

**BARIATRIC SURGERY
HAHNEMANN UNIVERSITY HOSPITAL
PHILADELPHIA, PENNSYLVANIA
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NARRATOR: Morbid obesity is a serious condition with significant medical consequences. The gastric-bypass procedure has helped many to lose weight and to regain control of their health. For the next hour, Hahnemann University Hospital's Center for Surgical Weight Loss, located in Philadelphia, Pennsylvania, will broadcast a live-panel discussion of the Roux-en-Y gastric-bypass procedure. Specialists who treat and evaluate potential bariatric patients will be on hand to discuss the benefits of minimally-invasive techniques, including the use of the Da Vinci robot to perform surgery. Dr. Andres Castellanos will lead the discussion and narrate a Roux-en-Y bypass he recently performed.

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DR. ANDRES CASTELLANOS: the benefit and the best way to look at the gastric-bypass surgery is that it's just a tool. We all know that diet, exercise, and medications are alternatives to losing weight, but once you reach certain amount of weight, it gets very difficult to really stay in line and achieve long-term results.

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NARRATOR: Viewers will learn about patient selection, preparing for surgery, the surgical procedure, and the recovery process. You can participate in this live program by e-mailing your questions to the panel at any time. Just click on the MDirectAccess button on the webcast screen.

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DR. ANDRES CASTELLANOS: Hello, and welcome to Hahnemann University Hospital live webcast. We are broadcasting live from Philadelphia, Pennsylvania, and today, we're going to be learning a little bit more about Roux-en-Y gastric bypass and how to get that there. I am Dr. Andres Castellanos and the director for the Center for Surgical Weight Loss, and I'll be your host and moderator tonight. I'm very fortunate to have several of the members of the bariatric team, and at my left hand have Dr. Ralph Petrucci, which is our clinical psychologist. Dr, Joanne Getsy, which is our pulmonologist and medical director. And Lori Jenkins that is our program coordinator. On my right hand, I have Marcie Amerstein, which is our clinical nutritionist. Today, we're going to be learning a little bit more about gastric-bypass surgery. Now, before we get into more details, I want to remind you to access your MDirect button for questions, and hopefully, we can make this an interacted process. During the footage, we're going to be showing you some bigger clips of a Roux-en-Y gastric-bypass surgery. This is an edited video clip of a surgery that we performed a couple of weeks ago. Now, before we get into the surgical details, I want to talk a little bit about obesity, what is obesity, and why we are so concerned about it. There is no questions that obesity is a disease. As a physician, we get to see the complications more often more often than none, and we understand...And what is concerning is this is a progressive problem, and if we look at what would happens – what happened in the United States over the last 20 years is that we have seen a dramatic increase. These days, about 60%, 64% of the American population is either

overweight or obese. The percentage in women is as high as 80%, and when we look at what we call morbidly obese – which are those that their weight is more than 100 pounds above their ideal body weight. That number seems to be going up higher. One area that is also concerning is that obesity has become the second leading cause of preventable death in the United States. This progression definitely has been over the last 20 years, and what is concerning is the physician – at the same time that we have seen an increase of obesity, we have also seen an increase of diabetes, hypertension, sleep apnea, and that’s why in this panel, you see a multidisciplinary approach. We understand that disease that affects everybody at different levels. When we talk about treatment options for obesity, we tend to focus in the diet, drug, exercise program, and unfortunately, even though these are always the first step, we need to recognize the problem is with the long-term results, what happens. For the most, we know that some people can achieve success, but it’s very hard to have these long-term results, and I think that that’s where surgery plays a significant role. Surgery can definitely help you to achieve long-term results, and is important that we do recognize that surgery might not be for everybody, but there’s a certain group that can be a good candidate. In this slide, you can see sort of common requirements that are needed in order to become a good surgical candidate. You have to follow the national recommendation and standards, and pretty much, you have to have significant medical problems. You have to try previous means to lose weight before. But what I consider to be the most important is that you need to be dedicated to make life changes for the rest of your life. This is not a short-term process. This is a long-term process, and that’s probably what makes surgery unique when we compare these with the other alternatives. Now, in the same way that we prepare you and we select you to have surgery, we undergo a lot of preparation to be sure that as an institution and as a center, we can offer you the best care. And that’s something that takes a lot of time and a lot of preparation, and I would to have Lori Jenkins, our program coordinator, to tell us a little bit about what it is, bariatric surgery, for the institution and we got to be what we have and what people do – what centers do in order to be prepared

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LORI JENKINS: Well, key components of a bariatric program are to have a surgeon who is certified by the American Society of Bariatric Surgery who is proficient in open and laparoscopic procedures. Programs should be at a full-service facility who can handle complications and emergencies on site. There should be close pre- and postoperative nutritional monitoring and counseling. The nursing staff who take care of the bariatric post-op patients should be specially trained in their care and potential complications. And there should be individualized patient education, and there should be support groups also, ongoing pre- and post-op. We believe that there should be a designated bariatric patient – in-patient unit where all the staff and supportive staff are specially trained and that there should be specialized equipment, including beds, walkers, commodes, wheelchairs, and O.R. tables that can accommodate large patients.

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DR. ANDRES CASTELLANOS: You can see in the slide, this is sort of some of examples of the equipment that we have to be sure that our patients are comfortable throughout the stay, and I’m pretty sure that we will have a little bit of time to talk about that. Definitely, it is important that we have to go through our preparation process, which probably is going to include interviews by several of the members of the team that are present here, and we will get the chance to ask some of the questions, and don’t forget to access your MDirect button. We definitely want to hear from you, and hopefully, we can answer your questions throughout this program. Now, I know that we’re all here because we want to learn a little bit about the

gastric-bypass surgery, and we promised you that we're going to be showing you some exciting clips. We're going to be talking about the Roux-en-Y gastric bypass. This is by far probably the most popular surgery that gets performed in the United States and around the world to help people to lose weight. If you can see in the chart, what we're trying to do is make the stomach a little bit smaller. That definitely is going to help with the portion control. We bypass the bigger stomach, and that's what the name comes from, and then we have to reroute the intestines inside just to be sure that the food can find its way out. I'm pretty sure this sounds kind of simple, and I hopefully can convince you that probably at the end of the show it is relatively simple even though you have to have certain skill. When we talk about the surgery, there is two ways to approach that. There is the open surgery, and there is the laparoscopic surgery. The open is the traditional way with the big incisions. The laparoscopic is the one that have the small incisions. We're going to be showing you a...The advantage of the laparoscopic is that it's a small incision. It's less pain for the patient. It's faster recovery, and definitely, over all, it is the surgery that I prefer the most. In the roll in, we're going to be seeing some of the steps that we need, too. This is us getting ready. The patient has already been put to sleep, and we are measuring where the placement is going to be. We focus in the upper abdomen. We're going to be making anywhere between five to six small incisions, and if you can see, we try to keep those incisions almost the size of your small finger. We're talking about five to ten millimeters at most in diameter. We are right now sort of selecting where our ports are going to be placed. Don't forget that during this process, if you have any questions, please feel free to be sending those. Through these incisions, we're going to be using special tools and special instruments which are going to be allowing us to access the abdominal cavity. Right now, we are getting ready to introduce the tocar, which is a special tool that is going to allow us the initial access. This is something that we have to be very careful. A question that I get all the time, it is related to persons – patients that have had previous intervention being a candidate for laparoscopic surgery, and definitely, having previous surgeries makes this a little more challenging, but is definitely a doable operation, especially focusing on where your previous interventions were done. You always have to be very careful. That's one of the critical aspects, but once you are inside and we have this tocar in place, we can place a camera, which is going to allow us a direct view of your abdominal cavity. Hopefully, everybody will be okay with this image. During the program, what we are going to be showing you are the critical steps of the procedure. As I already mentioned, we're trying to reroute the intestines. We're going to show you the different connections we do, two main connections, and we're also going to show you the creation of the pouch. As you can see, this is the first view. We always inspect the abdomen just to be sure there is not any other abnormalities. What you see in the top is the stomach, the liver. Here, we're put in the second ports. We do these under direct visualization, and as I already mentioned once, we use anywhere between five to six small ports to perform the procedure. While the tape keep s rolling, I want to ask Joanne a little bit about – what are the complications and the problems – the respiratory problems that obese patients have, and what do you think that, definitely, surgery plays a role in their treatment?

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DR. JOANNE GETSY: I think there are two major issues with obesity in terms of breathing, and the first one is really just what we call the work of breathing. It becomes difficult to breathe, and part of that is literally the airways can become smaller because fat can be deposited in your upper airways. So you're breathing through a smaller tube, essentially, and so it becomes harder to breathe. In addition to that, you have all that extra weight, and so you have to inflate your lungs against,

sort of, more resistance, particularly if there's a big belly or in women who have big chests. It's really hard to breathe, literally, with the weight strapped to you. So that's the first thing that's really important. Along with that, some lung diseases that people might have already, like asthma – it becomes much more important for people to lose weight when people have severe asthma because that extra weight, that extra work of breathing can become very, very difficult in an asthmatic and make the asthma flares more often and more serious. The other one that's really important is sleep apnea, and obstructed sleep apnea is a syndrome that is most common in overweight people. At least 90% of the people who have obstructed sleep apnea are overweight, and in that syndrome, that's when the throat actually collapses when people are sleeping. So they snore, and then they stop breathing, and that's actually a collapse of the upper airway, and again, that's usually because fat has been deposited within the airway, and it's more narrow, and it collapses while they're sleeping. And so the people might notice that they're tired, and they stop breathing in their sleep, and they snore loudly, and they're just not performing well. And that is a disease that is almost always curable with weight loss. And it's very hard for people to lose weight. I've been doing this for 20 years, and very few people can do it successfully on their own. And we do use the nasal CPAP machines when that's appropriate, and that's obviously the first step, but in the long run, my long-term goal for these patients is they lose weight, and that's why they really need to see someone to try to get that weight off.

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DR. ANDRES CASTELLANOS: Yeah, I think it is very important, what you just mentioned, because sleep apnea, like many other diseases that are related to obesity, sometimes can be silent, and a lot of people that have obesity problems don't know that they are actually suffering from this disease. I just want to remind you that tonight, on top of our panel, we have invited two of our former patients that maybe can tell us a little bit of what was their experience and what happens with their medical problem. Going back into the video clip, we're going to be showing you the second roll-in. As I already mentioned, there is several critical steps. Once we are inside the abdominal cavity, we pay attention to the small intestine. What you can see is that we have already divided the proximal part of the intestine, and we're getting ready to measure what we call the Roux-en-Y length. This is the part that is going to be connected to the new stomach. This is definitely the part that is going to help us to create a little of the absorption, and that's going to have some beneficial functions, but also in the future, can create some problems, and once we address the nutritional aspects, we'll get to learn a little bit more. As you can see, there we are navigating until we measure anywhere between 75 to 150 centimeters, which is what is the recommended length in order to get the maximum effect. We use these fancy tools that allow us to make holes in the intestine, and if you can see, we try to minimize bleeding, and that's what all these tools do. They use heat and energy to try to prevent excessive blood loss. You have to be very delicate. You can see us putting traction on the intestine. What you can see is that the initial part that we divided, we are reconnecting it distally. In this particular case, we use 120 centimeters. Once we have the opening, we use this fancy long tool that is going to help us to connect the two things together. There is no questions that technology have played a big role in how we do things today, and later during the footage, I'm going to show you a little bit of what the Da Vinci robot can do. I know that some of you have been asking me some questions about that. We'll definitely get to you. Once we have fired the instruments and internally connect the two pieces of bowel, we close the opening. As you can see, we use regular sutures and needles, definitely not the ones you use at home. These are the ones that are designed to be used in the medical field. If you can see – I want you to pay attention to this part, that we

use these long instruments to do the suturing. They are quite stiff, and definitely, we got to spend a lot of hours training to be comfortable in being able to do the things that we do. When we show you some of the later robotic footage, you're going to see a little bit different. Right now, what we're doing is just closing the opening where the large instrument went through. Now, while we continue to work in the closing – in the closing of the suture, I'm going to take some time to introduce some of our patients that have joined us on the stage. On my left hand, I have Donna and Phil. For privacy, I think I'm going to skip your last names, but they are very happy to be here. Down the road, we're going to have the chance to hear a little bit about your experience and how much your lives have changed after the gastric-bypass surgery. There is no question that a lot of the changes that we see related to surgery have to do with nutritional changes, and that is what is important, and that's what we think the involvement of the nutrition is an important part of this program. I wanted to reintroduce Marcie Amerstein, our clinical nutritionist, and she has been working with us for quite some time, and maybe she can tell us a little bit what is the role of the dietician and to expect in the preparation to have the surgery done.

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MARCIE AMERSTEIN: Well, my role is the dietician working with the bariatric program is to meet with patients prior to surgery, let them understand what the diet and expectations are going to be after surgery, and I help walk them through this process. And I will meet with patients before surgery and through follow-up visits as well.

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DR. ANDRES CASTELLANOS: And throughout this process, you're probably going to learn a little bit more about how a nutritionist going to come, and at the end, I think that we believe that learning about nutrition is going to be the key to success, no matter how we approach this. We're going to – once we finish the first anastomosis, we're ready to create the new stomach, to pouch. We're going to be showing you the formation of the gastric pouch. We're going to be showing you the third roll-in, and the me, this is one of the critical part of the operation. The gastric pouch is what is really going to help you limit your food intake, and we always – and I always remind this to our patients, that one of the key elements to a healthy nutritional habit is for some control, and that's what the small stomach does for you. Here, what we're doing is looking at the proximal part of the stomach, and the pouch really gets to be very small. It's normally 30 to 50 c.c.s in size, and just to give you an idea, it's almost the size of an egg, or maybe sometimes, a golf ball. It makes it really small. As I already mentioned, we have these fancy tools. As you can see, this is an instrument that close and cut the stomach at the same time and allow us to divide the stomach. There are instruments that are designed to minimize bleeding, and in these areas, you have to be very careful. There's always a lot of vessels. This is just the proximal part of the stomach, and we're going to...the distal part behind. And I get a lot of questions about what is going to happen with the stomach that is not being used. Well, it's still going to be there. It still has some functions, and it still produce some digestive juices. It obviously doesn't have the same function where the food used to pass before, but it does really fulfill a role. Right now, as you can see, we have a small bleeder, and we use instruments, and they're relatively easy to control. Now, if you look at the skin sometimes, the bleeding might look magnified. For those of you that are not used to the laparoscopic surgery, laparoscopic surgery make things look a little bit bigger. Here we're still trying to control that. I'm getting ready to make the pouch. And it's literally almost like carving and using scissors to create this tiny, tiny pocket. You have to, obviously, be very careful. On top of your pouch and your stomach, what you can see – what we're holding with the other instrument is your liver, and that is normally in that position, and you have to be

very careful just to retract it and get that out of the way. Can show you one more time: you can see how we use the stapling device to create the stomach, and what we'll do is we'll fire – we'll fire the staple multiple times until we get the size right. Sometimes we use special sizers and tubes to be sure that the pouch doesn't get too big. Obviously, you don't want the pouch too small, even though I really believe that you cannot make the pouch too small, because it's something we have seen through the years, that the pouch eventually tend to stretch. Someone is asking me what is the yellow tissues that you see around. That is internal fat. We have that internal fat. It doesn't matter if you have an obesity problems. Obviously, if you're obese, these seems to be more pronounced, and that fat distribution changes. There is dispersion to have a lot of internal fat. There is people that don't have too much internal fat. It's mostly in the outside part. Definitely, dealing with that is the easy part. Now that we have completed the pouch, I'd like to ask Dr. Petrucci, our psychologist – because there is no questions that emotion plays a big role in this process. As a matter of fact, I have someone that was asking about what is the role of a psychologist and the things that we ought to be aware of before we go into this process.

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DR. RALPH PETRUCCI: Well, welcome. The psychological and psychiatric evaluation is always a concern for patients. There's no real reason to be worried. We guide you through a structured interview and are responsible for taking a looking at your eating behaviors, which are very important. It helps us judge what direction to help you educate yourself, what direction to go in to educate yourself, and what we can do to maximize your support. One of the important aspects of the evaluation is to take a look at expectations, yours, ours, and to see if we're on the same page. We encourage you to be real honest with yourself, not necessarily with us but with yourself and your family because this is where the changes are going to really occur. We try to identify the factors that are contributing to your eating behavior. What's caused the eating pattern to get out of control, and where have you lost control? We've encouraged you to consider more adaptive behaviors as time goes by – that's very important – and to participate in a lifelong, gradual expectation for these changes. They're not short. They're not intermediate. They're extended. They're lifelong.

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DR. ANDRES CASTELLANOS: Now, Ralph, I have an interesting question here, and it is about someone that is concerned about having an emotional, psychiatric problem. Will that disqualify that person to be a candidate for surgery?

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DR. RALPH PETRUCCI: Now at all. As long as compliance and adherence remains consistent, we encourage that person to continue to see their doctor or their therapist and their primary doctor. We encourage them to maintain contact with us and open contact so that we can have an open communication with their doctors on the outside.

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DR. ANDRES CASTELLANOS: Now, I'm not so sure this will have to do with the psychological part, but someone is concerned about why 80% of the obese people are women, and do we think it has to do something with psychological problems that are typical with women?

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DR. RALPH PETRUCCI: Well, I'm not exactly sure how to answer –

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DR. ANDRES CASTELLANOS: Yeah, I don't want to get in trouble today by answering this question. But that is what we see. I think that definitely, there is a hormonal

component. There's other things that play a role in why we see the prevalence. There is no questions the female and male metabolisms are different.

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DR. RALPH PETRUCCI: I will add that women tend to organize and admit their problems more so than the males do.

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DR. ANDRES CASTELLANOS: But that's normally what we do, right? We have seen so far the first anastomosis. We have created our pouch, and now, we need to reconnect what we have done so far, and we're going to be showing you the second and final anastomosis. Once you reach this point, you're almost very close to the home line. You will ask, well, how long that surgery will take? This surgery, it takes between one, one and half hours sometimes, depending your body habits. It can take up to two hours. There is different ways to do this connection. What you can see on top is the new stomach, and in the bottom, it is the intestine that we divide at the beginning. What we have done is we have brought the two of them together, and almost using similar technique that we used for the first anastomosis, we are getting ready to create the connection. I think that this is definitely a critical part of the surgery. If you make the connection too small, the patients can have some difficulty swallowing and eating, and if you make it too big, you can have further problem, like some abdominal pain. Therefore, you have to be very careful that this gets done in the proper size. I used the same stapling device, but I tried to limit the length that I introduced inside, and it's almost similar to what we saw before. Once you fire the instrument, the instrument will connect the two things inside. This is one of the areas that we have to be concerned because that is where we get what we call leaks and complications. And we'll talk about that a little bit later down the road. Using a similar technique on the stitches, we close the opening that we used for the stapling device. One more time, this is a specialized suture that is designed for this type of job. Obviously, if you are a patient, you're not going to feel any of this inside. The type of suture, actually, that I use, is the one that gets dissolved and eventually doesn't form part of your body anymore. We finalize and put in the last couple of stitches, and at this point, we can almost say that the operation is almost done. What we need to do at that time is just to test to be sure that there is not any leakage or any problem, and we do that by performing an interoperative endoscopy. Now, I have a question here about if there is any risk related to surgery. Obviously, this is surgery. This is not like going to any dietary plan or taking medication. If you're going to have surgery, you have to be – you have to be well aware of the complications that this procedure can have. I think at the end of the day, it is important that we put in a balance, what are risks of having the obesity problem versus the risk of having the surgery, and if we find that the risk of obesity are greater, definitely there is a good role for surgery, and that is important. Now, as I mentioned, when we talk about the risks of the procedure, there are things that we have incorporated to help us a little bit to make this procedure more efficient. Here at Hahnemann University Hospital, we have incorporated the latest technology, and we have been performing the surgeries using the Da Vinci robot. This footage that you're going to see is courtesy of Intuitive Surgical, which is company that manufactures the robot, and what you're going to see is you're going to compare and see the difference of creating the first anastomosis using that surgical robot. As you remember, I pointed out to you that we were using these long instruments to do the anastomosis. Now we have these similar long instruments, but if you look at the robot handles, which is the ones right now in the middle of the screen, you can see the flexibility that they have at the tip. It's almost like having your hands inside. And there is no question that when we utilize this technology, we can make this process safer. We don't use the robot in all the patients. There are certain patients that will

benefit more, but it's definitely a good idea to have the alternative that we can do what we think is the best and offer you the best technology to be sure that this procedure gets done in a safe manner. As you can see, the movements with the robots are more fine, more neat. The suturing part looks a little bit easier, and I have to confess, it is a little bit easier compared with the laparoscopic one. And sometimes that might be a benefit for certain surgeons that they're not so used to laparoscopic surgery. Definitely for us, we find it to be a nice advantage and something we can offer to our patients. Now, there is no question that regardless of what we see here and what we do and what we talk about the surgery, none of this is worth it if we can not show good results and good outcomes, and we are very lucky to have some of our patients here. As I already mentioned, one of the things that has made a significant impact in the co-morbidities is the presence – the resolution of the co-morbidities. This is a graphic on the screen. You can see what is the impact in the diabetes, hypertension, sleep apnea, and you can see that we can actually achieve a significant degree of cure. In some cases, we can completely fix the problem. I don't want to speculate because you guys went through this over the last two years. Maybe you can tell me a little bit better what is your experience and how do you feel and how life has changed since you have the surgery.

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DONNA: Well, I'd say the biggest difference for me is mobility, simple mobility, being able to move more, more frequently, more quickly, and as a result, being inspired to do some things that a year – well, more than a year and half ago – I had my surgery in December 2004 – I wouldn't have even considered doing. So I can, you know, walk more. I can – I'm biking now. You know, I can do the treadmill, and it's almost like being out of prison relative to the mobility. Probably the biggest health benefit that I've had is really seeing my cholesterol level go from, you know, borderline high, you know – well, high, like 240, to having it be around 200-something, but learning that. Wow, it's mostly the good cholesterol. So I was really pleased about that. Fortunately, I had my surgery before any of the bad co-morbidities really kicked in. I didn't have the high-blood-pressure problem. I didn't have sleep apnea and fortunately didn't have any diabetes. So I guess I got to the party on time, I would say.

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DR. ANDRES CASTELLANOS: And that is important, that sometimes, you don't have to have the full spectrum of medical problems to qualify for the surgery. Sometimes, having your weight – that's what we call morbid obesity -- more than 100 pounds, it is a good reason to proceed and have the surgery. And that's something that definitely needs to be evaluated by the surgical team. Now, Phil, I know that your life has changed quite a lot since the intervention.

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PHIL: Yes, it has. I was experiencing the co-morbidities. I had high blood pressure, was taking two medicines a day for that. My cholesterol was extremely high. I was taking medicine for that. I had family background; my father had diabetes. He had a stroke, a heart attack. My mother had a bad valve. Since the surgery, I've stopped all my medications. The last time I had my cholesterol checked, it was 143. Previous to that, it was 262. Everything for me has just been going forward, and I am not looking back.

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DR. ANDRES CASTELLANOS: Now, Phil, how much weight have you lost since the surgery?

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PHIL: Right now, I'm at about 127.

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DR. ANDRES CASTELLANOS: That is very remarkable. And that is one of the things that we see. Someone from the audience is asking me why patients with gastric-bypass surgery tend to do better than patients that have other modalities. And I think it all has to do with how the surgeries are designed. The banding procedures are normally restricted procedures. They sort of limit your food intake but also can lead you to maladapted behavior. The gastric-bypass surgery has that malabsorptive component that we mentioned at the beginning of the broadcast that can also optimize, and there is no questions that you see rapid weight loss. There is people – there is big proponents of the bands. My favorite's still the Roux-en-Y gastric bypass. I think it gives the patients the best benefit for what they're doing, and if you can see – there's a slide. I can ask you this question: would you have this done again?
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DONNA: Absolutely. In a heartbeat.
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DR. ANDRES CASTELLANOS: And that is important, that we have not only improved your medical condition, but we also overall have changed your lifestyle. And I think that that is something that is important. Ralph, some people have been asking me what are things that you can do to help you prepare to make the surgery work a little bit better? Or how can you address this emotional issue? Because there is no questions that the surgery, more than anything, is going to be a tool that is going to help you change those behaviors and those things that we know that we do that we all do wrong.
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DR. RALPH PETRUCCI: It's important that you perceive yourself as making a gradual change. Change is not rapid. It doesn't have to be overnight. But this is a long-term process, and that the changes occur in small fashions, one or two at a time, not large changes over a short period of time. Always leave windows for surprises. I think it's very important for patients to understand that they too may be surprised with their interpersonal relationships as a result of their massive weight loss.
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DR. ANDRES CASTELLANOS: And that is important that we all remember that. Now, I have someone here that is concerned about what type of food can you eat before and after the surgery. One of the most important changes -- and I think that, probably, Marcie, you will be the best person to help us answer that question.
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MARCIE AMERSTEIN: The diet after surgery is primarily high in protein. Patients are only allowed to tolerate small amounts at a time. SO we focus on getting high-protein foods in first. We have to stay away from foods that are high in sugar, foods that are high in fat because this can actually cause patients to get sick. These foods get rapidly absorbed and can cause the shakes, sweats, diarrhea. So these are foods that we want patients to limit.
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DR. ANDRES CASTELLANOS: Now, I know we briefly mentioned this, but someone is interested in what kind of nutritional deficiencies are expected after surgery and what do we do to address those?
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MARCIE AMERSTEIN: Because there is some degree of malabsorption that happens with this procedure, it's very important that patients take vitamins for the rest of their lives, and we make sure that on follow-up visits, we check blood work, and we make sure that our patients are taking these vitamins.
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DR. ANDRES CASTELLANOS: Now, I have several questions here, and I'll try to address as many of these questions as we can. I know that someone is concerned:

at some point, are we planning to lower the bar for people that have a lower excess weight, and as I already mentioned, we'll be talking about morbid obesity, that you have to be 100 pounds overweight, but that is not the only criteria. If you have significant co-morbid problems, your weight might not be 100 pounds. It might be lower than 100 pounds, and you still might qualify if you have hypertension, if you have diabetes, and you have other co-morbid problems. And I think that is important that people understand that we have to really focus on those co-morbid problems as well. I know that a lot of things that we do is prevention. Sometimes we don't have to wait until you have a lot of those problems to lose weight, but by no means I want to come here and say that if you have, I don't know, 30, 40 pounds of excess weight loss, you should have a gastric bypass because we know there are other things that can work well for you. And as I already mentioned in one of our previous slides, that there is risk related to the surgery. Then we have to be cautious about how do we approach this and how do we offer? There is no question that this is not for everybody and that we have to be very cautious. I'm just going to go through some of the questions, but it's definitely important that when we work in changing this eating behavior, we recognize that this is – the surgery's just a tool, and I'm going to repeat this several times, because sometimes we focus a lot on how the surgery gets done, the different types. I always like to quote one of the phrases that at the end of the day, he's the one that's performing the surgery and just giving the tool. Because what we want to change is your eating behavior. If we cannot change your eating behavior, the surgery itself, it might help you for a short period of time, but it's not going to help you for a long run, and that is what we want. We want to fix these problems in the long run. We want to make you healthier in different levels, and I'm pretty sure that you guys have seen that in what your life is today and the things that you can do now that you were not able to do before. I have someone that it is asking if there's been a case where there was no weight loss. I guess the reality is that sometimes you're going to find people that might not lose what they expect to lose, and when we talk about expectations, we know that most of the people that have the surgery lose anywhere between 70 to 80% of the excess weight. And there is no doubt – because we follow up these patients for a long time – that some of them can regain their weight back. I don't know if we can safely say that no one lost the weight. Definitely some of them did lose the weight, probably was not through a fun way, but then they managed to regain some of the weight back. Marcie, I don't know what you think about that.

00:43:48

MARCIE AMERSTEIN: And this is also the reason why we encourage patients to follow up with us, and this is why we provide extensive counseling before surgery so patients know what the expectations are, and we do provide a support group monthly and encourage patients to attend that so that they can stay on track with the diet after surgery.

00:44:07

DR. ANDRES CASTELLANOS: And the support is critical, not only with the nutritionist, but as you mentioned, a support group, people that is involved with this process. There is – I have a couple of questions here regarding risk, concerns of pulmonary embolism, which is clots going from your legs into your lungs, which has been associated with this process. What can a patient do to minimize that? There is no question that the patient plays a big role in what is going to happen after the surgery, during the surgery, before the surgery. A lot of people focus on the surgery being the end of the process. I can tell you it's just the beginning and what we can – and probably you guys can answer that question better than anyone. What are the recommendations to prevent pulmonary embolism clots?

00:44:57

DONNA: Move. Get up. Walk.

00:45:00

DR. ANDRES CASTELLANOS: Move and walk. These are the important things that you need to do, and this is one of the things that I instruct my patients, that they know that the day after the surgery, three, four hours after the surgery, someone is going to come into the room and get you up and moving. And before the surgery, when I give those instructions, they all agree and say yes, we're going to do this, don't worry about it. Now the day of the surgery, things get a little bit tough, but that's what you need to remember, that the faster you start moving, the less chance you're going to have complications. Some people is concerned about how much the procedure costs. Obviously, this is – there is an inherent cost to the procedure. But these days, most of the insurance companies can approve you for the procedure as long as you meet specific guidelines. I know there have been recent changes in terms of what the insurance companies and what Medicare and what other companies do, but at the end, we all recognize that the main reason that we're doing this is because obesity is a disease, and if we do the right things and you meet the criteria, most of the insurance companies will cover the operation. Someone is asking, again, if we remove any part of the intestine. As you can see by the video clips, we didn't remove anything. Anything stayed inside, and what we did is we just reroute and reconnect things. As I already mentioned, the distal stomach, which is not excluded from food is still have an important role in your digestive function. It's not the same role that it had before, but definitely, it is there. I have a couple other questions that have been coming along. Ralph, there's someone that is concerned about what happens if they think they need emotional help before or after the surgery. Is that common that the people can have emotional problems after surgery?

00:47:11

DR. RALPH PETRUCCI: Absolutely. A good place to start is with a primary, maybe addressing the issue with a primary physician and then addressing it with the staff here. We are prepared to address and approach any of the upcoming problems that you anticipate. Many of these can be resolved just with some reassurance and education. Education is a big factor in settling many of the anxieties that people have.

00:47:43

DR. ANDRES CASTELLANOS: Yeah, everybody will think that this is a positive thing, that there's going to be all favorable changes, that there's reason to be happy, and for the most, they are. For those of you that have to struggle with obesity for a long period of time, you realize that sometimes, you're involved in dysfunctional relationships, that you have emotional constraints. Once you go through the surgery, you start gaining more self-confidence, and it depends on what is the status of your relationship. Things can be jeopardized. It's always very important that you talk about this ahead of time. I think that that's one of the areas where having a support group and coming ahead of time and discussing the surgery with your family and relatives and friends, that definitely puts you in an advantage to go through this process. I have a couple other questions that – someone is concerned about can the weight come back after the surgery? This particular person already went to a second opinion and is concerned that the surgeon said about 20% can back after the surgery. Marcie, what do you think about that?

00:48:56

MARCIE AMERSTEIN: Again, if patients are noncompliant with the diet and they don't keep up with the exercise program, they can gain weight back, and that's why we stress this is a lifestyle change. The surgery is just a tool to help you lose weight, but you really have to take it upon yourself to lose the weight and keep it off.

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DR. ANDRES CASTELLANOS: Centers are there because we know the statistics. We do follow-ups, and when I tell you that we are going to lose 70 to 80%, it's not necessarily that everybody's going to lose 70 or 80%. I have several of my patients that have been able to lose 100%. There are some of the patients that lose 60. What people need to understand that – because this is not about the surgery. If you're expecting that the surgery is going to do all the changes for you, there's a good chance you're going to put some of the weight back. I have patients that have been out from the surgery, and now they realize that food is not the most important part of their life. They can enjoy. They can do other things, and they seem to be doing well. I know one of our viewers is concerned about – how did you control those attack of being hungry? Phil –

00:50:10

PHIL: As far as having a real hunger pain, I haven't had one. I don't want to have one. I think a lot of misconception with the surgery is a lot of people think when they wake up from anesthesia that they're going to be lighter. Well, they weigh the same weight that they weighed before they went in for the surgery. It's up to the person to control what they're putting in their mouth to lose the weight, and it's a total commitment that they have to make and understand that.

00:50:39

DR. ANDRES CASTELLANOS: And as we mentioned at the beginning, probably the most important criteria to make a good candidate is your dedication. I know a lot of people get concerned about "I know that I have the tendency to overeat. Sometimes I have no control of what I do." I guess, Marcie, we see that quite often in our follow-up patients, and I have to say, you're probably more experienced than I am in counseling those patients, but for the most, we very rare get to see that person that says "Oh, I used to overeat and do binge eating, and now I'm struggling with that."

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MARCIE AMERSTEIN: Because the size of the stomach is so small, if you do overeat, you're going to get sick. So there's a negative reinforcement attached to that – to doing that.

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DR. ANDRES CASTELLANOS: And that just – reinforce one more time that this just a tool. This is something that is going to help you learn and control those emotions, and I'm pretty sure that if you're one of those persons that are not well-prepared and you go and do the surgery and you do the wrong thing, I guarantee you that the small pouch, the small stomach is going to let you know relatively quick. I know that someone is asking about dumping. What is dumping? And that probably goes very close to the previous question. Marcie, what can you tell us about what dumping is?

00:52:02

MARCIE AMERSTEIN: Have you guys experienced dumping before?

00:52:04

DONNA: Fortunately, I have not. I'm one of those patients who has been – I don't know if it's a fortune or a misfortune, but I have been able to eat and tolerate anything. So therefore, I have a large responsibility to control things with my head. And I agree with Dr. C. that if Dr. Petrucci had offered me a brain surgery that would have taken away that overeating tendency, I certainly would have opted for that rather than a gastric bypass. So I really can't address dumping.

00:52:34

PHIL: I have experienced dumping, and I can tell you, I will not be eating honey barbeque wings again. That was an experience that I do not want to go through again. I mean, the stomach pain, the vomiting, the sweats. It was just something that you experience once, and you know not to cross that line again.

00:52:58

DR. ANDRES CASTELLANOS: One common question that we seem to be getting have to do with hair loss. Is hair loss a problem? And it is something that we get to see very often. Everybody make comments about it, and sure, everybody – especially, we talk about women. They don't want to lose their hair. I'm pretty sure men don't want to lose their hair either. Hair loss: is that a real problem?

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MARCIE AMERSTEIN: It can be for some patients. Hair loss can happen when you have rapid weight loss, and that's why we make sure our patients take their protein supplements, make sure they take their vitamins, and the hair will come back once the weight loss stabilizes.

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PHIL: I've been fortunate with the hair – with the lack of hair loss, although my son may argue that point. I haven't seen it with myself, so...

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DONNA: Fortunately, I haven't either. I think I'm, in a way, kind of the textbook case because I'm 18 months out from surgery. I've never vomited. I've never dumped. I can eat anything that I've tried to eat. So I haven't had any of those problems, but I don't want to say that it's not still a struggle, because my tendency to overeat – any person who's suffered with obesity knows what it's like to be full, but there's still food on the plate, and for some reason, we just feel the need to keep going. That does not go away with the surgery. I think the portion control is much easier the closer you are to the surgery, and the further out you get, the more you have to really depend on your own commitment and all those things that brought you to the table in the first place. And it does get more difficult. Your stomach can grow. I know that I can eat more now than I could six months ago, than I could 12 months ago. So, you know, it's really up to me to take control and to keep coming to the support groups and, you know, just do all those things that brought me there in the first place. It's very important, very important.

00:55:02

DR. ANDRES CASTELLANOS: And that is good. You have to remember that as long as you do the right thing, you follow guidelines – the hair problems are minor problems. For the most, I can tell you, that, yes, within the first six to nine months can be a significant issue. After a year, most of the hair comes back as long as you are taking your proteins, taking your vitamins, and doing all the right things. And now that we are getting short one time – they always said that time goes fast when you're having fun. Hopefully you guys have had a little bit of fun today and have learned a little bit about what surgical treatment for obesity is and the things that we can do. I'm just going to try to go very quick to a couple of the last-minute questions. Someone wants to know how long the recovery process is. In general, if you have the laparoscopic surgery, you spend two days in the hospital, and the recovery time is anywhere between two to four weeks. If you have the open surgery, it can take a little bit longer. I always tell patients just plan two to four weeks. I don't know, Phil, you remember how long it took you before you went back to...

00:56:14

PHIL: I was back to work in four weeks. I don't have a desk job, either. I deliver soda for a living. So I'm lifting close to ten tons of soda a day. I was a little scared going back, but everything worked out fine. I got to my own physical therapy a little earlier than you had wanted me to, but we found a happy medium, I'm still going forward.

00:56:42

DR. ANDRES CASTELLANOS: And that is important, and obviously, we have several questions that we have not been able to answer. Tonight, I'll be sure that we will try to get back to you. Just quick things. Actually, if you have reflux, the gastric-bypass

surgery can help you with that. If you have bad knees, remember, that by losing weight – and you guys probably can tell .By losing weight, the knee pain goes away, and it is a gradual process. I'm not going to tell you that you're going to have arthritis and knee pain and two days after the surgery, you're going to be running. It's going to take you some time before you get there, but eventually, you will. Sometimes it might not be cured, but definitely, when we look at the outcomes and the numbers, what they show, there is significant improve – there is definitely a significant improvement in quality of life. I know that this has been real fun for us. I want to definitely thank everybody for joining us tonight. One more time, we are live from Hahnemann University Hospital, and on my behalf and also the bariatric team, my patients, thanks for joining us tonight. We definitely want to thank you for tuning in. Thanks for your time. Good night.

00:58:15

NARRATOR: This has been a live webcast panel discussion of a Roux-en-Y gastric-bypass procedure from Hahnemann University Hospital's Center for Surgical Weight Loss located in Philadelphia, Pennsylvania. For more information or to make an appointment or referral, click the buttons on the screen.