OAC News

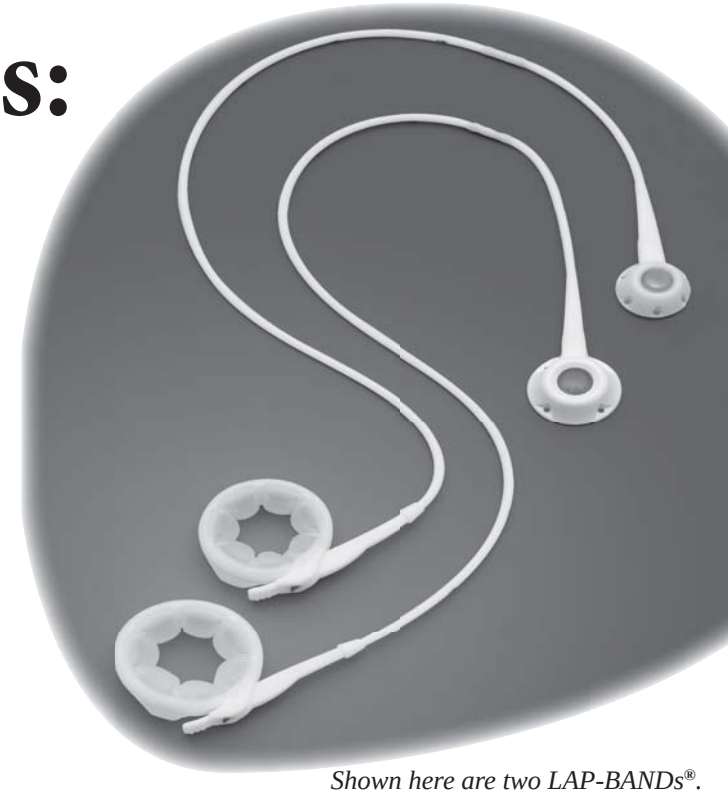
The Obesity Action Coalition's Quarterly Newsletter

Volume II • Issue 3 • July 2007

LAP-BAND® FAQs:

Questions Most Commonly Asked by Patients

By Dorothy Roedel Ferraro, MS, CS, ANP



Shown here are two LAP-BANDs®.
Photo courtesy of Allergan, Inc.

Obesity is on the rise, and so are the numbers of weight-loss surgeries being performed each year. Laparoscopic adjustable gastric banding (LAGB), or commonly referred to as the LAP-BAND®, is becoming increasingly popular because it is safe, effective and the least invasive of all weight-loss procedures currently available in the U.S.

The LAP-BAND® has been available in the U.S. since 2001. Because of its relative newness, patients often have many questions about the surgery, the band and what to expect afterwards. The purpose of this article is to answer some of the questions that I often receive from my patients considering the LAP-BAND® procedure.

What is Gastric Banding?

Gastric banding is a surgery performed through thumbnail-sized incisions during which a silicone band is placed around the upper part of the stomach creating a small gastric pouch. This band is adjustable, and if necessary, removable.

An overnight stay in the hospital is usually required, but some centers are now performing this surgery as an outpatient procedure or "same day" surgery. Most patients can usually return to work within a week.

How does the LAP-BAND® work?

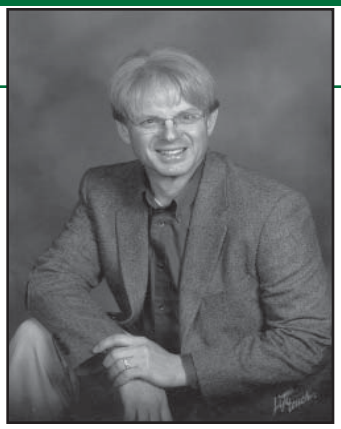
The LAP-BAND® works by controlling your hunger and your portion size. Eating a small portion of solid food will fill the small upper gastric pouch, sending a signal to your brain that you are full.

The LAP-BAND® can be adjusted by a simple procedure which, most of the time, can be performed in your surgeon's office. During this procedure, a small needle is inserted into the access port and fluid can either be added or removed, depending on your weight-loss and other factors. This is called an adjustment, or a "fill."

FAQs *continued on page 20*

In this Issue...

A Message from OAC Chairman, Jim Fivecoat



I was fortunate enough to be able to attend the American Society for Metabolic and Bariatric and Surgery (ASMBS) Annual Conference in June along with our board members and staff. We are very fortunate to have such a high level of professionalism and commitment in our board members.

Many of our board members are patients that dedicate their life to help others who are obese. Others are professionals who dedicate their career to caring for obese patients. It is an honor to be able to serve with these individuals. In coming issues, we plan to highlight some ways these board members are serving the community and the OAC membership.

The ASMBS Annual Conference was my first opportunity to meet some of our constituents and represent the OAC in my capacity as Chairman. OAC President and CEO Joe Nadglowski, Jr., and I were able to meet with many of the ASMBS officials, physicians, surgeons and industry leaders. In our discussions with industry supporters, they all expressed their encouragement and gratification with the work the OAC accomplished in its first two years. Of course, we have our energetic and committed staff and board to thank for that great work.

I was also impressed with the leaders of organizations such as the ASBS Foundation who we partner with on the "Walk *from* Obesity," Many organizations are working to serve patients with the total process of weight-loss by supporting surgery patients and helping those who do not elect to have surgery find the best treatment option. It heightened my awareness of everyone's commitment and of the OAC's need to increase our services to other parts of the medical community treating obesity.

As we move forward this year, we will be presenting articles on some of the key topics we discussed with these influential leaders, such as recently publicized issues around addiction and other issues around health and access to care. In this issue of *OAC News*, we present many important and timely topics for patients to be aware, such as how to treat weight regain and a look at some of the popular diet systems on the market, to name a few.

We will expand our work to explore how we can influence employers to cover all medically managed and surgical weight-loss procedures and mobilize our membership. The OAC will also continue our work with state and federal government agencies and insurance companies to improve access to coverage. The rest of this year should be exciting for all of us.

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

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.

OAC News is a quarterly educational and advocacy newsletter. OAC News is distributed in January, April July and October. Subscription to OAC News is a membership benefit, however, anyone is welcome to request copies at any time.

Education, Research & Treatment of Obesity

WALK*from*OBESITY℠

Join Us for the WALK*from*OBESITY℠

September and October 2007

The Walk from Obesity is the nation's largest gathering of individuals affected by the disease of obesity. In September and October 2007 in cities all across the country, those living with the disease of obesity and survivors alike will join forces and walk to raise money for research, education, prevention and treatment of obesity.

To register for a Walk, locate a Walk site in your area or become a volunteer, please visit **www.walkfromobesity.com**.

Donating is a great way to help in the fight against obesity. If you are unable to participate in this year's Walk, please consider making a donation today. Giving makes a difference!

OUR OUTREACH: *Increasing*

OUR PURPOSE: *Expanding*

OUR DEDICATION: *Enduring*

ASBS American Society for Bariatric Surgery® FOUNDATION

"Partnering to improve the lives of all of those affected by obesity through education, research and advocacy."

OAC Obesity Action Coalition

Top 10 Facts *about* Food Choices

By Chef Dave Fouts

The relationship we have with food is personal. Each one of us, including myself, can remember where we had the perfect steak, or who makes the best pizza in town, and we know exactly where to go to get award-winning barbeque. Now, ask yourself these questions:

- Do you know which type of bread has the highest fiber count?
- Which is better for you: low-fat cottage cheese or fat-free cottage cheese?
- Can you name three different grains other than the obvious ones such as corn, wheat and oats?

Do not worry if you do not know the answer. You are not alone. I surveyed many people around the country and found that when it comes to eating healthy and knowing which foods are the most healthful, most draw a blank. Therefore, I have put together a list of the top 10 facts about eating healthy that everyone should know.

10. All whole wheat breads are created equal.

Whole wheat can be priced from $1.29 a loaf, to as much as $2.99. The difference in cost is related to how much whole grains are actually in the loaf of bread. Breads on the higher end of the $2.00 price margin are made not only with whole wheat flour, but in some cases contain nuts and seeds as well. My number one pick is the 12 grain bread made by Brownberry.

9. Potatoes are high in fat.

A potato with nothing on it has 0 percent fat. It is only after we add the cheddar cheese, sour cream, butter

and bacon bits that it becomes a nightmare food. When making mashed potatoes, use low sodium chicken or beef broth instead of milk. In addition, add fresh chopped herbs and in an instant, you have a low fat side.

Also, let us not forget the sweet potato. Placing them in a 350 degree oven for one to one and a half hours with the skins on will let their natural sugar caramelize inside the sweet potato. Peel back the skin and sprinkle with a dash of cinnamon, and serve.

8. All deli meats are created equal.

Deli meats are convenient, but stay away from processed meats. Choose deli meats such as ham, turkey, top round roast beef and corned beef. These are all cuts from the animal and are processed the least. Lunch meats such as salami, bologna and pepperoni are processed more; therefore, eat these meats less often.

7. Cottage cheese: fat-free or low-fat.

Let's talk fat for a minute. Fat not only gives more flavor to food, but it also adds moisture. When fat is removed, another product is generally put in its place. In most cases, sugar is added. In baking, sugar is counted as a liquid ingredient, because once heated, it turns to liquid. Sugar not only sweetens a food, but also aids in keeping food moist.

Fat-free cottage cheese contains no fat, so sugar is usually what replaces the fat. In low-fat cottage cheese, however, only a majority of the fat is removed, but enough is left to maintain moisture and flavor. So, if you are watching fat, I suggest fat-free, and if sugar is the culprit, go with the low-fat.

6. All the hype about trans-fat.

Wikipedia defines trans-fat as "Unlike other fats, trans-fats are neither required nor beneficial for health.[1] Eating trans-fats increases the risk of coronary heart disease.[2] For these reasons, health authorities worldwide recommend that consumption of trans-fat be reduced to trace amounts."

Trans-fats were first used commercially in the 1900's in Crisco. In addition, trans-fats are used to extend the shelf life of products because they have a much higher meting point and reduced tendencies for oxidation (when oxygen is introduced to food, the breakdown of food starts). Trans-fats have NO nutritional value and in addition can cause bodily harm. Therefore, I recommend to only buy foods that are trans-fat free.

Instead of deep-frying or pan-frying your food, try to oven fry your food and coat it on your own. Use a low-fat pan spray and generously spay your pan. Next, use an egg white wash (one egg white to one teaspoon of water) and dip your food into the wash to coat your food evenly. Next, sprinkle with your favorite dry ingredients, using dried herbs, spices and a small amount of bread crumbs or flour for crunch. In a preheated 350 degree oven, spread your coated food onto a single layer and bake. Some thicker foods like chicken and fish will need to be turned halfway through.

5. Five golden delicious, make your mouth water. Onion rings are good for me if fried in healthy oils.

Healthy oils such as corn, canola, safflower and olive oil are good if used in moderation, but when foods are fried in them they normally have the crunchy coating attached. Not only does this crispy coating absorb some of the oil, it puts enough fat in your diet for the whole day. Remember no more than 30 percent of your calories should come from fat.

4. Do canned meats have the same amount of protein as their fresh counter parts do?

Canned meats such as chicken and tuna fish, and seafood such as crab and shrimp are all good sources of protein. Canned meats are helpful for when you are in a rush or on days you are not sure when a break will come your way. There is never a substitution for the real thing, but in a crunch, reach for a can of water-packed tuna. Deviled hams, Vienna sausage and other processed meats are much lower in protein, contain fillers and if eaten should be done only sparingly.

Top 10 continued on page 23

Children in Motion

By Arrin Larson, BS, NSCA-CPT, Certified Wellness Coach

Obesity is a growing health concern across the nation, especially with our nation's children. Results from the 2003-2004 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, indicate that an estimated 17 percent of children and adolescents ages 2-19 years of age are overweight.

Taken directly from the National Center for Health statistics, "Childhood obesity involves significant physical and emotional health risks. In 2000, it was estimated that 30 percent of boys and 40 percent of girls born in the United States are at risk for being diagnosed with type 2 diabetes at some point in their lives."

Physical activity and proper nutrition are two key components to preventing and treating the disease of obesity. Physical activity can prevent or delay hypertension, prevent diabetes, increase bone density, decrease anxiety, improve body image and mood, improve scholastic performance in school, develop good physical fitness and promote weight control, just to name a few.

How Much Physical Activity is Enough?

The American College of Sports Medicine and Center for Disease Control recommend that adolescents and adults engage in 30 minutes or more a day of moderate intensity exercise most days of the week. It is recommended for children to engage in 60 minutes of moderate intensity exercise most days.

The Centers for Disease Control, the National Association for Sports and Physical Education and the American Heart Association all recommend a comprehensive daily physical education program for children K-12.

Did You Know?

- Only 25 percent of high school students participate in daily physical education (PE).
- Only 19 percent of high school students are active for at least 20 minutes a day during PE class.
- Only 47 percent of middle/junior high schools and 26 percent of high schools require at least three years of physical education.

What are the Benefits of Physical Education?

- Develops motor skills
- Promotes physical fitness
- Increases energy expenditure
- Promotes positive attitudes
- Enhances academic performance
- Enhances good mental health and self concepts

What Can We as a Society, as Parents and Family Members, as well as Educational Professionals Do?

1. Get yourself moving

- Be a good role model for your kids/community.
- Children of active parents are SIX times more likely to be active than kids whose parents are sedentary.
- Make it a joint effort!

2. Shut off the television, video games and computers

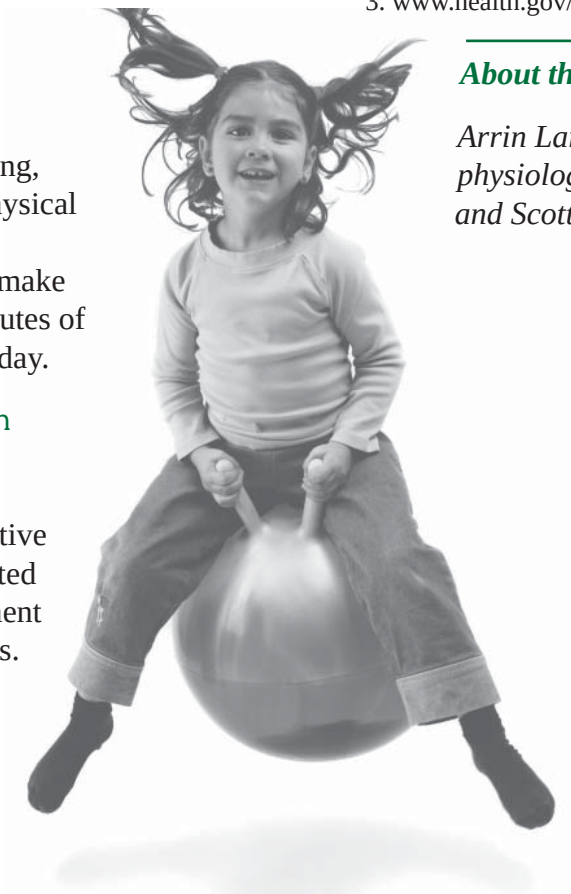
- Set guidelines.
- More than 60 percent of childhood obesity is directly related to watching too much television.
- The rate of obesity rises 2 percent for each hour of television watched a day.

3. Promote PE in school

- When your child is registering, encourage them to take a physical education class.
- If your child is in day care, make sure it offers at least 20 minutes of physical exercise/activity a day.

4. Promote activity rather than exercise

- Sometimes when we call it "exercise," it can have negative feelings or thoughts associated with it. Activity and movement are much less charged words.
- Try free play activities such as: tag, hide and seek, hopscotch, jump rope, Simon says, capture the flag, etc.



- You can do something very informal. It does not have to be sports or dance class.
- Walk to the park, wash the car, nature walk/hike and walk to the library or the store.
- Get the whole family involved, even pets!

5. Be supportive

- Children of all ages need acceptance and encouragement.
- Use positive reinforcement of the physical activities.
- Be sensitive and find activities that are not difficult or that may cause embarrassment.
- Add variety and let them choose.

A fun and interactive tool is on the My Pyramid Web site. Visit the "For Kids" section at **www.mypyramid.gov** to start playing. This Web site also has great information on exercise and nutrition and a game for kids to play, learning about fuel (food) and activity. Check it out!

Resources:

1. win.niddk.nih.gov/publications/child.htm
2. www.cdc.gov/mmwr/preview/mmwrhtml/mm5336a5.htm
3. www.health.gov/dietaryguidlines

About the Author:

Arrin Larson, BS, NSCA-CPT, is an exercise physiologist educator at Scottsdale Healthcare and Scottsdale Bariatric Center in Scottsdale, AZ.

Did You Know?

- At least 75 percent of Americans live within a 2-mile walking distance from a public park

Where is your nearest park?

Treating Weight Regain after Weight-Loss Surgery

By Lloyd Stegemann, MD

One of the greatest fears of patients seeking weight-loss surgery is the fear of weight regain. This is understandable considering that virtually every patient that has undergone weight-loss surgery has at some point been a "Yo-Yo Dieter" during their weight-loss journey.

It is not uncommon for a surgical candidate to relate stories of losing 10 pounds, 20 pounds, sometimes even 50-100 pounds with dieting attempts, only to see it return over time.

The good news is that with weight-loss surgery, the weight-loss seen post-operatively can maintain throughout a long period of time. However, it is important that patients keep in mind that obesity is a chronic disease that is not cured by surgery. Surgery provides a powerful tool for significant weight-loss, but without proper care "the tool" can lose its effectiveness, leading to weight regain.

There are several causes of weight regain after weight-loss surgery, most of which if addressed properly, results in a loss of the gained weight and resumption of weight maintenance. In this article, I would like to share with you my thought process in dealing with the patient who experiences weight regain.

Keys to Prevention of Weight Regain

The key to prevention of weight regain is education and follow-up. Both before and after weight-loss surgery, patients need to be taught how to use their surgery to optimize their success. The optimal education should involve counseling in dietary, behavioral health and exercise issues.

I believe one of the most important things that a program can do to promote long-term weight maintenance is to create an environment in the clinic where a patient feels comfortable coming, not only when they are doing well, but also when they are struggling. By creating an environment where patients feel safe to share their struggles, we can often intervene early-on before the patient regains a significant amount of weight.

When I initially see a patient who regained some weight, I congratulate them for having the courage to come in to see me. My main focus of the visit is to begin to get an understanding of whether their weight regain is due to an anatomical problem (something wrong with the surgery), a medical problem or a behavioral problem (returning to old habits). It is extremely helpful if the patient brings a food journal to the visit.

I find the following questions to be quite helpful when sorting out the issue of weight regain:

1. How many times a day do you eat?
2. How many times a day do you get hungry?
3. Do you ever feel full and if so, how long does it last?
4. How much can you eat in one sitting?
5. Are you having heartburn or reflux?
6. Have you started any new medicines?
7. How has your energy level been? Your sleep?
8. Are there any new or ongoing stressors in your life?
9. Why do you think you are regaining weight?

If a patient is suddenly able to tolerate much larger meals, experiences an increased frequency in the sensation of hunger or develops new or recurring acid reflux, then I am much more concerned that I am dealing with an anatomical problem (something wrong with the surgery). Anatomic problems are best diagnosed with an upper GI series or an upper endoscopy. The following are some anatomic causes of weight regain:

Anatomic

- Pouch dilatation
- Anastamotic dilatation
- Adjustable gastric band system problem (balloon leak, hole in tubing, port disconnection, etc.)
- Gastric-gastric fistula due to staple line breakdown

There are certainly some medical conditions that can lead to weight regain as well. I have listed some common ones below. Most of these will be diagnosed with a good medical history and blood work.

Medical

- Pregnancy
- Thyroid issues
- Adrenal issues
- New medications
- Kidney and/or heart problems

In my experience, anatomic and medical causes of weight regain after weight-loss surgery are rather uncommon, but they certainly should be considered. In the vast majority of patients, weight regain is the result of the patient slipping back into old, unhealthy habits.

The good news is that by intervening early and addressing the particular patient's issues, we can often prevent the patient from regaining a significant amount of weight.

It is important that patients keep in mind that obesity is a chronic disease that is not cured by surgery. Surgery provides a powerful tool for significant weight-loss, but without proper care, the tool can lose its effectiveness, leading to weight regain.

About the Author:

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.

Want more information on weight regain?

Various resources/programs are available to help those who are experiencing weight regain.

Back on Track with Barbara
Internet mentoring program specifically devoted to those who are struggling with weight regain.
www.backontrackwithbarbara.com.

Obesity and Me
An educational organization dedicated to empowering individuals regarding obesity issues.
www.obesityandme.com.

Eating to Live

By James Zervios, OAC Director of Communications

For Larry Davis, being obese was nothing new to him. Since a young age, Larry's parents would often bet him on what his weight would be by the time he graduated high school. "I dieted all through middle and high school, but it never seemed to do anything for me," said Larry.

After high school, Larry joined the Air Force. This was a good change for Larry as it allowed him to lose some of the weight, but by the military's standards, Larry was still on the high end of the scale.

"I was in the 'Fat Boy program' as they used to say in the Air Force," said Larry. The program basically meant that Larry had to do more than the other enlistees. This worked, to a point, but Larry would eventually regain the weight.

Twelve years ago, Larry's wife was pregnant with their first child and he began to eat in conjunction with her. "My wife, at the time, would gain weight and eat. And, in return, I would eat and gain weight," said Larry.

In 2005, Larry weighed 333 pounds. "I felt like I was getting bigger. Like I just kept gaining weight," said Larry. Even though Larry was not affected by the many co-morbidities often associated with morbid obesity, such as diabetes, hypertension, etc., he knew at this weight that he had to make a change. In fact, he knew this more than a year before he even realized it.

A year before Larry reached 333 pounds, in 2004, Larry began to research Roux-En-Y gastric bypass. Larry wanted to find a surgeon that incorporated all the facets of what he believed to be a successful approach to weight-loss. Larry knew he had to change his eating habits, resist urges to eat junk food, exercise and modify his lifestyle behaviors. "I wanted a practice that would be there for me from the start to finish. If I was

Larry Davis, post-surgery, became a triathlete following his successful gastric bypass surgery.

Not Living to Eat

going to do this, I was going to go all the way with it," strongly said Larry.

Larry found exactly what he was looking for in his surgeon. "I really enjoyed working with my surgeon and his staff. At all times throughout the process, I always felt involved in the decision making process," said Larry. On September 23, 2005, Larry underwent weight-loss surgery.

For Larry, the decision to have weight-loss surgery was an easy one. He was a young man at the age of 38, had children, a good career and wanted more out of life.

"Looking at my life, I knew I had to do something about my weight. I would always think of food. I was a stress eater. For me, the gastric bypass is a tool. It's not an end-all solution," said Larry.

Today, Larry's life is quite different from the years past. Larry enjoys dancing with his wife, playing with his five children, two cats and two dogs and training for triathlons. That's right, triathlons. Larry has invested a great amount of time and energy into "Athletes Who Care," an organization that encourages fun and fitness for all family members of all ages. "For me and my family, we love working with this group. You can teach your kid how to play baseball, but you can't actually play in the game with them. With 'Athletes Who Care,' both parent and child can participate," said Larry.

Larry has made a tremendous transformation from the "lovable big guy" to the "athletic guy." Exercise, proper nutrition and dedication are vital keys to Larry's success. "I exercise, eat well and just take one thing at a time these days. I don't let the stress get to me," said Larry.

"Recently, my daughter hugged me and said she could fit her arms around me now. This was one of those moments that I realized why I decided to make a change in my life. Today, I eat to live – not live to eat," proudly said Larry.

For more information on "Athletes Who Care," please visit **www.athleteswhocare.com/home.html**.

Larry Davis, middle, poses with fellow racers after a triathlon.

An Overview of *Popular* Diets

By Jacqueline Jacques, ND

Americans seemingly have a love affair with dieting. In the year 2000, American consumers spent $34.7 billion out-of-pocket dollars on weight-loss products and programs – a number that experts suspect continues to climb[1]. On any given day if you check out the New York Times best-seller list, you will likely find at least two diet books in the top 10 list for non-fiction. When I looked this week, it was The Volumetrics Eating Plan by Barbara Rolls, PhD and The Extreme Fat Smash Diet by Ian K. Smith. Wait a month, and these will likely be replaced by something new.

> Diet (*v. intr.*): To eat and drink according to a regulated system, especially so as to lose weight.
>
> – American Heritage Dictionary

Since roughly two-thirds of the American public is either overweight or obese, the real question is: *Do any of these plans result in the desired goal of getting weight off and keeping it off*? After all, the advice always given to those who need to lose weight is to diet and exercise. When this fails to produce the desired result, the blame is always put back on the dieter. Naturally then, the golden ticket everyone is looking for is the perfect program that will help people both lose weight and maintain weight-loss. So, those seeking the answer invest year after year in new diet books and programs and new hope.

Benefits to Diets

What will follow here is a brief overview and review of a handful of popular diet systems. Since it is currently impossible and unreasonable to state that any of them will produce a long-term result for weight-loss, I tried to place the emphasis on other factors, such as how healthy and scientifically sound the program is.

While short-term weight-loss can be achieved by many means, healthier programs that teach good dietary habits seem more likely to have other positive health outcomes. Moreover, there are some weight-loss trends that are potentially unhealthy in terms of the foods and eating habits they promote.

Another important way to evaluate the potential benefit of a diet is to look at what has worked for the people who have effectively lost weight and kept it off. The National Weight Control Registry is an ongoing investigation that started in 1994.

The registry enrolls adults over the age of 18 who have lost 30 or more pounds and maintained their weight-loss for more than 12 months. They are currently monitoring the behaviors and characteristics of approximately 5,000 successful individuals, and have published more than a dozen papers on their findings. Some of the keys to success found to be common among their subjects are listed in the box to the right.

Popular Diet Systems

Sometimes it is true that there is nothing new under the sun. Though there are hundreds of diets all claiming to have the single best method for you to lose weight, there are really very few differences between them. It is, therefore, easiest to look at diets by classifying them into their basic strategies.

Despite the many names they go by and the small variations, most diets can fit easily into a few discrete categories Therefore, rather than look at dozens of programs individually, this article will focus on the categories and give examples for each. This list breaks down the diets as follows:

1. **Low Calorie**. While virtually all the programs mentioned here restrict calories to some degree, there are programs that use calorie control or reduction as the primary method or philosophy of weight-loss.
2. **Low Fat.** Fat is the most caloric of the macronutrients and diets high in fat may contribute to some chronic diseases. For these reasons, low-fat diets have been a mainstay of the weight-loss world for many decades.
3. **Insulin Controlling.** Insulin is a hormone that helps regulate both blood sugar and the way that the body stores calories as fat. Especially with the surge in diabetes, diets that focus on the control of insulin and blood sugar using a variety of methods have become increasingly popular.

***Diets** continued on page 14*

Dieting Keys to Success

Eat breakfast. Approximately 78 percent of those successfully maintaining an average weight-loss of approximately 70.5 pounds for six years eat breakfast every single day[4].

Restrict serving sizes. There is no successful weight-loss or maintenance that does not restrict overall intake of food[5].

Limit fat intake. Successful dieters also tend to limit calories from fat to between 23 and 25 percent of their total calories[6].

Select healthy foods. Along with selecting low fat foods, successful dieters tend to eat more foods that are high in fiber, more fruits and vegetables and fewer high calorie drinks (especially soda).

Use a scale. While some diet programs promote other means such as measurements or the fit of your clothes, 75 percent of those with long-term success report weighing themselves at least once per week[7].

Exercise regularly. Not all diet programs have their own exercise regimen, although many recommended physical activity. Exercise has been shown to be important to weight-loss maintenance, with one-hour per day of moderate intensity exercise being a common habit among those keeping their weight off long-term[8].

Limit food variety. A common diet strategy is the limitation of food choices – the extreme being meal replacement programs where dieters are only given the choice of shakes or bars for many months. Studies of successful dieters show that they tend to limit their food variety from all food groups[9].

Diets *continued from page 13*

There are also strategies that fall into some other classifiable categories:

1. **Food Combining**
2. **Mono-Diets**
3. **Cultural Diets**

Finally, there are few diets that are so unique that they don't readily fall into any of these categories, and for the purpose of our discussion will simply be classified as "other."

Low Calorie Diets

The gold standard of dieting is the low calorie diet. Fundamentally, for any weight-loss program to work, the calories taken in have to be less than calories taken out. There are actually two classes of low calorie diets:

The Low Calorie Diet (LCD) restricts food intake to between 800 and 1500 calories per day and the Very Low Calorie Diet (VLCD), which generally restrict dieters to between 500 and 800 calories per day. VLCDs should only be done under strict physician supervision because of the medical risk associated with them. LCDs are often done under physician supervision, but many programs are also available direct to consumers

LCDs and VLCDs tend to produce very good short-term weight-loss, with 12-week averages of 13 to 40 pounds lost. While more weight is initially lost with a VLCD, the weight-loss tends to equalize at around six months due to decreased compliance with the VLCD over time. For this reason, the safer LCDs are more commonly used.

The biggest challenge with either type of program is keeping weight off. Most of these programs utilize some form of meal replacements such as shakes, bars, soups or pre-packaged foods to help dieters in making food choices, and in accurate calorie control. However, when people stop using the fixed meal replacements; however, many migrate back to pre-diet foods at pre-diet portions. Studies looking at five year results on either form of program show that most people regain all weight initially lost[10]. Dieters who adhere to behavior modification and exercise have been shown to be more successful at keeping weight off long term[11].

Research in *Diets*

When we look at research on long-term outcomes of diet as a treatment for obesity, the results are not encouraging. In a recent review using Medicare treatment criteria, researchers from the University of California Los Angeles reviewed controlled trials of a variety of dietary interventions for weight-loss. They concluded the following:

> *"… the benefits of dieting are minimal Sustained weight-loss was only found in a small minority of participants, whereas complete weight regain was found in the majority. Beneficial health outcomes have not been consistently or frequently demonstrated in the long term, and very few studies were able to show clinically significant health benefits that persisted after weight regain[2]."*

The UCLA researchers found more evidence that dieting behavior is predictive of weight gain than it is of weight-loss. They concluded this because by and large, studies that tracked long-term maintenance of weight after a diet found that not only did people regain weight, they regained more than they lost initially.

This is not entirely new news in the medical community. The American Dietetic Association 2002 position paper on Weight Management also projected minimal benefit for diet and exercise plans. They state:

> *"Currently, available data on lifestyle weight-loss interventions indicate that they produce low levels of sustained loss. Typically reported weight-losses remaining after four to five years are about three to six percent of initial body weight[3]."*

This means that from the data they reviewed, a 250-pound dieter could expect to maintain a weight-loss of seven to 15 pounds after four to five years.

It is important to note that there are health benefits from even small amounts of sustained weight-loss, especially for control of blood sugar and blood pressure. Still, if we consider the resolution of overweight or obesity to be a primary goal of dieting, the results are simply not there for most people.

Examples of Low Calorie Diets and Very Low Calorie Diets include:
Optifast® (Novartis Medical Nutrition), Medifast® (Jason Pharmaceuticals, Inc), Slimfast (Unilever), HMR (Health Management Resources) and the Cambridge Diet.

Low Fat Diets

Low fat diets were very popular in the 1980's and 1990's and many low fat programs have maintained a large base of adherents. The principle of low fat diets is simple: fat has more calories per gram (nine) compared to carbohydrate and protein (which each have four). Reduce the fat in your diet, and you reduce the calories and you lose weight.

Most low fat diets reduce intake from fat to between 20 and 30 percent of total calories. There are some very low fat diets (Pritikin being an example) that reduce fat intake to below 20 of total calories. As the general public grows weary of the high-protein regimens that have held sway for the past 10 years, some of these low-fat principles are re-emerging with more modern twists. Volumetrics, with its emphasis on bulky/filling low fat foods (bigger volumes to fill you up, with low fat to keep calories in check) is an excellent example.

As with many diets, short-term weight-loss has been demonstrated with low fat programs. Reviews of randomized controlled trials have shown that overall results vary little from other types of plans, and that maintained weight-loss after 12-18 months only averages 4.4 to 8.8 pounds[12].

Low fat diets have often been pointed out as healthier than other types of diets, and it has been proposed that they may reduce other health risks such as heart disease and cancer. While some small trials do demonstrate these benefits, larger trials have not shown the benefits to be significant.

The Women's Health Initiative Dietary Modification Trial followed approximately 19,000 women on a low fat diet for 13 years. They found no reduced risk of breast cancer[13], colon cancer[14], or cardiovascular disease[15]. They also did not see any difference in weight from women who did not modify their diet to lower fat[16]. The primary reason proposed for the lack of health risk reduction was the lack of weight-loss. Excess body weight is a known risk factor for all of these conditions. Thus, it appears that following a low fat diet without losing weight does not impart any reduction in cancer or heart disease risk.

Examples of Low Fat Diets include:
Volumetrics, the Ornish Plan, the Pritikin Diet, Weight Watchers, vegetarian diets and Fit for Life.

Currently the best selling diet book in the U.S., and having been given thumbs up by Consumer Reports[17], Volumetrics (Barbara J. Rolls, PhD), is rapidly recharging the interest in low fat dieting. The general difference between Volumetrics and other low fat diets is the emphasis on eating large portions of foods that provide minimal calories (soups, salads, fruits and vegetables) so that you feel full due to the volume of food eaten.

A recent study compared a standard low calorie diet to the Volumetrics diet. At one year, researchers found that those following the Volumetrics principles lost 3.5 pounds more (17.5 pounds versus 14 pounds) while eating about 25 percent more food[18]. The Weight Watchers program, which has been around for about 45 years, is not only still popular, but has been studied in controlled trials. Weight Watchers is famous for their patented formula that assigns points to servings of foods with the goal of simplifying calorie counting. Studies of Weight Watchers show that long-term (two year) adherents tend to maintain a 5 percent weight-loss, and have improvements in blood pressure, cholesterol, blood sugar and insulin levels[19].

Insulin Control

Following two decades of low-fat dieting, Americans were swept up by a new wave of weight-loss plans that were focused around controlling the hormone that signals the body to store fat – insulin. There are really two versions of insulin controlling diets: Low Carbohydrate (also called High Protein) and Low Glycemic.

The general principles are the same – some foods (especially simple sugars and starches) cause a greater surge of blood sugar and a bigger release of the hormone insulin. The low carbohydrate programs take the strategy of dramatically reducing overall carbohydrate content of the diet in place of a much greater percentage of protein (and, in some cases, fat). The Low Glycemic (Low GI) diets allow adherents to eat a much greater range of food so long

***Diets** continued on page 16*

Diets continued from page 15

as the carbohydrates they eat have a minimal impact on raising blood sugar levels. Some of these programs also encourage more frequent eating of smaller meals, the theory being that this helps to keep blood sugar from rising and falling throughout the day.

Most studies have not shown insulin controlling diets to be any better than other forms of dieting for overall weight-loss. A 2004 study that compared low-carb to low-fat dieting found that after 11 months, the weight-loss in the two groups was virtually identical[20].

A much more recent study, however, came up with different and interesting results. In this trial, researchers randomly assigned dieters to either a low-glycemic or low fat diet[21]. They followed participants for 18 months, tracking not only weight but also insulin secretion, cholesterol and triglycerides. After 18 months, it was found that those with the highest baseline insulin secretion that followed the low-glycemic diet lost the most weight and had the greatest health improvements.

What this may tell us is that some diets work better for people with specific health conditions – in this case, that people who have high insulin secretion have better success on a diet that helps to control their insulin secretion.

These programs vary a lot in the way they allow dieters to select foods, when and how they suggest eating and in supportive areas like exercise. Several of them are "phased," meaning that dieters start with a very low carbohydrate introductory period and work their way up to a more varied eating plan.

In these programs (such as Atkins and South Beach), the goal is to have the body in a state of ketosis (where the body is actively burning and using fat for energy instead of carbohydrate). Because of this, individuals with kidney disease should not engage in low-carbohydrate dieting without physician supervision.

Cultural

Cultural diets are often based on the thinking that because people from a certain place who eat a certain way are healthier than you are, eating like they do will allow you to obtain a similar health status. The Mediterranean Diet is probably the best example of a cultural diet that has attracted a lot of attention from the medical community. This diet is high in fish, whole grains, beans, vegetables, olive oil (monounsaturated fat), red wine and fiber.

Examples of diets that use insulin control include: the South Beach Diet, the Atkins Diet, The Zone, Protein Power, Sugar Busters, Nutrisystem, The 3-Hour Diet and the Extreme Fat Smash Diet.

While not specifically studied for weight-loss, the large scale Lyon Diet Heart Study, did suggest that the Mediterranean diet is very beneficial for the cardiovascular system. After 46 months, subjects following the Mediterranean-style diet had a 50 to 70 percent lower risk of recurrent heart disease[22]. Other examples of cultural diets include the Okinawa Diet and the Sonoma Diet.

Food Combining

Adherents to food combining diets believe that the body processes particular combinations of foods differently from other combinations. Some examples of this thinking include the idea that starches should be eaten separately from proteins and fats, fruits should be eaten on an empty stomach, or that foods should be eaten at specific times of the day.

While some of these programs are healthy in the foods that they recommend and are low calorie (which can result in weight-loss), there is no scientific evidence that specific combinations of foods will produce more weight-loss, burn fat more efficiently or impart other health benefits. Some examples of food combining diets include Fit for Life, the Schwarzbein Principle, the Beverly Hills Diet and the Suzanne Somers diet.

Mono Diets and Miracle Foods

Every once in a while you may be standing in the checkout line at the grocery store and catch a magazine cover praising some miracle food for weight-loss. These diets are usually based on eating large amounts of a single food for a period of time, or adding a "miracle" food to a strictly controlled diet to

enhance metabolism or weight-loss. Virtually all mono diets and miracle food diets will produce acute weight-loss, but they are not healthy, balanced or sustainable as a real weight-loss method. Examples of these concepts include the Grapefruit Diet, the Cabbage Soup Diet, the Apple Cider Vinegar Diet and the Milk Diet

Other

The Fat Flush diet was developed by Anne Louise Gittleman[23]. The program claims to promote weight-loss by cleansing and detoxifying the liver and thereby promoting better metabolism. The program is phased and eventually it ends up looking like a standard low-carbohydrate diet. While the idea is interesting, there is no current scientific evidence to support the concept of "fat flushing."

The Blood Type Diet was developed by Dr. Peter D'Adamo who published the book Eat Right for Your Type in 1996[24]. The theory put forth by Dr. D'Adamo is that blood type is a genetic fingerprint more powerful than race, culture or geography.

He believes that sickness is caused by negative reactions between complex molecules in foods (lectins) and markers on the cells of the body. The book purports that eating foods that "agree" with your blood type will reduce your risks for cancer, heart disease, diabetes, infections and cancer. The author and other adherents believe that eating the foods deemed appropriate for your blood type will assist with weight-loss.

Conversely, eating the wrong foods can cause all sorts of health problems. If carefully examined, the blood-type diet is really a low calorie diet with intakes of 1,150 to 1,250 calories per day. Beyond that, the diet may be difficult to follow due to many restrictions and hard-to-find foods, and no evidence exists to prove that it would be more beneficial than any other low-calorie program.

About the Author:

Jacqueline Jacques, ND, is a Naturopathic Doctor with more than a decade of expertise in medical nutrition. She is the Chief Science Officer for Catalina Lifesciences LLC, a company dedicated to providing the best of nutritional care to weight-loss surgery patients. Her greatest love is empowering patients to better their own health. Dr. Jacques is a member of the OAC National Board of Directors.

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Advocacy News
Advocacy Action

We often hear the question, *"Does advocacy really work?"* One of the best examples of advocacy in action is represented by just one patient. Jeff Haaga is a resident of the state of Utah, and while trying to access bariatric surgery, he hit a stumbling block - the procedure wasn't covered under his insurance. But that stumbling block wasn't enough to stop Jeff. Below, Jeff tells his remarkable story of how he continues to fight for something for which he strongly believes.

I have always been politically active in my community and volunteered for many efforts.

In 2003, my brother had gastric bypass. I was impressed that he lost 150 pounds with the surgery. Of course, over time, we all (my siblings) have lost hundreds of pounds and gained the weight back plus more. We were not obese as children; therefore, why all my siblings and I have a predisposition for weight gain is unknown. This procedure showed us hope in a longer life free from the disease of obesity.

I began to study the surgery and consulted my doctor. After much meditation, I decided to proceed to have my surgery authorized by our health insurance company. I never thought for one minute they would not cover the operation since they were spending thousands yearly to maintain treatment for my co-morbidities. But, I was wrong.

In Utah, it is a law that insurance providers offer you two levels of appeal. My first appeal was before a small board handpicked by the CEO of the insurance company in July 2006. I felt I had made my case in a humbling way in front of people that all were of normal weight. Of course, the denial came in the mail citing the written exclusion without any empathy for my situation.

I decided to appeal to the CEO and the Board in September 2006 and prepared data and a presentation to explain my position. I entered a room with some of my peers and some that I have worked with on other political issues. It was again a humbling meeting where I practically begged for help. I do remember the CEO asking me what I would do if I was denied and I simply said "activism." What I learned on the OAC Web site informed me on ways I could take a proactive step in advocating for my health and care.

Taking Action

As a marketer, I ran Steve Mascaro's re-election campaign that fall. I had a lunch with him after his victory and I asked him if he would run a bill on morbid obesity. I never thought I could write state legislation. I studied other states that passed or are in the process, and decided to write the legislation.

I have been involved in government for many years and understood it would be a long process. Interestingly, once the legislation was published, the interest in morbid obesity seemed high. People began to call and ask to help or tell me how their life changed by treatment and others in tears having been denied.

I decided to set up the Utah Obesity Coalition and get organized. You need to have the realization that it might not only help you, but others too. When you have multiple voices sounding your chorus you can accomplish many things. I recognized the strengths we had in the tens of thousands of people that were post-operative. I knew it would be hard for others like me to stand up publicly and fight with the stigma of obesity being so painful. I solicited the forum groups on obesity and asked for help. Most of these people were post-operative patients who lost hundreds of pounds and were seeking ways to help others stay strong. While the other individuals I found, were still fighting their disease but were willing to write letters. In two short months, I had thousands of people writing our legislature asking them to support the bill HB225.

We have had our setbacks with the legislation, but we are determined to proceed. Our goals will be to financially organize so we can legally ask for funds to target legislators with a marketing campaign to support our new proposed legislation for 2008. Senator Chris Buttar said, "You have a huge education process in front of you." We will, with his help, proceed with the legislation and ask constituents of those legislators to support the 2008 bill to help us communicate the message. It will take time, but in time we will have success.

Obesity Action Coalition Celebrates Two-Year Anniversary

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

Throughout the past year, the OAC accomplished tremendous strides in the obesity community. With the introduction of the OAC's "Understanding Obesity" series, the OAC continues to provide an excellent source of valuable materials for those affected by obesity, morbid obesity and childhood obesity.

In 2006/2007, the OAC distributed more than 250,000 educational and advocacy-related materials throughout the United States. These materials consisted of valuable information, such as obesity/morbid obesity treatment options, nutritional information, insurance information and much more.

On the advocacy front, the OAC played an instrumental role in 2007 with its involvement in major issues affecting patients, such as calling on BlueCross/Blue Shield of Tennessee to rescind its IQ testing requirement for those wishing to seek weight-loss surgery and representing the patient voice with TUFTS Health Plan in revising their policies regarding weight-loss surgery. And recently, the OAC represented the patient voice in Utah where OAC President & CEO Joseph Nadglowski, Jr., testified before a hearing committee on the need for access to safe and effective obesity interventions and the importance of improving the quality of health and life for all those affected by obesity.

"Throughout the past year, the OAC maintained a continuous level of service to all of its constituents. Since 2005, we continue to expand our resources on all fronts. Looking ahead, this year we are partnering with the ASBS Foundation on the Annual '*Walk from Obesity*.' In September and October in more than 70 cities across the country, patients will join together and walk to raise money for research, education, prevention and treatment of obesity. The OAC will continue to increase obesity education, work to improve access to medical interventions 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 President & CEO Testifies at Utah Hearing on Access to Obesity Interventions

OAC President & CEO, Joseph Nadglowski, Jr., testified Wednesday before the Utah Health and Human Services Interim Committee on access to safe and effective obesity interventions. The hearing was co-chaired by Senator D. Chris Buttars and Representative Paul Ray

Mr. Nadglowski detailed the severity of obesity and demonstrated the upward trend of this disease in the state of Utah.

"Today, more than 20 percent of the residents of Utah are obese and approximately five percent are morbidly obese or 100 pounds over ideal body weight. This is a dramatic explosion considering that in 1991, fewer than 10 percent of the citizens of Utah were obese. In less than 15 years, the number of obese citizens of Utah has doubled," said Mr. Nadglowski.

Mr. Nadglowski also expressed the importance of expanding prevention efforts and improving access to safe and effective treatment options, such as medical nutrition therapy, physician supervised weight-loss and for appropriately selected candidates, bariatric surgery.

The committee also heard testimony from patient advocate Jeff Haaga, a Utah resident affected by morbid obesity. Mr. Haaga has been attempting to qualify for weight-loss surgery for more than a year now. He has been instrumental in bringing this issue to the forefront in the state of Utah and expressed his concerns with passion and poise during the hearing. *(To read more about Jeff Haaga's efforts in Utah, please see page 18.)* In addition, post-bariatric patients Genevieve Winegar and Colleen Cook provided their personal stories of successfully treating their obesity through bariatric surgery and the differences the obesity intervention made in their quality of health and life.

All of those providing testimony Wednesday took part in a pivotal step and expressed a great demand for intervention related legislation to fight this disease on all fronts.

FAQs *continued from page 1*

Is it possible to get down to my ideal body weight?

It is possible to get down to your ideal weight following gastric banding. Most patients lose about half of their excess weight following gastric banding, and they lose it slowly and steadily, about one to two pounds per week. The weight-loss pattern is very different as compared to gastric bypass, which is usually rapid and radical. What you eat, how often you eat and how much you exercise will determine your success. Your LAP-BAND® will help you control your portion size. You will need to control the rest. If you eat too much too fast, or do not chew thoroughly, you will probably experience some discomfort or regurgitate your food.

After I lose all my weight, can I have the LAP-BAND® removed?

Many patients wonder if after they get down to their goal weight, they can have their LAP-BAND® removed. The LAP-BAND® is meant to remain in place indefinitely. We know that once the band is removed, patients no longer feel satisfied with small portions, and often times start eating larger meals again. Although gastric banding is a reversible procedure and the LAP-BAND® can be removed laparoscopically, it is not advisable to have the band removed once you meet your goal weight.

Can I be allergic to the LAP-BAND®?

There have been no case reports of an allergic-type reaction to the LAP-BAND®.

Is it safe to get pregnant with a LAP-BAND®?

It is safe to get pregnant with a LAP-BAND®, but women are usually advised to wait a year or two after surgery before becoming pregnant. Most weight-loss occurs during the first year, so it is usually better to wait until your weight stabilizes before considering a pregnancy. Check with your doctor if you are planning a pregnancy. They will want to make sure you are eating a well-balanced diet, taking your supplements and feeling fit before you become pregnant. And if you do become pregnant, make sure you tell your weight management team. They will want to monitor your nutritional status and weight gain closely.

Will I need to have my LAP-BAND® removed if I become pregnant?

Your LAP-BAND® will not need to be removed if you become pregnant. Your LAP-BAND® will assist you with hunger and portion control during your pregnancy. The notion of "eating for two" often gets women into trouble with too much weight gain. Your band can be adjusted during pregnancy. Some surgeons recommend emptying the band before delivery.

Will I need to take vitamin supplements for the rest of my life?

Because there is no malabsorption with the LAP-BAND®, you will not require the same types of supplements as gastric bypass patients. Usually, taking a daily multivitamin with minerals along with eating a balanced diet is sufficient for most patients. Women may sometimes require a calcium supplement as well.

The LAP-BAND® port.
Note: Not Actual Size.
Photo courtesy of Allergan, Inc.

What about the medications I already take? Will I still be able to take them?

For one month after surgery, any medicine you take will need to be crushed, chewable, in liquid form or smaller than a plain M&M. After the first month, you should be able to take most pills. You may find that as your weight starts to come off and your health starts to improve, you may no longer need all your medications. Many weight-related medical conditions tend to improve or completely resolve with significant weight-loss. Make sure you schedule regular follow-up visits with your healthcare provider, so that he or she can monitor your weight-loss, your medical conditions and your medication needs.

Will I feel the LAP-BAND® inside me?

Most patients are only aware of their LAP-BAND when they eat. You may, however, notice your access port, particularly right after surgery when you are recovering, healing and still feel a little sore.

How many times can the LAP-BAND® be adjusted?

There is no limit to how many times it can be adjusted. Most patients need about three adjustments during the first year after surgery. Your LAP-BAND® can be adjusted as many times as your surgeon finds it necessary.

How will I know if I need an adjustment?

Your surgeon can help you decide if you need an adjustment. If you are hungry, looking for food, and not having optimal weight-loss, you probably need fluid added to your band. If you are experiencing early and prolonged satiety (feeling full after a small portion of food for several hours), and losing one to two pounds per week, your band is working fine, and you do not need an adjustment. If you are having symptoms such as difficulty swallowing, night cough, regurgitation, acid reflux or heartburn, you might need fluid removed.

When your band is optimally adjusted, you should feel satisfied after eating a small portion of food, and you should still be able to tolerate most foods. If you find that you are having difficulty swallowing solid foods, you might not be chewing well enough, you might be eating too fast or your band may be just too tight. Check with your surgeon if you are not sure.

Eating after LAP-BAND® Surgery

Most surgeons require their patients to follow a special diet for the first month after surgery. The diet is progressed from liquids to pureed foods, to soft and then solid foods during the first postoperative month. This gradual progression from liquids to solids allows you to get used to eating with your LAP-BAND®, and allows your stomach to heal.

Eventually, you should be able to tolerate most foods in small portions, provided you chew them thoroughly, eat slowly and avoid foods that are dry, tough or stringy. You will, however, need to change your eating habits. The key to long-term success after LAP-BAND® surgery is making permanent changes in your lifestyle, which include choosing nutritious foods and exercising.

Are adjustments painful?

An adjustment is a quick, simple and relatively painless procedure. It is usually performed in your surgeon's office. On rare occasions, your doctor will want to do your adjustment using x-ray or fluoroscopy. X-ray is needed if your surgeon cannot feel or find your access port. Fluoroscopy is also helpful if your surgeon suspects you may have a problem.

About the Author:

Dory Roedel Ferraro, MS, CS, ANP, has specialized in the field of obesity surgery for more than 13 years and has been instrumental in the development of bariatric practices throughout the United States. She is a graduate of the School of Nursing at Stony Brook where she earned a Master's degree and certification as a Nurse Practitioner. She is the Clinical Director of Columbia Presbyterian's Center for Obesity Surgery at Lawrence Hospital and the Medical Director of the Long Island Bariatric Center in Levittown, New York. Dory is also a member of the OAC Advisory Board.

Have *You* registered for a Walk *yet*?

Education, Research & Treatment of Obesity
WALK from OBESITY™

Plans for the 2007 *Walk from Obesity* are well underway. Walk event locations are now available.

Find a Walk Near You!

Alaska
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www.walkfromobesity.com

Chairman's Council

The OAC is grateful for the generous support of its Chairman's Council Members:

Platinum
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New Dimensions Weight Loss Surgery
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SmartForme

The Chairman's Council is the OAC's most prestigious membership level. Membership in the Council is accompanied with several exclusive benefits. By joining as a Chairman's Council member, you are making a commitment to improving education and advocacy efforts for the obese and morbidly obese. Most importantly, your membership strengthens the voice of patients in the obesity community.

To add your name to this list, please visit **www.obesityaction.org** or contact us at (800) 717-3117.

Top 10 continued from page 5

3. Use fresh pre-cut vegetables and fruit to help in meal preparations.

Precut vegetables and fruits may cost more, but it is one of the fastest growing industries in fresh food production. These already-cut vegetables and fruits can make most recipes quick, ready in less than 15 minutes. Most local grocery markets cut their own produce daily and have everything from chopped tomatoes to diced bell peppers in their refrigerated case.

In addition, check your deli and produce sections for already prepared fresh fruit salads and take home salads. The shelf life of precut fresh fruits and vegetables is normally half than if left whole and uncut. So when you buy them, use them.

2. If a recipe call's for alcohol, do I have to use it?

Absolutely not! Alcohol is added to give the dish a unique flavor, but if you as the cook choose not to use alcohol then be sure to substitute with another liquid that has flavor. For chicken dishes, use chicken stock, for beef dishes use beef stock and for fish or seafood use vegetable broth or chicken stock. In addition, if you are using alcohol, do not use cooking wine. This type of wine is almost vinegar. As a rule, if you will not drink it, do not use it in cooking.

1. Be your own chef!

Instead of looking for a recipe where every ingredient fits your preference, think of a recipe as a guide. If you do not like asparagus, change it to broccoli. If the recipe you are interested in contains shrimp and you are allergic, change it to fish or chicken. The amazing part about cooking is that the possibilities are endless.

About the Author:
Chef Dave Fouts is known as the world's premier culinary expert for Weight Loss Surgical Patients. Chef Dave can be found speaking around the country on the importance of Culinary techniques and cooking methods to ensure the weight loss patients success. For more information please visit ***www.chefdave.org****.*

OAC Membership

The OAC was founded as the "patient voice" in obesity. As a membership organization, the OAC exists to represent the needs and interests of those affected by obesity and provide balanced and comprehensive education and advocacy resources. Membership in the OAC is integral in strengthening the voice of the millions affected by obesity. Various membership levels are available and each is accompanied with several valuable benefits such as:

- Official membership card/certificate
- Annual subscription to *OAC News* – OAC's quarterly educational and advocacy newsletter
- Subscription to *Obesity Action Alert* – monthly e-newsletter distributed on the 1st of each month
- Access to valuable educational resources and tools
- Patient representation through advocacy, in addition to information on advocacy issues concerning patients

Yes! I would like to join the OAC's efforts. I would like to join as a/an:

- ❑ Patient/Family Member: $20
- ❑ Professional Member: $50
- ❑ Physician Member: $100
- ❑ Surgeon Member: $150
- ❑ Institutional Member*: $500 *(Surgery centers, doctors' offices, weight-loss centers, etc.)*
- ❑ OAC Chairman's Council*: $1,000 +

** These membership levels have exclusive benefits.*

Mail to: OAC
4511 North Himes Ave., Ste. 250
Tampa, FL 33614
Or Fax to: (813) 873-7838

Name: _____
Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

Payment Information

Enclosed is my check (payable to the OAC) for $ _____.

Please charge my credit card for my membership fee:

❍Discover® ❍MasterCard® ❍Visa® ❍Amex®

Credit Card Number: _____

Expiration Date: _____ Billing Zip Code: _____

www.obesityaction.org

About the OAC

The Obesity Action Coalition (OAC) is a non profit patient organization dedicated to educating and advocating on behalf of those affected by obesity, morbid obesity and childhood obesity. The OAC distributes balanced and comprehensive patient educational materials and advocacy tools.

Obesity Action Coalition

The OAC believes that patients should first be educated about obesity and its treatments and also encourages proactive patient advocacy. The OAC focuses its advocacy efforts on helping patients gain access to the treatments for morbid obesity. As a membership organization, the OAC was formed to bring patients together to have a voice with issues affecting their lives and health. To learn more about the OAC, visit www.obesityaction.org or contact us at (800) 717-3117.

OAC Resources

The OAC provides numerous beneficial resources for patients, as well as professionals. All OAC resources are complimentary and may be ordered in bulk. To request materials, please contact the OAC National Office at (800) 717-3117 or send an email to **info@obesityaction.org**.

Newsletters

- *Obesity Action Alert* - the OAC's free monthly electronic newsletter
  OAC News - OAC's quarterly education and advocacy newsletter

Brochures/Guides

- *Are you living with Obesity?*
- Advocacy Primer: *Your Voice Makes a Difference*
- BMI Chart
- OAC Insurance Guide
- State-specific Advocacy Guides
- *Understanding Obesity* Series
  - *Understanding Obesity* Brochure
  - *Understanding Obesity* Poster
  - *Understanding Morbid Obesity* Brochure
  - *Understanding Childhood Obesity* Brochure
  - *Understanding Childhood Obesity* Poster

OAC News

The Obesity Action Coalition's Quarterly Newsletter

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