

Laparoscopic Procedures for Obesity

Bariatric Consent

Procedure Type (check one):

- Laparoscopic Roux-en-Y Gastric Bypass**
- Laparoscopic Gastric Banding (Lap Band™)**
- Laparoscopic Sleeve Gastrectomy**

Surgeon: Trace W. Curry, MD

**PLEASE READ THIS ENTIRE DOCUMENT, AND INITIAL EACH PAGE.
IF YOU HAVE A SPOUSE OR FRIEND WITH YOU, HAVE THEM
WITNESS YOUR SIGNATURE. TURN THE ENTIRE DOCUMENT IN TO
THE FRONT DESK. THANK YOU!**

Background

These procedures are advanced laparoscopic surgical procedures (or a surgical procedure performed via very small incisions) designed to promote weight loss and reduce the complications associated with morbid obesity.

This procedure will either:

1. transect (cut) your stomach, surgically create a small pouch, recreate a new outlet for your stomach and bypass a portion (75cm-250cm) of your small intestine (gastric bypass)
2. reduce the capacity of your stomach by placing a device on it (gastric band)
3. reduce the capacity of your stomach by removing a significant portion of it (sleeve gastrectomy).

We feel it is important to understand the risks of all three procedures therefore this document is broken down into general risks of the procedures and risks specific to each one.

Indications – Understanding the Process of Becoming a Surgical Candidate

Becoming a surgical candidate for this procedure is a rigorous process, which you need to comprehend fully.

Initially, you have been fully evaluated by a registered dietitian and, if necessary, a psychologist-psychiatrist. You have undergone a complete evaluation by your primary care physician if requested. All your surgical risk factors or co-morbid factors (if any) were identified, explained in detail to you, and are currently well controlled, and you have undergone at least two consultations with Dr. Curry's staff.

You have been screened by the dietitian and recommendations have been made and followed regarding current and post-operative dietary modification.

The following parameters have been met for you to qualify as a surgical candidate:

You have failed repeated attempts at losing weight and controlling your weight.

You are have a BMI or Body Mass Index greater than or equal to 40 (35 if you have an associated medical complication or co-morbid factor).

If you lie outside these criteria then this is considered a “cosmetic” procedure. However, there is data in the surgical literature to show a good success rate with a very low risk of complications for patients with a BMI of 30-35.

HIATAL HERNIA

Roughly 20% of patients will be found to have a hiatal hernia at the time of operation. This means that the diaphragm has stretched out somewhat and the stomach has herniated out of the abdomen up into the chest to some extent. Often times this must be repaired so that your surgical weight loss procedure can be completed. If this is the case this may result in additional billing to your insurance company for the extra procedure.

Risks of Your Specific Surgical Procedure

All the risks of these procedures (as set forth in the following document) as well as the impact on your future life style have been explained to you by our staff. All your questions have been answered to your satisfaction.

Please, read the following very carefully. It summarizes some of the most common risks associated with these procedures.

The Issue of Open Conversion

These procedures are performed via laparoscopy, i.e. via small puncture type incisions. This will allow you to recover quicker than with conventional surgery, where a large incision is made. In some cases, the laparoscopic procedure will have to be converted, meaning a larger incision will be made to continue and safely complete the procedure. Although this is a **rare** occurrence with Dr. Curry (less than 0.3% overall), he may decide to do so if he foresees too many technical complications, or if he cannot complete the procedure safely. If the laparoscopic procedure is converted, it will lengthen you hospital stay on the average by three days.

PATIENT INITIALS _____

General Surgical Risks

These risks are rare but do occur. The most significant are as follows:

1. **Injuries to Other Intra-Abdominal Organs:** As with all surgical procedures, injuries to other intra-abdominal organs could rarely occur. Your surgeon would attend to them as needed.
2. **Bleeding:** Bleeding may occur during the procedure or in the early post-operative period. Although *unlikely*, you may require the transfusion of blood products as needed. If you are religiously opposed to blood transfusions, your doctor needs to be made aware of this. Refusing blood or blood products could ultimately lead to death.
3. **Deep Vein Thrombosis and Pulmonary Embolus:** This is a rare but potentially dangerous complication. A blood clot could form in your leg or in your pelvic veins and could travel to your lungs, endangering your life. To prevent this you should carefully follow the surgical instructions given by your surgical team. It is crucial you ambulate (walk) after surgery as much and as frequently as you can.
4. **Heart Problems:** Severe cardiac problems can occur. This office has made efforts to assess your cardiac condition prior to the surgical procedure. You should receive cardiac clearance by your primary care physician before undergoing this procedure.
5. **Lung Problems:** Respiratory insufficiency or problems may occur after the surgery necessitating the use of a ventilator. This potentially would lengthen your hospital stay and your recovery.
6. **Hair Loss:** Some patients report some form of temporary hair loss, which is believed to be due to a reduced and insufficient post-operative intake of protein. Again, patients need to follow post-operative instructions meticulously.
7. **Future, Altered Psycho-social Interactions:** This procedure and the resulting weight loss and lifestyle changes may strain the psycho-social interactions of the patient with his or her family.

COMPLICATIONS SPECIFIC TO GASTRIC BYPASS

1. **Breakdown of a Gastro-Intestinal Anastomosis (a "leak"):** The small bowel and the stomach are usually re-attached or put back together (an anastomosis) using sophisticated surgical instruments (i.e. laparoscopic stapling and suturing devices). Occasionally, this "attachment" does not heal well and will breakdown generating a sequence of complications that may significantly lengthen your hospital stay. In some instances you may have to undergo an additional surgical procedure. This happens in less than 1% of cases in Dr. Curry's care.
2. **Gastro-Enterostomy Stenosis:** The "attachment" of the stomach to the bowel is made a certain size to restrict the rapid emptying of your new stomach. In some patients, scarring does occur at this site and will shrink this opening further, which will lead to vomiting. This complication is classified as a *gastro-enterostomy stenosis* and is managed by performing an endoscopic dilatation (enlarging the opening via an upper GI endoscopy).
3. **Bowel obstructions/Internal Hernias:** These complications are very rare, but, if they do occur, you may need surgery to correct it.
4. **Malabsorption:** As you know, this procedure creates malabsorption of the food and nutrients you eat (**Vitamin B12, Iron, folate, etc.**). Certain vitamins may not be absorbed well enough for you to meet the recommended US daily requirements. For this reason, we recommend you take a calcium, a multivitamin (with iron) daily, and Vitamin B12 sublingual for the rest of your life. Other supplements may or may not be prescribed as well.
5. **Dumping Syndrome:** This syndrome has been reported by patients after this procedure, especially after ingesting concentrated sweets. Although not dangerous it is bothersome to patients who have not been educated on the subject. Short period of dizziness, fatigue and low blood sugar can occur.
6. **Diarrhea:** Diarrhea can occur immediately after surgery but usually subsides. Permanent diarrhea is not a common side effect of this procedure.
7. **Renal Problems:** Although rare with this procedure, kidney stones can occur.
8. **Gastric Pouch - Gastric Body Fistulas:** A re-connection of the gastric pouch to the remaining stomach can form and create significant late problems, such as bleeding, nausea, poor weight loss, etc.

Surgical procedures are associated with an average rate of complications (or morbidity) and an average mortality rate or overall rate of death within thirty days after these procedures. These statistics are published in the American medical literature and can be easily verified. **For the laparoscopic gastric bypass with Roux en Y Reconstruction, the morbidity rate (this means any non-fatal complication) is averaging 3-5% and the mortality rate (death rate) is averaging 0.1 to 2%. Dr. Curry's in-hospital death rate for Roux en Y is less than 0.3%**

COMPLICATIONS SPECIFIC TO GASTRIC BANDING

1. **Band Slippage:** Rarely the band can slip from its usual position farther down the stomach. If this happens it may result in poor weight loss, pain, nausea, or vomiting. This typically would require surgical correction.
2. **Device failure:** Cases have been reported where the inflatable cuff has broken or the catheter used to inflate it either leaks or kinks. This would be attended to as needed, and sometimes could require an additional surgical procedure.
3. **Erosion:** Rarely the band can erode through the wall of the stomach, sometimes completely. This would likely cause poor weight loss, pain, nausea, or vomiting. When this happens the band usually must be removed completely. Our erosion rate is around 0.025%, which is one of the lowest in the country.
4. **Infection:** Any implantable foreign body carries a small risk of infection. If your entire band would get infected it would have to be removed. If your port only became infected then it would need to be removed and replaced at a later date.
5. **Port issues:** The chance of a port complication is about 1%. This could involve:
 - a port flip, that may require a minor surgical procedure to correct
 - a port leak, that may require removal and replacement of the port
 - a port infection, which could require removal followed by delayed replacement

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mortality (death) rate is averaging 1 in 2000. We have had no band-related deaths.

COMPLICATIONS SPECIFIC TO SLEEVE GASTRECTOMY

1. **Breakdown of Staple Line (a "leak"):** This is very similar to a leak for a gastric bypass and carries the same overall risk. Occasionally, the staple line does not heal well and will break down generating a sequence of complications that may significantly lengthen your hospital stay. In some instances you may have to undergo an additional surgical procedure.
2. **Obstruction of Gastric Tube:** Occasionally, due to post-surgical swelling, the narrow tube that we create out of the stomach can swell shut completely. This causes inability to keep liquids down and can take several weeks to resolve.
5. **Heartburn:** This symptom can sometimes worsen following sleeve gastrectomy.
6. **Diarrhea:** Diarrhea can occur immediately after surgery but usually subsides. Permanent diarrhea is not a common side effect of this procedure.

Realistic Expectations for Patients Undergoing Bariatric Surgery

You must understand that by undergoing this procedure, it will not solve all your problems but will help you lose weight and maintain it. In addition, it may correct or improve some of the medical problems (diabetes, hypertension, etc.) or help your physicians manage them. Statistically, patients who undergo this procedure and stay with the program will lose on the average 60-80 % of their excess weight and will sustain it. Long-term success however does require a lifetime of commitment from the patient.

Post-operatively your eating habits will change as described in the provided education package. You will need to comply with the monitoring schedule proposed our team.

It is strongly advised that women of childbearing age use the most effective forms of birth control during the first 16 to 24 months after obesity surgery. The added demands pregnancy places on your body and the potential for fetal damage make this a most important requirement.

This operation is not a guarantee of weight loss. There are patients that have a gastric bypass who either do not lose weight, or lose weight and then regain. Adherence to our recommendations greatly increase your chance for success!

Patient's Name: _____ DOB / /

Patient Signature: _____

Witness Signature: _____

Date of Signatures: _____