Bariatric Program | Provider Seminar

The First Step in your Weight-loss Journey

Anirban Gupta, MD, FRCSC, FACS, FASMBS | Medical Director, Bariatric
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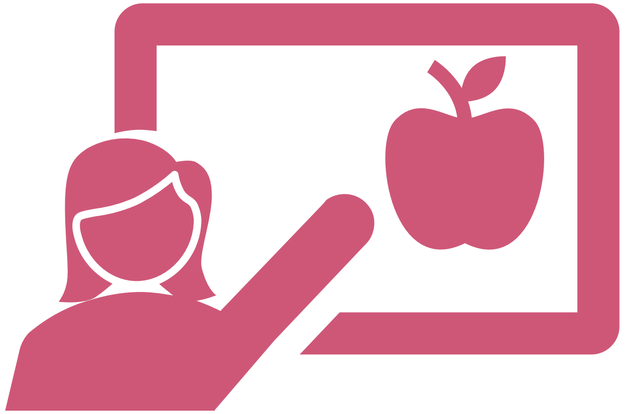
Webinar Attendees Chatroom Etiquette



- No personal questions will be shared with the other participants, without approval
- **Public Chatroom**:
  - This **IS** a safe and respectful forum for members to ask questions that will be answered at the end of the seminar.
- This **IS NOT the proper forum for:**

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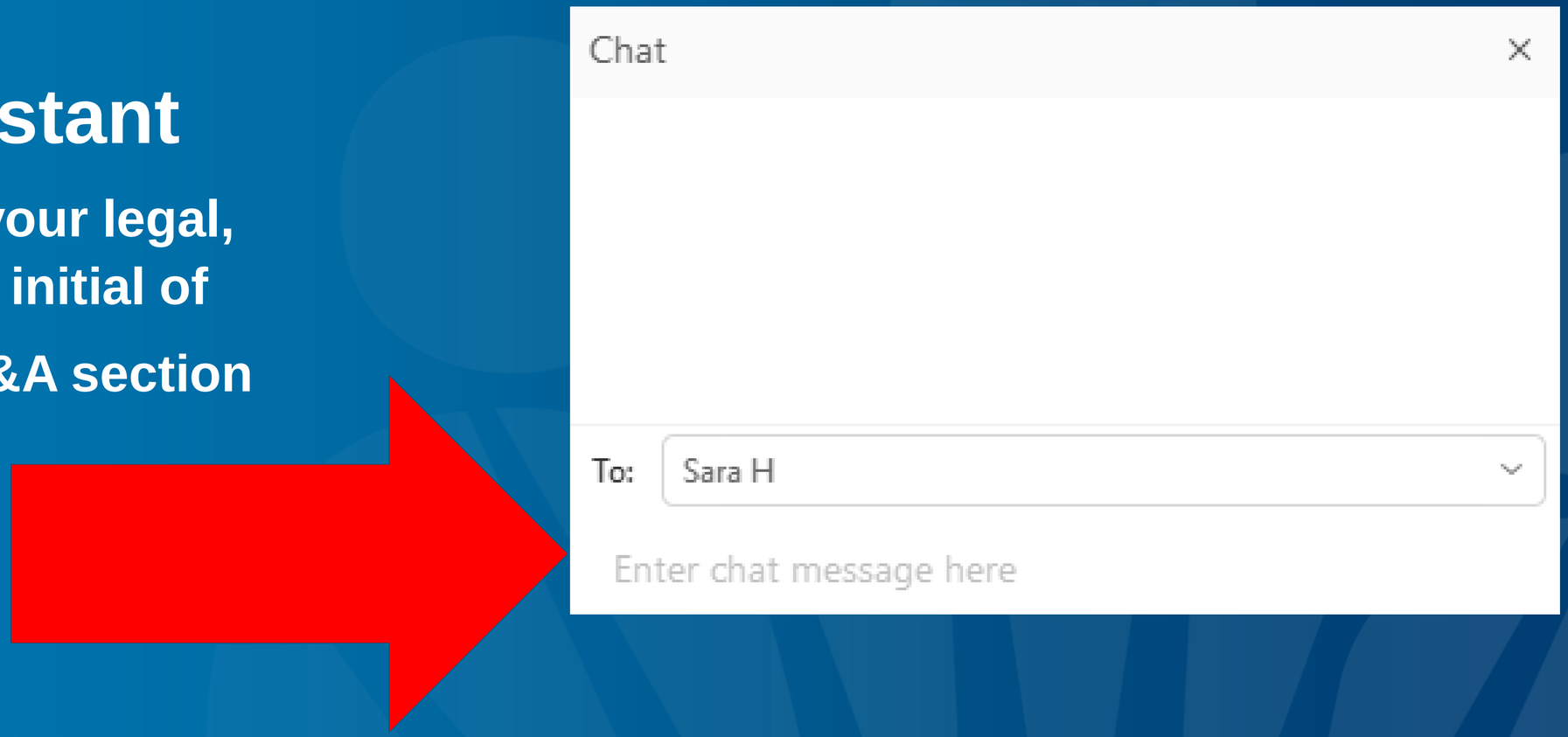
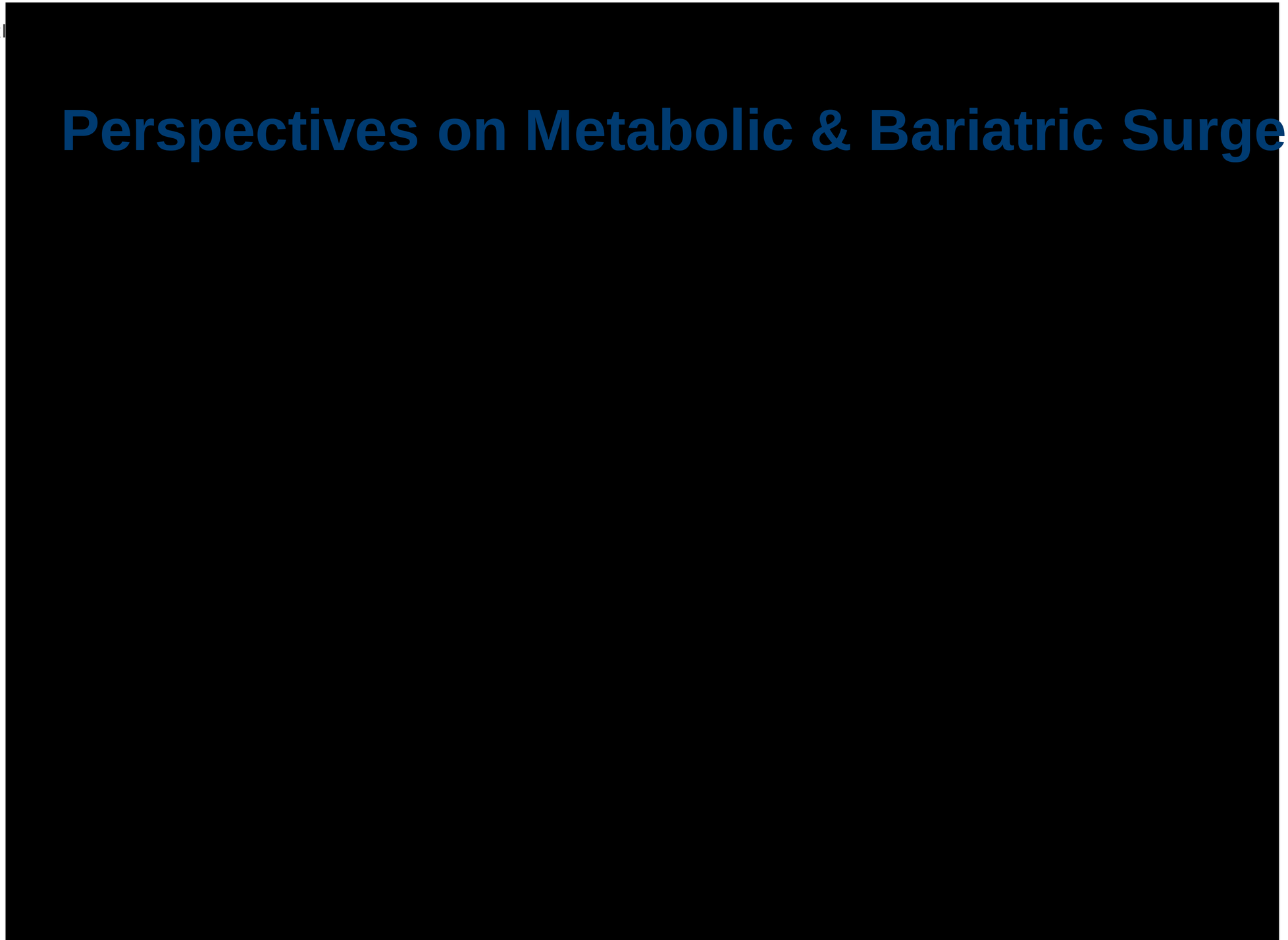
Chat Questions

Please direct your chat questions to our Medical Assistant Team and type your legal, first name and first initial of last name in the Q&A section at the beginning of class.



Perspectives on Metabolic & Bariatric Surgery



Agenda

Program History & Data

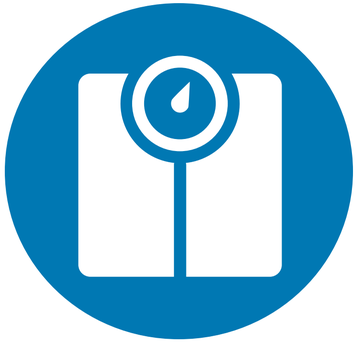
Our Team

The KPWA Program

The Scope of the Disease

Treatment Options

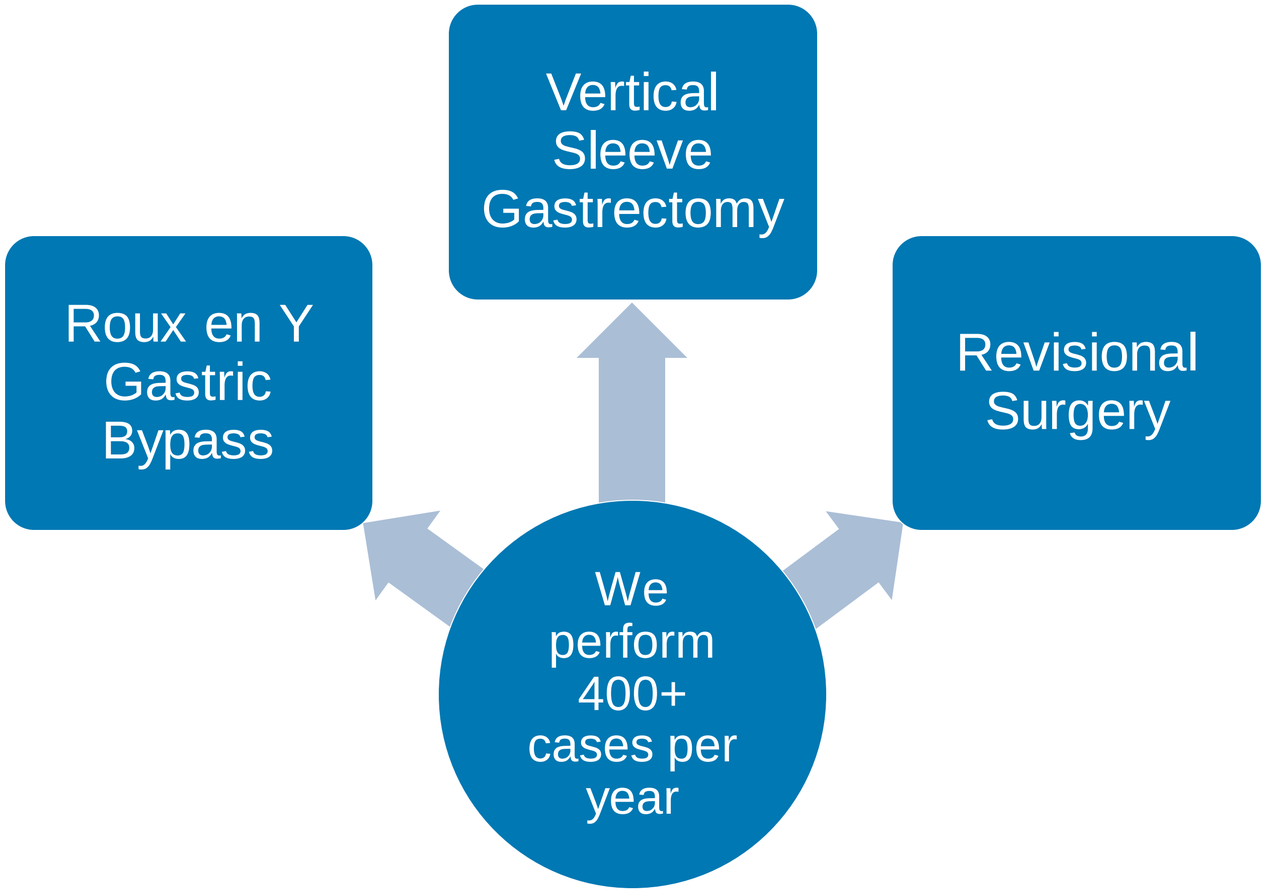
Making a Treatment Decision



Weight Loss & Maintenance

Next Steps: Your Journey to Success

Our Performance and Outcomes



The Only **5-Star Center** (based at Overlake) in all of Washington State

Recognized as top 5% of programs in the U.S.

#1 Program in Washington State for overall and risk-adjusted outcomes

So, what’s the key to our success?

We are a **truly integrated program** with a multi-disciplinary team that leverages best practice and evidence-based care to deliver a **comprehensive experience** designed to meet our members’ individual needs and **promote long-term success**.

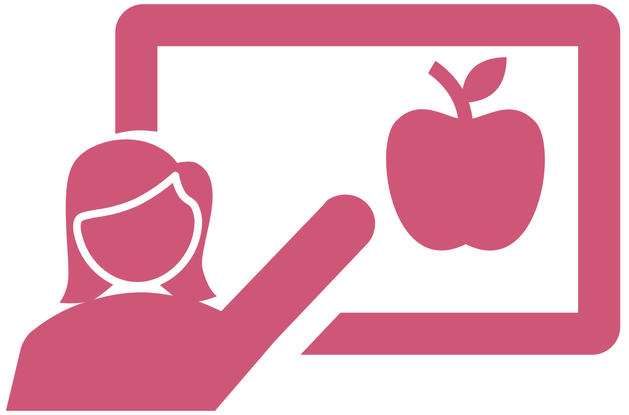
Your Bariatric Care Team

Expert Surgeons & Advanced Practice Providers

Anirban Gupta, MD
Shireesh Saurabh, MD
Imad Haque, MD
Lori Gokee, ARNP
William Young, PA-C
Travis Sears, PA-C
Lynda Crescenzi, PA-C
Heather Vincent, PA-C
Sierra Widmer-Rodriguez, PA-C

Specialized Nurses & Medical Assistants

Elizabeth Puckett, RN
Sarah Chan, RN
Karen Kucera, MA-C
Sara Hernandez, MA-C



Bariatric Trained Dietitians

Lisa Stariha, RD
Fionna Marave, RD

Bariatric Focused Psychologist

Janet Ng, PhD

The KP Washington Bariatric Program

Phase 1: Optimize for Success

- Provider Seminar
- Coordinated Initial Visit & Nutrition Class
- Psychology Consultation
- Optimization
- Coordinated Secondary Visit
- Case Review
- Pre-op Visit

Phase 2: Surgery

- Pre-op Preparation
- Surgery & Hospital Stay
- Discharge to Home

Phase 3: Follow Up Care

- 3-Day Phone Visit
- 2-Week Post-op Visit
- 2, 6, & 12 Month Visit
- **Annual Visits for Life**

Understanding the Scope of Obesity & Related Illnesses

What is obesity?
Who is considered overweight?

- Rather than using “body” types to determine who is overweight, we use a simple calculation called **Body Mass Index** or BMI.
- BMI relates a person’s weight to their height.
- BMI is not the only measure of health. Other important measures include:
  - Waist circumference
  - Body composition

WEIGHT	lbs	90	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	2
	kgs	41	45	50	54	59	64	68	73	77	82	86	91	95	100	104	109	113	118	122	127	1
HEIGHT			Underweight					Healthy				Overweight				Obese				Extremely Obese		
ft/in	cm																					
4'8"	142.2	20	22	25	27	29	31	34	36	38	40	43	45	47	49	52	54	56	58	61	63	6
4'9"	144.7	19	22	24	26	28	30	32	35	37	39	41	43	45	48	50	52	54	56	58	61	6
4'10"	147.3	19	21	23	25	27	29	31	33	36	38	40	42	44	46	48	50	52	54	56	59	6
4'11"	149.8	18	20	22	24	26	28	30	32	34	36	38	40	42	44	46	48	51	53	55	57	5
4'12"	152.4	18	20	21	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	5
5'1"	154.9	17	19	21	23	25	26	28	30	32	34	36	38	40	42	43	45	47	49	51	53	5
5'2"	157.4	16	18	20	22	24	26	27	29	31	33	35	37	38	40	42	44	46	48	49	51	5
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5'4"	162.5	15	17	19	21	22	24	26	27	29	31	33	34	36	38	39	41	43	45	46	48	5
5'5"	165.1	15	17	18	20	22	23	25	27	28	30	32	33	35	37	38	40	42	43	45	47	4
5'6"	167.6	15	16	18	19	21	23	24	26	27	29	31	32	34	36	37	39	40	42	44	45	4
5'7"	170.1	14	16	17	19	20	22	24	25	27	28	30	31	33	34	36	38	39	41	42	44	4
5'8"	172.7	14	15	17	18	20	21	23	24	26	27	29	30	32	33	35	37	38	40	41	43	4
5'9"	175.2	13	15	16	18	19	21	22	24	25	27	28	30	31	33	34	35	37	38	40	41	4
5'10"	177.8	13	14	16	17	19	20	22	23	24	26	27	29	30	32	33	34	36	37	39	40	4
5'11"	180.3	13	14	15	17	18	20	21	22	24	25	27	28	29	31	32	33	35	36	38	39	4
5'12"	182.8	12	14	15	16	18	19	20	22	23	24	26	27	28	30	31	33	34	35	37	38	3
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6'2"	187.9	12	13	14	15	17	18	19	21	22	23	24	26	27	28	30	31	32	33	35	36	3
6'3"	190.5	11	13	14	15	16	18	19	20	21	23	24	25	26	28	29	30	31	33	34	35	3
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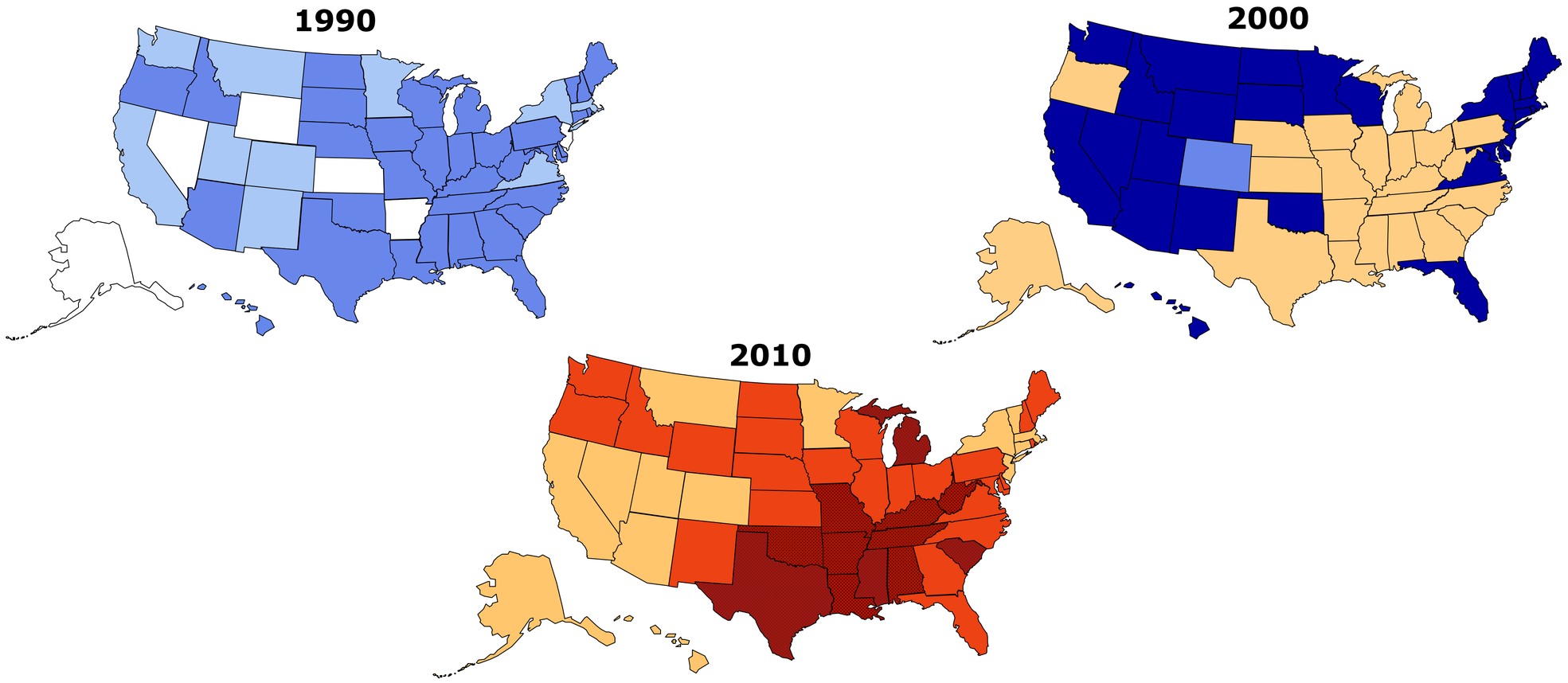
6'9"	205.7	10	11	12	13	14	15	16	17	18	19	20	21	23	24	25	26	27	28	29	30	3
6'10"	208.2	9	10	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	3
6'11"	210.8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	25	26	27	28	29	3

Obesity Trends* Among U.S. Adults

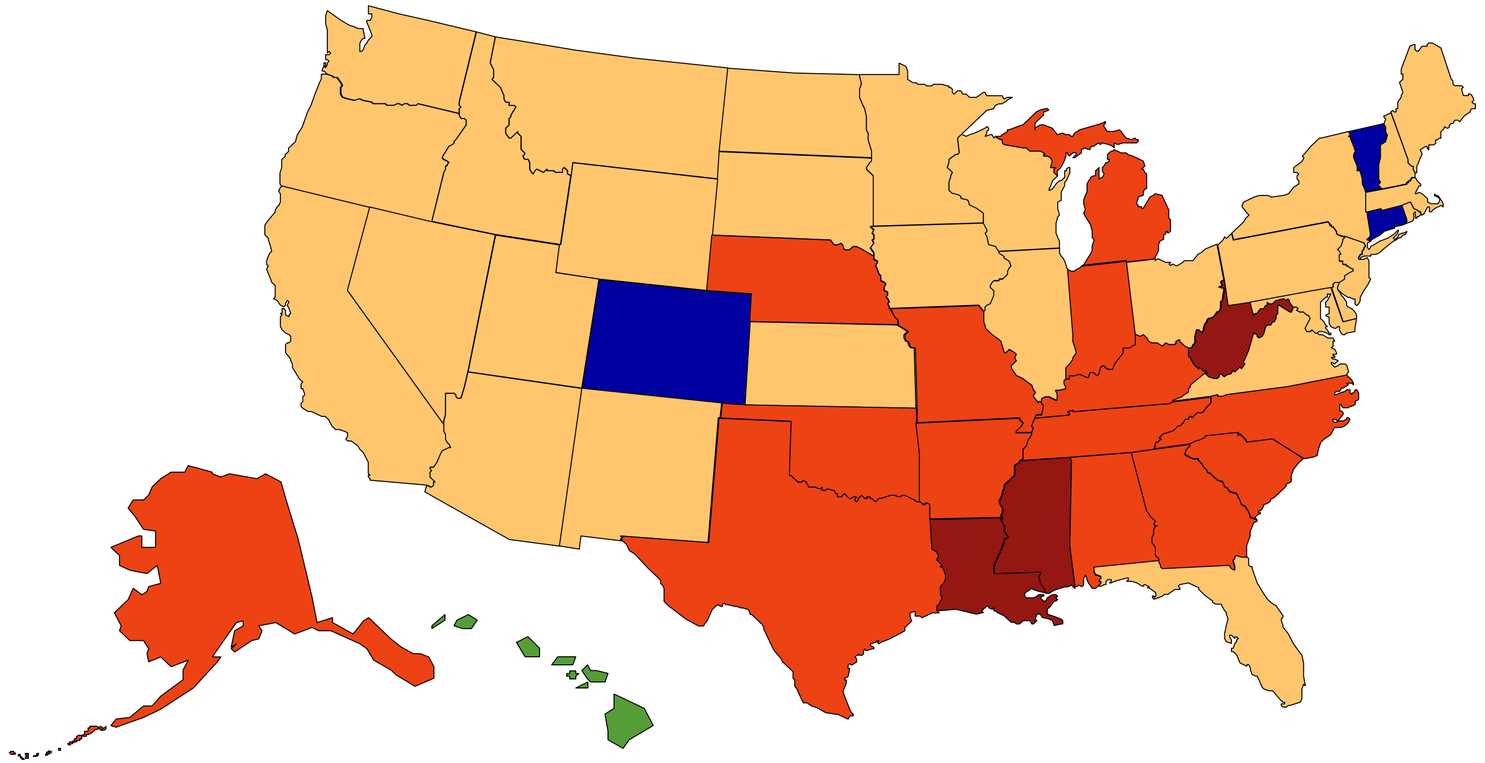
BRFSS, 1990, 2000, 2010

(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)



Obesity Trends* Among U.S. Adults
BRFSS, 2005

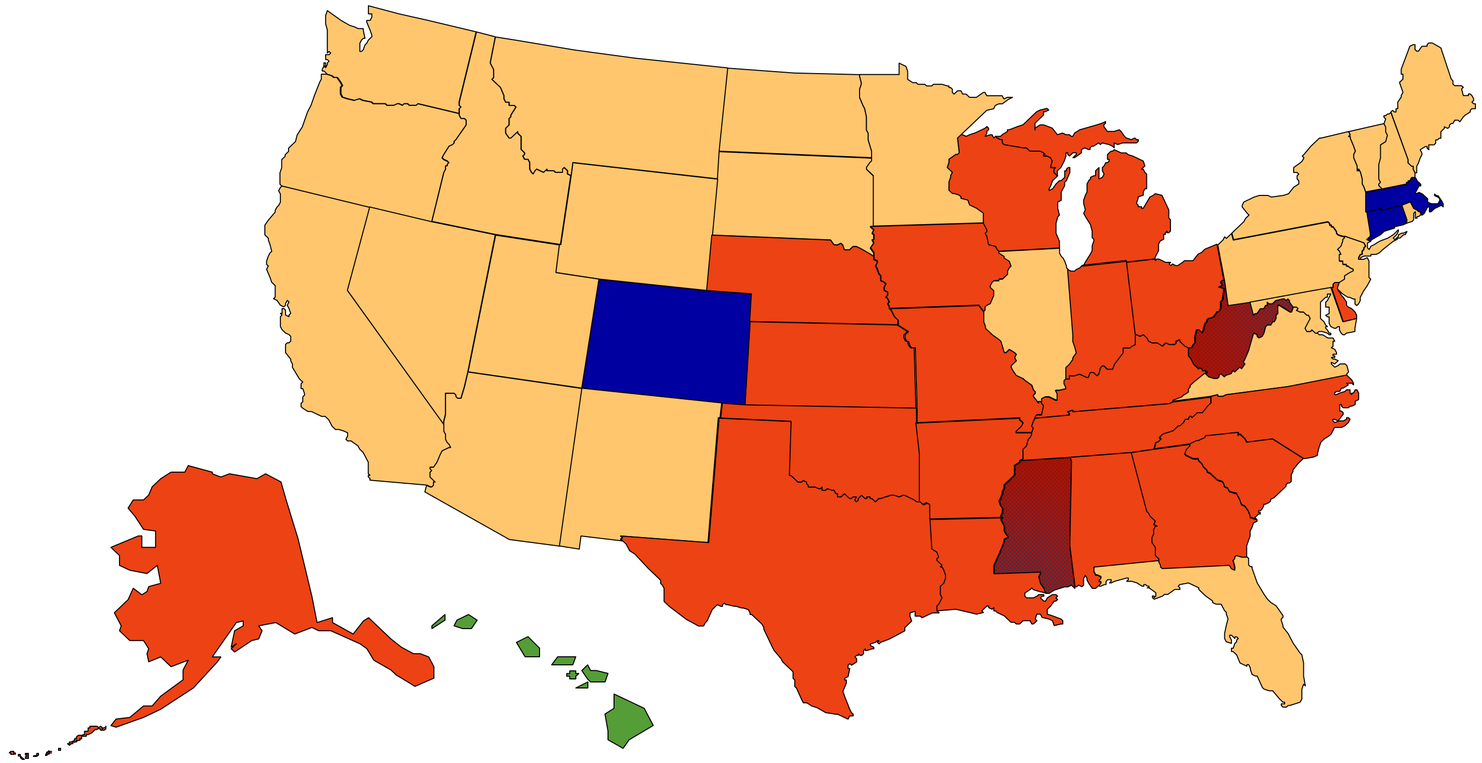
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 2006

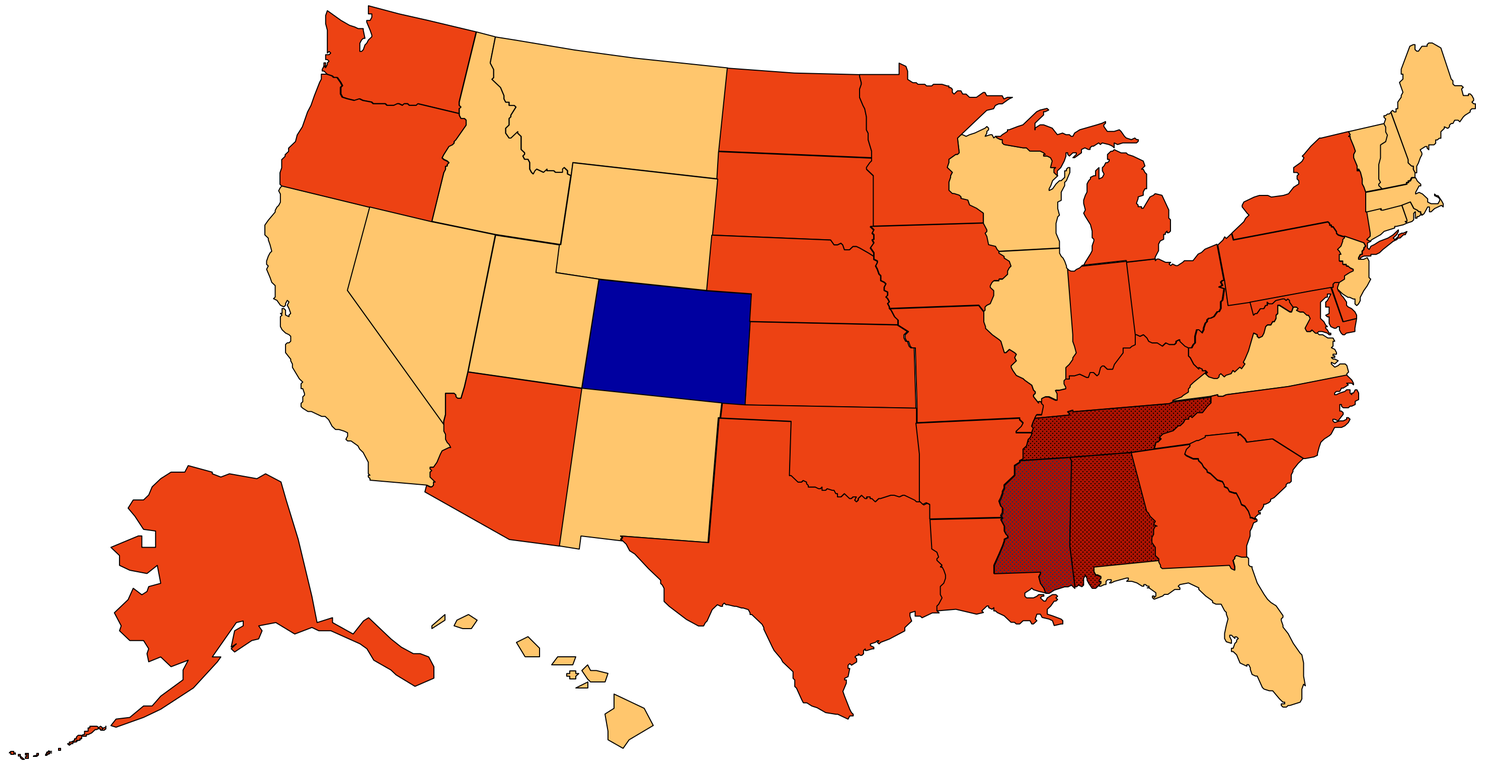
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 2007

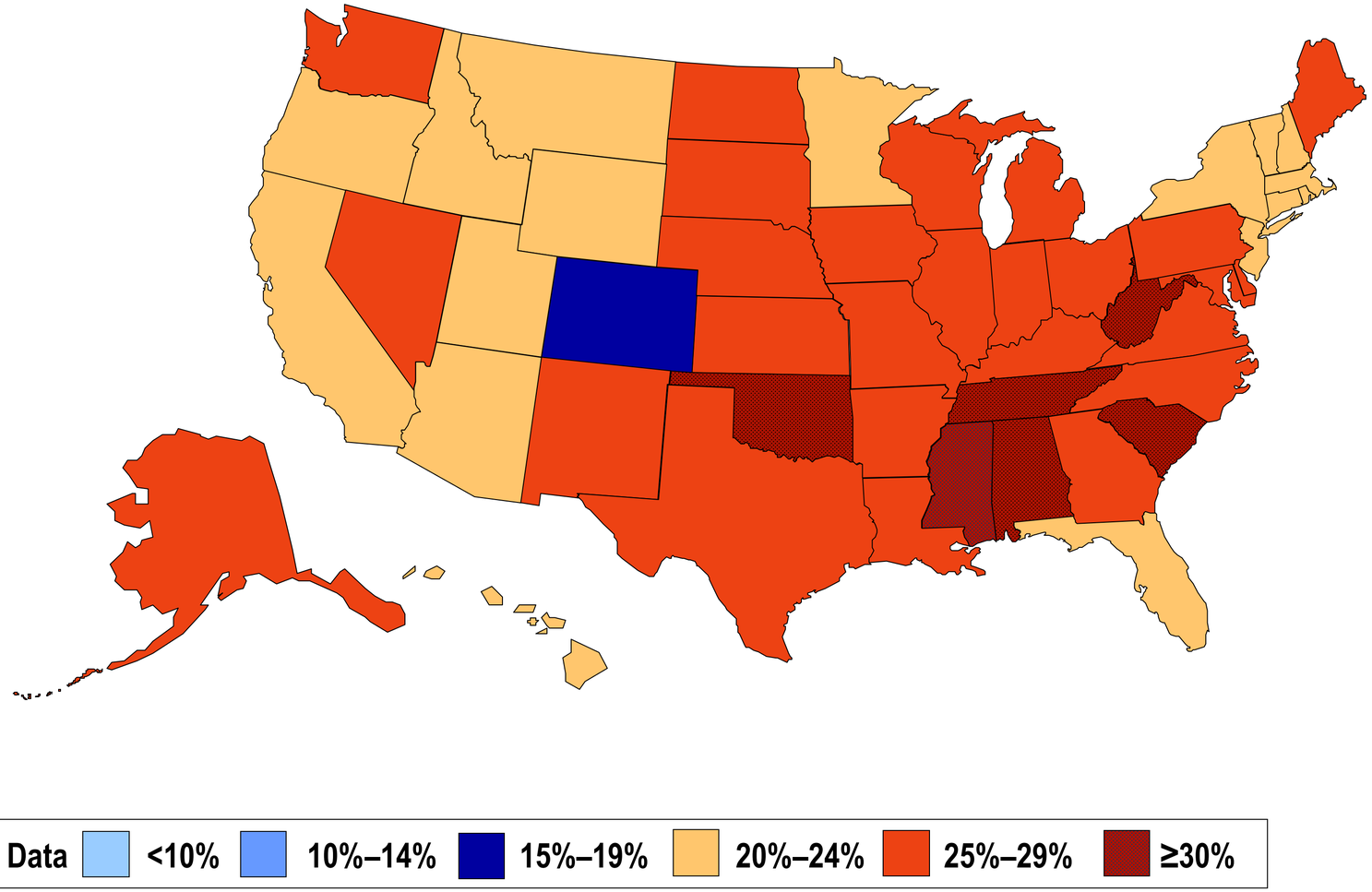
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

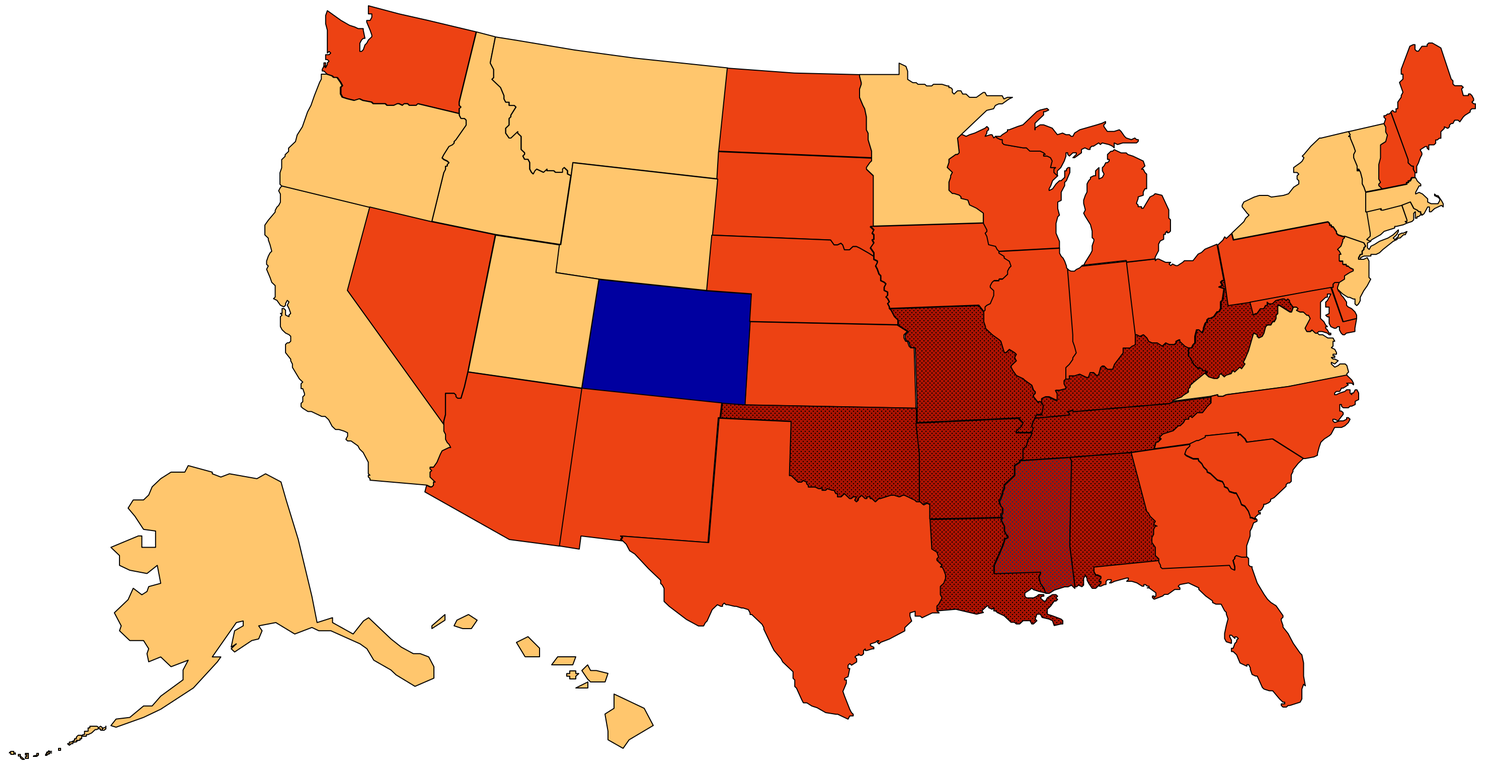
Obesity Trends* Among U.S. Adults
BRFSS, 2008

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



Obesity Trends* Among U.S. Adults
BRFSS, 2009

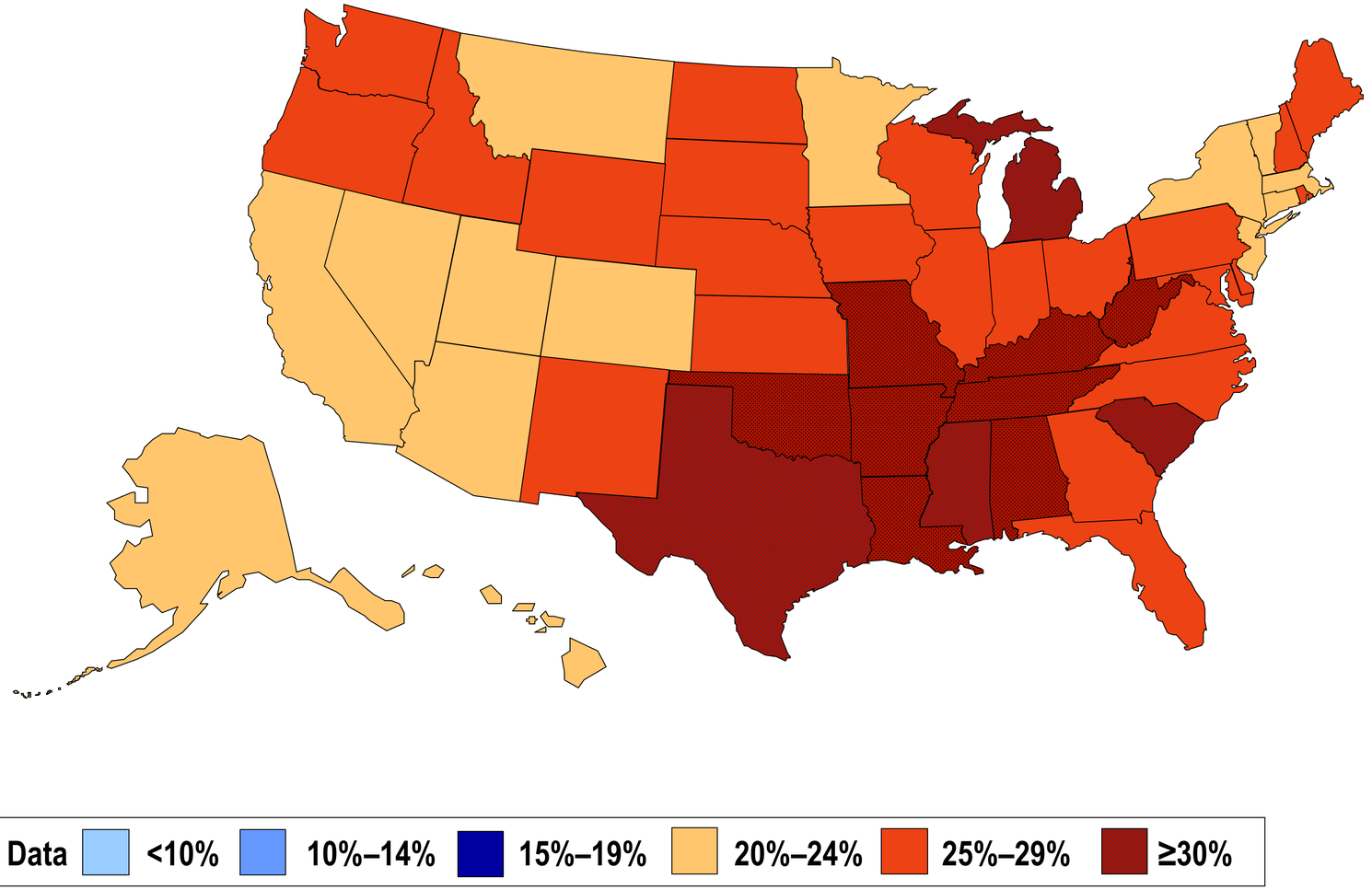
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

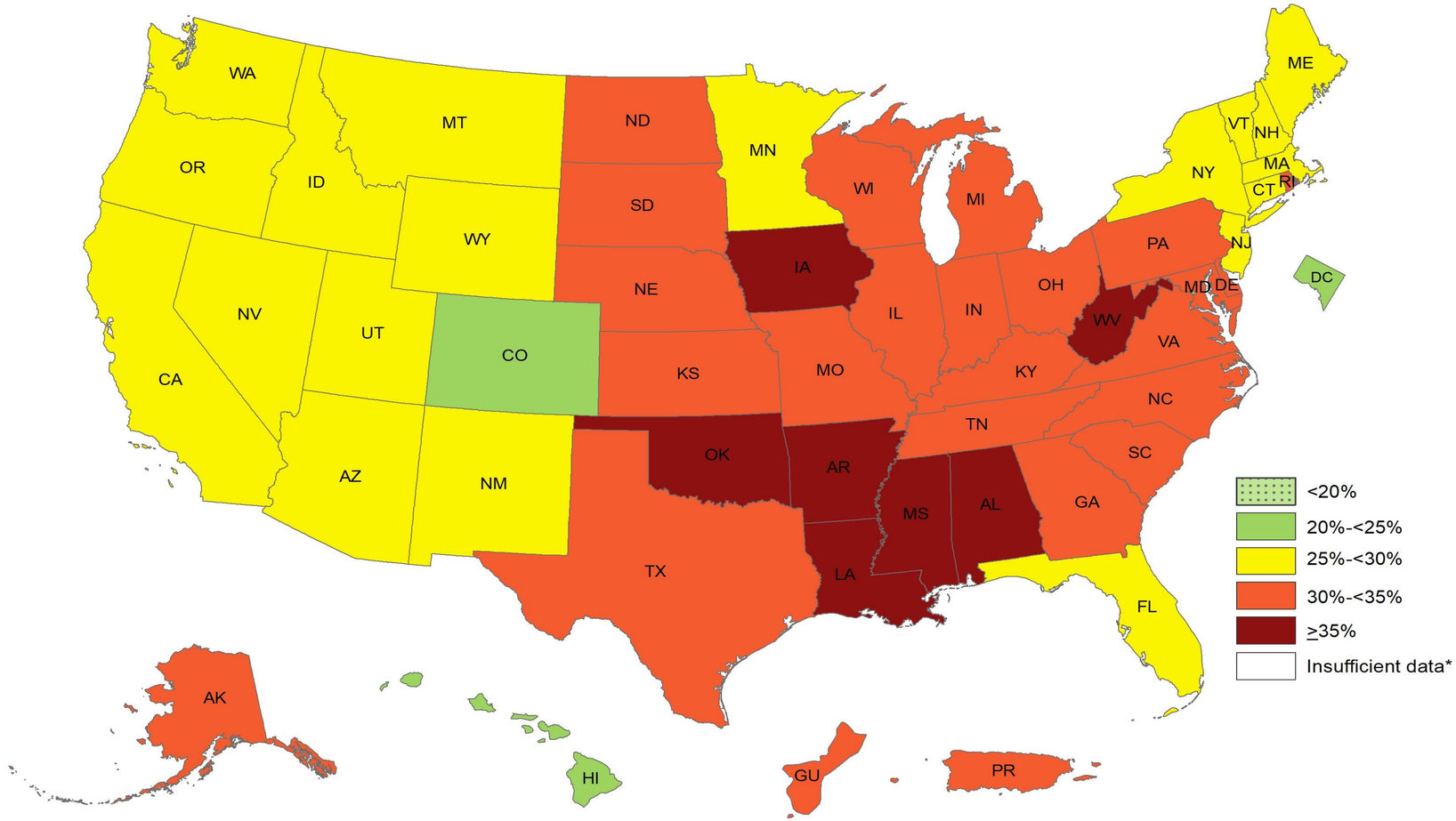
Obesity Trends* Among U.S. Adults
BRFSS, 2010

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



Prevalence* of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2017

* Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.

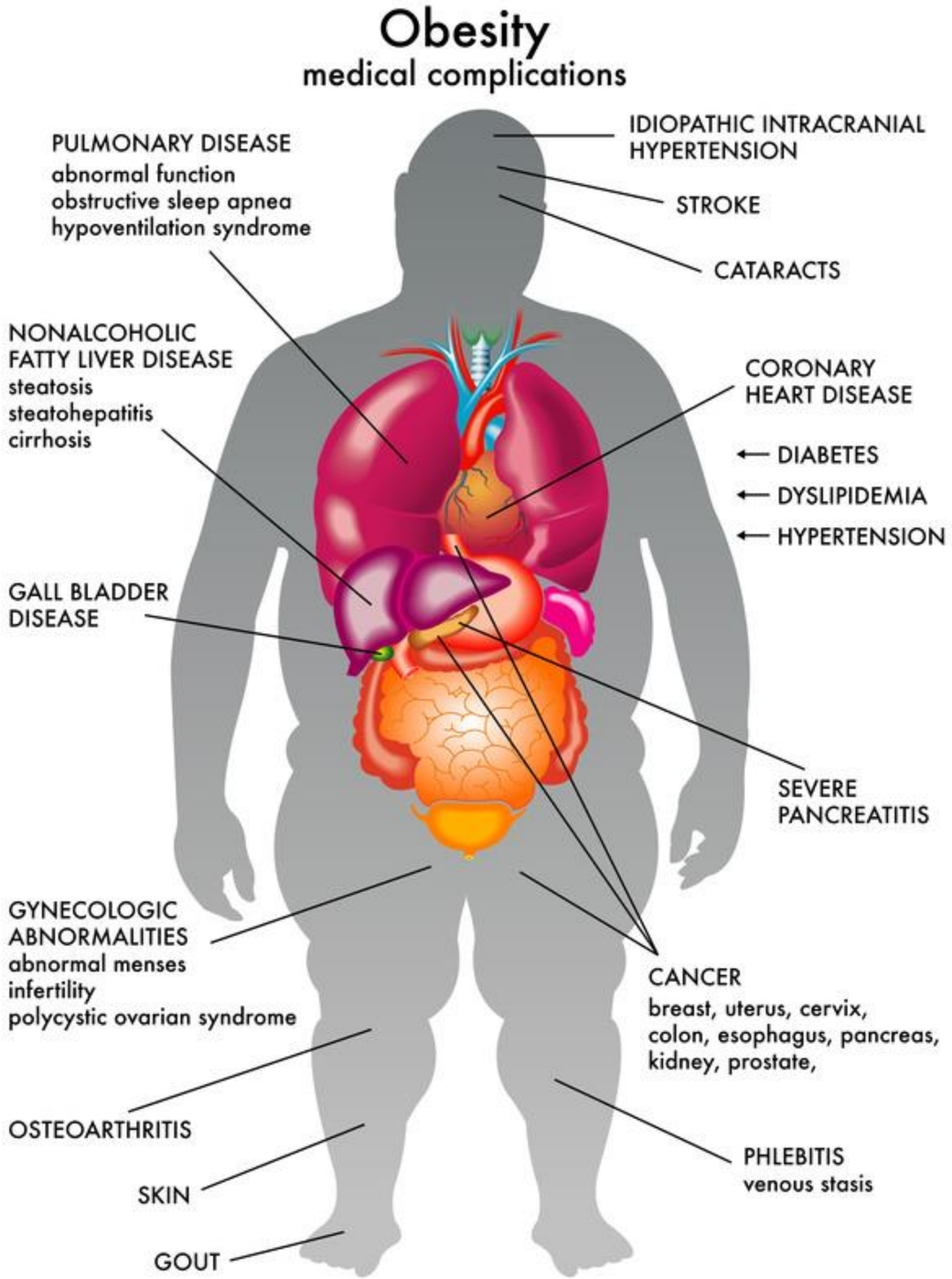


*Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥ 30%.

How does the growing rate of obesity impact us?

Each year, **400,000 Americans die prematurely** due to obesity-related diseases. This number is increasing rapidly and soon obesity will replace tobacco and smoking as the number one preventable health problem in the United States.

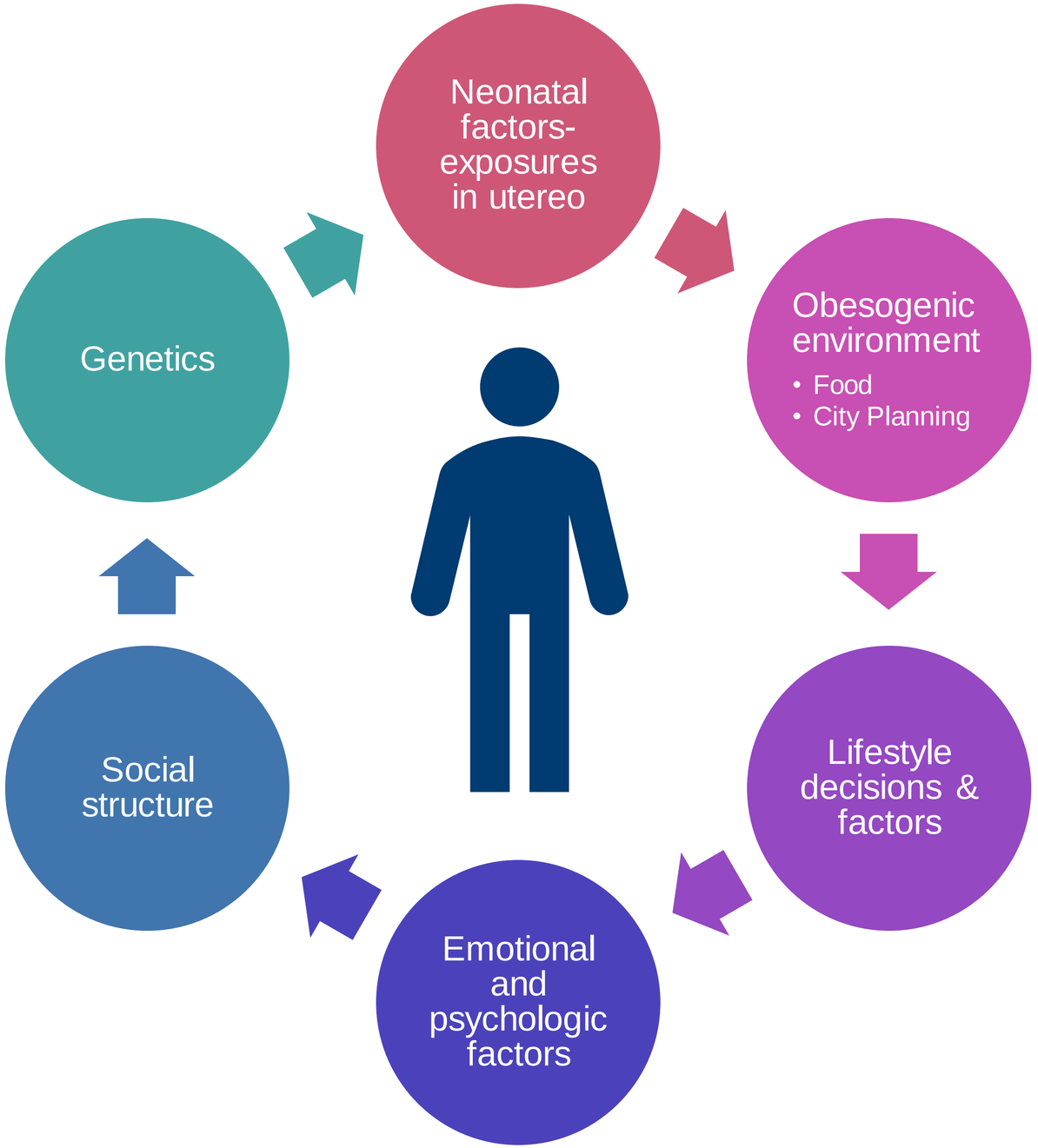
What medical complications are related to obesity?



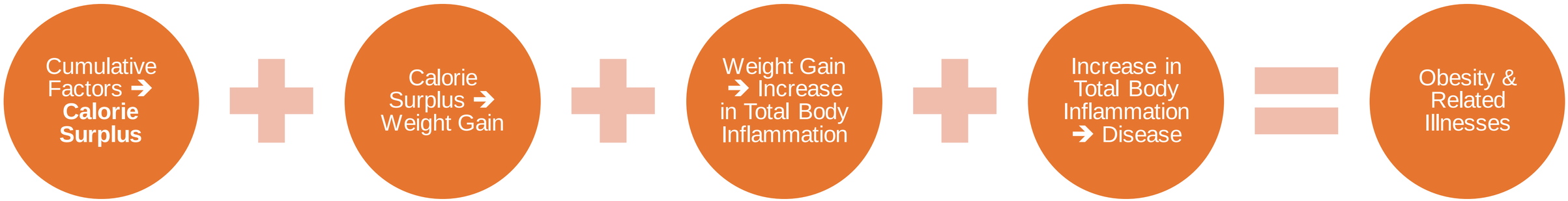
Morbid Obesity

When obesity is so severe that it **threatens one’s health and affects the lifespan of the individual**

How did we get here?



Cumulative Lifetime Effect: Simplified Model

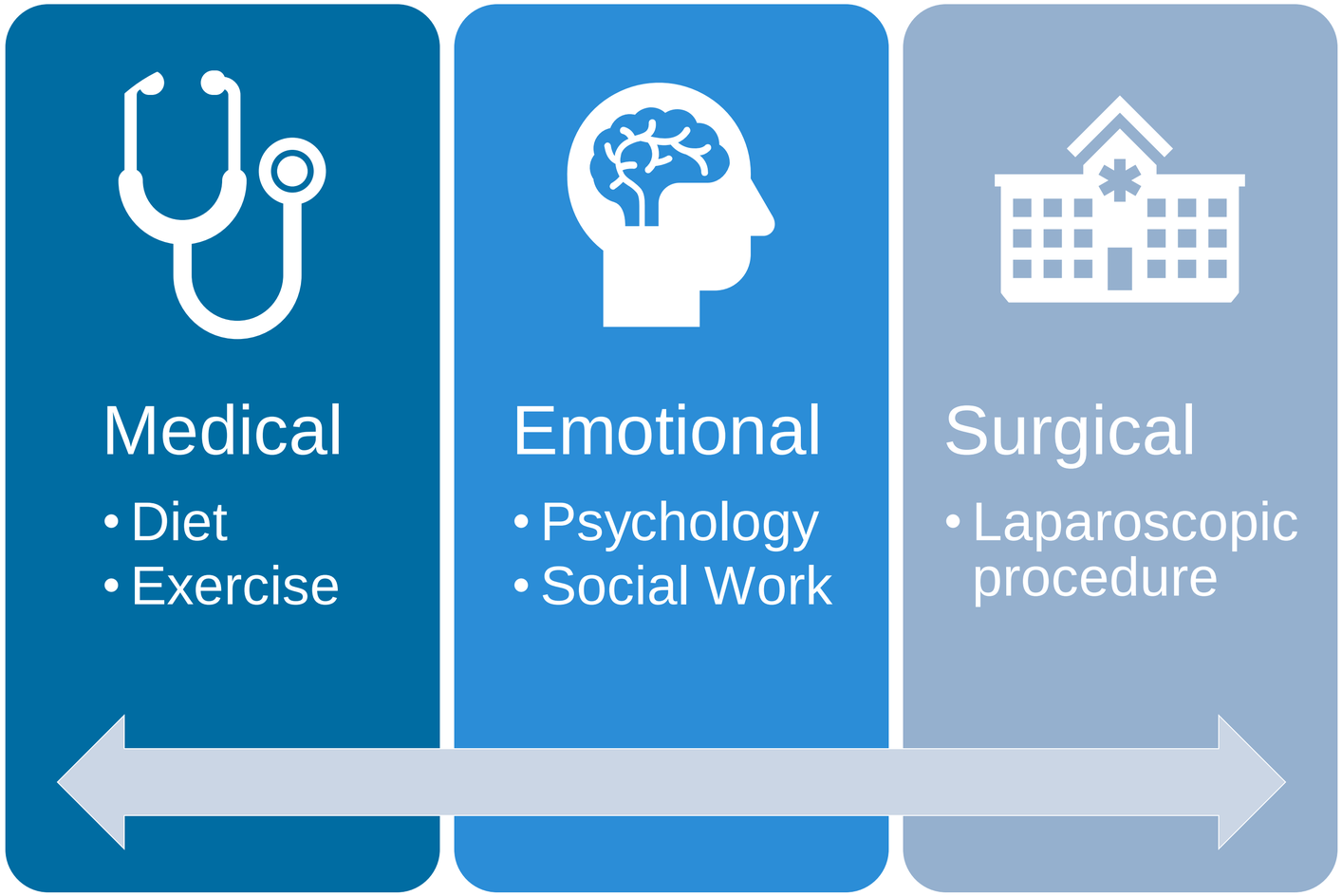


How can I lose weight and keep it off?

The Answer: Create and maintain
a healthy calorie deficit.

Understanding Your Treatment Options

Weight Loss Options | An Integrated Continuum for a Chronic Illness



Indication for weight loss surgery

- BMI ≥ 40 with or without medical problems
- BMI ≥ 35 – 40 with medical problems like diabetes/hypertension/obstructive sleep apnea
- Age: 20 – 65 years
- > 65 years: case by case evaluation

Bariatric Surgery Options at KP Washington

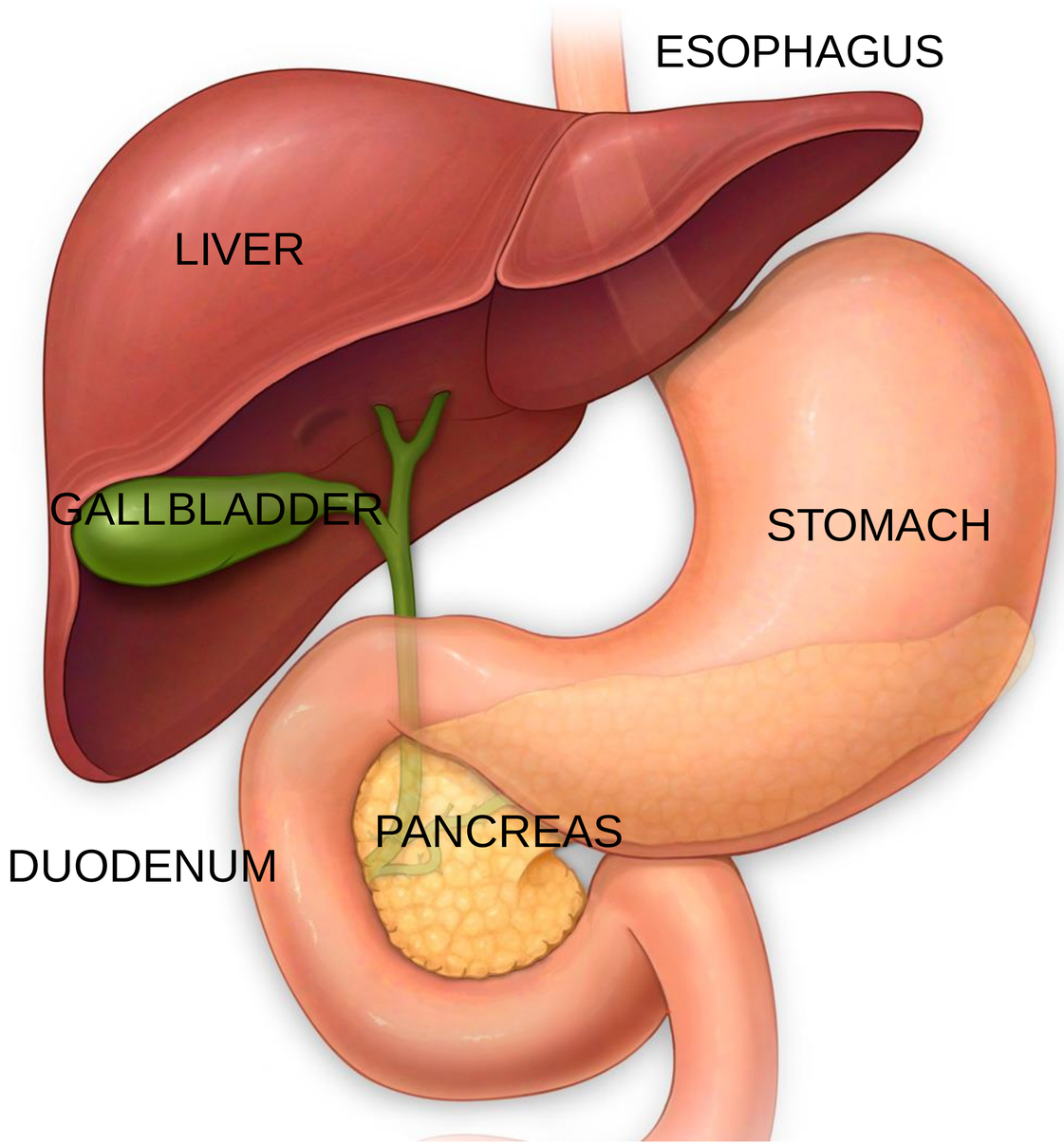
Laparoscopic roux en y gastric bypass

Laparoscopic Vertical Sleeve Gastrectomy

Revisional Surgery

Normal Anatomy

- **Esophagus:** transports food from mouth to stomach
- **Stomach:** creates and secretes acid and digestive hormones and enzymes
- **Liver:** creates and secretes bile
- **Gallbladder:** stores bile that was made in the liver
- **Duodenum:** 1st part of small intestine, connected to the stomach, pancreas, bile & pancreatic ducts
- **Pancreas:** creates and secretes enzymes and hormones to digest starches, carbs, sugars

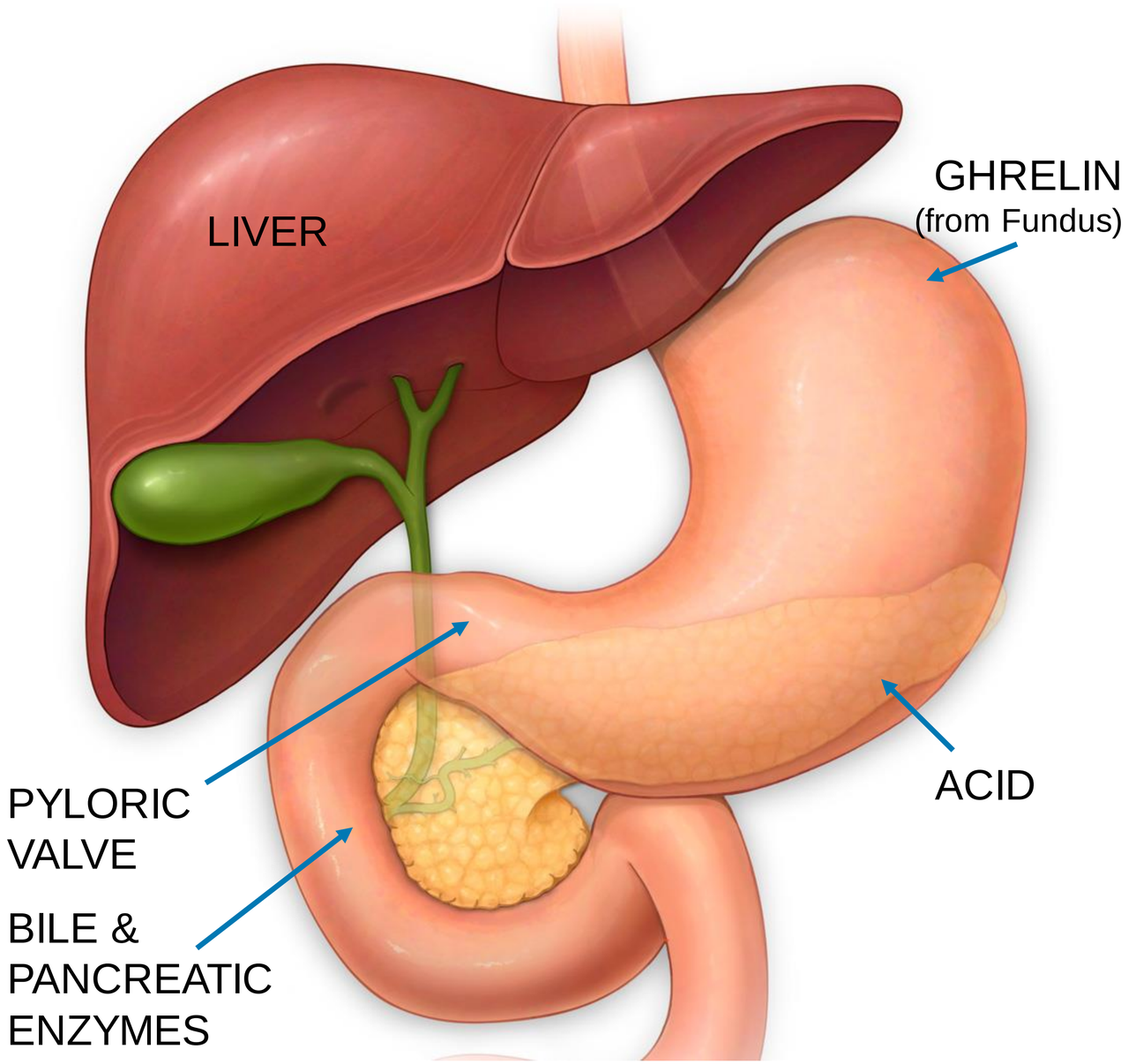


Normal Anatomy

Pyloric Valve – controls the rate of the release of food and liquid from stomach to the duodenum

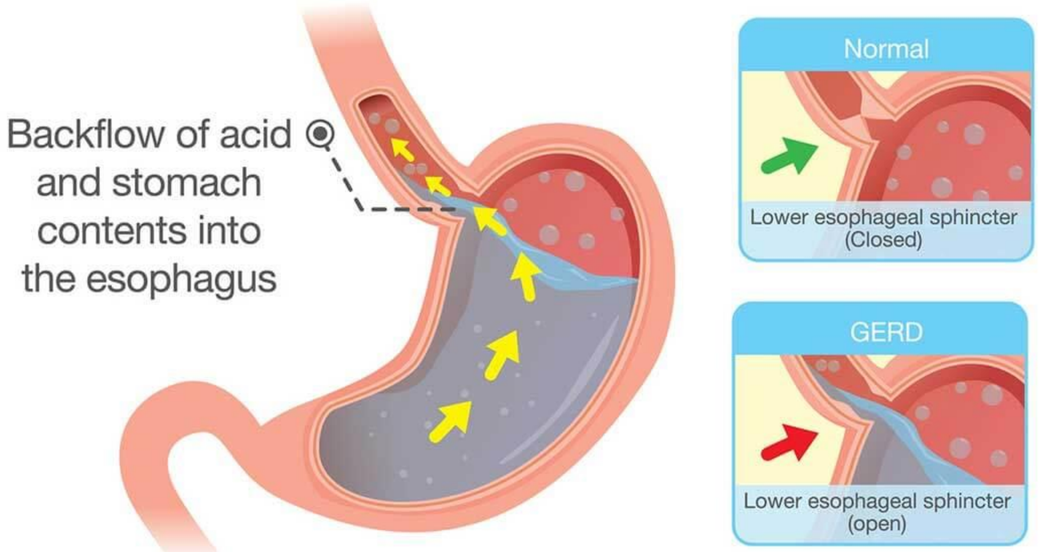
Normal Anatomy

- **Ghrelin:** Hunger Hormone. Mostly secreted in the **fundus** of the stomach.
- **Acid:** Helps digest food. Mostly secreted in the body of the stomach.
- **Bile:** Made in the liver and stored in the gallbladder. Released in the duodenum to help absorb fat.
- **Pancreatic Enzymes:** Made in the pancreas and released in the duodenum to absorb carbs, starches, and sugars.



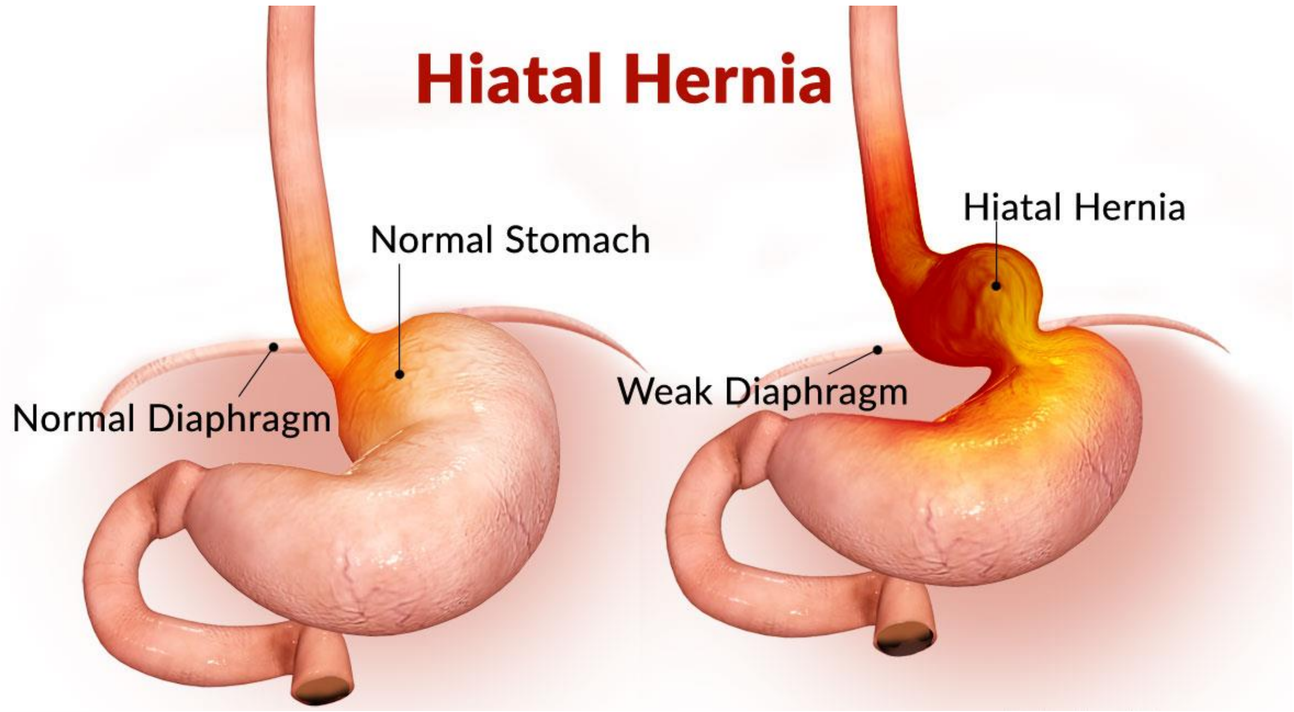
GERD: Gastroesophageal Reflux Disease

- Occurs when stomach acid flows back into the tube connecting your mouth to your stomach (esophagus).
- Symptoms
  - Typical
    - Burning sensation in your chest (heartburn)
    - Chest pain
    - Difficulty swallowing
    - Regurgitation of food or sour liquid
    - Sensation of a lump in your throat
  - Atypical
    - Chronic cough
    - Laryngitis
    - New or worsening asthma
    - Disrupted sleep



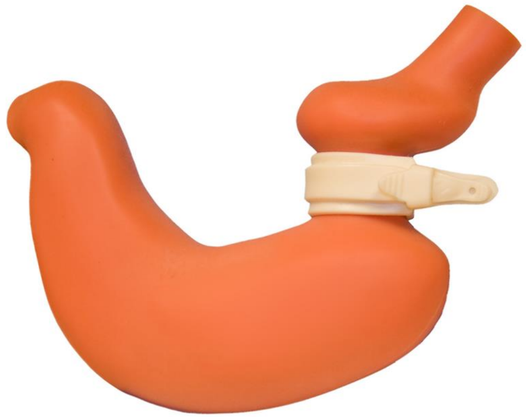
Hiatal Hernia

- Occurs when a weakness/gap in the diaphragm results in a portion of the stomach migrating into the chest from the abdominal cavity.
- Seen in at least 40% of bariatric patients
- Can cause GERD or make symptoms worse
- If present, hiatal hernia is corrected during bariatric surgery

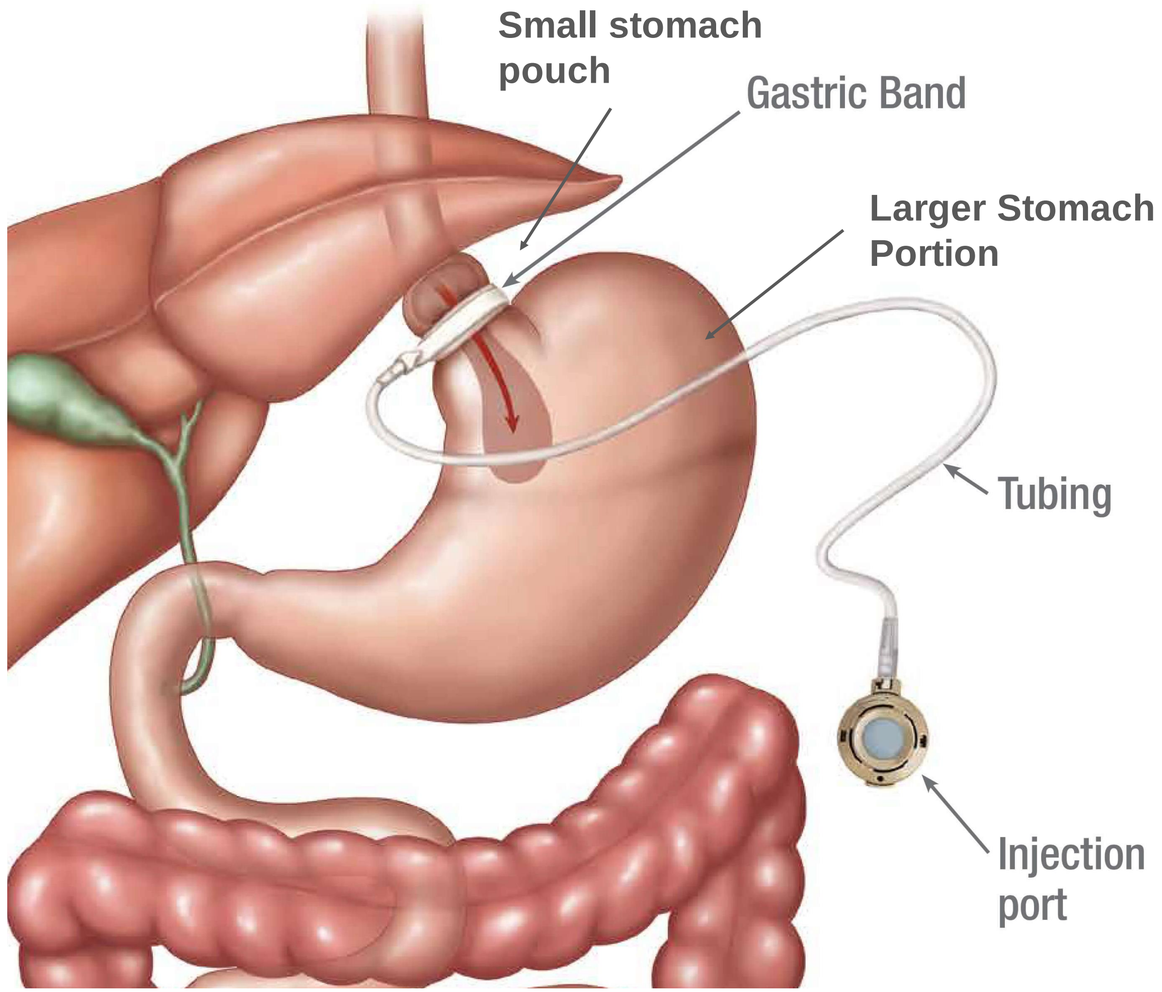


Understanding Your Surgical Options

Laparoscopic Adjustable Band, “Lap Band”



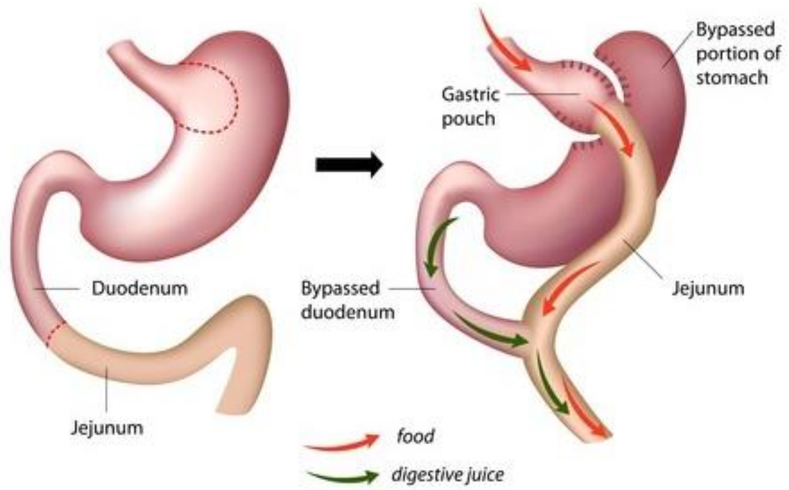
Lap Band | Components



Lap Band | Outcomes

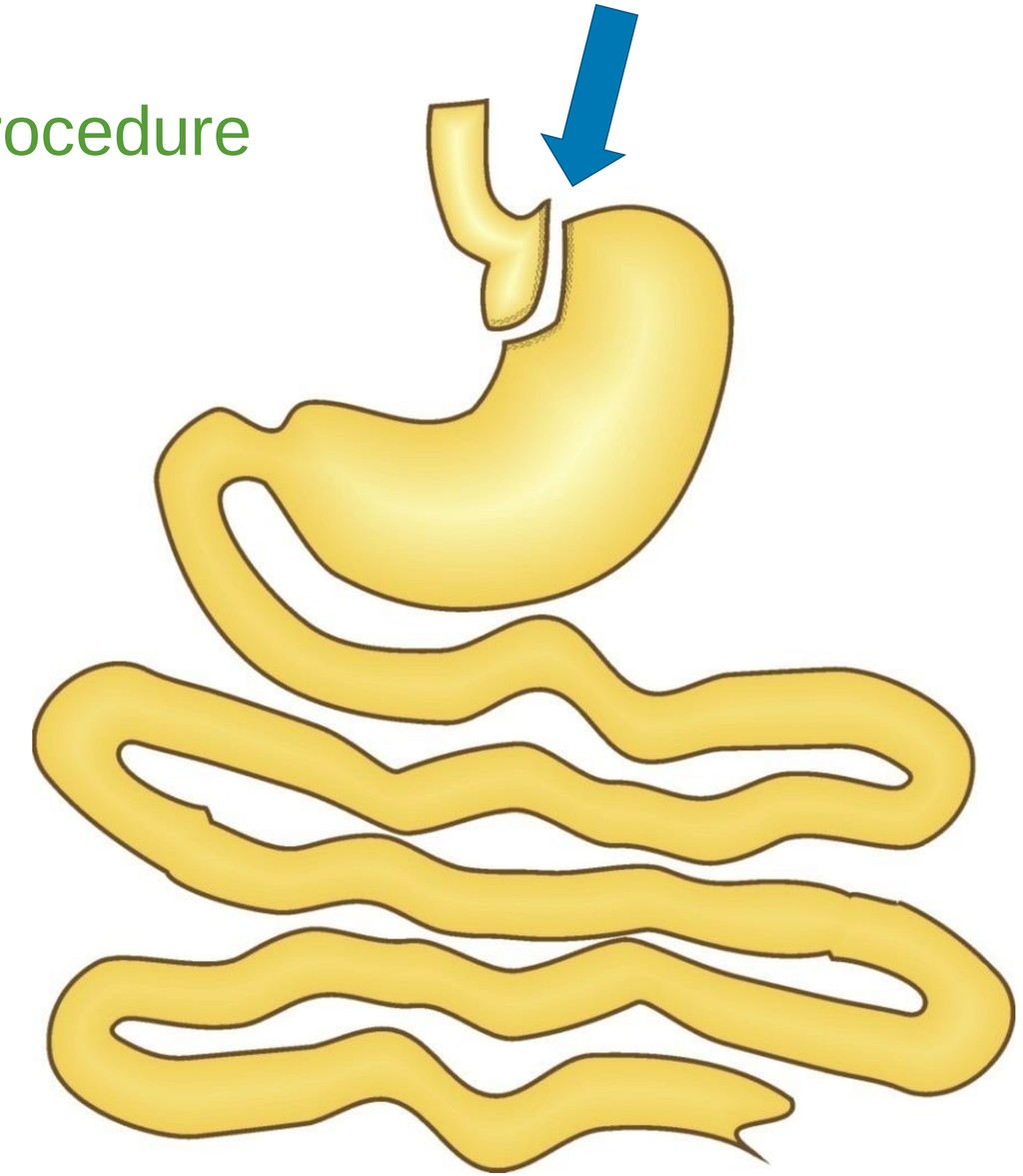
- Patients with lap band achieve less than 50% excess weight loss over two years
- The band can be “cheated” if you eat carbs / high-calorie liquid / pureed food
- 50% 10-Year Removal Rate
  - Mechanical and other complications
    - Pseudo achalasia
    - GERD
    - Barrett’s
    - Other esophageal motility disorders
    - Slipped, eroded, migrated band causing one or more the following:
      - Gastric obstruction
      - Hemorrhage
      - Sepsis / infectious complications
    - Inability to lose or maintain weight loss
    - Lap band is falling into disfavor around the world

The Roux en Y (RNY) Gastric Bypass Procedure



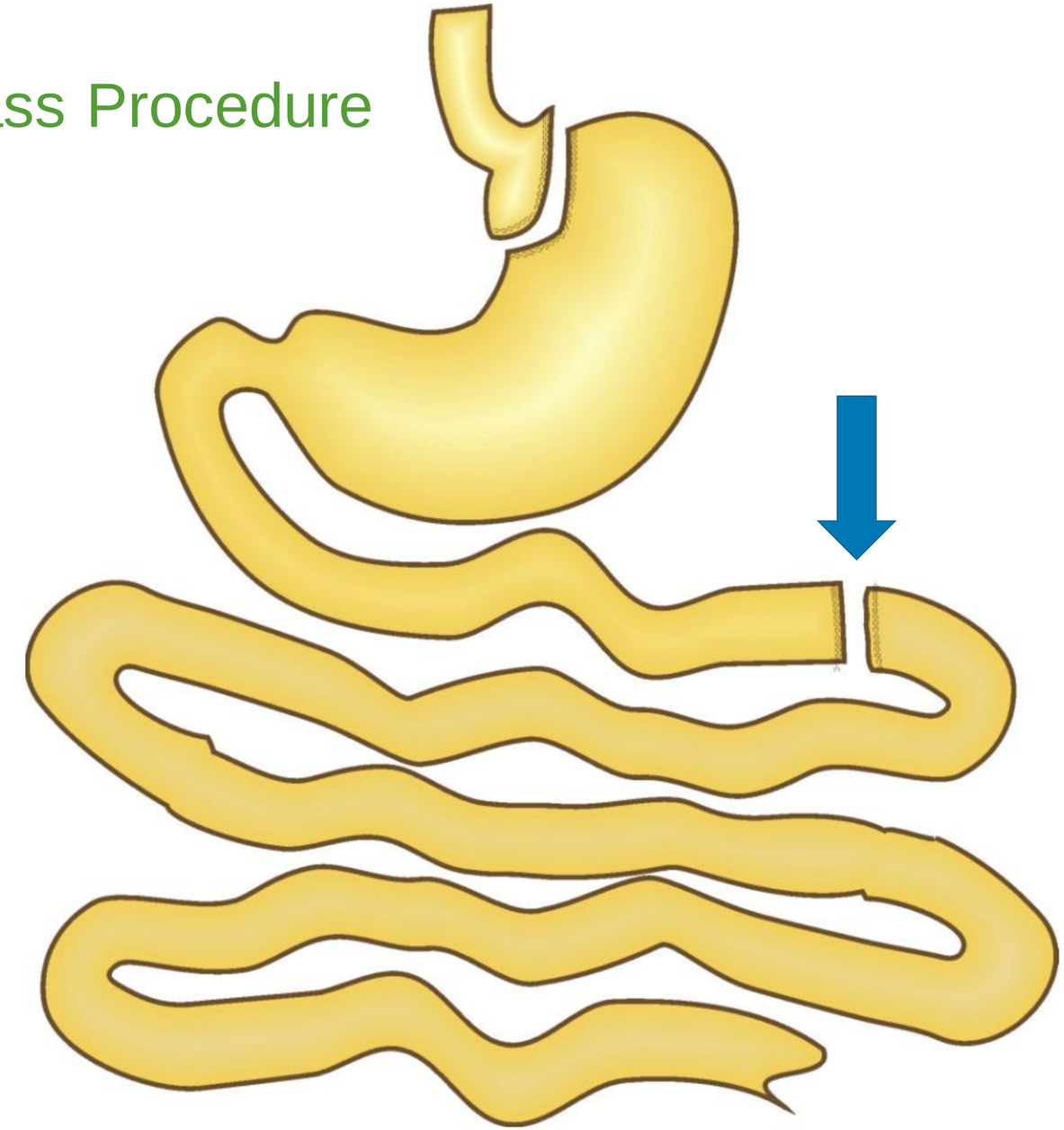
The **Roux en Y (RNY)** Gastric Bypass Procedure

- The stomach is stapled into 2 pieces, one small and one large. The small piece becomes the “new” stomach pouch
- The pouch is 5% of the size of the old stomach, therefore holds much less food - generally about 1.5-2 oz in size
- The larger portion of the stomach stays in place, however will lie dormant for the remainder of the patient’s life.



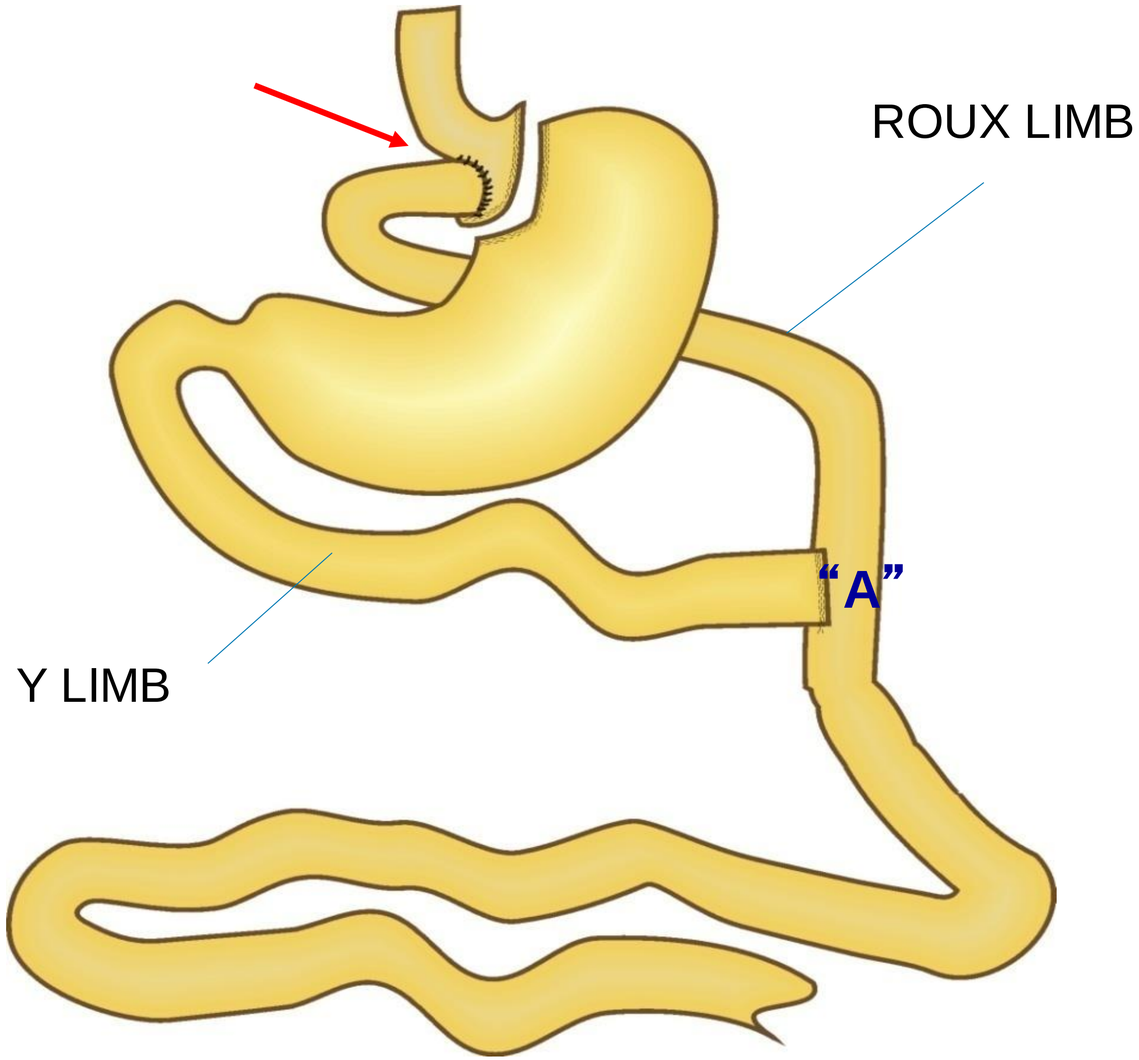
The **Roux en Y (RNY)** Gastric Bypass Procedure

- The beginning section of the small intestine (the jejunum) is divided using a surgical stapler approximately 40-60 cm from the end of the stomach.



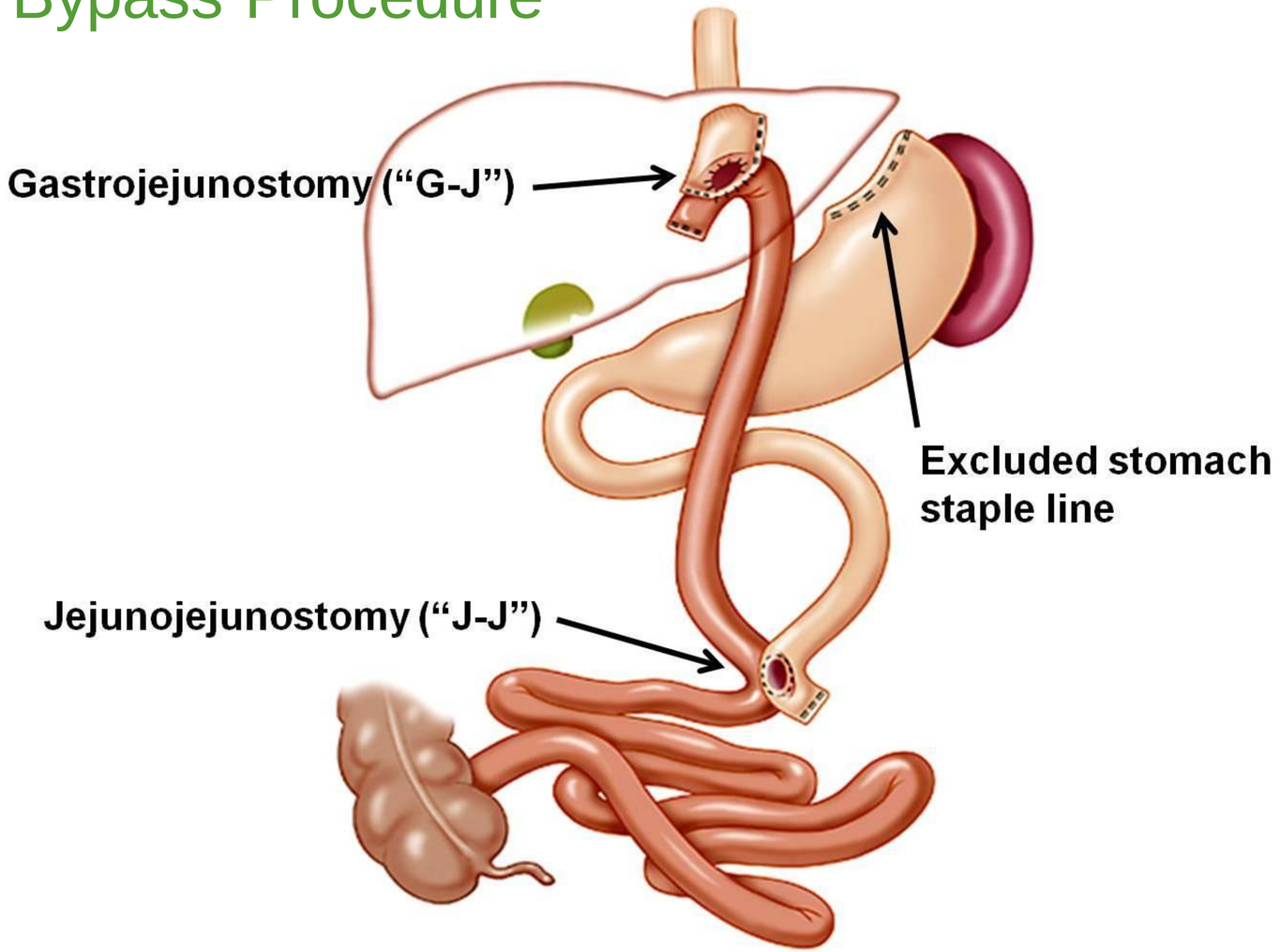
The **Roux en Y (RNY)** Gastric Bypass Procedure

- The end of the Roux limb is then attached to the newly formed pouch (red arrow)
- The Roux limb carries food to the intestines
- The Y limb carries digestive juices from the pancreas, gall bladder, liver and duodenum to the intestines
- The food and the digestive juices mix where the Roux limb and Y limb meet (“A”) – this is referred to as the “common channel” – where the food and the digestive juices finally meet or are “re-united”.



The **Roux en Y (RNY)** Gastric Bypass Procedure

The final arrangement of the lap RNYGB.



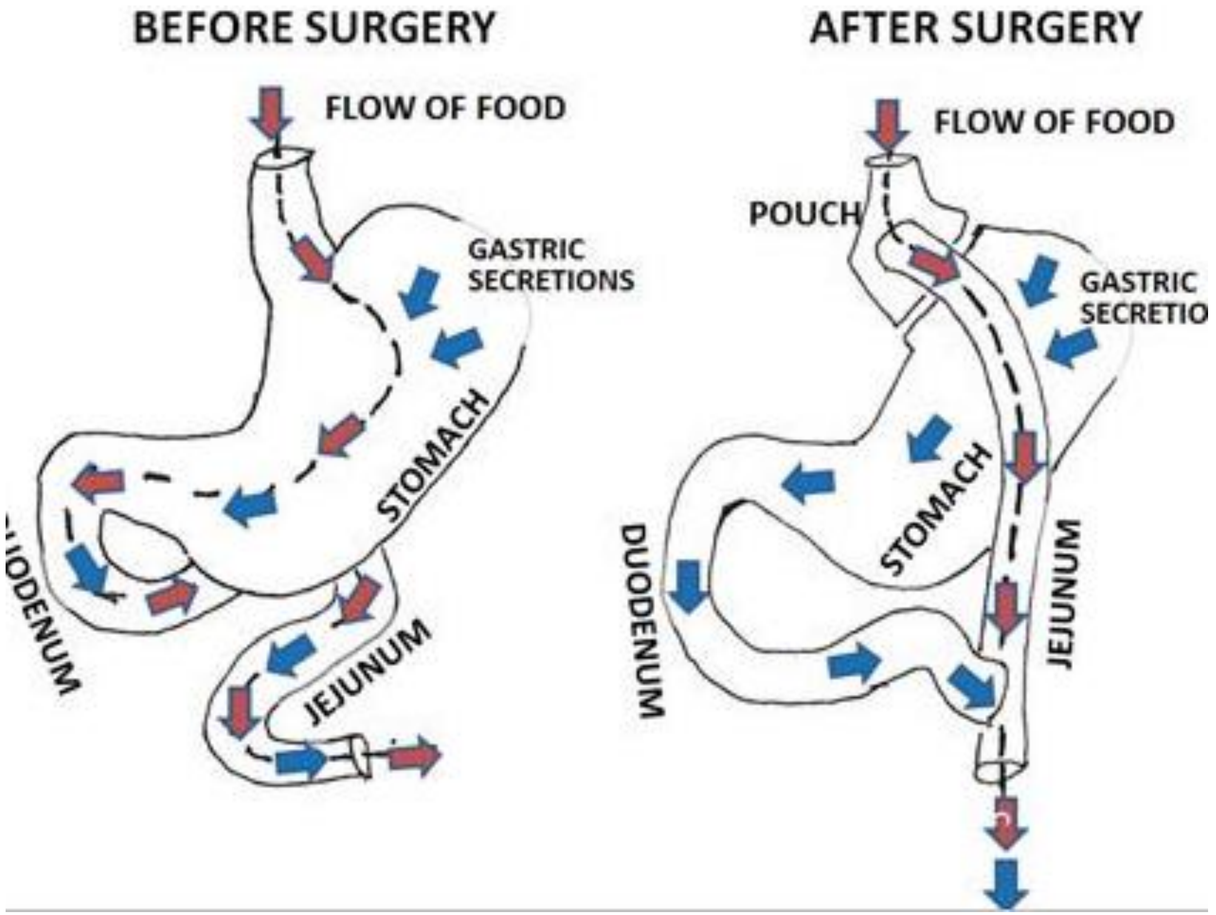
The **Roux en Y (RNY)** Gastric Bypass Procedure

Consequences for GERD

The Pylorus

The **Roux en Y (RNY)** Gastric Bypass Procedure

- Food separated from digestive juices UPSTREAM
- Results in decreased GHRELIN ➔ Decreased appetite (hormonal effect)
- Small 1-2 oz pouch ➔ less food consumed (restriction effect)
- Food reunified with digestive juices DOWNSTREAM (less absorption & hormonally mediated effects on blood glucose, metabolism, etc.)

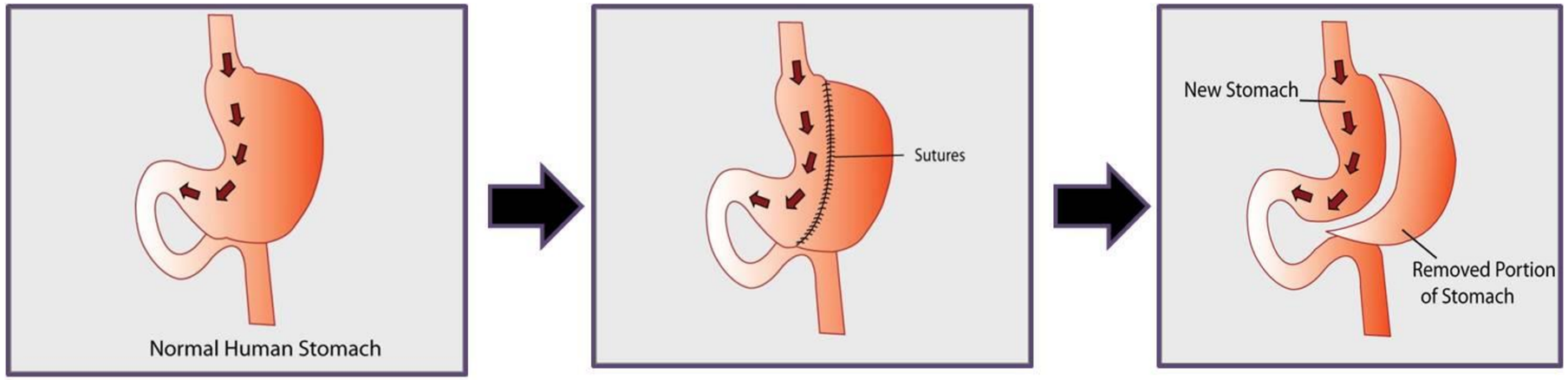


The **Roux en Y (RNY)** Gastric Bypass Procedure

The Bottom Line:

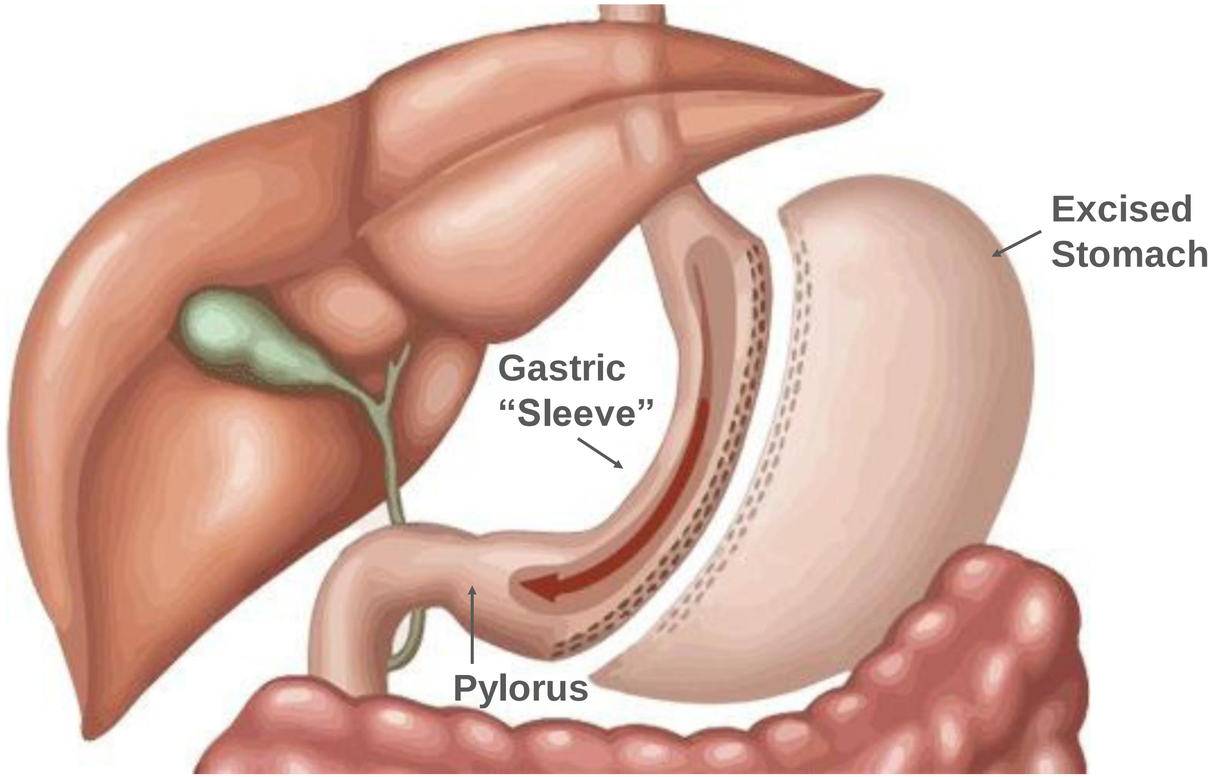
- RNYGB is the gold standard procedure.
- It has existed for over 50 years in various forms.
- It is a laparoscopic procedure, with 6 small incisions.
- The procedure lasts about 2 hours.
- Requires a 1-2 night hospital stay.
- Requires liquid diet (stage 2 post-op) for two weeks after surgery.
- Requires 2-4 weeks recovery, away from work.
- Accounts for 18-20% of all procedures in the US and the world.

The Vertical Sleeve Gastrectomy (VSG) Procedure



The **Vertical Sleeve Gastrectomy (VSG)** Procedure

- The esophagus is still connected to the acid-producing portion of the stomach *
- The sleeve capacity is 3-6 oz *
- Pylorus/Pyloric valve still part of the circuit*
- The sequence in which food mixes with gastric juices (acid, bile, pancreatic enzymes) does not change *
- Fundus is resected (whereas in bypass fundus is preserved) *



The **Vertical Sleeve Gastrectomy (VSG)** Procedure

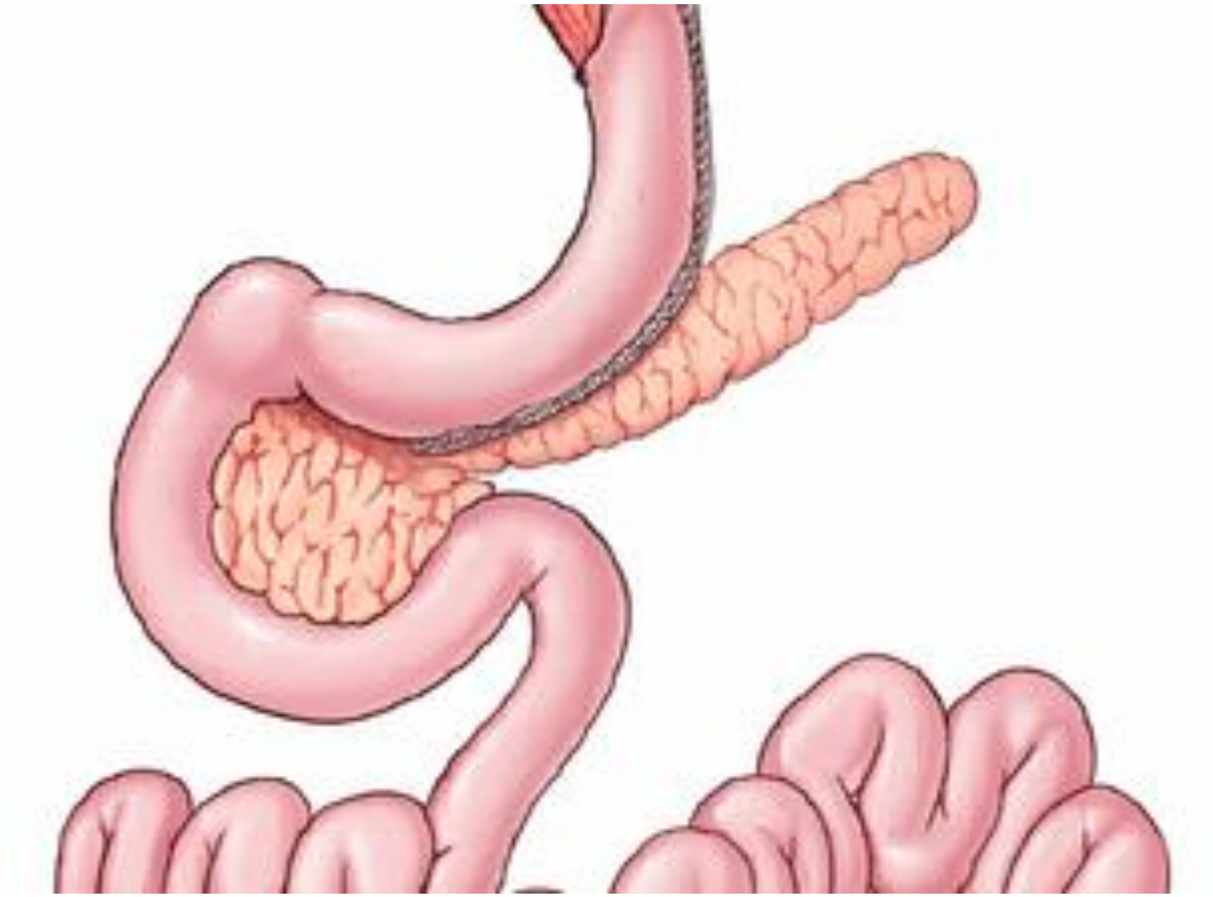
Consequences and Important Differences from RNYGB:

- GERD (Heartburn and reflux) is a potential consequence of the VSG procedure.
- The VSG is larger than the gastric pouch of the RNYGB ➔ **less weight loss** than RNYGB.
- The “brake” is still present, which means **“dumping” is not an issue**. This also creates more pressure, which is what increases the likelihood of reflux.
- **Malabsorption is not an issue.**
- Results in **decreased hunger**, similar to the RNYGB.

The **Vertical Sleeve Gastrectomy (VSG)** Procedure

RECAP

- The VSG creates a 3-6 oz capacity narrow high-pressure tube that maintains relationship between the esophagus, stomach, pylorus, duodenum, and pancreas.
- Preserves normal mixing of food with gastric juices (acid, bile, pancreatic enzymes)
- Fundus resected ➔ Less Ghrelin ➔ decreased hunger
- Restriction ➔ less consumption
- Narrow tube ➔ faster transit ➔ less absorption



The **Vertical Sleeve Gastrectomy (VSG)** Procedure

The Bottom Line:

- VSG is the relatively new kid on the block.
- The procedure has existed for about 13 years.
- It is a laparoscopic procedure with 6 small incisions.
- The procedure lasts 1 hour.
- Requires a 1-2 night hospital stay.
- Requires liquid diet (stage 2 post-op) for 4 weeks after surgery.
- Requires 2-4 weeks recovery, away from work.
- Accounts for 60-70% of all bariatric procedures in the US and in the world.

Revisional Bariatric Surgery

Conversion

Corrective

Reversal

Revisional Bariatric Surgery | Common Types

Conversion

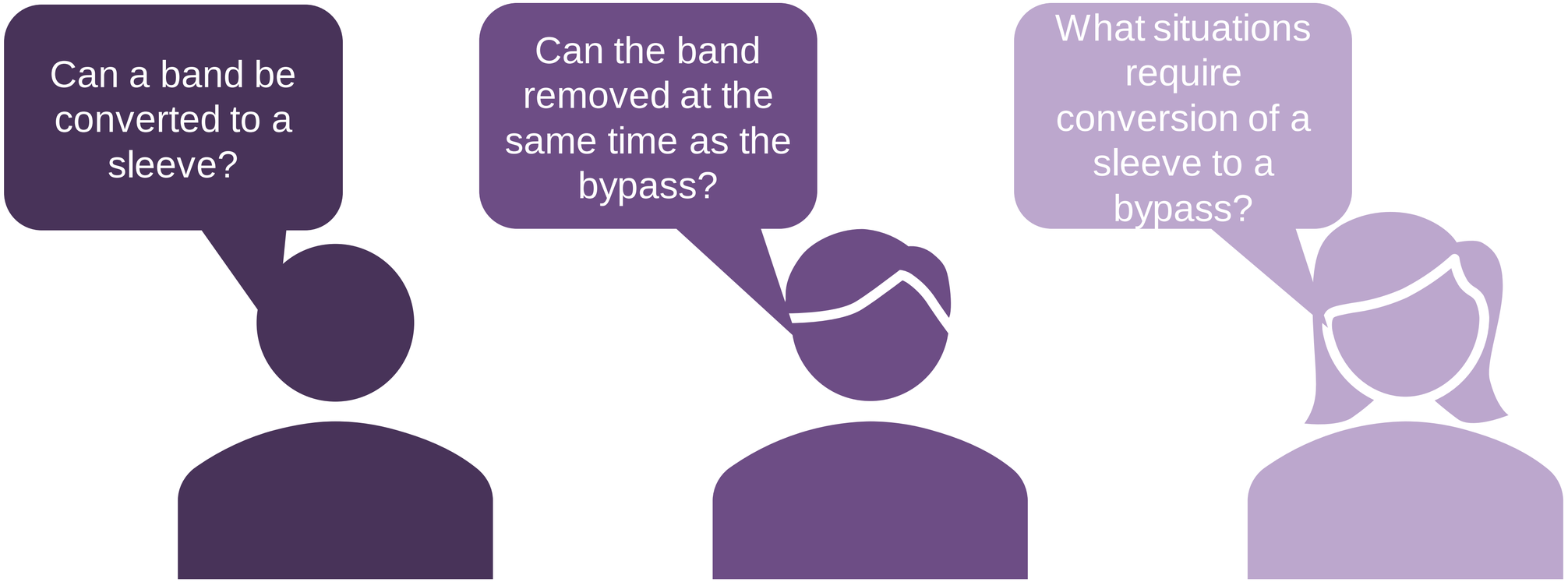
- Band to bypass
- Sleeve to bypass
- Nissen to bypass
- VBG to bypass

Corrective

- Conversion procedures for patient who didn’t meet weight loss goals
- Re-pouch
- Re-sleeve
- Fistula resection
- Limb lengthening/adjustment

Reversal

Revisional Bariatric Surgery | Common Questions



Revisional Bariatric Surgery

Important Considerations Based on Recent Studies:

- Conversion of band to VSG may be associated with a higher risk of short term complications, such as leak, when compared to band to RNYGB conversion.
- Conversion of band to VSG done in two stages may result in **lower complication rates**.
- Band to RNYGB done in two stages may result in **lower complication rates**.

Making a Decision about Treatment

How to decide on an operation?

Which is the best option?

Which is the safest option?

Which will provide me the best results?

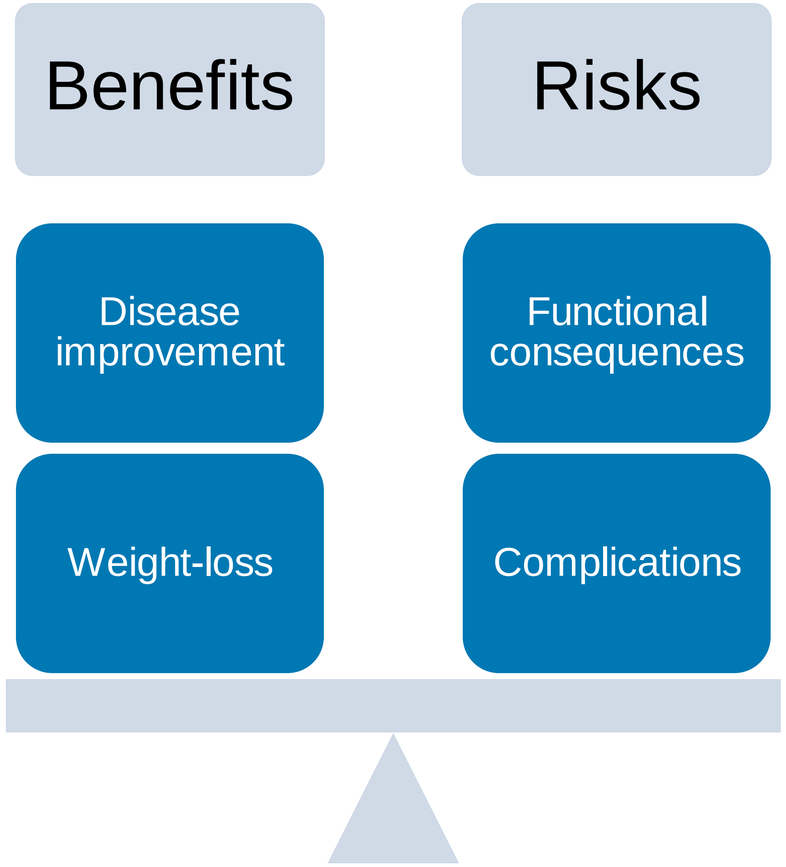
Which operation is the least invasive?

How to decide on an operation? **Let's reframe the questions…**

Which is the best option?	Which is the safest option?	Which will provide me the best results?	Which operation is the least invasive?
• There's no "best" option	• They're equally safe overall	• No operation can provide the best results	• They are both equally invasive in terms of incisions and recovery

So then how do I decide?

The decision to choose a bariatric operation is aligning your personal convictions with the balance that exists for each operation, in terms of benefits and risks.



Bariatric Surgery | Outcomes & Risks (PCORnet Bariatric Study)

Operation	RNYGB	VSG
OUTCOMES		
Total weight loss (TWL) at 1 year TWL at 5 year	31 % 26%	25% 19%
Weight loss failure at 5 years (<5% weight loss from baseline.)	3.3 %	12.5%
Diabetes Remission (HbA1c <6.5 after 6 months without meds); 5 year	86 %	84%
Remission rate at 5 years: Insulin users	73%	66%
Diabetes relapse rate	33%	42%

- Overall rate of remission was 10% higher for RYGB vs VSG
- Lower rate of remission for patients > 65 years

COMPLICATIONS

	RYGB	VSG
Overall Complication Rate	8%	5%
Major complications in 30 days after surgery	3.2%	2.4%
5 years reoperation and reintervention rate	20%	18%
Short-Term Complications		
Leak	0.3%	0.3%
Bleeding	1%	2%
PE/DVT	1%	1%
Death	0.2%	0.2%
Medium-Long Term Complications		
Ulcer	1-16%	Minimal
Stricture	1-2%	1-2%
Fistula	1-2.6%	Minimal
Dumping	5%	Minimal
Small Bowel Obstruction	1.2-4.5%	0%
Malnutrition	5-7%	Minimal
Reflux/GERD	Treatment	10-30%

Other Considerations

- Overall RYGB has better weight loss, better chance of DM remission, less DM relapse, more reoperation/reintervention/rehospitalization as compared to VSG

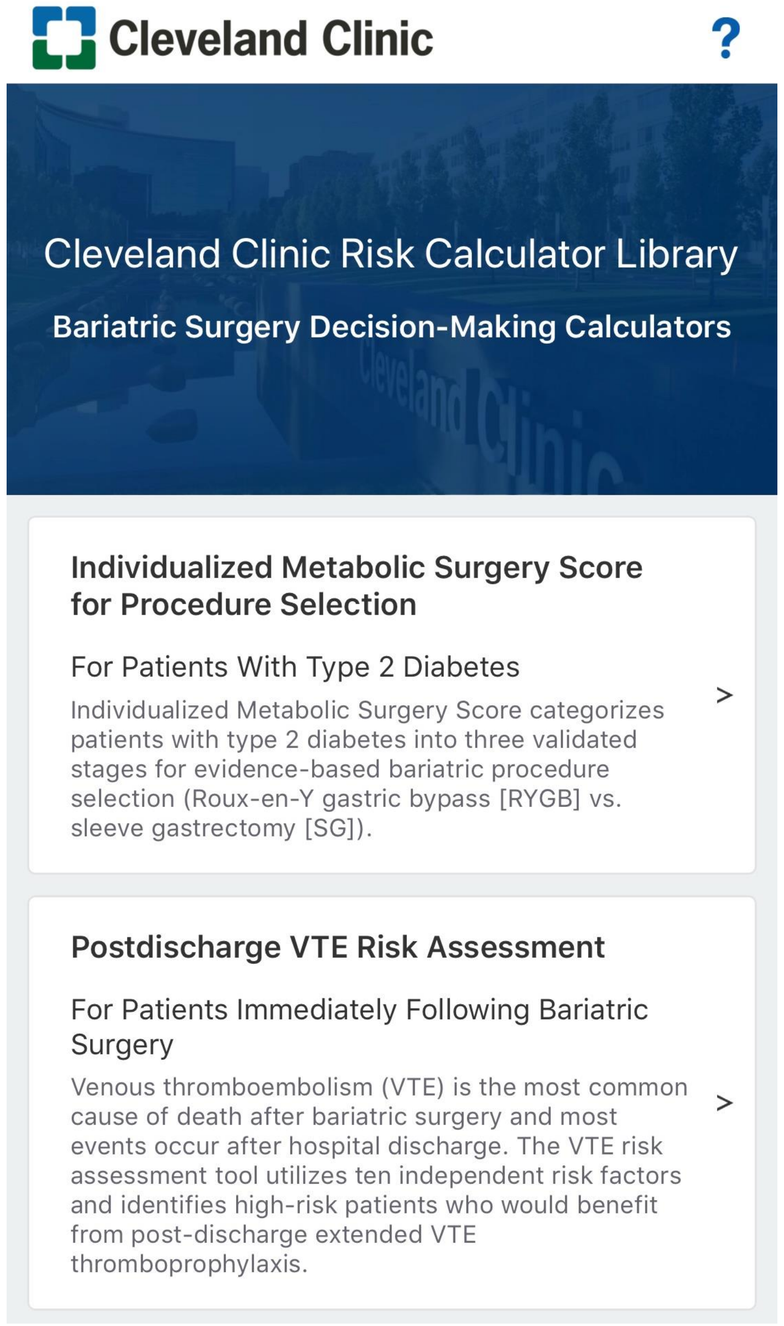
- RNYGB is associated with a higher risk of kidney stones.
- RNYGB is associated with a higher risk of anemia and iron deficiency, and in some cases, may require iron transfusion post-operatively.

Bariatric Surgery | Decision Analysis

- Those patients who are more interested in the potential greater weight loss and reversal of medical problems AND are more tolerant of the specific long-term risks and required lifestyle will choose a RNYGB.
- Those patient who don’t need the greater benefit of the RNYGB and/or are less risk-tolerant of the long term consequences and lifestyle of the RNYGB, will choose a VSG.
- It would appear that in the past 5 years, the national trend has been towards the latter, where around 65-70% of all bariatric procedures performed is the VSG.

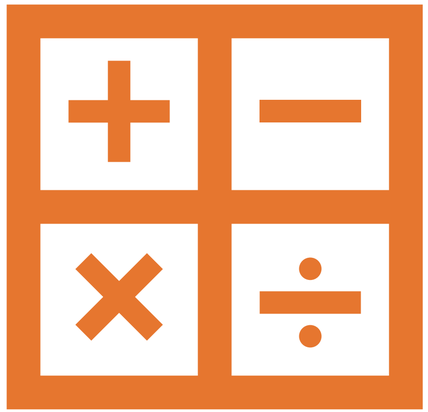
There are other factors which may impact treatment choice…

- NSAIDS
- GERD
- Type 2 Diabetes
- Previous Abdominal Surgery


Cleveland Clinic
Cleveland Clinic Risk Calculator Library
Bariatric Surgery Decision-Making Calculators
Individualized Metabolic Surgery Score for Procedure Selection
For Patients With Type 2 Diabetes
Individualized Metabolic Surgery Score categorizes patients with type 2 diabetes into three validated stages for evidence-based bariatric procedure selection (Roux-en-Y gastric bypass [RYGB] vs. sleeve gastrectomy [SG]).
Postdischarge VTE Risk Assessment
For Patients Immediately Following Bariatric Surgery
Venous thromboembolism (VTE) is the most common cause of death after bariatric surgery and most events occur after hospital discharge. The VTE risk assessment tool utilizes ten independent risk factors and identifies high-risk patients who would benefit from post-discharge extended VTE thromboprophylaxis.

Individualized Metabolic Surgery Score for Procedure Selection for Patients with Type 2 Diabetes

- Preop # diabetes medications (oral and injectable)
- Preop Insulin use
- Preop Duration of Diabetes (years)
- Preop Glycemic control (A1c < 7%)



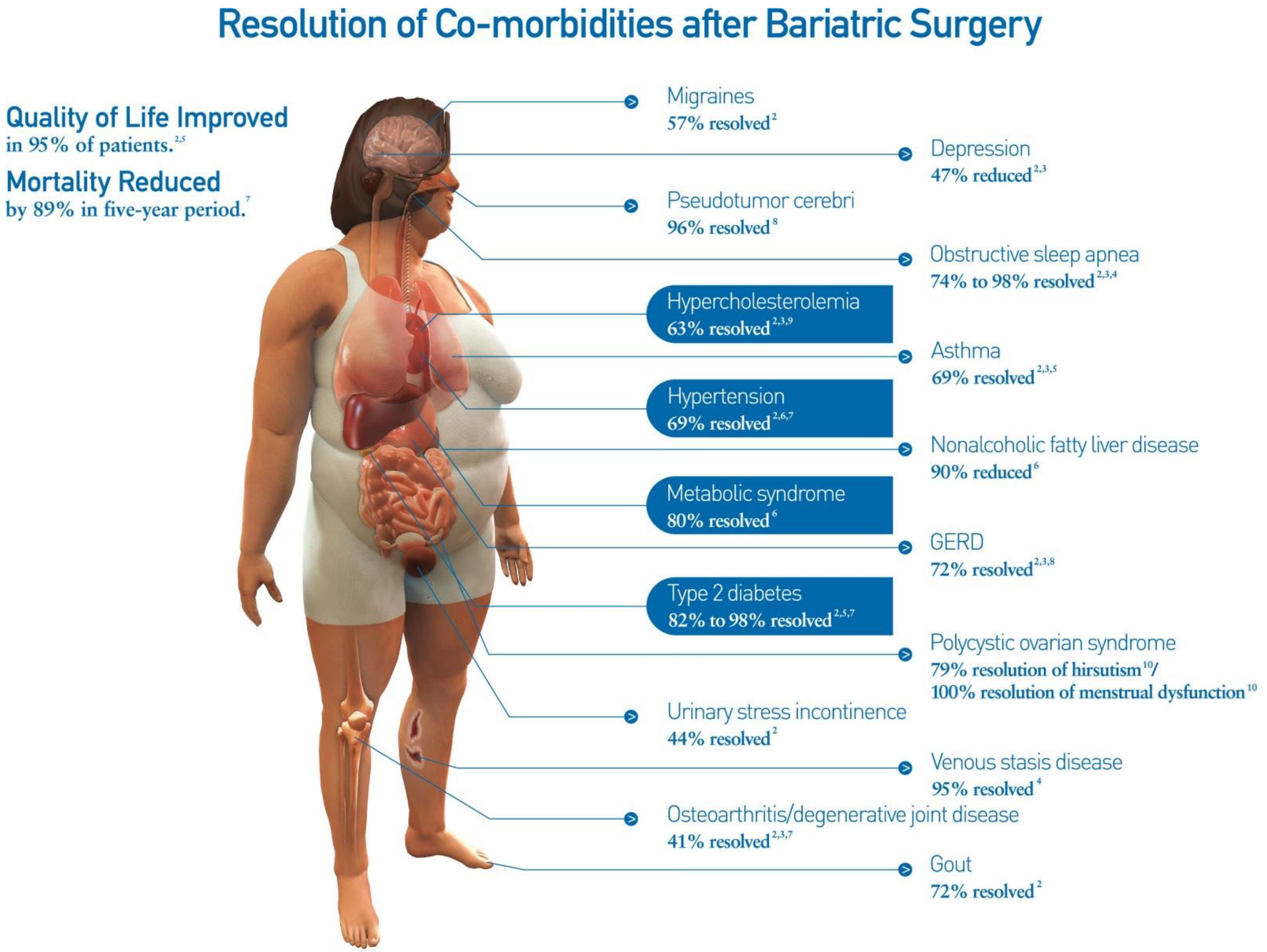
Score helps determine severity of disease.

Severity of disease impacts likelihood of long term resolution of T2D.

This impacts how suitable a bypass, which may have higher risk, is for a patient with T2D (risk vs. benefit)

Risk Calculator

Resolution of Co-Morbidities



The Bottom Line

- Roux en y gastric bypass (RNYGB) may provide greater reward for the right patient, but also comes with slightly higher risk.

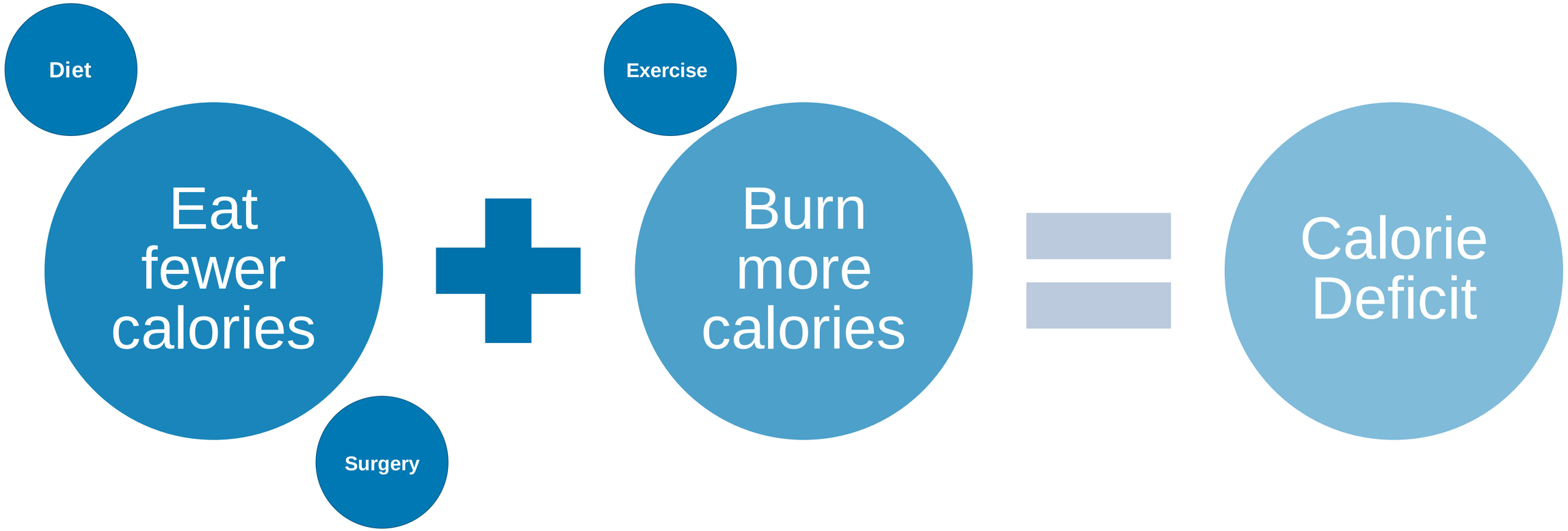
- Sleeve gastrectomy (VSG) provides a bit less weight loss, may be less durable, and less effective in terms of resolution of co-morbidities, but for the right patient it is a good operation with less risk than the roux en y gastric bypass.

IMPORTANT CONSIDERATIONS

STOP	CONTRAINDICATIONS FOR SURGERY
• Use of any tobacco or nicotine products creates a significant safety risk both before and after surgery. If you need resources to quit, please inform a member of our team. • Avoid marijuana or other recreational drug use, which can also create risks for surgery and be counter-productive to your weight-loss. • Carbonated beverages, sugary beverages, caffeinated, and alcoholic beverages must be eliminated prior to surgery. Work on eliminating these from your diet now. • Consider contraception carefully. Pregnancy immediately after bariatric surgery could be high risk for both mother and child.	• Individuals with a substance use disorder, eating disorder, or major psychiatric illness must receive treatment and resolution prior to be considered for surgery. • Individuals actively using tobacco or nicotine products cannot have surgery. • Women who may become pregnant (within 2 years) are not eligible for surgery. • Individuals who are looking for a quick-fix and are unwilling to engage in all aspects of the program and care management plan may wish to consider alternative options to surgery.

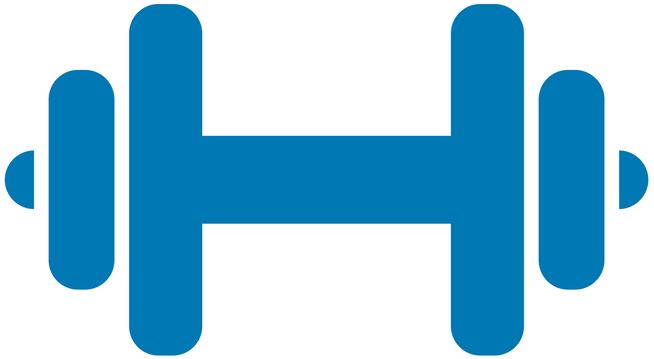
Weight-loss and Weight-loss Maintenance

How to create a calorie deficit



The downside of calorie deficit

- Calorie deficit ALSO results in **muscle loss** (you don’t just lose fat)
- **MUSCLE MASS** is the #1 determinant of your metabolism
- Muscle loss ➔ decrease in basal metabolic rate (BMR)
- Decrease in BMR ➔ decrease in calorie deficit ➔ plateau and you hit a wall



How do you delay the plateau and maximize weight loss?

You can control your muscle mass, which is the #1 driver of your basal metabolic rate.

How do you build muscle mass?

Adequate Fuel

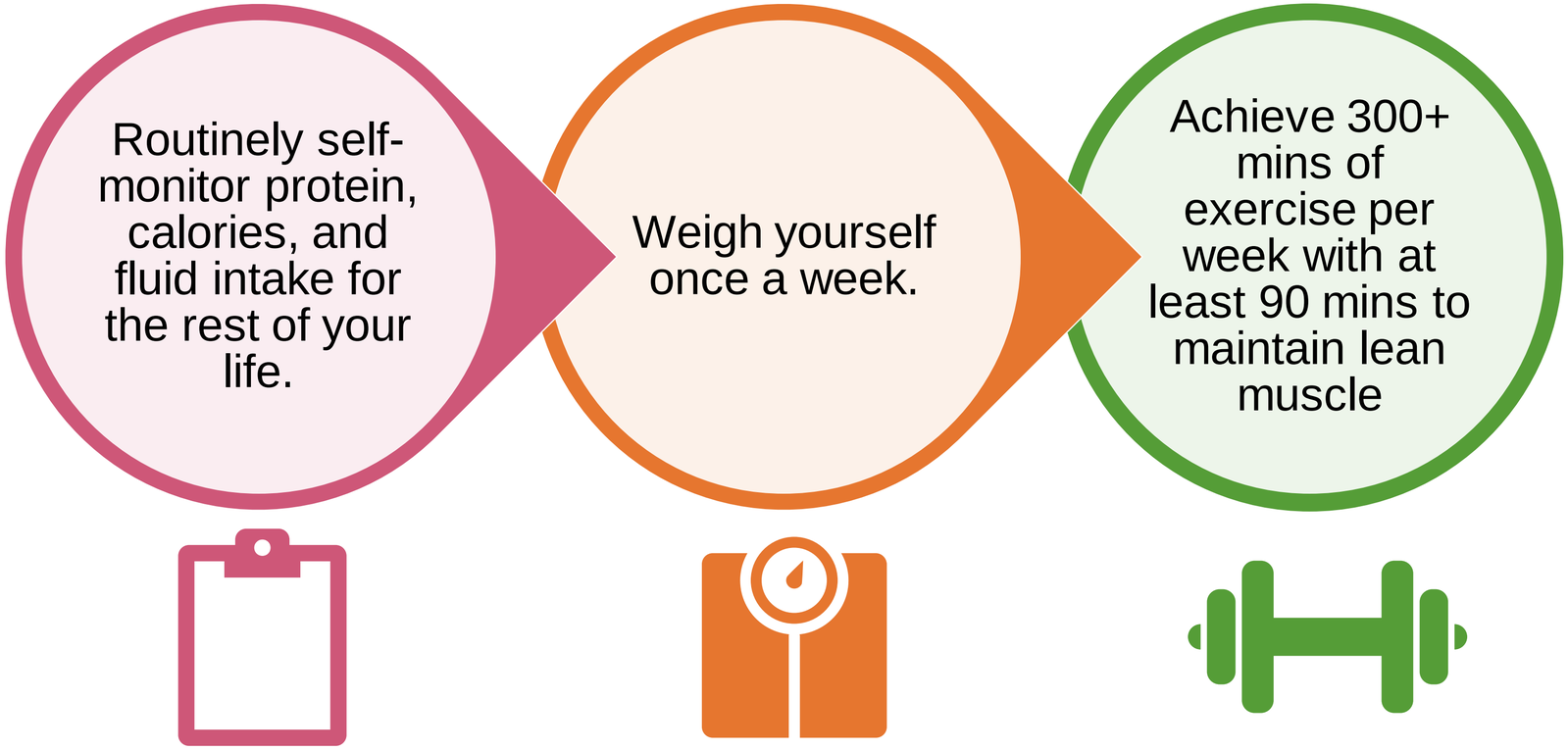
- At least 1-1.5 gm protein/kg body mass/day
- For example, a 90 kg individual would have at least 90, but as high as 135 grams of protein per day

Adequate Exercise (Resistance Training)

- At least 90 + minutes of resistance training a week, in addition to “cardio”
  - Free weights/body weight/machine weights/resistance bands/Pilates/yoga/swimming
  - Personal trainer who can tailor a plan for you with these goals in mind of functional fitness and high quality muscle mass retention

Maintaining Healthy Weight-Loss

The American College of Sports Medicine and the National Weight Control Registry Recommend:



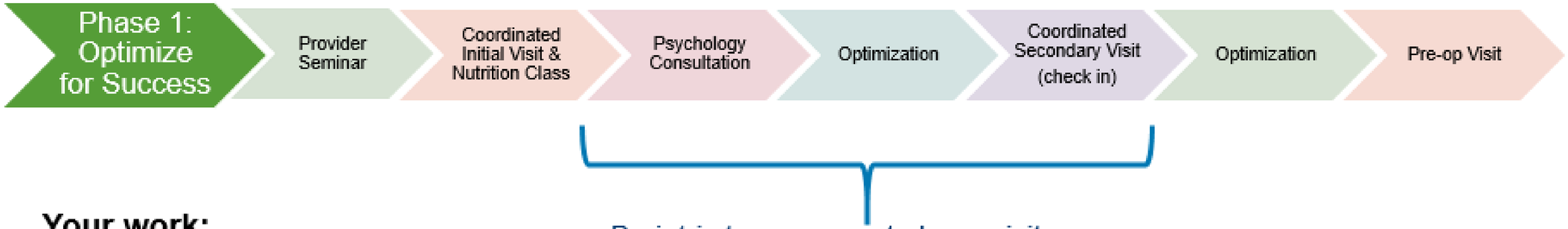
Next Steps: Paving the Path to Success

Your journey starts today

- Evaluate your commitment to the journey
- Start keeping records of your current lifestyle & habits
- Start making changes today
- Build a good social support structure
- Plan groceries and meal prep
- Take ownership of your journey and don’t lose momentum
- Read the Bariatric Binder and ask questions
- Take advantage of the many resources available to you in the program

Program Roadmap

You are here



Your work:

- Medical work up
- Creating healthy habits & diet
- Weight loss trend
- Follow recommendations from Dr. Ng & Lori Gokee, ARNP

Bariatric team support phone visits:

- Nurses – review progress with medical work up
- Dietitians – review progress with goals in healthy food plan & habits
- Dr. Ng & Lori Gokee, ARNP as needed

Phone visits: if you are not available at the time of your appointed phone visit, we will leave you a message to call our direct team line.

Phone: (425) 502-3454

Press OPTION 3 to reach the team
Press OPTION 1 to reschedule visit.

If you are over 15 minutes in returning your call, the phone visit will need to be rescheduled.

Next Steps

Within the following week:

We will contact you to schedule your next appointment for a video visit with a provider. You will also be scheduled for an afternoon nutrition education class.

Before your next appointment:

Contact Member Services at 1-888-844-4607 if you have questions regarding your coverage & benefits for Bariatric Care and Surgery.

KAISER PERMANENTE®

Attendance

In order to receive credit for the class you will need to sign in with your name at the beginning of class and at the end. You must remain in the class for the entire presentation to receive credit. This will allow you to move on to the next steps of the Bariatric program.

Q&A

KAISER PERMANENTE®

Frequently Asked Questions

1. If I have hiatal hernia and reflux how does it affect the operation?
2. If I don’t have my gallbladder, how will that affect my surgery? If I do still have my gallbladder, will it be taken out at the same time?
3. What is the best operation for me?
4. I have Diabetes, I thought by pass is the right operation for me
5. I’ve had previous abdominal surgeries am I still a candidate
6. Can I get pregnant after this surgery, how soon?

