RACGP | Specific Interests

Nutritional needs of patients with obesity, post metabolic surgery webinar

Frequently asked questions

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Do we have to prescribe ursodeoxycholic acid and omega 3 fatty acid whilst on VLED to prevent gallstone? If so, at what strength and how long? Currently not in Australian guidelines however in Europe they do; compliance to take it is difficult - There are some studies looking at omega 3 FA and VLED - and also in NAFLD - so yes we should prescribe them in addition

VLED - any special precautions to be taken in patients with asymptomatic hyperuricemia? We know that initially during rapid weight loss phase uric acid levels may rise; thus patients are advised against discontinuing their allopurinol during rapid weight loss phase. Yes they are safe – however need to monitor blood levels and also may need medication management / dose adjustment. We know that many arthritides are associated with inflammation; and independent of this obesity is a pro-inflammatory state. Therefore, with weight loss this improves as their inflammatory illness improves.

I am concerned that post operation management presents significance risks: compliance, cost, lack of understanding, particularly in patients on low incomes There is very strong level of evidence for bariatric metabolic surgery as the most effective therapy available at present for significant and sustainable weight loss. Based on the latest evidence; bariatric metabolic surgery is endorsed as safe and effective by the NHMRC, RACGP, ADS, ANZOS and Diabetes Australia. These peak bodies all endorse adherence to lifelong follow-up. Whilst bariatric clinics try their best to follow-up their patients, we know that over the course of time, many patients are list to follow-up. Therefore, as GPs we need to be upskilled and empowered to do this, especially if patients don't want to or find it difficult to, return to their surgical practice. The ALMs in obesity management which were held in GP16, GP17 and this 5 part webinar series is part of the upskilling process, which will continue moving forward.

Furthermore, GPs should flag patients who have undergone a bariatric metabolic operation or bariatric endoscopy procedure, so as to facilitate at least 3-6 monthly follow-up (chronic care management).

However, remember that metabolic surgery or any intervention for that matter is only a tool, an "enabler"-please refer to my 3 legged stool analogy. As always, the cost of surgery needs to be weighed against the costs, benefits and risks of the alternatives.

The decision to go ahead should be also considered on a case by case basis. The post-operative transitional staged based diet is quite challenging for most patients, however it is short lived. Most understand it's important to reduce peri-operative complication risks and so tend to comply.

PriceWaterhouseCoopers produced a document in October 2015 entitled “Weighing the cost of obesity- a case for action” which showed that with weight management, the cost savings both to the individual but also society, are numerous eg smaller grocery bills, less medications, less workforce absentees, increased productivity & QALY etc

I also agree that patients need to be well informed about the need to adhere to lifelong multivitamin supplementation, adoption of healthy lifestyle behaviours and to have regular (min 2 x year) review of bloods. Therefore education and preparation of patients’ pre op & postop through a series of consultations is essential. Learning is an ever-evolving life long process.

Surgery should preferably be done by a dedicated specialist unit with an interdisciplinary team who assesses the patient before the decision to proceed with surgery is made. Whilst initial management after surgery by the Clinic’s IDT is quite intense, there should be bi-directional communication between the Clinic & patient’s usual GP, with a view to eventually adopt a "shared care" model. This will assist with compliance with supplements, blood tests, healthy lifestyle habits, and include upskilling of GPs to identify "red flags" necessitating urgent referral back to the bariatric unit for a review.

Do you recommend a particular multivitamin and mineral supplement / dose?

I recommend a bariatric MV supplements bd - initially a chewable supplement: If not tolerated I would recommend a comprehensive tablet MV with higher Fe for pre-menopausal patients.

Most patients will also need additional Ca with D (preferably calcium Citrate due to reduced acid in the stomach post metabolic surgery), additional D (high level of deficiency even pre op - sitting in the sun does not treat deficiency), B12 supplementation (could be 3rd monthly injection or daily oral or sublingual) as well as Fe (mostly in menstruating women). An experienced bariatric dietitian should be advising the patients and tailoring the MV & mineral supplementation according to the patient’s individual health profile and needs, taking into account their preference for method od administration to enhance compliance. If not written elsewhere, they can be directed to the ANZMOSS website and find a suitably trained dietitian under the tab “search for a dietitian”.

Do you have any suggestions on how to find a dietitian who will help a patient with VLED? Using the DAA website to find a dietitian closer to your clinic or your patient is a good start. Most dietitians are able to initiate and review patients on a VLED. However often it's the patient that is not keen to go on an intensive phase of VLED. In a small cohort of patients, they may need small doses of adjuvant pharmacotherapy to help control hunger until they go into genuine ketosis.

Can VLED be used in conjunction with the pharmacotherapy? Or is that unsafe? Yes as with other chronic progressive diseases, need combination therapy and to escalate therapy. However, patients will require regular medical reviews especially for adjustment of medication which is sensitive to weight changes eg antihypertensive, glucose-lowering agents, thyroxine, digoxin, warfarin and some psycho-active medication etc.

Do the VLED based on bars work as well as the shakes? Yes they do, any of their products are appropriate. 3 per day in general and as long as we keep CHO <50-60 gr/d and total energy 500-800 Kcal/d. In certain situations, the dietitian may recommend 4x VLED meal replacements /day in certain population groups eg BMI >50 etc

VLED as so short term. Unless it's pre-op bariatric surgery... I don't see the point. The literature shows it is an effective medical treatment option, but I agree compliance with it long-term, is often variable. Different people have different responses and different compliance abilities to different diets or eating regimes; the plan is to find an approach that is safe, effective and sustainable for the individual. It's probably best that we avoid generalisations and assumptions.

. That's where adding pharmacotherapy afterwards for weight maintenance is important. Ask yourself, what happens when a patient stops their BP meds? Their BP goes up again....Dr Sumithran in the second webinar in this series discussed the "set point" theory of weight & why weight maintenance is the more challenging part of the journey (and when patient needs integrated health team support & ongoing regular follow up with their GP & other health care professionals). We know that obesity is a chronic and progressive condition as so with time we will need to escalate therapy, often via combination therapy and ongoing care.

What about protein load for the kidney on VLED? The total protein in a VLED is ~ 50-60 gr/d which is not as high as most people think. However it is always good to check with the patient nephrologist if the patient is on a daily protein +/- water restriction as this may affect your Mx plan. There is a specific protocol for professionals to follow RE VLED in certain population groups including CKD.

How many days after gastric sleeve sx patients can take their tablets? Sleeve & bypass: if tablet is small eg Pariet size->can take immediately postop; otherwise swap them to liquid or crushable forms; don't forget in gastric bypass patient to avoid slow release meds & oral contraceptive pill-> absorption is unpredictable & hence unreliable

Is there a limit for number of eggs one can eat per week? In theory up to 5/ week is considered ok if blood lipids remain good. Agree with variety and also individualised recommendation.

High dose of calcium is unsafe, if someone is on ca supplements, I think they should have regular ca checked, which Medicare will question. Blood calcium level is not a good indicator of what is happening in the body. I have very rarely seen abnormal Ca levels but what I do see is elevated PTH.

Remember there is malabsorption of Ca with our bariatric patients post op and 57% have pre op vitamin D deficiency (so poor absorption even pre op due to vitamin D sequestration in the fat cells).

The American ASMBS guidelines recommend 1200 - 1500 mg/d calcium including from diet and supplements - so a much higher recommendation than non-bariatric patients. Using

calcium Citrate, making sure we consider what calcium is coming from dietary sources as well as the multivitamins.

Reviewing patient's 25-OH Vit D, PTH and also DXA scan every few years (definitely all RGVP patients; some sleeve patients-refer to Bariatric Surgery webinar of this series). Medicare allows for Ca 25-OH vit d & PTH to be done twice a year, more often if you have changed their management ie. added supplements & you want to check progress/outcomes.