The operation is almost exclusively done laparoscopically (minimally invasive). The adjustable gastric band is a purely restrictive weight-loss operation, meaning that it works by limiting the amount of calories (i.e. food) a person can take in. Unlike a diet, however, individuals still feel “full” with this reduced intake.

How It Works

This operation involves placing a silastic “belt” around the upper part of the stomach. The “belt” essentially separates the stomach into two parts: a tiny upper pouch and a larger lower pouch. The band is connected by tubing to a port or reservoir that sits below the skin of the abdominal wall usually around the belly button (the port site varies widely by surgeon). The port can’t be seen (and often can’t be felt) from the outside. Inside of the “belt” is a balloon that can be

Gastrointestinal Tract after Laparoscopic Adjustable Gastric Banding



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filled by placing fluid through the port. As the balloon is filled, it slows the passage of food from the upper pouch into the lower pouch. As the band is progressively filled, patients will feel “full” with smaller amounts of food. Typically patients will need two band fills before they feel significantly restricted and four to six band fills total in the first year after surgery.

Weight-loss & Health Benefit

Weight-loss with an adjustable gastric band is typically slow and steady. Band patients generally lose one to two pounds per week during the first year after band placement. Weight-loss can be seen for two to three years after surgery and most patients will eventually lose 50 to 60 percent of their excess weight.

Band patients often see a significant improvement in

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their weight related medical problems. Most patients will see a reduction in their need for medications to treat diabetes, high blood pressure, and high cholesterol and in fact many will come off of their medicines completely. Many patients will see resolution of their sleep apnea and will no longer have to sleep with a CPAP machine. Most patients also report a significant improvement in the quality of their life, as they are able to do activities they haven't been able to do for years.

Advantages

There are several features that make the adjustable gastric band appealing. There is minimal stress to the body at the time of surgery because the band is almost always done laparoscopically and does not involve cutting the stomach or rerouting the intestines. Most patients can go home the same day or the next morning.

Recovery from surgery is usually quick and most people return to work a week or so after surgery. The risk of death from band surgery is 0.1 percent, although many centers report even lower rates.

The adjustability of the band makes it unique among weight-loss operations. This feature makes it possible to make band adjustments based on the individual weight-loss goals and needs of the patient. The stomach and intestines aren't bypassed, so vitamin, mineral and nutrition problems after banding are unusual, but still possible. Many programs still recommend vitamin supplementation after banding.

The adjustable gastric band can be easily removed if necessary. Clearly we are learning more and more about obesity every day and there may come a time when medical management proves to be very effective in controlling weight. Band patients could have their band removed at that point and their gastrointestinal tract returned to normal.

Considerations Before Choosing A Band

Patients contemplating adjustable gastric banding must be comfortable with the thought of having a "foreign

LAGB and Weight-Loss

Band patients generally lose one to two pounds per week during the first year after band placement. Weight-loss can be seen for two to three years after surgery and most patients will eventually lose 50 to 60 percent of their excess weight.

body" in them for life. Although no problems have been reported to date, it is unknown what the effect of having this foreign body will be in 20 to 30 years. It is also unclear at this point what the long-term (more than 10 years) weight-loss results with this operation will be, although the early data is promising.

After banding, patients need to be available for regular follow-up, especially in the first year after surgery when the band is being "tightened". If you live several hours from your surgery center this can be difficult. Filling the band involves sticking the patient with a needle, so if you "hate shots," a band may not be the right choice.

Band patients do not suffer adverse effects from eating sugars (dumping syndrome) so they need to be more disciplined in their food choices. Things like sodas, ice cream, cakes and cookies slide through the band easily, but obviously these choices will not lead to the desired goal of significant weight-loss.

Although the band has an excellent safety profile, there are complications that can occur with any weight-loss operation, and the band is no different. About 10 percent of patients will require a second operation to address a problem with their band.

Conclusion

Adjustable gastric banding is a safe, effective weight-loss operation that can lead to meaningful, sustained weight-loss. No matter what weight-loss operation is chosen, however, to ultimately be successful one needs to change their lifestyle and learn to work with the surgery.

Editor's Note: *The Cover Story of this issue is designed to inform you of the various weight-loss surgery treatment options available. It is important to note that there are risks involved with bariatric surgery, as well as any other surgical procedure. Before making a treatment decision, it is important to discuss these risks with your physician and/or surgeon. The OAC also encourages patients to discuss these risks with their family members. For more information on the risks of bariatric surgery, please view the January issue of "OAC News" on the OAC Web site at www.obesityaction.org.*

Biliopancreatic Diversion with Duodenal Switch

By Debra Salvatore, RN, BS, CNOR, CFN

The Biliopancreatic Diversion with Duodenal Switch (BPD/DS) is most often an open operative procedure. It is performed in some bariatric centers laparoscopically, though in most cases, is still done “open.”

BPD/DS is based on a smaller stomach and combines a lower restriction and a high level of malabsorption. The outer margin of the stomach is removed (approximately two thirds), and the intestines are then rearranged so that the area where the food mixes with the digestive juices is short. A portion of the stomach is then left with the pylorus still attached and the duodenum beginning at its end. The duodenum is then divided, allowing for the pancreatic and bile drainage to be bypassed. It is a pyloric saving procedure, which eliminates the “dumping syndrome” that is inherent to gastric bypass.

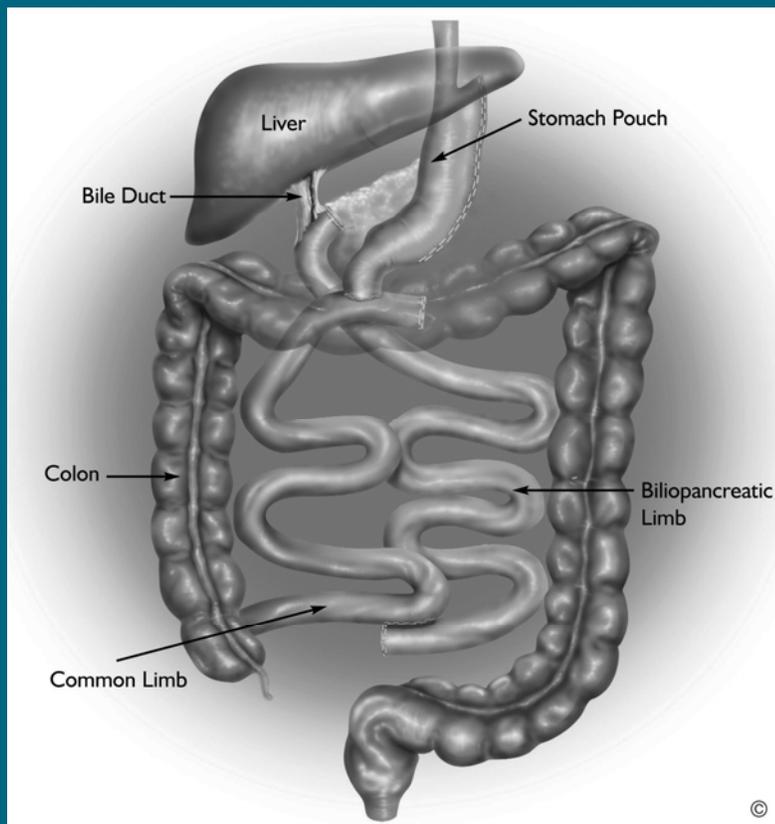
The BPD/DS requires a much longer recovery period (usually six to eight weeks), causes the greatest risk for infection (due to the size of the incision, increased operative time and exposure of the digestive organs) and usually carries a 25 percent chance for development of incisional hernia post-operatively (due again to the length of the incision). The BPD/DS also carries the highest risk of nutritional deficiencies post-operatively due to malabsorption.

There are minimal iron deficiencies and B-12 deficiencies are not created by the Duodenal Switch. Of course, all patients are monitored for iron and B-12 as well as other water soluble vitamin deficiencies. Patients who undergo BPD/DS are able to enjoy nutritional foods and eat more normally without the restriction of a small pouch (one to two ounces) as in a gastric bypass.

The BPD/DS is a more invasive operation. According to a recent analysis, BPD/DS carries a mortality rate of 1.1 percent within 30 days after surgery.

The procedure allows for increased malabsorption, resulting in increased weight-loss. Foods high in fat content are not easily absorbed and will be eliminated along with

Gastrointestinal Tract after Biliopancreatic Diversion with Duodenal Switch



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the usually high calories associated with the high fat. In all weight-loss surgery options, carbohydrates and sugars are absorbed, so eating foods high in sugar (and calories) will still cause unwanted weight gain or inability to lose weight. In all weight-loss surgery options, emphasis is placed on nutritionally beneficial and nutrient dense foods.

BPD/DS patients enjoy “normal” sized food portions at meals. The BPD/DS allows patients to increase portion size over time, allowing for greater diversity in food consumption at each meal.

Patients are always encouraged to maintain the commitment to lifestyle and food changes associated with weight-loss. BPD/DS patients are asked to first increase protein intake, then vegetables, and lastly, if able at all, breads, pastas or rice in very limited amounts.

AdvocacyNews AdvocacyAction

Medicare National Coverage Decision and its Effect on Patients

Were you impacted by the February 2006 Medicare decision regarding bariatric surgery?

If you were personally impacted by this decision as a patient seeking bariatric surgery, either positively or negatively, we want to hear from you!

Please let us know how the Medicare NCD personally affected you. If your surgery was cancelled, please let us know if you have been re-scheduled, identified and begun the process of accessing surgery at a different bariatric program or have been unsuccessful in finding a program to perform your surgery. For those of you that have been unable to find a program to perform your procedure, please let us know what barriers you have faced.

We also would like to hear from those of you that have positive experiences with the new ruling. For example, those of you that were able to access adjustable gastric banding or the duodenal switch.

The OAC will summarize any information received and share it with the leaders at Medicare and with the other key parties interested in improving access to bariatric surgery.

Please send your responses to the OAC at info@obesityaction.org. If you are a bariatric surgeon, coordinator or allied healthcare professional, we urge you to distribute this message to your impacted patients so that they may respond to us directly.

To read a positive result from the Medicare NCD, please see the story to the right.

A Real Impact

June 1, 2006

I was scheduled for gastric bypass surgery on March 13, 2006. It had taken me almost a year to get here. I had been turned down by my insurance three times, so I decided to go with my primary insurance (Medicare).

I had all my pre-op work done, and three days before my surgery, my surgeon's office called and told me it would have to be cancelled because of the change with Medicare. I had been scheduled for over a month. I called Medicare on my own asking questions and telling them that I had been scheduled before the change, but it didn't matter. They said they wouldn't pay for it.

I went on a message board, and after telling everyone how upset I was, someone directed me to a Web site to find Centers of Excellence (COE) in Florida. I found one five minutes away, but my husband had wanted the same surgery with the same surgeon two years ago and that surgeon wouldn't accept Medicare.

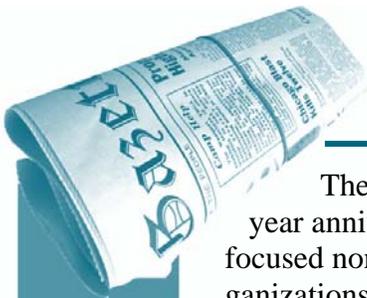
I called the office the very next day and was told the surgeon is now taking Medicare. However, it was one month before I could get in to see him. I waited, went to see him, then had to wait another month because they had to send yet another request to my secondary insurance for the surgery.

However, I am very excited to let you know that I am having laparoscopic gastric bypass surgery Tuesday, June 6, 2006.

It was frustrating and aggravating when I had waited so long, given my down payment, completed my pre-op work, only to be cancelled because Medicare did not grandfather those who were scheduled before the change took place.

Although I'm extremely excited about my surgery, I'm sad it's not with a surgeon I trusted and came to love. I'll never forget the distress I felt when I was cancelled.

*Sincerely,
Elizabeth H. Myers, Ocala, FL*



Obesity Action Coalition Celebrates One-Year Anniversary

The OAC is proud to celebrate its one year anniversary as one of the leading patient-focused non profit obesity/morbid obesity organizations.

Throughout the past year the OAC has accomplished great strides in the obesity community. With the introduction of the OAC's latest brochure, titled "Understanding Obesity," the OAC continues to be an excellent source of valuable materials for those affected by obesity.

In addition to the educational resources, the OAC continues to produce many one-of-a-kind advocacy resources to educate patients about access to care issues. To date, the OAC has distributed more than 15,000 advocacy guides across the United States.

"This past year has truly been phenomenal for the OAC. We've reached thousands of patients, family members and healthcare professionals throughout the United States. Offering members the most up to date information, our resources have grown tremendously. Looking ahead, the OAC will continue to educate the public on obesity and morbid obesity, increase obesity education, work to improve access to medical treatments for obese patients and strive to eliminate the negative stigma associated with all types of obesity," said Joseph Nadglowski, Jr., OAC President and CEO.

For more information on the OAC, please visit www.obesityaction.org or contact the National Office at (800) 717-3117 or info@obesityaction.org.

OAC Releases "Understanding Obesity" Brochure

The OAC is excited to announce the release of its newest educational brochure, titled "Understanding Obesity."

This free brochure, a first of its kind, offers readers an in-depth look and complete understanding of obesity and morbid obesity, who it affects, health risks, causes, treatment options and much more.

"The OAC recognized that there wasn't an educational brochure available to patients and the public that really looked at obesity as a whole. Often times, people overlook the many facets of living with obesity or morbid obesity, such as the diminished quality of life, the negative stigma associated with it, the lack of the ability for individuals to access safe and effective care and much more. This brochure does a great job of

addressing those topics," said Joseph Nadglowski, Jr., OAC President and CEO.

Recognizing the importance in providing a comprehensive look at this disease and its effects on the public, this brochure is the first in a series of brochures that will discuss obesity, childhood obesity, treatment options and much more.

Copies of "Understanding Obesity" are available free of charge. To request copies, please visit www.obesityaction.org or contact the National Office at (800) 717-3117.



Support Group Tools Now Available!

The OAC recognizes the importance of support groups in managing and treating obesity. As such, the OAC has added a "Support Group Tools" section to its resources on the OAC Web site.

The new section offers visitors a helpful kit for

support group members that allows them to become more active in the fight against obesity. In addition, the OAC also provides visitors with the resources needed to find a support group in their area or post information about their group online.

Baby Steps

Emotional Adjustments

after Weight-Loss
Surgery



By Lynne Routsong-Wiechers, MSW, LISW

- *I look in the mirror (if I get the nerve up) and see somewhat of a familiar face, but unsure as to whom is looking back.*
- *I look at my body and wonder how on earth I allowed myself to get this way... I then cry.*
- *I see the disappointment in my children's faces when they ask me to play with them, but I just don't have the energy nor the will to move.*
- *I wake up in the morning and dread putting my feet on the ground because of the pain that I know is coming.*
- *I avoid public places and gatherings with friends because I fear the stares and the comments that may come.*
- *I look at my closet, and realize that the majority of my closet consists of blue and black stretch pants and wide slip on shoes.*
- *I dread traveling far distances, especially by plane, for fear that my luggage gets lost and I can't find clothes in my size at the stores and the fact that I can no longer comfortably sit in a seat.*
- *I pretend that my seatbelt fits on an airplane because I don't want to ask for an extension.*
- *I go grocery shopping at night so I am not judged by what I put in my cart.*
- *I am convinced that my arms are becoming shorter because my bathroom habits are becoming difficult.*
- *I notice that walking even short distances feels like I have run a marathon.*
- *I am always hot and sweating even when it's cold outside.*
- *I no longer feel attractive towards my significant other.*
- *I feel like I have lost all sense of myself.*
- *I am scared that today may be my last.*

These are the thoughts that race through an obese person's mind daily. Obesity is something that you go to sleep and wake up with. You can't get away from it. It becomes your identity. There is so much shame and guilt that is associated with being overweight.

Having weight-loss surgery causes a ripple effect and many other areas of your life will change. A person will often experience changes in their emotional state; for example, depression may often times go away. Pa-

tients also could experience less physical pain and obstacles. Some changes that could occur include:

- Career
- Relationships
- Marriage
- Friendships
- Spirituality

Currently, I no longer suffer with the physical comorbidities. I am able to walk and even sometimes run

“Food issues become an addiction and we must learn that we no longer live to eat, but instead we eat to live.”

around the yard with my children. I even got on a bike! I no longer suffer from depression and my energy level is off the charts. After having undergone my surgery, I realized that many people don't truly understand what its like to be obese unless they walked in our shoes.

Obese patients need a voice and they need to be heard. I decided to open up a counseling practice specifically for gastric bypass patients and obesity-related issues. I see the relief in my patients' eyes when they see my pre-surgery picture and realize that, “I have walked in their shoes.” There is so much shame and guilt that is associated with being overweight. I try to encourage my patients to let the guilt go and focus on the reality that they will lead a very different life after surgery.

The Changes: This is Not the Easy Way out.

We dream about it. We think about it. We almost become obsessed with the thoughts of being a healthy person. It sometimes keeps us up a night. We finally see the light at the end of the tunnel and realize that we will get there. We wait for weeks sometimes months for that “letter.” You know which one I am talking about - the letter from the insurance company. Then one day you go to the mailbox and there it is. You realize that it's now a reality! All of the preparation has paid off, but now the reality of what is about to happen sets in.

Getting patients to realize that weight-loss surgery is not the easy way out is essential in successful weight-loss. Regardless of what we hear in the media and from society, this is not easy. Deciding to have this surgery is difficult, but living as a weight-loss surgery patient is not always easy.

Fear of the Unknown: “Baby Steps”

Although we are looking for a change in our lives, change can be scary and unknown. Many of us fear change, but at the same time look forward to it. I can't tell you how many times patients, including myself, ask themselves, “why did I do this,” right after surgery. Most often this emotion is short lived, but it's an example of how change can affect us.

I realized that I was no longer going to allow food to control me. Food issues become an addiction and we must learn that we no longer live to eat, but instead we eat to live.

In addition, we all go through a phase where you have a difficult time realizing the new you. For example, although patients may reach their goal

*Emotional continued
on page 22*

Lynne's Story

I was 285 pounds at 5'4" tall. I had tried every diet known to man, including rigorous exercise programs, usually ending up with only a five to 10 pound weight-loss. I realized that my weight gain was not going to stop.

Physically, I was hurting. Emotionally, I suffered from depression, and my career became a struggle. I was counseling in a private practice but barely had the energy to see three patients per day, often having to take a nap in between. I came to the realization that “I” was the one who needed to gain control and get help. That's a tall order coming from a psychotherapist. After all, we are the ones who are supposed to be helping others. I swallowed my pride and decided to take control of my life. I wanted to be free; free of this body and free to “live” life, not just exist.

I began living my new life three years ago. I underwent gastric bypass surgery in Dayton, Ohio and have not looked back. I lost 160 pounds and went from a size 24 to a size 4/6. My whole life has changed.



Emotional continued from page 21

weight, they may look in the mirror and ask themselves, “who is that thin person?” Losing a massive amount of weight can make a person feel vulnerable and afraid. Remember, obese individuals like to “blend in” with the crowd, but all of a sudden we are now the focus of attention. People are watching us. They are now watching what we eat, asking us how much we have lost and even giving us compliments. This can make us feel uncomfortable.

I call it taking “baby steps.” We are re-learning who we are in life. In relation to baby steps, we have to re-learn how to eat according to our surgery. We have to adjust to eating smaller portions, chewing food to a pulp, not drinking while eating, avoiding high sugar and fatty foods and changing our eating behaviors for good.

Food is a central part of our life. If you’re an alcoholic, the cure for alcoholism is to stop drinking. Unfortunately, we need food for survival. Food issues become an addiction and we must learn that we no longer live to eat, but instead we eat to live. It took me a long time to understand this concept. There were so many things in my life related around food. I realized that I was no longer going to allow food to control me.

What’s in my Toolbox: “Surgery as a Tool”

Weight-loss surgery is a great tool. This means that it is not the fix all, but if you correctly use the tool then you will have increased chances of success. If you choose to misuse the tool, then chances are you will have less success. This surgery will enable you to only eat small portions and feel a sense of fullness.

Seven Steps to Improving Emotional Adjustments Post-Surgery

1

Follow your doctor’s orders and recommendations. This means following the dietary changes from the start. Get lots of rest and take care of your physical needs.

2

Journal. I know what you are thinking. Journaling is boring and tedious and we don’t like it, right? By keeping track of the foods you eat and how you feel will truly help you feel more in control emotionally and physically. This is especially helpful if you find that you are emotionally eating.

3

Set realistic goals and expectations. For many, goals may be getting off their medication(s), walking without getting winded or the ability to cross their legs. So whatever your goals are make sure that you write them down and modify them as needed.

4

Reflect on the past. Although it is important to move on, it’s also important for patients to remember the moment when they decided to have weight-loss surgery. It’s sort of like we have to hit our “low or bottom” to realize that we have to change.

5

Take lots of pictures, measurements and keep your pants. It is important that we take pre-op pictures and post-op pictures regularly. This reminds us about our success. Measurements and pre-op clothing are important especially during the dreaded plateaus. We may be losing inches and it’s important that we have visual aids to help us realize our success. Although you may be a smaller size, you may still view yourself as the larger you. It’s important to have a visual reference point to remind us that we are losing weight.

6

Seek help. It is important to ask for help if you find that you are having difficulty adjusting to the many changes after surgery. Seek support via support groups, family, friends and/or professional counseling. Support groups and counseling are especially rewarding and helpful because we realize that many patients often experience the same adjustment issues and it makes us feel less isolated and alone while we travel our journey.

7

Live life to the fullest. You deserve to be healthy, happy and have fun! Enjoy and savor every moment of your weight-loss journey. You deserve it.

Although this sounds so “simple” it can be difficult. In addition, we go through phases where we long for food. This is also known as “food grief.” It is as if we long for our “friend” of food. We turn to food in times of celebration, sadness, for reward and for comfort. When a person can no longer turn to food to fill the void, they must find other ways.

Many of my patients, including myself, find other hobbies or activities. In addition, this is when bariatric support groups become so helpful and beneficial.

About the Author:

Lynne Routsong-Wiechers, MSW, LISW, has worked in private practice counseling since 1996. She underwent gastric bypass in 2003 and has dedicated her practice to working with gastric bypass and obesity patients. She is currently a Bariatric Psychotherapist in Dayton, Ohio, providing consultation to medical professionals and speaking to the public regarding gastric bypass.

Walk from Obesity continued from page 7

- Increasing public education about this devastating disease
- Increasing professional education concerning effective treatments of the disease

This year, the OAC is proud to be a partner in the “Walk from Obesity.” Each person that signs up for the Walk at

their designated Walk location will have the opportunity to receive a FREE six-month membership in the OAC.

The OAC encourages you to get involved and participate in this year’s Walk. To find a designated Walk location in your area and register online, please visit www.walkfromobesity.com/index.php.

OAC membership

Membership in the Obesity Action Coalition allows the patient voice to be heard in the fight against obesity. By building a coalition of members, consisting of patients, family members and professionals, the OAC strives to educate and advocate on behalf of the millions who are affected by obesity. Membership benefits include:

- Official charter membership card/certificate
- OAC News - the OAC’s quarterly newsletter
- Subscription to *Obesity Action Alert* - a monthly e-newsletter
- Representation through advocacy in addition to information on advocacy issues concerning patients

Membership Application

Name: _____
 Company Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 E-mail: _____

- Patient/Family Member: \$20
- Allied Health Professional Member: \$50
- Physician Member: \$100
- Surgeon Member: \$150
- Institutional Member: \$500 (Bariatric surgery centers, weight-loss management centers, etc.)*
- Chairman’s Council: \$1,000 and up*

* Different benefits apply. Contact the OAC National Office for more info.

Payment Information

Enclosed is my check made payable to the Obesity Action Coalition for \$_____.
 Please charge my credit card for my membership fee of \$_____.

- Discover® Mastercard® Visa® American Express®

Credit Card #: _____

Expiration: _____ Name on Card: _____

Signature: _____

Please mail to: Obesity Action Coalition
 4511 North Himes Ave, Suite 250
 Tampa, FL 33614

Or fax to: (813) 873-7838

If you have questions about OAC membership, please contact the National Office at (800) 717-3117.

The mission of the Obesity Action Coalition is to elevate and empower those affected by obesity through education, advocacy and support.



About the OAC

The Obesity Action Coalition is a non profit patient organization dedicated to educating and advocating on behalf of the millions of Americans affected by obesity. By strictly representing the interests and concerns of obese patients, the OAC is a unique organization with a patient-focused approach to obesity. To learn more about the OAC, visit www.obesityaction.org or contact the National Office at (800) 717-3117.

OAC Resources

Through education and advocacy, patients need to get involved to help drive change in the obesity community. The OAC provides several beneficial resources for patients, as well as professionals.

- OAC Introductory Brochure
- Obesity Action Alert
- OAC News
- State-specific Advocacy Guides
- Understanding Obesity Brochure
- *Your Voice Makes a Difference. A Guide on How You Can Help Fellow Patients Affected by Obesity*
- *Working with Your Insurance Provider: A Guide to Seeking Weight-Loss Surgery*
- The OAC Web site: www.obesityaction.org

All OAC resources are complimentary and may be ordered in bulk. To request materials or an order form, please contact the OAC National Office at (800) 717-3117 or send an email to info@obesityaction.org.



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