Bariatric Surgery Risk Education Packet
Walter J. Chlysta MD, FACS

Date: _____

Patient Name: _____

Height: _____

Weight: _____

Ideal Body Weight: _____

Excess Weight: _____

Realistic Gastric Bypass Weight Goal (77 % Excess weight loss): _____

Realistic Sleeve Gastrectomy Weight Goal (70 % Excess weight loss): _____

Surgery alone will not result in the realistic weight noted above. There are two other critical requirements.

Exercise: 20-30 minutes a day at least five times a week.

Diet: Three meals per day plus a snack if needed. The goal is for each meal to be high in protein and relatively low in fat and carbohydrates. A meal should only last approximately 30 minutes (anything longer would be considered "grazing"). Ideally you should not drink with your meals or for 30 minutes afterward as theoretically this will speed transit of food through the pouch and has several other potential disadvantages.

I have read the above risks and understand them. I have had all of my questions answered by my surgeon.

Patient Initials: _____ Date: _____

Bariatric surgery is safer than many other procedures such as gallbladder removal. For your procedure, many efforts are made to reduce the risk of complications such as oversewing staple lines, use of blood thinners, early ambulation and incentive spirometry in addition to using meticulous surgical technique. However, there is still risk associated with bariatric surgery.

Risks associated with Bariatric Surgery are as follows:

Death

In general, the risk of death is 0.1 % with bariatric surgery. This is usually from a blood clot or staple line leak so every measure is taken to prevent these complications. Fortunately, they are not common.

Bleeding (Hemorrhage)

Whenever surgery is performed, blood vessels must be cut. This is done by using various surgical techniques. Despite these techniques to control bleeding, a vessel may begin to bleed again, either inside the abdomen, or into the intestines. The fact that you will receive a low dose of blood thinner (to help prevent blood clots) may make you more likely to bleed, but this risk is felt to be offset by the decreased risk of a blood clot. Post-operative hemorrhage is usually managed without having to go back to the operating room. Occasionally, a surgery to control bleeding may be necessary.

Transfusions

Transfusions of blood may be necessary if you develop a bleeding problem. The blood supply is very safe however there is still a small risk of contracting hepatitis, HIV or another disease from a transfusion. It is also possible to have an allergic reaction to a transfusion.

Splenectomy

The spleen is near the surgical area and can bleed significantly if damaged. Occasionally during surgery this can occur. Usually the bleeding can be stopped without removing the spleen, but sometimes removal of the spleen is necessary. The spleen is not necessary for life or health. However, the absence of a spleen does increase the risk of certain infections later in life.

I

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Infections

Wound infections may occur after Bariatric Surgery. Opening the incision coupled with oral antibiotics treats most infections adequately. While it is an inconvenience, a wound infection is usually not a serious problem.

Abscess

An abscess is a collection of infected fluid or pus that occurs in the body. After an abdominal operation, a pocket of fluid may develop. If bacteria are present, the fluid can become infected, creating an abscess. Most abscesses are treated by draining the infected fluid and administering antibiotics.

Staple line leak

A staple line leak can occur at any staple or suture line. If this occurs, fluid leaks out of the bowel into the abdominal cavity and may cause a serious infection or abscess. This is always a very serious complication and the diagnosis and treatment are made much more difficult by severe obesity. The risk of an anastomotic leak is 1 – 2%.

Depending on the size of the leak and the condition of the patient, additional surgical procedures may be necessary. Smaller leaks may be treated by inserting a drain. Until the leak seals, the patient is unable to eat or drink. Anastomotic leaks almost always result in a longer hospital stay. There may be discomfort from the drain and repeated X-ray studies are necessary.

Bladder infection

A urinary catheter is usually not used during bariatric surgery. Occasionally, urinary catheters are used. They can occasionally lead to a bladder infection. However these are usually easily treated with antibiotics.

Surgical injury to the bowels, bladder or vessels

During surgery it is possible that bowel, bladder, blood vessels or other structures could be injured. This is unlikely to occur but is a known risk to any surgical procedure. If this should occur, additional surgical procedures may be required.

Bowel Obstruction

After any abdominal surgery scars or adhesions can form. The bowel may become kinked around an adhesion and blocked. This is called a bowel obstruction and another surgery may be needed.

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Anastomotic Stricture

During gastric bypass surgery, the opening that allows food to leave the stomach is purposely created to be small. As healing scars form, the opening between the stomach and bowel may become too small to allow food to pass through. This problem occurs in 1-5% of cases. This is called an anastomotic stricture and can be treated on an outpatient basis with endoscopy and dilation. Strictures or "kinking" may also occur with the sleeve gastrectomy procedure, usually at the midpoint of the stomach. This may be treated with endoscopic dilation or rarely conversion to gastric bypass.

Lung Problems

Atelectasis
Atelectasis is a partial collapse of small air passages in the lung. After surgery, the patient's breathing may not fully inflate the lungs, so the tiny air passages may not be able to stay open. This can lead to pneumonia. The best treatment for atelectasis is prevention: walking after surgery, performing the cough and deep breathing exercises that are taught by the nurse and using your CPAP machine if you have sleep apnea.

Pneumonia
Pneumonia is an infection in the lungs that can occur when respiratory secretions are not cleared. It is often a result of atelectasis. The risk for pneumonia can be decreased by preventing atelectasis.

Pulmonary Embolus
Deep Vein Thrombosis is a blood clot that can form in the veins of the pelvis or legs. Both obesity and surgery increase the risk, because the person is less active and blood flow slows, creating the potential to clot. If a clot breaks off and floats through the veins to the lungs, it is called a pulmonary embolism. This is a very serious condition because it affects the ability of the lungs and heart to transport blood and oxygen to the rest of the body. We try to prevent blood clots by thinning the blood with medications. There is no consensus on the appropriate dose of blood thinners for morbidly obese patients. We have in place a protocol that has been effective at preventing blood clots.

Gallbladder issues

We do not usually remove the gallbladder at the time of surgery due to the additional risk involved. If one has a diseased gallbladder with symptoms, then the gallbladder may be removed prior to weight loss surgery. Patients that have gallbladders are placed on a bile thinning agent (one pill twice a day) for six months to decrease the risk of gallstones forming. Despite this, approximately 10% of patients may have a gallbladder issue within the first year after surgery.

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Abdominal wall issues

Open Incision
Surgery is performed laparoscopically (through small incisions) over 99% of the time. However, this is not always possible and rarely a larger incision will have to be made. A larger incision is associated with a higher risk of wound problems, cardiopulmonary issues and more pain.

Hernias
Hernias are defects in the strength layer of the abdominal wall that can cause pain or blockage of the bowel. After any surgery there is a risk for hernias to later form. In general the smaller the incision, the lower the risk is of a hernia.

Ulcers

An ulcer can occur 1-5% in gastric bypass patients.

Gastric Bypass patients should avoid excessive alcohol, smoking, caffeine, NSAID type drugs (Advil, Aleve, aspirin, Celebrex, etc.), and steroids (prednisone, medrol, etc.) as these greatly increase the risk for ulcers.

USING NICOTINE CONTAINING PRODUCTS SUCH AS TOBACCO PRODUCTS AFTER THE GASTRIC BYPASS WILL SIGNIFICANTLY INCREASE THE CHANCES OF AN ULCER THAT CAN BLEED, PERFORATE OR STRICTURE.

Ulcers usually can be treated with medication.

Other Intestinal issues

Gurgling
After surgery, some patients experience an "active stomach". Gurgling noises can be heard by others occasionally but they do not cause symptoms.

Malodorous Gas
After gastric bypass surgery, some patients experience foul smelling gas from below. This is usually a consequence of the patient's diet (sugars, fat). If the offending food is avoided this problem is usually solved. Alternatively one can try commercially available products such as simethicone or Devrom.

Gastroesophageal Reflux Disease (Heartburn)
Usually heartburn symptoms improve or resolve after gastric bypass. Sleeve gastrectomy may cause heartburn symptoms up to 10-20%. These symptoms are usually easily managed with medication.

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Nutritional problems

Nutritional problems are quite rare after bariatric surgery if the patient follows the instructions of the surgeon, dietician and nurse practitioner. Nutritional problems are avoided by taking the proper vitamin and mineral supplements and eating a healthy diet. The more common nutritional deficiencies and eating difficulties are discussed below.

Protein Deficiency
A constant supply of protein is needed to keep the body's tissues in good health. Because bariatric surgery reduces stomach volume, additional protein-rich foods must be eaten, preferably at the beginning of every meal.

Vitamin and Mineral Deficiency
After bariatric surgery, patients usually will not be able to eat enough food to meet recommended vitamin and mineral requirements. A high potency multivitamin, adequate calcium and iron must be taken daily. Anemia, osteoporosis and other conditions can occur if proper supplementation is not taken and laboratory evaluations not performed periodically.

Nausea & Vomiting
After bariatric surgery, vomiting may result. Some patients experience this until they learn to consume appropriate portions, eat slowly, and chew food well.

Hair loss
Some amount of hair loss can occur to varying degrees in the first 3 – 9 months following surgery. In most cases hair grows back to the normal state.

Food Intolerance

Red Meats
Red meat is initially not well tolerated after bariatric surgery but this improves with time.

Dumping Syndrome
After gastric bypass surgery and less commonly sleeve gastrectomy, a condition called "dumping syndrome" may occur. When sugar is consumed, it passes rapidly through the stomach and draws a large amount of fluid into the bowel. Abdominal cramping, nausea, bloating, diarrhea may occur initially. This may be followed approximately 45 minutes later by lightheadedness, profuse sweating, a rapid heart rate, and low blood sugar.
The problem can be prevented by avoiding food that contains a large amount of sugar or fat.

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Excess skin

After significant weight loss excess skin can be evident. There may be associated skin fold infections and hygiene issues. This may be an issue that may be handled best with plastic surgery. However there is additional cost associated with plastic surgery that may not be covered by your insurance company.

Pregnancy

Patients should not get pregnant within two years after bariatric surgery. Pregnancy could result in very poor weight loss and could be potentially harmful to the baby.

If you do desire to become pregnant (two or more years after surgery) then it is recommended that you first seek care from a bariatric professional and make sure there is no laboratory evidence of deficiencies of vitamins, minerals, or protein. Additional supplementation can be guided from lab results. Continued close follow-up with obstetrical professionals during your pregnancy is recommended.

Poor weight loss or weight regain

It is estimated that approximately 10 -15% of bariatric surgery patients will fail to have an adequate weight loss or they will regain their weight. Usually the cause is poor dietary choices ("grazing") and a lack of exercise. Bariatric surgery is only part of the process of losing weight and sustaining weight loss.

Unknown Risks

Gastric bypass has been performed in one form or another since 1967.
Sleeve gastrectomy is relatively new (2001) compared to gastric bypass.

With all bariatric procedures there may be long term risks that may not yet be evident or known to medicine.

Hiatal hernia repair with or without absorbable mesh

A hiatal hernia is a condition where part of the stomach slips into the chest. This condition is not uncommon and is usually associated with symptoms of gastroesophageal reflux disease (heartburn). In the general population this condition is usually not treated surgically unless the hernia is very large or causes symptoms that are not controlled by medication and/or the patient desires surgical repair to avoid medications to treat heartburn.

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Some patients have known hiatal hernias that are diagnosed on preoperative studies such as an upper GI x-ray or endoscopy. Some small hiatal hernias not discovered during the preoperative evaluation are discovered at the time of surgery.

If you have a significant hiatal hernia, it is recommended to have it repaired at the time of your weight loss surgery to help minimize the chances of postoperative heartburn or further herniation of the gastric pouch or sleeve into the chest. This will also make it possible to create make a smaller gastric pouch. There may be instances when it is not ideal to repair a hiatal hernia at the time of weight loss surgery (i.e. difficult exposure and/or visualization, poor patient tolerance of anesthesia, bleeding concerns, etc.). These conditions may make the risk of hiatal hernia repair greater than the potential benefit. This decision can only be made during your surgery by your surgeon.

A hiatal hernia repair consists of removing or reducing the hernia sac, dissecting around the esophagus to bring the stomach and lower esophagus back into the abdominal cavity, and placing sutures to repair the hiatal hernia. Sometimes, if the tissue appears thin, an absorbable synthetic mesh may be used to reinforce the hiatal hernia repair. This mesh may also help reduce the risk of hiatal hernia recurrence.

Hiatal hernia repair is very safe. However, there are additional risks associated with a hiatal hernia repair with or without mesh. These risks include injury to the esophagus, stomach, spleen, liver, pancreas, kidneys, heart, lungs and great vessels and other organs. Mesh infection in this area is very rare. Hiatal hernia recurrence can occur.

Robotic Surgery

Dr. Chlysta may choose to perform your sleeve gastrectomy surgery with robotic assistance using a surgical robot. You will know this well before your procedure and this possibility is usually discussed at your initial visit if it is being considered. Dr. Chlysta considers utilizing robotic assistance when a patient desires sleeve gastrectomy and the patient has a body mass index over 50 and a thick or stiff abdominal wall on exam. In some of these patients Dr. Chlysta believes it is easier, and therefore safer to used robotic assistance.

With any technology, there are risks and benefits. The benefit of robotic surgery is noted above. The risks are that the robot could become non-functional or dysfunctional. Dr. Chlysta is trained to manage these issues and if they would occur, he would remove the robot and perform the surgery in a standard laparoscopic fashion. The incisions for a Robotic sleeve and a standard laparoscopic sleeve are almost identical in size and number.

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Acknowledgment of Teaching

Dr. Chlysta is on the teaching faculty of three medical schools and two surgical residency programs. During your surgery, residents, medical students and nursing students may be present for teaching purposes as observers in the operating room. They are bound by strict privacy rules and regulations.

During your procedure, physician surgeons- in- training (surgery residents), under the direct supervision of Dr. Chlysta, may participate in portions of your procedure. Medical students' participation is very limited to holding scope cameras and occasionally suturing skin incisions under close supervision.

Please realize that this teaching process has been occurring since Dr. Chlysta started performing bariatric surgery in 2002. He has achieved excellent surgical results and has helped to train many excellent surgeons. With this experience, these surgeons can go on to provide excellent care for others.

Similar teaching occurs by any surgeon on the teaching staff at any hospital where surgeons-in-training are taught (Summa, Cleveland Clinic Akron General, Western Reserve Hospital, Cleveland Clinic Main Campus, UH Portage Medical Center, etc.)

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Acceptance of risk

	Initials	Date
I have carefully read the information in this packet.		
I understand all the information in this packet.		
I have had all of my questions answered by Dr. Chlysta		
I give consent for my surgeon to perform my surgery: _____ Sleeve Gastrectomy _____Robot Assisted Sleeve Gastrectomy _____ Gastric Bypass _____ Possible hiatal hernia repair with absorbable mesh		

I accept the general risks which apply to all major abdominal surgery including but not limited to: anesthetic risks, pulmonary embolism, death, infection, bleeding (possibly requiring transfusion-- unless I specifically indicate that I will not accept a transfusion even if this potentially puts my life in jeopardy), staple line leaks, blood clots, pneumonia, cardiac events including heart attack, stroke and subsequent neurologic problems, bowel obstruction (early or delayed), intra-abdominal abscess, deep vein thrombosis, adhesions, bowel or vessel injury, nerve injury, and others.

Patient: _____ Date: _____

Surgeon: _____ Date: _____

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