ADIRONDACK MEDICAL CENTER

Weight Loss Surgery Program Handbook

Please keep this handbook. You will need this throughout the program and after surgery

AMC Mission

Excellent Health Care Close to Home

Center of Excellence BARIATRIC SURGERY

Revised 08/19/10

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Introduction

We would like to welcome you to the Adirondack Medical Center Bariatric Program and commend you on your interest in dealing with your obesity. Obesity is a major health problem in the United States today. You are not alone. Over thirty million adults in the United States are obese and of these, approximately sixteen million are so severely obese, that their obesity affects their health and well-being.

The program that the Adirondack Medical Center and the Adirondack Surgical Group developed is based on the AMC Mission: Excellent Health Care Close to Home. People in the Adirondacks have had to travel great distances to receive health care/surgery for severe obesity. One of the keys to success for people with severe obesity is follow up and support. AMC's obesity program provides easy access for follow-up as well as monthly support groups and networking with others who have had surgical treatment of their obesity.

We hope that this Program Handbook provides you with the important information you need to make an educated decision about treatment for your obesity. We look forward to working with you and helping you find the best solution for your problem.

Weight Loss Surgery Program Philosophy

The Weight Loss (Bariatric) Surgical Team at Adirondack Medical Center, along with the hospital community, believes that severe obesity is a disease caused by complex genetic, social, psychological, and environmental factors. For most severely obese people, diet and exercise programs alone are ineffective for long term significant weight loss. Surgery, within a framework of a comprehensive Weight Management Program, following the Guidelines of the *American Society for Metabolic and Bariatric Surgery* is an additional tool along with behavior modification, psychological adjustment, proper nutrition and exercise that can best help an obese individual lose weight, reduce co-morbidities and live a happier, healthier and more productive life.

Please read this entire handbook. There will be a quiz at one of your appointments.

Definitions

Bariatric: The study and treatment of obesity

Ideal Body Weight: For height, sex and body frame the weight that is commonly accepted as weight that is associated with the lowest death rate in insured populations

Overweight: Weighing up to 20% more than recommended for height or a BMI of 25 or more

Obesity: 20-30% or more above Ideal Body Weight or a BMI of 30 or more

Morbid obesity: Either double ideal body weight or 100lbs over ideal body weight usually associated with a more severe case of obesity

Super Morbid Obesity: BMI above 50.

BMI: Body Mass Index. Weight and height are used to determine BMI which helps your doctor or nurse determine your health risks associated with your weight.

Co-Morbidity: Health conditions that are related to additional weight. Examples of co-morbidities are: Type II diabetes, high blood pressure, high cholesterol, sleep apnea, joint pain, etc… We will go over your co-morbidities at your initial evaluation.

What is obesity?

Obesity is a body weight over 20-30% normal. Severe or morbid obesity is defined as body weight that is twice or 100 pounds above desirable body weight. The National Heart, Lung, and Blood Institute, in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases, released the first Federal guidelines on the identification, evaluation, and treatment of overweight and obesity (NIH). About 97 million adults in the United States are overweight or obese.

More than half of U.S. adults are overweight (BMI ≥25, which includes those who are obese)

All adults (20+ years old): 97.1 million (54.9 percent)
Women (20+ years old): 46.9 million (50.7 percent)
Men (20+ years old): 50.2 million (59.4 percent)

Nearly one third of U.S. adults are obese (BMI ≥30).[5]

All adults (20+ years old): 39.8 million (22.3 percent)
Women (20+ years old): 23 million (25 percent)
Men (20+ years old): 16.8 million (19.5 percent)

Obesity and overweight substantially increase the risk of death from high blood pressure; high cholesterol and fats; type 2 diabetes; coronary heart disease; stroke; gallbladder disease; osteoarthritis; sleep apnea and respiratory problems; and endometrial, breast, prostate, and colon cancers. Higher body weights are also associated with increases in "all-cause" deaths.

Recent studies show that obesity is on the rise and is a chronic illness. One way doctors and other health care providers determine if a person's weight is a risk factor for health problems is to use a calculation of body to height. This is call the "Body Mass Index".

Body Mass Index Table

Body mass index (BMI) is one of the most accurate ways to determine when extra pounds translate into health risks. To find your body mass index, follow the following directions:

1. Look down the left column to find your height (measured in inches).
2. Look across that row and find the weight nearest your own.
3. Look to the top or middle of the column to find the number which is your Body Mass Index (BMI).

Body Mass Index Chart

Height (inches)	Body Weight (pounds)																
	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287

Body Mass Index Table

Height (inches)	Body Weight (pounds)																			
	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
58	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Why is Obesity a Problem?

Obesity is associated with increasing health risks and shortened life expectancy. The following chart shows what can happen to a person as the result of obesity:

Overweight and obesity are known risk factors for:

- diabetes
- heart disease
- stroke
- hypertension
- gallbladder disease
- osteoarthritis (degeneration of cartilage and bone of joints)
- sleep apnea and other breathing problems
- some forms of cancer (uterine, breast, colorectal, kidney, and gallbladder)

Obesity is associated with:

- high blood cholesterol,
- complications of pregnancy
- menstrual irregularities
- hirsutism (presence of excess body and facial hair)
- stress incontinence (urine leakage caused by weak pelvic-floor muscles)
- psychological disorders such as depression
- increased surgical risk

People who suffer from obesity often experience body image and self esteem problems. Sometimes people who are obese are discriminated against in the work world and often struggle in their daily activities of living. Bending, moving, lifting, walking, sitting, sleeping, hygiene may all be affected by obesity. These problems improve or disappear with weight loss. A major problem today is the lack of long-term success with diet, behavioral and drug therapy for obesity. Many severely obese patients have spent large sums of money in various media driven weight reduction programs, only to lose and then regain large amounts of weight. Many experts now wonder if weight cycling itself will add to the health risks associated with obesity.

What Causes Obesity?

The exact cause of obesity is unknown. We do know that too many calories eaten and not enough calories used by exercise or metabolic processes will lead to obesity. **BUT**, the disease is not just a problem of eating too much or lack of will power. After much research and study it is now understood that obesity involves many factors. Genetics, environmental factors, social factors, hormones, psychological factors all can play a part in the disease. For many years physicians as well as the public did not view obesity as an illness, but we now think of obesity as a chronic illness with no known cure.
So what factors are important in the regulation of weight?

Genetics
Cultural factors
Psychological factors
Endocrine and metabolic factors
Neurotransmitter imbalances

Genetics does play a role. Sometimes entire families suffer from obesity. Sometimes the environmental or Cultural factors play a role as well. Certain societies revere or approve of an "overweight" appearance. Eating habits of certain cultures can lead to obesity too. Endocrine and metabolic factors affect the development and maintenance of obesity. There are several glands in the body that are factors in controlling appetite and metabolism. Parts of our brains signal hunger and this can be part of the problem of obesity.

The food we eat has calories. Calories are a way to measure how much energy there is in the food. When we eat more calories (energy) than we need for energy we then have an imbalance between energy consumption and energy expenditure. Our bodies are always "burning" energy calories in both our metabolism and physical activity. How much energy we burn in a given day is unique to us and is influenced by genetic, environmental, psychological and emotional factors. How much exercise we do also affects how much energy we burn. Whenever energy consumption as food exceeds energy expenditure, the excess energy calories consumed are stored as fat. Eating more calories than what the body needs for energy will result in obesity if consistent. Weight loss happens when energy expenditure or calories "burned" is greater than the calories consumed in diet. Fat in the body is then used for energy. Weight loss occurs when energy intake consistently remains less than energy expenditure.

What Treatments are there for Obesity?

Treatments include diet, exercise, medications and surgery. Diet can help, but most morbidly obese people have tried multiple diets and had some success and then regained any weight lost. Many obese people are just too uncomfortable to exercise and do not have the energy to do so. Medications can help somewhat, but when stopped obese people tend to regain the weight lost. Surgery is an option that offers an excellent tool to help people lose weight. Surgery has the best potential for long-term weight loss in the morbidly obese patient.

The Weight Management team will ask you about previous treatments you have tried. If you haven't tried many, we may suggest that you try our medically-supervised program of diet and exercise. Some insurance companies require a period of medically-supervised weight loss prior to approval for surgery. Our team is dedicated to helping you with your problem of obesity and we will help you decide what is best for you.

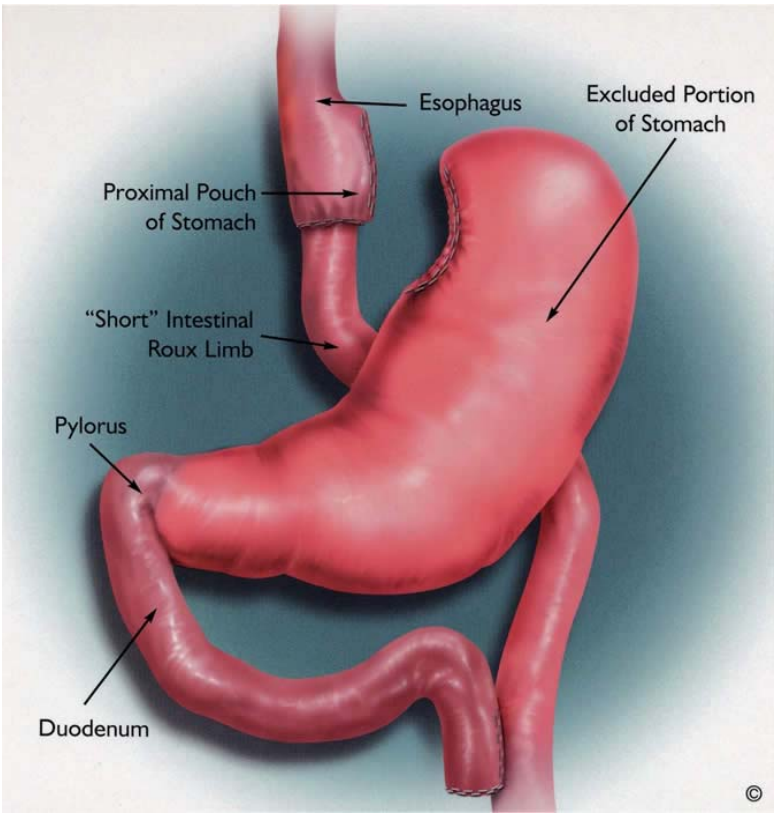
Surgery for Obesity

Because of the poor results with weight reduction programs, surgical methods of treatment of morbid obesity have been developed. Surgery for the treatment of morbid obesity has been performed for 20 years and more recently the surgery has been refined causing less complications and side effects. Currently, surgery for the treatment of severe or morbid obesity is THE treatment of choice. 70-80% of patients having surgery for obesity can expect long term weight loss if they follow all the postoperative guidelines. Patients can also expect to either eliminate or reduce the severity of most of their co-morbidities (high blood pressure, diabetes, orthopedic pain etc). For almost all patients who succeed at losing weight after bariatric surgery, lifestyle improves along with self-esteem and many people resume a very active life.
Surgery for morbid obesity can be an effective tool for long-term weight loss in people who have tried other means to lose and keep weight off.

The Different Weight Loss Surgical Procedures

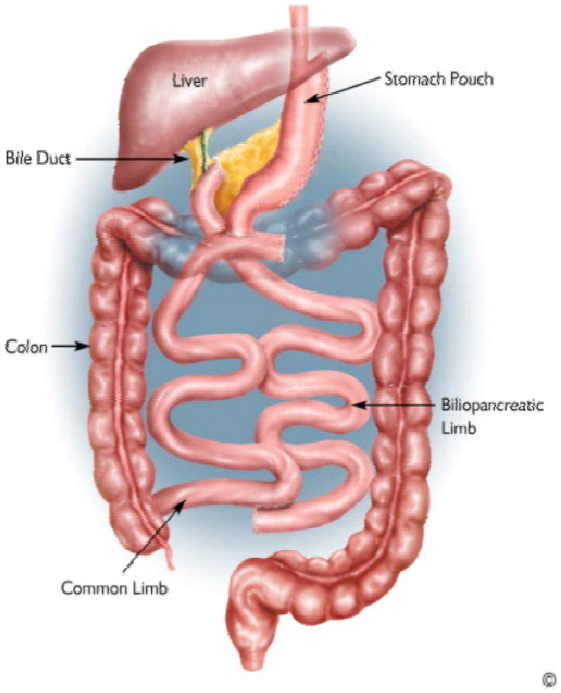
Currently our surgeon performs the **Gastric Bypass**, also know as the *Roux-en-Y*, the **Duodenal Switch**, and **Laparoscopic Adjustable Gastric Banding** also known as the *Lap-Band***.** The Gastric Bypass is done open or laparoscopically. The Duodenal Switch is performed open in our program.

The **Roux-en-Y Gastric Bypass** surgery creates a very small stomach capacity (size) from one quart to one ounce. This is accomplished by partitioning the stomach or by creating a "new" stomach with surgical staples. The result is that after the ingestion of a small amount of food, patients will develop a sensation that resembles satiety. The "new" small stomach pouch empties through a narrow opening into the small intestine. This is a new connection that is created in surgery. Some of the small intestine is also by passed which causes fewer calories to be absorbed. After surgery food bypasses the lower stomach and the duodenum. The advantage of this operation is better weight control. Patients lose an average of two thirds of their excess weight after this surgery. Patients can expect to stay in the hospital for three or four days after surgery.



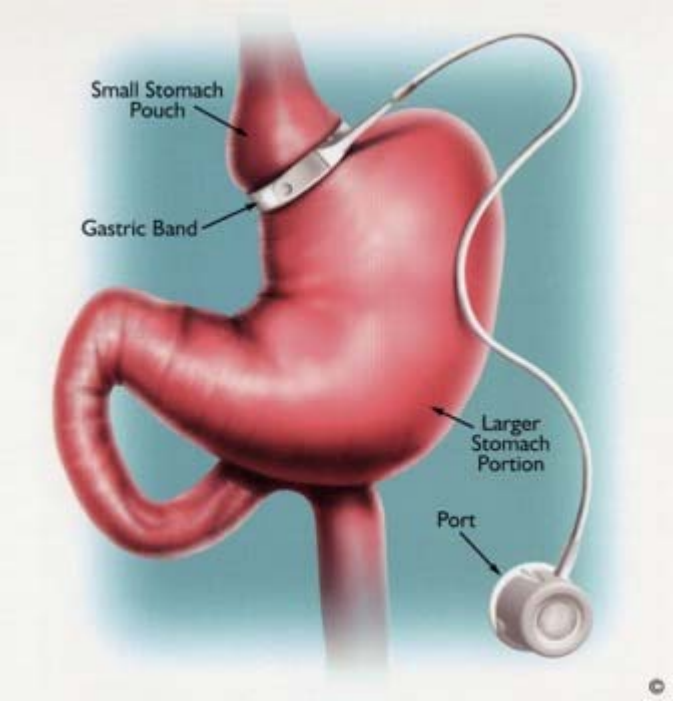
- A patient who is looking for a quick solution or who look to others to solve their obesity problems for them is likely to be unsuccessful with surgery.
- Stomach reduced from one quart to one ounce.
- On average lose 65-70% of excess body weight within 18 months of surgery
- May get *dumping syndrome* if sugar is consumed.
- Must take vitamins and mineral supplements for life.
- May not consume liquids for 30 minutes before meals and 45 minutes after eating.
- Three to four day hospital stay.
- 70-80% of people having weight loss surgery for obesity can expect long term weight loss if they follow all of the post-operative guidelines
- Causes foul smelling bowel movements due to bypass of intestine
- Many people with Type II Diabetes improve their condition

The **Duodenal Switch** operation by-passes more intestine than the Roux-N-Y and causes more malabsorption of calories. The stomach is about four ounces in size. Your doctor will help you decide which malabsorptive procedure is right for you. Patients can expect to stay in the hospital for three or four days after surgery.



- A patient who is looking for a quick solution or who look to others to solve their obesity problems for them is likely to be unsuccessful with surgery.
- Stomach reduced from one quart to four ounces.
- On average lose about 70% of excess body weight within 18 months of surgery
- Three to four day hospital stay
- Must take vitamin and mineral supplements for life
- May take fluid with meals.
- Foul smelling bowel movements due to bypassing of intestine.
- Many people with Type II Diabetes improve condition.
- 70-80% of people having weight loss surgery for obesity can expect long term weight loss if they follow all of the post-operative guidelines.

With **Laparoscopic Adjustable Gastric Banding** (the **Lap-Band),** the surgeon implants an adjustable gastric band around the upper part of the stomach. Like a belt, the Lap-Band helps to create a new stomach pouch that limits and controls the amount of food you eat. There is no cutting of intestine with the Lap-Band. There is no malabsorptive element of this procedure. Typically patients stay in the hospital overnight after this procedure.



- A patient who is looking for a quick solution or who look to others to solve their obesity problems for them is likely to be unsuccessful with surgery.
- Procedure has less risk than bypass surgery. No intestine is bypassed.
- Fully reversible procedure.
- Weight loss is more gradual than bypass procedures.
- Overnight hospital stay is required.
- Lap-Band adjustments done with a needle through the skin into the port.
- Requires multiple doctor visits for adjustments.
- Weight loss at five years post-op is about 50% of excess body weight.
- No foul smelling gas or foul smelling bowel movement due to procedure.
- May not consume liquids for 30 minutes before meals and 45 minutes after eating.
- Less effective than bypass for patients with Type II Diabetes.

Surgery for severe obesity should not be considered a simple solution or a quick fix. It is not done for cosmetic reasons. The surgery is a means for patients to help themselves, by providing a better chance to modify eating behavior. Patients who are looking for a quick solution or who look to others to solve their obesity problems for them are likely to be unsuccessful with surgery.

Am I a Candidate for Weight Loss Surgery?

All patients considering bariatric surgery must meet minimal criteria for Bariatric Surgery as listed by the American Society for Metabolic and Bariatric Surgery and the Adirondack Medical Center Bariatric team. You and your surgeon will decide your options. The criteria include, but may not be limited to:

- BMI over 40
- BMI of between 35 and 40 and at high risk for serious obesity related conditions which threaten life such as sleep apnea, heart problems, or diabetes. *(These criteria were established by the National Institute of Health in 1991 and are strictly adhered to in our program. If you have questions about these criteria, please ask us for clarification during your initial evaluation).*
- A person who is motivated to commit themselves to a change in his or her life. Surgery is simply a tool to facilitate weight loss. You will still need to follow a special diet, take vitamin and mineral supplements, exercise regularly, and follow-up with your surgeon.
- Attendance at an information meeting and a pre admission meeting.
- Tobacco free a minimum of 8 weeks pre-operative. (Nicotine patches and nicotine gum will cause a positive urine test for nicotine. We recommend Chantix, "cold turkey" or off patches and gum two weeks prior to testing.)

What Results Can I Expect After I Have Weight Loss Surgery?

The small pouch gives a sensation of fullness also called satiety. Each person responds to this satiety signal in a unique way. The usual response, which occurs in 70-80% of the patients, involves a cessation of eating until the satiety signal disappears and normal hunger develops. This will result in decreased calorie intake, and ultimately weight loss. If a normal response to the feeling of satiety or fullness occurs, total daily caloric intake usually drops to less than 1000 to 1400 calories a day which results in excellent weight loss. However, the ultimate success of your obesity surgery will depend on your ability to respond appropriately to the new sensation of fullness when the "new" small stomach is full.

Surgery will result in long-term weight loss in 70-80% of people, thus weight loss is not a guarantee. Another aid in helping people reduce intake is a common experience called *dumping syndrome* that occurs with some people who have the **Roux-en-Y Gastric Bypass**. When sugary foods are ingested, rapid emptying of the stomach pouch to the small intestine causes uncomfortable symptoms. The symptoms are: sweating, nausea, faintness, weakness, pain and diarrhea. These symptoms are usually mild and are well controlled with adherence to appropriate diet. Because the symptoms are uncomfortable most people avoid sweets, leading to better weight loss. The keys to success involve detailed patient understanding of the rationale for surgery and the required commitment to change eating behavior.

It is not possible to predict how much weight a person will lose after surgery since metabolism, eating behavior and exercise factors influence the final outcome. Patients who have had the **Roux-en-Y Gastric Bypass** lose about 65-70% of their excess weight* (on average) within eighteen months of their surgery. The *average* patient enters surgery at about 300 pounds. At 12 to 18 months the average *weight loss* in pounds is about 115 pounds for patients who have had the **Roux-en-Y Gastric Bypass.** Patients who have had the **Duodenal Switch** can expect excess weight loss of about 70%* as well. Since the majority of severely obese patients have moderate to large body frames (bone and muscle), it is unlikely that even the most motivated patients will achieve ideal body weight. Indeed, such massive weight loss might be unhealthy. The good news is that almost everyone will feel terrific even at 40-50% above ideal body weight and that at this degree of weight loss, most of the obesity related medical problems would be resolved.

Weight loss is more gradual for patients who have the **Laparoscopic Adjustable Gastric Banding (Lap-Band)**. Weight loss at five years post-op is about 50% of excess body weight* for patients who have had the Band.

The Medical Director will go over the different procedures with you at your first visit. We will work with you to help you decide which procedure is best for you.

* Source: MEDSURG Nursing-June 2006-Vol. 15/No. 3

What Other Benefits Can I Expect from the Surgery?

Since many people who suffer from morbid obesity also suffer from other medical problems, it is anticipated that many of these medical problems will improve.
The following disorders may show improvement after weight loss from bariatric surgery:

Diabetes
Many people with Type 2 diabetes improve. You may be able to stop your oral medications and possibly insulin.

Heart Disease
If you already have heart disease it probably will not be reversed after surgery, but your lighter weight means less work for the heart. If you do not have heart disease, losing weight is one way of reducing the risk that you might get heart disease.

Sleep Apnea
This can improve dramatically after surgery, since most people with sleep apnea have obesity. If you use CPAP you may not need it once you have lost weight.

Joint pain
Less stress on your joints and back will probably decrease. Arthritis progression will most likely slow down.

High Blood Pressure
Most obese people with high blood pressure see improvement after weight loss.

High Cholesterol
Losing weight may mean that your cholesterol level reduces.

Improved mood and attitude
Lots of people are depressed and discouraged because of their obesity. Weight loss can help improve body image and self esteem.

What are the Complications from Weight Loss Surgery?

Gastric bypass surgery does have a number of potential complications associated with the procedure. The complications can be divided into early and late complications. The early complications are related to the operation and tend to be more serious. They include complications related to any operation and anesthesia such as heart attack, infection, bleeding, blood clot, injury to other organs, and even death. Specific complications of obesity surgery include mortality of 1%, severe abdominal infection necessitating a second operation in 1-3%, injury to the spleen in 7%, anastomotic leak in 1-2%, wound infection in 3-5%, and major blood clots in 0.5%. Surgery on the stomach for severe obesity, like any major operation in a severely obese patient carries significant risks.

Later complications usually occur after discharge from the hospital. The most serious of these is failure of the operation to work, related primarily to enlargement of the pouch or rupture of the staples. This is usually caused by overeating and is prevented by adhering to the postoperative diet progression. Transient loss of hair is not uncommon during the first 4-8 months after surgery and is associated with rapid weight loss and possibly inadequate protein in the diet. This responds to dietary therapy. Other later problems include nutrient deficiency (iron and vitamins), difficulty tolerating certain foods such as red meat, wound hernias, gallstones, lactose intolerance, vomiting and stomach ulcers. Dumping Syndrome also occurs when high sugar foods are ingested.

Unfortunately, some severely obese people, especially those with disorder of eating behavior may attempt to continue their usual eating pattern. This causes over distention of the “new “ stomach pouch with a risk of rupture in the early postoperative period. Later the operation can become a failure if the patient overeats and the staple line does not hold. Unless abnormal eating behavior is controlled, the long-term results of stomach surgery will be at a risk for failure.

The disadvantages involve issues related to the excluded stomach and upper small intestine. These areas are important for the re-absorption of iron, calcium and Vitamin B12. Thus iron, calcium and Vitamin B12 must be supplemented in the diet as medications in order to prevent future deficiency states. These medications must be taken on a daily basis. The replacement will be started prior to surgery. In addition, because the lower stomach and upper small intestine are excluded, these areas are subsequently more difficult to visualize should diagnostic studies such as an upper GI or endoscopy be necessary later in life. Despite the by-passed stomach and upper small intestine, there are no known adverse consequences to date.

The Road to Surgery

Attend the Information Session for weight loss surgery is the initial step and a requirement of our program. After attending the Information Session, there are a few steps we want you to take before your initial evaluation:

1) **Call your insurance company.** You need to find out what your insurance company covers. Due to the number of insurance companies and the rate at which they change their policies, we ask that the patient take personal responsibility to understanding their own insurance policy. There are some questions that you should ask your insurance company. Specifically, you will want to ask the following questions:
   a. Is Weight Loss Surgery a covered service?
   b. Does your insurance cover the surgery at Adirondack Medical Center?
   c. Does your insurance company cover the surgery performed by Dr. Michael Hill or Dr. Taesun Moon of the Adirondack Surgical Group?
   d. Does your insurance cover dietary consultation?

2) **Have your primary care provider send your medical records to our office.** The medical records will help us start your chart and will make your initial evaluation a productive visit.

3) **Call our office to set up your initial evaluation.** (518) 897-2531. Your initial evaluation may be postponed if we do not receive your medical records and personal health questionnaire before your appointment.

At your initial evaluation, you will find out what other testing and consultation you require to complete your work-up. The office will help to coordinate your testing and consultation. Since most of our patients have to travel a distance to see us, we schedule many of these appointments to happen on the same day to limit your travel.

All patients will be required to have three core consultations: *Nutrition, Physical Therapy, and Mental Health.* After your initial evaluation, testing, and core consultations are complete, most patients are required by there insurance to be in a medically-supervised weight loss program for a period of time (most often six months). Patients who are on the path to surgery will be attending monthly classes or office visits to weight-in as required by their insurance until they are cleared for surgery.

When a patient has qualified for surgery according to their insurance and our Medical Director, a *Letter of Medical Necessity* is sent to insurance for their approval for surgery. Once approved, a patient will receive a surgical date. The patient will also be scheduled to meet with the surgeon and attend *Pre-Admission Testing (PAT)* that same day. Pre-Admission Testing is an educational session with the hospital nursing staff that prepares you for your day of surgery and hospital stay following surgery.

All patients are required to do a nine-day liquid diet immediately prior to surgery.

Informational and Support Group Meetings

Information Sessions**: Every person wishing to enter the Bariatric program must attend an informational meeting about the problem and treatment of obesity. The program coordinator or nurse and a surgeon conduct this meeting.**

Meetings are offered twice a month and are by registration only. A slide presentation and a Program Handbook are given to attendees. Attendance is free and people who wish to attend more than once are welcome to do so.

Interested persons should call (518) 897-2531 to reserve a seat. Guests are welcome.

Post-Operative Support Group: A separate support group only for people who have had surgery meets on the second Tuesday of every month (rain, snow or shine) at 6:00 PM in the hospital Redfield Room. Sorry, no family or friends. No registration required.

Support Group: A group for anyone wishing to get more information or just talk about their upcoming surgery may attend. Family members are welcome. This group meets on the fourth Tuesday of every month at 600 PM. No registration required.

What Can I Do Now to Prepare for Surgery?

Quit smoking: **All patients must have 8 weeks free from tobacco prior to surgery. We check urine samples to make sure.**

Lose weight: We do not require (in most cases) that people lose a certain number of pounds prior to surgery, but we want you to lose some. Do not gain weight or we will postpone your surgery. We will help you lose weight. Losing weight before surgery tells us that you are serious about the surgery and it also reduces the risk of complications from the surgery. Eat 3 meals a day. Avoid hi fat and sweets.

Exercise: All weight loss surgical patients are expected to exercise before surgery. We expect you to begin slow and build up your tolerance. Our physical therapist will help you with this, but start now!

Vitamins: Start taking a good quality (Centrum type) multiple vitamin.

Hydration: Drink at least 2 quarts of water a day. Start now.

Your active participation tells us you are serious about surgery.

The Weight Management Program Team

The following people are members of the team that has designed the Weight Management Program. Following their name is a brief description of their role.

Edward Hixson, MD:	Program Medical Director
David Merkel, MD:	Consulting Surgeon
Michael Hill, MD:	Primary Bariatric Surgeon
Taesun Moon, DO:	Primary Bariatric Surgeon
Karen Hixson, RN, CS, ANP:	Clinical Coordinator, Provider
Debbie Zale, R-PA:	Physician Assistant, Provider
Linda Finn, RN:	Office RN
Kim Branch, RN:	Office RN
Jessie Ano LPN:	Office LPN
Mark Keating,	Mental Health
Sandra Gothard, RN	Behavior Modification
Sharon Sorgule, RD:	Registered Dietitian
Liz Cassini, RD:	Registered Dietitian
Richard Preston, RPT:	Director of Rehabilitation Services
Lisa M. Smith:	Program Office Coordinator

Important Phone Numbers

Weight Management Program at Adirondack Medical Center…… (518) 897-2531
FAX…...(518) 897-2535

Edward G. Hixson, MD Program Medical Director

Mailing Address:
Bariatric Program
PO Box 471
Saranac Lake, NY 12983

Adirondack Surgical Group…….(518) 891-1610
Weight Management New York……..(518) 897-2455

Internet Resources

Adirondack Medical Center
www.amccares.org

Obesity Help
www.obesityhelp.com

Obesity Action Coalition
http://www.obesityaction.org/home/index.php

American Society for Metabolic and Bariatric Surgery
http://www.asmbs.org/

Lap-Band
www.lapband.com

National Institutes of Health
http://health.nih.gov/result.asp/476

Obesity Law
http://www.obesitylaw.com/