



OAC News

The Obesity Action Coalition's Quarterly Newsletter

Understanding the *Risks* of Bariatric Surgery



By Lloyd Stegemann, MD

If you listen to the popular press, you would think that every weight-loss patient has a complication or dies after weight-loss surgery. The truth of the matter is that the majority of people come through their operation with few to no complications. Even though the number of bariatric surgeries being performed is increasing exponentially, it has never been safer to undergo a weight-loss operation.

It is important to understand, however, that there are real risks when undergoing a major operation like weight-loss surgery. This article discusses some of the common risks facing patients undergoing weight-loss surgery.

Let's start out with the worst possible complication: death. Despite what the media would have you believe, death is actually unusual after weight-loss surgery. If you look at the most popular weight-loss operations, the death rates are: Adjustable Gastric Banding 0.1 percent, Gastric Bypass 0.5 percent, and Biliopancreatic Diversion 1.1 percent. In many experienced programs, the rates are even lower. While the risk of death is very low, it is very real and must be seriously considered when contemplating weight-loss surgery. It is vital that each individual considering weight-loss surgery ask themselves the question, "Does my weight problem concern me enough that I am willing to put my life on

the line to get it under control?"

With any major surgery there are risks while you are in the hospital and after you have gone home. The tables, located on page 8, list some of the more common complications that can occur during these time frames.

There are additional risks that are specific to a particular weight-loss operation and are beyond the scope of this article. You should talk to your surgeon about specific risks once you have decided which operation is right for you. Keep in mind that the medical problems you bring into the operating room also affect your level of risk (i.e. the "sicker" you are the riskier the weight-loss surgery).

On a more positive note, there are some things that you can do before your operation to minimize your risk. One of the most important things you can do is to select an experienced weight-loss surgeon with an established, multi-disciplinary program. Second, if you are a smoker, stop immediately. Smoking impacts multiple organ systems and has serious effects on the lungs and on wound healing. Most weight-loss programs will want you to lose some weight prior to weight-loss surgery. The 10-20 pounds that most pro-

Risks continued on page 8

Inside This Issue:

Obesity-Related Diseases from A-Z
Page 3

Medical Weight-Loss Myths
Page 5

Post-Surgery Diet: What to Expect
Page 6

Surgery Risks Studies
Page 9

Patient Profile: "Ryan's Story"
Page 10

Advocacy: CMS Releases Proposed NCD
Page 12

Meet the OAC Board
Page 13

Centers of Excellence
Page 14

Join the OAC!
Page 19

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OAC

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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.

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

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

Happy New Year! Inside the second issue of *OAC News*, you will find a wide variety of educational articles we hope you will find beneficial.

I would like to highlight that the OAC has selected our 2006 – 2008 Board of Directors. Biographies of our Directors can be found on pages 13 and 17. It is our strong belief that in order to conduct effective patient advocacy, patients must be involved. As such, you will see that the vast majority of our Directors are comprised of those who have been personally affected by obesity.

Please help us spread the word by sharing this newsletter with your family, friends and healthcare professionals. If you have already joined the OAC, thank you! If not, I encourage you to join by completing the membership application included in this newsletter. Whether a patient, family member, friend or healthcare professional, the greater our membership, the stronger our voice.

If you have any questions about the newsletter, would like to receive additional copies or would like more information on any of the OAC's activities, please do not hesitate to contact our National office at (800) 717-3117 or info@obesityaction.org.

Sincerely,



a National Board of Directors. Members of the OAC Board of Directors include: Robin Blackstone, MD, Jim Fivecoat, Ralph L. Guatelli, RPH, 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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Opinions expressed by the authors are their own and do not necessarily reflect those of the OAC Board of Directors and staff. Infor-

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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

information contained herein should not be construed as delivery of medical advice or care. The OAC recommends consultation with your doctor or healthcare professional.

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

A General Look

Obesity-Related Conditions from A-Z

It is not uncommon that people affected by morbid obesity also deal with obesity-related illnesses accompanied by this disease. Once a patient is considered morbidly obese, these conditions become serious health risks. Obesity-related diseases also negatively impact the quality of life for a patient and their family members affected by morbid obesity.

In this issue of *OAC News*, we have listed common co-morbid conditions affecting the morbidly obese. Many of these co-morbidities are serious and may even be as life threatening as morbid obesity itself.

Cancer: Cancer involves the uncontrolled growth of abnormal cells that have mutated from normal tissues. These cells prevent normal function of vital organs, damaging essential systems.

Recent studies suggest that those with a Body Mass Index (BMI) more than 40 (morbidly obese) had death rates from cancer that were 52 percent higher for men and 62 percent higher for women, as compared to rates for normal-weight men and women.

In both men and women, higher BMI is associated with higher death rates from cancers of the esophagus, colon and rectum, liver, gallbladder, pancreas and kidney. The same trend applies to cancers of the stomach and prostate in men, and cancers of the breast, uterus, cervix and ovaries in women.

Almost half of post-menopausal women diagnosed with breast cancer have a BMI greater than 29. One study indicates (Nurses' Health Study) women who gain more than 20 pounds from age 18 to midlife double their risk of breast cancer, compared to women whose weight remained stable.

Diabetes: Diabetes is a life-long disease

marked by high levels of sugar in the blood. It can be caused by too little insulin (a hormone produced by the pancreas to regulate blood sugar), resistance to insulin or both.

Among those diagnosed with type 2 (non insulin-dependent) diabetes, 67 percent have a BMI greater than 27 and 46 percent have a BMI greater than 30. Nearly 17 million people in the U.S. have type 2 diabetes, accounting for more than 90 percent of diabetes cases.

An additional 20 million have impaired glucose tolerance, sometimes called pre-diabetes, which is a strong risk factor for developing diabetes later in life. An estimated 70 percent of diabetes risk in the U.S. can be attributed to excess weight.

Gallbladder Disease: Gallbladder disease includes inflammation, infection, stones or obstruction of the gallbladder.

Heartburn: Heartburn is a painful burning sensation in the esophagus, just below the breastbone. The pain often rises in your chest and may radiate to your neck or throat.

Heart Disease: Heart disease is any disorder that affects the heart's ability to function normally. The most common cause of heart disease is narrowing or blockage of the coronary arteries, which supply blood to the heart.

High Cholesterol: Lipid disorders are when you have excess fatty substances in your blood. These substances include cholesterol and triglycerides. Having a lipid disorder makes you more likely to develop

A-Z continued on page 4

Obesity-Related Diseases

A General Look

A-Z continued from page 3

arteriosclerosis and heart disease.

High Blood Pressure: Blood pressure is measured in millimeters of mercury (mm Hg). Hypertension (high blood pressure) is when your blood pressure frequently goes higher than 140/90 mm Hg.

About one in every five adults in the U.S. has high blood pressure. High blood pressure occurs more often in men than in women. In addition, African Americans are affected almost twice as much as Caucasians. More than 75 percent of hypertension cases are reported to be directly attributed to obesity.

Osteoarthritis: Osteoarthritis is a chronic disease causing deterioration of the joint cartilage (the softer parts of bones which cushion their connections to each other) and the formation of new bone (bone spurs) at the margins of the joints.

Psychological Depression: Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. True clinical depression is a mood disorder in which feelings of sad-

ness, loss, anger, or frustration interfere with everyday life for an extended time.

Sleep Apnea: Sleep apnea is a condition characterized by episodes of stopped breathing during sleep.

Stroke: A stroke occurs when a blood vessel (artery) that supplies blood to the brain bursts or is blocked by a blood clot. Within minutes, the nerve cells in that area of the brain are damaged, and they may die within a few hours. As a result, the part of the body controlled by the damaged section of the brain cannot function properly.

In conclusion, those who are affected by obesity and morbid obesity are encouraged to talk with their physician concerning the co-morbidities listed here. The earlier these are detected, the more advantage a patient may have to keep them under control with the assistance of a physician.

To learn more about obesity-related conditions, please visit the OAC Web site at www.obesityaction.org.

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Obesity Action Alert
Obesity Action Coalition Electronic Newsletter

Three Reasons Why You Need to Subscribe to the *Obesity Action Alert*, the OAC's FREE E-Newsletter:

- Up-to-date information on obesity and morbid obesity, such as treatment options and advancements on the disease
- The latest advocacy news helping you become a proactive advocate for change
- The most current information on the OAC and its efforts in the fight against obesity and morbid obesity

Visit www.obesityaction.org or e-mail the OAC at info@obesityaction.org today to subscribe.

Medical Weight-loss: Dispelling the Myths

By Robert Skversky, MD

As a bariatrician (a physician who specializes in the medical treatment of the overweight or obese person), I am constantly amazed at the amount of misinformation disseminated to the public by nutritionists, personal trainers, the media, and yes, healthcare professionals too, in reference to effective treatment for weight-loss and more importantly, long-term weight-loss maintenance.

Obesity is of epidemic proportions in this country with more than 60 percent of adults now considered overweight or obese. As a result of this "epidemic," the incidence of obesity-related co-morbid diseases, such as cardiovascular disease, diabetes, hypertension, hyperlipidemia (high cholesterol/triglycerides) and even various types of cancer, are also increasing.

Defining Obesity as a Disease

Obesity has been classified as a disease by various medical associations such as the American Medical Association (AMA), the American Society of Bariatric Physicians (ASBP), the North American Association for the Study of Obesity (NAASO) and since 2002, even the Internal Revenue Service (IRS).

Obesity is a metabolic, chronic and progressive disease with a significant genetic predisposition. Childhood studies conclude obesity to be as high as 70 percent genetic with 30 percent being related to psychosocial and environmental factors. Studies of identical twins separated at birth have shown that they much more closely resemble the weight of their biologic parents than their adoptive parents. Scientists believe there are approximately 1,000 genes related to weight and more than 200 have already been discovered.

Obesity in fact is a disease, very much like the previously mentioned co-morbid conditions that it can cause and/or

make worse. This is because they also are genetic, metabolic, chronic and progressive. However, there are a few notable differences that make it that much more important that we understand how to treat this disease effectively.

The Impact of Obesity

Unlike diabetes and hypertension, obesity cannot hide from those around you. As a result, this disease is virtually 100 percent diagnosable, whereas less than half the people who have diabetes or hypertension do not even know they have those diseases. Another important difference is the obvious psychological impact that obesity has on the person and its associated prejudice and discrimination that is well documented. Studies show that the morbidly obese, if given a choice, would prefer blindness or deafness to obesity.

Weight-Loss Strategies

The traditional paradigm for weight-loss in this country (diet, exercise, behavioral modification and the "occasional" use of prescription medication) has proven time and again to be ineffective for the vast majority of people. Commercial weight-loss programs have a greater than 95

percent failure rate at three to four years. Although Weight Watchers® may be a good source of nutritional information and support, the average weight-loss after two years of weekly meetings is about six pounds.

To treat an overweight person by telling them to "eat less and exercise more" is paramount to telling the diabetic to control the disease by simply eating less sugar. This also applies to treating the hypertensive patient by telling them to simply "relax" or telling the depressed person to think "happy" thoughts.

Myths continued on page 18

The keys for weight-loss success are based on three major factors:

- Genetics
- Sensitivity to medication over which we have no control
- Compliance or discipline over which we do have control

Nutrition



Corner

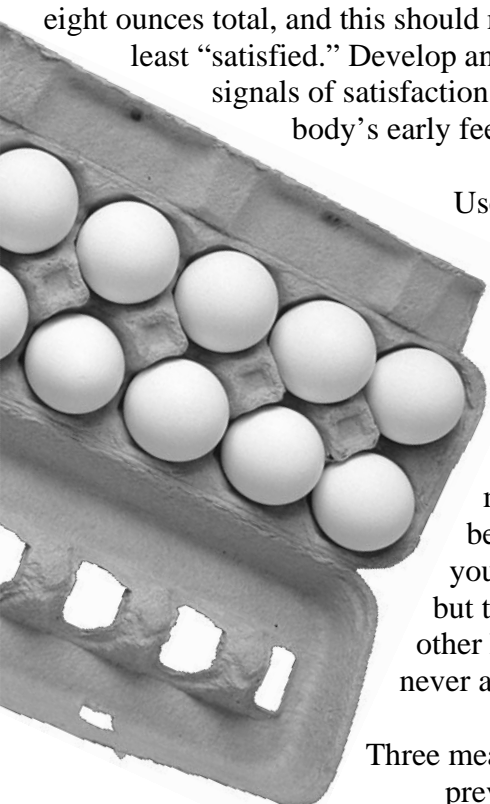
The Post-Surgery Diet for Bariatric Patients: What to Expect

By Denise Addorisio, RD, CDN

Have you decided to have bariatric surgery, or are you already post-op and on your way to losing weight? That's great, but first you need to understand the basic principles of the post-op diet so you can properly use the tool the surgeon has created for you to lose weight, while meeting your nutritional needs.

Optimizing Nutritional Value

First and foremost, remember that your overall dietary goal is to optimize the nutritional value of the small portions of foods you eat so you get the nutrients your body needs to be healthy. Portion sizes for meals should be no more than six to eight ounces total, and this should make you feel full or at least "satisfied." Develop an awareness of your body's signals of satisfaction, and be in tune with your body's early feelings of fullness.



Use measuring tools and a food scale to check your portion sizes. Serving meals on smaller plates, such as salad or luncheon plates, will help make these small portions look more appealing. You may be tempted to skip meals if you are not feeling hungry, but this behavior can lead to other health problems and is never advised.

Three meals each day also helps to prevent snacking or "grazing,"

which can add many calories between meals. Most long term post-op bariatric patients find they need to limit their total caloric intake to less than 1,000 calories per day to maintain their weight-loss.

Foods should be eaten slowly, perhaps taking 20-30 minutes to complete your meal. Since most bariatric patients were fast eaters in their previous life, this can be a difficult behavior to change. Use tools such as small baby spoons and forks to help slow you down. An egg timer is a handy way of making sure that you wait two minutes between bites, which helps you stretch the meal period to the suggested 20 to 30 minutes.

Chewing your food carefully, perhaps up to 15-20 chews per bite, until the foods feels pureed before swallowing, will help slow you down. It is also important to chew foods well to ensure that nothing gets stuck passing through the narrowed outlet from the pouch. Failure to eat small portions, eat slowly and chew carefully can lead to vomiting, which is never considered normal.

Nutrients

Protein is the most important nutrient in the bariatric diet. Foods high in protein should be eaten first, in case you feel full and cannot finish your meal. While the best sources of proteins are eggs, poultry, meats, fish, cheese and milk, other protein sources to consider adding to your diet include beans, lentils and soy products such as soy burgers found in your grocer's freezer section.

* Helpful Nutrition Tip:

If preparation time is a stumbling block, buy pre-cut, pre-washed vegetables such as baby carrots, sliced mushrooms, melon bowls or salads in bags. Go to the supermarket salad bar and buy cut-up fruits and vegetables in small quantities by the pound. Treat yourself to your favorite fruit for dessert, even if it was expensive. You wouldn't have thought twice about spending for an ice cream, why hesitate to spend it on melon or berries even when not in season? Try exotic or tropical fruits, you may be surprised to discover you like them.

Be sure not to overcook meats and try using moist cooking methods such as braising, steaming and stewing to prevent proteins from getting too dry or tough. Leftover meats can also become too dry, so consider adding liquids when reheating foods such as broth or fat free gravy, or add last night's leftover chicken to today's salad for lunch with some low fat salad dressing instead.

Red meats such as beef, pork, lamb or veal can be particularly difficult for a bariatric patient to digest. Be sure to choose tender cuts, but watch out for the potential for higher fat content (that means higher calories). Some bariatric programs encourage regular use of protein supplements, but your best choice is always traditional foods unless you have a particular situation that requires you to add protein supplements to your diet. Suggested long term post-op protein intake may range from 55-80 grams per day.

Because starches such as bread products, rice and pasta can be trigger foods for many formerly obese patients, many bariatric programs limit their intake. Although carbohydrates are your body's primary fuel source, carbohydrates are also found in fruits and vegetables. Unfortunately, many patients have had limited intakes of fruits and vegetables in their pre-op diet, and never consciously thought about their importance to a balanced diet, which is even more important now.

Besides fruit for dessert, try sugar free ice pops or diet gelatin. While artificial sweeteners have a place in the bariatric diet, beware of low sugar cakes, cookies and ice cream and read food labels to determine if they are truly low calorie. Sometimes these foods are just a tease, and may trigger your desire for the real thing.

Dumping with Roux-En-Y

Some types of bariatric surgeries such as the Roux-En-Y (RNY) gastric bypass create a situation where dumping occurs if the post-op patient eats sweets such as cake, cookies or ice cream. The aspect of the RNY surgery that creates malabsorption through bypassing part of the intestine is the reason for the symptoms of dumping. These symptoms may include abdominal pain, nausea, diarrhea, dizziness and hot flashes or cold sweats. For most patients, knowing they will become sick after eating sweets will be a strong deterrent, preventing them from wanting to eat those foods. However, if you eat "just a bite" of sweets over time, you can build up a tolerance for them. This means that you will eventually be able to eat more sweets without experiencing dumping, and then only willpower will help you avoid these high fat, high sugar, high calorie foods. Of course, that can ultimately lead to regaining of weight or perhaps not even reaching your expected weight-loss.

Fluids

Fluids are an important part of any diet, but particularly for the bariatric patient. All liquids should be consumed between meals, never with a meal. Again, this can be a hard habit to break, but it is very important to your success. Drinking with meals can lead to "pushing" the solid food through your pouch more quickly, which leads to faster emptying of your pouch. What does that mean? When your pouch is empty, you feel hungry. The sooner your pouch is empty, the hungrier you will feel and you will be tempted to eat between meals. That's definitely a recipe for failure.

Choose fluids that are non-carbonated. Yes, that means no soda, diet or regular. Besides making you feel uncomfortable, the gas produced by the carbonated beverage can stretch the pouch or its outlet. Stretching means that you will soon be able to fit larger portions of foods in your pouch before you feel full. Remember, more food equals more calories. Your best choices for fluids are water (try squeezing some lemon in there), artificially sweetened, non carbonated beverages such as Crystal Lite[®] and Diet Snapple[®], flavored waters, decaf coffee or tea, herbal teas, broth and diluted 100 percent fruit juices. Read labels carefully to be sure your healthy sounding "vitamin water"

Post-Op Diet continued on page 19

Risks continued from page 1

grams want you to lose may not seem like much, but for your surgeon it makes a world of difference, especially if they are performing your surgery laparoscopically (through small incisions). Increasing your daily activity and modifying your diet prior to your weight-loss operation will also have a positive impact.

Finally, when considering the risks of weight-loss surgery, one must consider the risks of not having weight-loss surgery. Clearly there are a host of risks that come along with being morbidly obese including such life threatening problems as diabetes, high blood pressure, heart disease and sleep apnea. Morbid obesity also significantly impacts the quality of life of individuals by decreasing energy, stamina and mobility.

While weight-loss surgery is safer than it ever has been, it is still a major operation, which has inherent risks associated with it. Although the majority of patients will make it through their operation with minimal to no long-term problems, there is a small minority of patients that will have significant long-term problems. Each individual must decide if the risks of surgery are less than the risks of continuing to live with their morbid obesity.

About the Author:

Lloyd Stegemann, MD is a bariatric surgeon in private practice with New Dimensions Weight Loss Surgery in San Antonio, Texas. He is active in patient advocacy on the state and national level. He can be contacted at www.ndwls.com. Dr. Stegemann is a member of the Obesity Action Coalition.

Editors Note: This article is provided to illustrate the risks of bariatric surgery. 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.

Risks of Bariatric Surgery

Operating Room Risks

- Bleeding
- Injury to organs
- Problems with anesthesia

Hospital Stay Risks

- Wound infection
- Pneumonia
- Urinary tract infection
- Blood clots in the legs
- Blood clots in the lung
- Leak from bowel connections
- Heart attack
- Stroke
- Kidney problems

At Home Risks-Early

- Dehydration
- Ulcer
- Stenosis (narrowing)
- Kidney stones
- Prolonged nausea

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A Look at the Studies of the Risks of Bariatric Surgery

By Harvey Sugerman, MD

There have been several recent articles in the Journal of the American Medical Association (JAMA)¹⁻³, that raised newspaper and television comments regarding the safety of weight-loss surgery, several of which were not justified.

Comparing the Numbers

The risk of death following weight-loss surgery in the non-Medicare studies^{1,2} were much better than had previously been reported from Washington State in October 2004. The report by Santry et al¹ from the National In-patient Sample (NIS) noted a 0.1 to 0.2 percent in-patient mortality nationwide and the Zigmund et al study² noted an 0.18 percent in-patient mortality, and a 0.33 percent 30-day mortality for the State of California using the State's Patient Discharge Database for gastric bypass. These are much lower than the previous report by Flum and Dellinger from Washington State,⁴ which noted a 1.9 percent 30-day mortality following weight-loss surgery.

Like these recent reports from JAMA, the earlier Flum and Dellinger study

received negative press coverage stating that the mortality of weight-loss surgery was much greater than single series studies suggested⁵. Yet, the mortality in California is actually lower (0.1-0.2 percent vs. 0.5 percent in-patient risk of death) than many of the case series reports.

Why the discrepancy between the mortality in these two states? Could the better results be due to centers which perform greater numbers of bariatric surgeries and are therefore more proficient in their technique and patient care? Or, are there more ill Medicare and Medicaid patients in the Washington State database? Are the California surgeons operating on lower risk patients?

Obesity-Related Diseases

The Charlson Index was used to determine obesity-related illnesses in these reports. This measurement shows that 50-60 percent of the morbidly obese patients in these studies had no obesity-related diseases; whereas, it is clear that almost 100 percent of severely obese patients have one or more obesity-related conditions. Therefore, it is impossible to determine the degree of illness in these patients *before* their obesity surgery in order to compare these reports. Collection of this information is extremely important and will be undertaken by the American Society for Bariatric Surgery (ASBS) Centers of Excellence (COE) program.

Risk for Medicare Patients

The study by Flum et al³ regarding the risk of death in Medicare patients found a much higher mortality in these patients than previously reported for bariatric surgical procedures⁵. This is no surprise, since 90 percent of patients who undergo weight-loss surgery with Medicare coverage are social security disabled and are under the age of 65. These are the sickest patients, almost certainly a consequence of their obesity, and they therefore have the greatest risk of surgery.

It may cost more for these patients to undergo surgery than the surgeon or the hospital are reimbursed for, which may be one of the reasons that they are under-represented in the Santry et al study². In fact, according to MedPAR data, the age adjusted risk of death after laparoscopic and open cholecystectomy (gallbladder surgery) from 2001 to 2003 were *higher* than the risk of gastric bypass surgery. Of greater concern, is the increased risk of death with obesity surgery noted by Flum et al in those more than 65 years of age. Several studies noticed an increased mortality associated with age⁶⁻⁸. However, the data may not be as grim as the press reported. The Flum et al study noted that those centers who have the highest number of Medicare cases (and it may be presumed the greatest number of bariatric procedures regardless of status) had a 1.1 percent 30-day mortality rate in those more than 65

Studies continued on page 16



Inspiring, Motivating, Encouraging, Sympathetic
Achievement, Triumph, Success, Goals, Sharing

Patient Profile

Inspiring Stories from Inspiring Patients

■ ***“I don’t want to be older and still fat. I think I’ll do better when I am older if I can lose some of the weight,” said Ryan.***

You have all heard it before, “Good evening ladies and gentleman. Our lead story tonight: obesity in children continues to rise in the United States.” Time and time again the media rattles off some staggering statistic about this disease with a chart or graph in the background displaying the ever-increasing trend of childhood obesity in the U.S. However, you rarely hear the effects of this disease straight from those it affects the most – children.

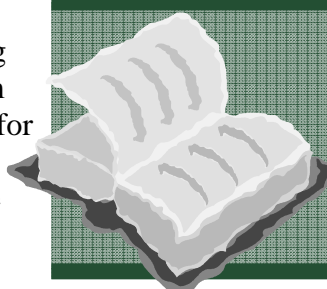
In mid-November, I had the privilege to interview a very intelligent, well-spoken young man named Ryan who is affected by obesity. Currently, Ryan is 11-years-old and weighs more than 200 pounds. In addition to Ryan dealing with obesity on a day-to-day basis, this disease has also led him to having to take high blood pressure medication.

When I asked Ryan how being obese made him feel, he paused for a moment. It was as if for the first time, he stopped and

thought about the way he felt. As this disease carries an extreme amount of discrimination along with it in the adult community, the emotional and social effects among children can be just as devastating, if not worse.

“I feel angry. I am angry at myself,” said Ryan. His anger was visible, not only through emotion, but also through expression. His eyes looked to the floor, closely followed by his eyebrows turning inward and down. This was something that Ryan was angry at, but also frustrated by the lack of self-control he had over his own weight. He was scared. Scared at what this disease could do to him. Ryan’s grandfather was diabetic and obese, and eventually passed away from diabetes. This young man knows firsthand what this disease can do to someone.

Although angry, frustrated and scared, Ryan was not alone in his battle. His mother, Laura, underwent bariatric surgery more than a year ago and is doing great. As his mom lis-



Ryan’s Story

By James Zervios, OAC Director of Communications

tened to him during the interview, you could tell she was also hurting inside for her son. She knows all too well how this disease can affect the quality and duration of life.

Unless you have had the privilege of talking with Ryan, it is very hard to truly know the spirit this young man possesses. “I find a lot of my support from my teacher, parents, Dr. Cromer and nutritionist. When we have PE (physical education) at school, my teacher walks with me and then eventually we jog. She is great support,” said Ryan.

When I asked Ryan how often he had PE in school, he said two times a week for 45 minutes. “I wish we had PE everyday. I think it would help me lose weight,” seriously said Ryan.

This seems to be an ever-growing trend in the U.S.

where children are limited to the amount of time they have for PE each day. Long gone are the days of PE Monday through Friday.

Currently, Ryan is undergoing nutritional therapy and seems to enjoy it. Only two sessions have been covered by insurance and his mom is working very diligently at getting future sessions covered; however, even if they are not covered she still plans on him continuing the therapy.

“I don’t want to be older and still fat. I think I’ll do better when I am older if I can lose some of the weight,” said Ryan.

Children who are considered obese are 70 percent more likely to continue being obese into adulthood. In addition, they are at greater risk for serious medical issues such as heart disease, high cholesterol, high blood pressure, diabetes, sleep apnea and cancer.

“The nutritionist is very good. She always tells me to eat healthy. Next month we are making menus for me to use to eat healthier,” said Ryan. The menus are a great idea for Ryan as I learned during the interview that he is an aspiring chef (for a recipe from Ryan, please see below). “I would like to cook someday. I enjoy watching the food channel,” laughed Ryan.

When I asked Ryan what he would tell other children that are obese, he said he would tell them to eat right and exercise. “I think being healthy helps you do better in school and physically feel better,” said Ryan.

Ryan is a young man, a smart young man, with goals, wishes and dreams. He knows what he wants out of life and is prepared to work for it.



Ryan, 11 years old, poses in his karate Gi (gee).

On December 13, 2005, Ryan was mayor of the Junior Achievement Village, a program developed by schools to allow children to take on the roles of consumers and workers for a day. “There were six other kids who wanted to be mayor, but I got it,” said Ryan.

Ryan and his family live in Florida where he enjoys karate, as a second degree brown belt, cooking and watching television.



Along with karate, Ryan enjoys cooking and trying out different recipes. Above, Ryan is preparing one of his favorite recipes, spinach-stuffed chicken breast with mushrooms and asiago cheese.

Ryan's Recipe

Spinach-Stuffed Chicken Breast with Mushrooms and Asiago Cheese

1/2 tsp toasted sesame oil	1/3 cup fresh lime (2 to 3 limes)
1/2 tsp black pepper	2 tbsp reduced-sodium soy sauce
2 boneless skinless chicken breasts (approx. 1 lb.)	2 tsp finely chopped fresh ginger
1 oz Asiago cheese, shredded	1 tsp Dijon mustard
1/2 cup chopped mushrooms	2 cloves garlic, finely chopped
1 cup fresh spinach leaves, chopped	1/4 cup water

In small bowl whisk together lime juice, soy sauce, ginger, water, garlic, mustard, sesame oil and black pepper. Measure out 2 tablespoons and reserve. Pour the remainder into a shallow dish, add chicken and turn to coat well. Cover and refrigerate for at least 30 minutes. In a small bowl, toss together the chopped spinach, mushrooms and asiago cheese with the 2 tablespoons of reserved marinade and set aside. Remove chicken from the marinade and cut a large pocket into the side of the chicken breast, leaving about 1/2" border around the edge. Stuff the pocket with the spinach mixture. Reserve marinade for basting. Place chicken in a shallow dish and bake at 350 degrees for 15 minutes, then baste with marinade and cook for an additional 15 minutes. Garnish with parsley, serve and enjoy. Serves 4.

Nutritional Information Based on 4 oz serving	Calories	167.0	Cholesterol	81.0 mg	Fiber	.5 g
	Fat	2.5 g	Sodium	311.0 mg	Sugar	0.0 g
	Saturated Fat	2.0 g	Total Carbs	2.2 g	Protein	31.0 g

AdvocacyNews AdvocacyAction

Medicare Releases Proposed New Rules for Weight-Loss Surgery

As many of you are aware, on November 23, 2005, the Centers for Medicare & Medicaid Services (CMS), the governing agency of Medicare, released proposed new rules under a National Coverage Decision (NCD) for weight-loss surgery.

The OAC strongly believes these proposed rules are a positive change that will improve access to the treatment of morbid obesity. Understanding the rules and regulations proposed under the NCD are important not only for those currently insured by Medicare, but also for those covered by commercial insurance policies, as many insurance companies base their coverage decisions on Medicare's policies.

The proposed rules validate the treatment of morbid obesity through weight-loss surgery. Surgical treatment options for Medicare recipients, who are under the age of 65, will now include both open and laparoscopic Roux-EN-Y gastric bypass as well as laparoscopic adjustable gastric banding (commonly known as Lap-Band) as long as the patient has a body mass index (BMI) of 35 or greater, one obesity-related health problem and has been previously unsuccessful with the medical treatment of their obesity.

The OAC's Response

The OAC supports the coverage of weight-loss surgery, as studies show the surgical treatment of morbid obesity decreases mortality, improves or resolves obesity-related illnesses and improves quality of life.

However, the OAC does have specific concerns with portions of the NCD as it proposes eliminating coverage of weight-loss surgery as a benefit for those more than 65 years of age. Other concerns include not specifying or defining the requirement of being unsuccessful with the medical treatment of obesity to access surgery,

failure to provide coverage of biliopancreatic diversion with duodenal switch (BPDS) and a lack of information on payment for the required future follow-up physician and healthcare professional visits required for optimal post-operative care.

"We received an overwhelming response of support from our members on this subject, and we greatly appreciate all those who submitted comments to CMS," said Joseph Nadglowski, Jr., President and CEO.

In order to assist patients, the OAC developed *A Patient's Guide to Advocating for Improved Access to Weight-Loss Surgery under Medicare* to encourage and assist those affected by obesity in their advocacy efforts. Please visit www.obesityaction.org to view an electronic and printable version of this guide.

OAC Calls on Wal-Mart to Renounce Discrimination against Obese Employees

On November 2, 2005, the OAC issued a letter to S. Robson Walton, Chairman of the Board of Directors of Wal-Mart Stores, Inc., urging the company to renounce their proposed discriminatory healthcare statements in a recent memo, titled "Reviewing and Revising Wal-Mart's Benefits Strategy," which discusses projected changes to employee benefits and hiring practices.

On November 21, the OAC received a written response from Wal-Mart commenting on the OAC's request. An excerpt from the letter states, "We hire people who are qualified to do the job we're hiring them for. Period. For those we hire, we want to help our associates live the healthiest lives possible," said Greg Goggans, Director of Benefits Design.

For the most current information on this topic or to read Wal-Mart's response in its entirety, please visit the "Advocacy" section of the OAC Web site at www.obesityaction.org and click on the "National Issues" link.



OAC is Proud to Announce its National Board of Directors

On January 1, 2006, the Obesity Action Coalition (OAC) elected its 2006-2008 National Board of Directors. Members of the OAC Board of Directors are responsible for establishing the mission and goals of the organization, developing long range plans and much more. As a patient organization, each of the members of the OAC Board of Directors have been personally affected by obesity.

Meet the OAC Board



Robin Blackstone, MD

Dr. Blackstone is a practicing bariatric surgeon from Scottsdale, Arizona. She first became interested in gastric bypass surgery for the morbidly obese after a close family member had the procedure in 1999. Dr. Blackstone established the Scottsdale Bariatric Center and throughout the last four years, the center has emerged as one of the best examples of excellence field of bariatrics in the United States. She is also the Vice Chairman of the Surgical Review Corporation, Center Review Committee.



Jim Fivecoat

Mr. Fivecoat, a manager for retirement plans, is a bariatric surgery patient. In 2003, Jim Fivecoat underwent weight-loss surgery. Currently, he remains incredibly successful with his weight-loss. Mr. Fivecoat brings knowledge of how the benefit process works with major employers and an immense passion to help others affected by obesity to the OAC Board of Directors.



Ralph L. Guatelli, RPH

Mr. Guatelli is a registered pharmacist with more than 30 years experience in the pharmaceutical field. In 2003 he underwent weight-loss surgery and has currently lost more than 130 pounds. Having gone through the surgery himself, Mr. Guatelli possesses the ability to relate to patients at all stages of weight-loss from pre-op to post-op.



Julie M. Hill-Janeway

Ms. Hill-Janeway is the author of "The REAL Skinny on Weight Loss Surgery: An Indispensable Guide to What You Can REALLY Expect!" and co-owns Little Victories Support Specialists. She is also the co-owner of Little Victories Press and serves as its Executive Editor and Chief Legal Counsel. In October 2003, she underwent weight-loss surgery and has lost more than 180 pounds. Ms. Hill-Janeway is also a professor at Central Michigan University.



Georgeann Mallory, RD

Ms. Mallory began her career in bariatrics as a registered dietitian (RD) for an eminent bariatric surgeon in Florida. Ms. Mallory became a member of the American Society for Bariatric Surgery (ASBS) in 1987. Subsequently, she became chair of the ASBS Allied Health Section and in 1996 was appointed Executive Director of the Society. The ASBS is the largest organization for bariatric surgeons in the world and is committed to educating medical professionals and the lay public alike about bariatric surgery as an option for the treatment of morbid obesity.

Meet the Board continued on page 17

Q: I am interested in bariatric surgery. What is the ASBS Centers of Excellence Program?



Answer provided by Gary M. Pratt, CEO of the Surgical Review Corporation.

Health



Surgical Excellence Involves More Than Just the Surgeon

The National Institutes of Health (NIH) determined that bariatric surgery is the only effective treatment for severe obesity and its associated co-morbidities. Obesity is an increasingly common condition: eight million Americans now have a body mass index (BMI) more than 40. Bariatric surgery provides what had previously been considered impossible: durable weight-loss with full, long-term remission of diabetes and other co-morbidities of severe obesity. While technically challenging, the procedures can be performed safely and at reasonable cost with significant prolongation of life.

The tragedy is that less than one percent of the individuals affected have access to bariatric surgery that could free them of diabetes, sleep apnea, cardiopulmonary failure and other debilitating co-morbidities. Although there are numerous reasons for the failure to deliver care to those who need it, one important fact is that the quality of bariatric surgery is uneven.

The American Society for Bariatric Surgery (ASBS) identified this glaring deficiency and took an aggressive step to improve the delivery of bariatric surgery by founding the Surgical Review Corporation (SRC) and initiating the Bariatric Surgery Centers of Excellence program. SRC is an independent, not-for-profit organization which designates Centers of Excellence in bariatric surgery based upon their resources and outcomes. In a bold and unprecedented move, the founders of SRC included in its board of directors a representative from stakeholder groups outside the surgical profession including patients, allied health personnel, health insurance plan CEOs, and medical malpractice

insurance carrier CEOs. The reasoning was clear-cut: if such stakeholders are not convinced that bariatric surgery can be delivered safely and effectively, everyone will lose, especially the morbidly obese patient with no other viable alternatives.

The mission of SRC is simple: promote the delivery of bariatric surgical care with the highest levels of efficacy, efficiency and safety. The Centers of Excellence program was established with the following goals:

- Foster close cooperation between hospitals and surgeons.
- Standardize operations and care pathways.
- Obtain full reporting of outcomes with uniform database definitions as the foundation for research.
- Confirm data by site inspections.
- Utilize the data for continuous quality improvement.

Across the country, Centers of Excellence programs are popping up left and right. Today, it isn't unusual to hear or read that this center or that surgeon is "excellent." How can patients be assured that they are at a center that truly provides excellent care and are not just the target of a marketing campaign? The answer lies in understanding how the ASBS Bariatric Surgery Centers of Excellence program differs from programs that offer a little more than hype.

First of all, SRC recognizes that while the surgeon is

one important component of excellent care, an “excellent” center is comprised of more than just the surgeon. Bariatric surgery, more than some other medical specialties, relies on the coordinated efforts of a multi-disciplinary team including nutritionists, psychologists, nurses, a compassionate office staff and a host of others. It involves a hospital making a long-term commitment to effective care of the morbidly obese with strong support from the highest levels of its administration. It involves a surgeon who devotes a majority of his or her practice to bariatric surgery – not just someone who dabbles in it.

Imagine having the very complex Roux-en-Y gastric bypass operation performed by a surgeon that does only two per month. While some Centers of Excellence programs focus exclusively on the hospital or exclusively on the surgeon, SRC believes that if you remove one or more of the above components from the equation, the center may be good, but it isn’t truly “excellent.”

Second, hospitals and doctors’ offices can hire architects and interior decorators to offer luxurious environments to entice their patients. But SRC excellence requires that the furniture and the equipment be specifically designed for and suited to the needs of the obese. More importantly, SRC requires that the staff be trained on how to handle obese patients without endangering both the patients and themselves.

Third, SRC looks closely at the outcomes for the center and the surgeon. Site inspectors who are experienced bariatric surgery nurses review adverse events, such as the deaths, re-operations and complications that have occurred at the applicant center during the prior 12-month period.

Patients can spend a significant amount of their time evaluating these various components of care; however the ASBS Centers of Excellence program is designed to save them the effort and enhance confidence in their decision. The application process to become an ASBS Center of Excellence is one of the most rigorous in the country. A center must first apply for Provisional Status, a designation that remains in place until the institution can demonstrate that it qualifies for Full Approval. Provisional Status is based on the adequacy of resources;

Full Approval is based upon the achievement of acceptable outcomes.

To obtain Provisional Status, a center must prove that it has the resources necessary to provide safe and effective bariatric surgery and must demonstrate the proper training and experience of the staff and surgical group. SRC’s Bariatric Surgery Review Committee, which is comprised of some of the top bariatric surgeons in the country, reviews the information provided in the application, determines whether the guidelines are met and then grants or denies the designation. Once Provisional Status is granted, a center has two

years to apply for Full Approval. Since this is a preliminary step toward reaching Full Approval, the center may not disclose that it has the Provisional Status designation.

For Full Approval, the application process involves assurance by the Center that the requirements for Provisional Status remain satisfied. The application requests additional information regarding patient populations, operations performed and outcomes. SRC conducts a site inspection of all Full Approval candidates to verify that the information provided in the

application is accurate. A review of the bariatric surgery patients’ charts is conducted in accordance with the Health Insurance Portability and Accountability Act (HIPAA) guidelines. The information collected during the site inspection is then submitted to SRC’s Bariatric Surgery Review Committee for review along with the Full Approval application.

By comparison, some of the other centers of excellence programs ask the surgeon and/or the hospital to complete a multi-paged application and mail it in. Site inspections are rarely performed. Non-surgeons look at a respondent’s answers and stamp “approved” or “not approved” on the application.

The ASBS Bariatric Surgery Centers of Excellence program isn’t about marketing and doesn’t stop at designating its Centers as “excellent.” The designation is only the beginning of the process. The program requires that all centers who receive Full Approval submit outcomes information on their bariatric surgery patients to SRC. As a goal, it requires that follow-up be performed on a minimum of 75 percent of bariatric surgery patients over a five year period. As long as a Center maintains its Full Approval designa-

The graphic is a dark grey rectangular box with a light grey background. At the top, the title "Progress of Centers of Excellence Program" is written in a serif font. Below the title, there is a horizontal line. Underneath the line, there are three bullet points, each consisting of a small grey circle followed by text. The text for the first bullet point is "More than 500 hospitals and more than 900 surgeons have applied for Provisional Status." The text for the second bullet point is "More than 130 have applied for Full Approval." The text for the third bullet point is "To date, more than 60 Centers have been designated as an ASBS Bariatric Surgery Center of Excellence."

years of age, a very reasonable number in this age group. In a series study of patients more than 60 years of age, 19 of which were more than 65 years of age, there were no deaths at one year after surgery⁹. In another series of 27 patients, 13 had a laparoscopic gastric bypass and were more than 65 years of age¹⁰.

Risk after Surgery

Lastly, there are serious concerns regarding the study by Zigmund et al, which noted a marked increase in hospital visits in the three years after weight-loss surgery as compared to the three years preceding weight-loss surgery³. There are three groups in this study which warrant further comment and account for more than 50 percent of the hospital visits after surgery.

Early readmissions for complications related to nausea and vomiting (15-20 percent) are probably associated with pressures from health insurance companies for early hospital discharge. The second group (15-20 percent) are those who are readmitted for incision related problems (hernias and wound infections) and are almost certainly related to the high frequency of open weight-loss surgery during the time period of this study. These complications have been virtually eliminated with the currently laparoscopic approach. The third group (another 20-30 percent) is for patients who have undergone plastic surgical or orthopedic procedures following their weight-loss surgery. The orthopedic operations, such as hip and knee replacement, are more likely to be successful following a surgically induced weight-loss. Lastly, the costly and life-threatening readmissions for serious medical conditions, such as chest pain, coronary artery disease, congestive heart failure, obstructive lung disease and cellulitis, were all decreased following weight-loss surgery. Readmissions for life-threatening complications of the surgery (leak, internal hernia) are of concern, but represent a minority of the cases. Again, this study noted that surgery performed at a low volume medical center was more likely to result in hospital readmissions.

ASBS Centers of Excellence

These studies confirm other reports that surgeons who perform a significant number of cases at hospital centers with a dedicated staff and appropriate numbers of surgical procedures have noted much lower risks of deaths and complications. We recommend that patients who undergo obesity surgery have their operation at an ASBS Center of Excellence, which mandates these centers to perform more than 125 cases a year with surgeons who perform more than 50 cases a year and have processes and facili-

ties designed to optimize the care of the bariatric patient. (To learn more about the Centers of Excellence program, see page 14.) Outcomes of these Centers will be collected on an annual basis and the Center will have to be re-designated one to three years after the initial approval.

There is no other effective treatment for severely obese patients. Bariatric surgery performed in an approved high volume Center of Excellence can provide profound improvements in obesity co-morbidities and quality of life, at a reasonable cost and with a very low risk of death and complications.

About the Author:

Harvey Sugerman, MD, is a retired bariatric surgeon. Formerly, he was Chief of the General Surgery/Trauma Division at Virginia Commonwealth University in Richmond, VA. He is the immediate Past-President of the American Society for Bariatric Surgery and was a non-voting member of the Medicare Coverage Assessment Committee on Bariatric Surgery. He is currently the Chairman of the Bariatric Surgery Review Committee which evaluates applications for Bariatric Surgery Centers of Excellence under contract to the American Society for Bariatric Surgery. Dr. Sugerman is a member of the Obesity Action Coalition.

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Paulette Massari, LCSW, CAP, CS

Ms. Massari has been a weight-loss surgery patient for more than eight and a half years. She has been a private practicing psychotherapist for the past 30 years in substance abuse and mental health and for the last eight, providing services to bariatric surgery patients. As a social worker, she has worked with insurance providers and government officials advocating for access to care for weight-loss surgery.



Melissa Parish

Ms. Parish, along with her husband, underwent weight-loss surgery in 2003. Today she has gone from a size 24 down to a size four. As a leader of a bariatric surgery support group, Ms. Parish offers patients a great enthusiasm and willingness to share her experiences with this life changing procedure. She also hosts a Web site and message board, and works with 3,000 - 5,000 patients monthly in dealing with the emotional, physical and social aspects of obesity and morbid obesity. Currently, Melissa is authoring a book for morbidly obese patients due out in 2006.



Christopher Still, DO, FACN, FACP

Dr. Still has been studying developments in nutrition support and obesity for nearly a decade. He serves as principal investigator on a rural elderly nutrition and aging study of some 22,000 individuals. Dr. Still's interest in weight-loss comes from his personal experiences with obesity, once weighing 365 pounds. Dr. Still is certified by the American Board of Internal Medicine, the American Board of Nutrition, and the American College of Nutrition, among others.



Barbara Thompson, MLS

Ms. Thompson is an accomplished national speaker on the subjects of obesity sensitivity, weight-loss surgery, and successful weight-loss maintenance. In 2001, she wrote the first patient guidebook, Weight Loss Surgery; Finding the Thin Person Hiding Inside You, now in its 3rd edition. In 2005 she co-authored Weight Loss Surgery for Dummies. Ms. Thompson had weight-loss surgery in 2000 and has lost 125 pounds.

Surgical Excellence continued from page 15

tion, it must report this information to SRC for as long as it follows its patients. We expect to accumulate data on more than 50,000 patients each year, an unprecedented database from which to improve quality.

Armed with a powerful database, SRC plans to take the meaning of Centers of Excellence to a higher level. Rather than simply having centers named and operating individually, SRC will ask Centers with the Full Approval designation to form a research and education consortium that will use the information from the database and the expertise at each of the Centers to pioneer breakthroughs in bariatric surgery. This consortium of excellence will ensure that bariatric surgery is delivered with optimal efficacy, efficiency and safety.

And the database will have another important benefit. As tough as the standards are for the ASBS Bariatric Surgery Centers of Excellence program, they are about to get tougher. Results from the database will be used to establish more rigorous criteria and standards to become a Center of Excellence.

SRC believes that bariatric surgical care isn't as simple as choosing a good surgeon. We believe that the surgeon is an integral component, but the hospital and qualified multi-disciplinary team are equally vital. Patients shouldn't be deceived into thinking that a program is "excellent" because a center did an "excellent" job of completing an application to become "excellent," but should insist on evidence that the center is committed to an ongoing quality-improvement process that doesn't stop once the certificate is issued.

"Excellence" is also about obtaining information that can be used to set higher standards and generate information that can save lives. Our Centers will be unified in their quest to deliver bariatric surgery safely, efficiently and most effectively. The ASBS Bariatric Surgery Center of Excellence is the gold standard upon which the patient can rely.

About the Author:

Gary M. Pratt is CEO of the Surgical Review Corporation. A graduate from the University of Tennessee with degrees in marketing and accounting, Mr. Pratt has started seven successful businesses and was a partner in a national accounting firm.

Admittedly, all diets work initially because they are based on caloric restriction. However, they do not work long-term due to sound physiologic reasons. Almost as soon as one begins to eat less, their metabolism begins to slow down to compensate for a lower caloric intake. Similarly, when one increases caloric intake, their metabolism begins to speed up to compensate for the increase in food intake.

Many articles on diet suggest that if you want to take off 10 pounds, all you need to do is decrease your caloric intake by 500 calories a day. In one week, you will have lost 3500 calories or the equivalent of one pound, and in 10 weeks you would lose 10 pounds. Although the "math" may seem accurate, our bodies do not understand math. When you consume fewer calories your metabolism drops.

Exercise

Exercise is a very important part of any prudent long-term weight-loss program. It is important for many reasons including improved cardiovascular fitness, lowering cholesterol, increasing good cholesterol (HDL), promoting a feeling of well being, firming, strengthening, etc. However, exercise for weight-loss is highly overrated.

How many calories does one burn with exercise? The answer is "not too many." For example, if you weigh 180 pounds and you want to lose one pound of fat, you would have to swim seven and one half miles at 25 yards per minute; or you could walk at four miles per hour (fast pace) for eight hours and cover 32 miles to lose that same one pound. The more you weigh, the less one has to exercise to lose a pound, but you have more pounds to lose, and vice versa. Parking your car further away in the parking lot or taking the stairs instead of the elevator may be great for many things, but weight-loss is not one of them. Exercise has its main advantage in a weight-loss program in helping one maintain their weight.

Dietary Supplements

What about over-the-counter (OTC) dietary supplements for weight-loss? There are currently more than 29,000 supplements on the market, and several hundred of them have been touted for weight-loss. The required labeling on these OTC products should make even the least skeptical of us suspicious: "This product has not been evaluated by the Federal Drug Administration (FDA). This product is not to be used to diagnose, treat,

prevent or cure any disease."

In addition, dietary supplements do not even have to prove that they are safe or effective. Often, when they are carefully evaluated clinically, they are found to be 99 percent less effective than claimed. Dietary supplements work best to slim your wallet, not your waist.

Pharmacotherapy

What really works for weight-loss and more importantly long-term weight-loss maintenance? Obesity is a chronic disease. Chronic diseases whether diabetes, hypertension, arthritis, high cholesterol, etc., need long-term drug therapy (pharmacotherapy) for control, not cure. At the present time, we are not able to cure these chronic diseases and the same is true for obesity. But, we are learning to control them.

As previously stated, the traditional model for weight-loss in this country has failed, and failed miserably. In this physician's opinion, the model needs to be reversed, with pharmacotherapy as the foundation and diet, exercise and behavioral modification as essential adjuncts, and not the other way around. Since obesity is a chronic disease, prescription medications should be used either on a long-term basis, or not at all. Once a desirable weight is achieved, a maintenance program needs to be continued using pharmacotherapy, diet, exercise and behavior modification. The medications act by multiple mechanisms to promote weight-loss. They suppress appetite, control cravings, improve insulin sensitivity and lower the metabolic set point.

Keys for Weight-loss Success

The goal of any prudent weight-loss program goes well beyond weight-loss itself, but extends to the improvement in self esteem and sense of empowerment as unexpected gifts of long-term weight-loss success.

About the Author:

Robert Skversky, MD, is the Medical Director of Weight No More, and has committed the past 10 years of his professional career to the medical treatment of overweight and obese patients.



is not loaded with calories. And, do not forget that alcoholic beverages are full of calories with no nutritional value.

Vitamins and Minerals

All bariatric patients need to take vitamin and mineral supplements as recommended. While the specific amounts and types of supplements may vary by their bariatric program, professionals agree that these supplements are necessary to prevent vitamin and/or mineral deficiencies. Besides multiple vitamin and mineral supplements that all bariatric patients need, RNY patients need additional supplements of iron, calcium and Vitamin B-12. Regular, periodic lab tests should be monitored annually or semi-annually to ensure that the post-op bariatric patient is meeting their nutritional needs. Of course, proper dietary choices are important in this respect as well. Do not assume that if you are feeling well, you have met your needs for vitamins and minerals. The only way to be sure is to take your supplements and have regular lab tests to confirm.

Having a good understanding of proper nutrition is critical for the success of bariatric surgery. Consult your dietitian regularly to learn all you need to properly use the tool that the surgeon has given to you. Further post-op, reach out for guidance if you feel you are slipping back into old habits and get yourself back on track. Use support groups to help deal with any psychological issues related to eating. Your commitment to being compliant with the post-op diet, eating behaviors, and a regular exercise program will improve your health and change your life!

About the Author:

Denise Addorisio, RD, CDN, is a registered Bariatric dietitian.

Please Note: The information contained in this article is for educational purposes only and should not be substituted for medical advice or treatment from a healthcare professional. The OAC recommends consultation with your doctor or healthcare professional before initiating any dietary plans.

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
- *Obesity Action Alert* - a monthly e-newsletter
- *OAC News* - the OAC's quarterly 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 Guides to Advocating for Improved Access to Obesity Treatments
- *Your Voice Makes a Difference. A Guide on How You Can Help Fellow Patients Affected by Obesity*
- Weight-loss Surgery Coverage Fact Sheet
- 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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