Practitioner Education

Learn with me

Evolving Concepts in Care

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Supporting People After Bariatric Surgery

November 2025

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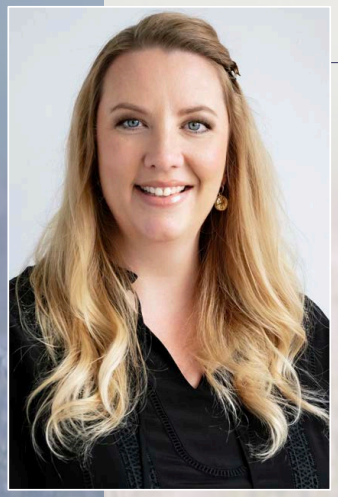

Carla Wrenn

- Degree Qualified Naturopath & Nutritionist in practice for 23 years.
- Founder of Vitae Mosaic – Naturopathic Functional Medicine practitioner training program.
- Founder of PROSPER Naturopathic Oncology supporting patients to use CM before, during & after cancer treatment & training practitioners in cancer support.
- Owner & Director of Peninsula Herbal Dispensary & Naturopathic Clinic in Mornington, Victoria.

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Learning Objectives

- Understand bariatric surgery types in Australia
- Apply integrative strategies through the 4 clinical stages
- Design safe CM and dietary care suitable for SG, RYGB, OAGB and SADI-S
- Identify nutritional, metabolic, microbiome and psychological needs post-op
- Create supportive lifestyle medicine strategies for long-term wellbeing
- Recognise red flags requiring urgent escalation

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Bariatric Support is a ‘niche’ worth exploring!

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The Basic What

Bariatric surgery is a metabolic intervention that reshapes the digestive system to assist with long-term weight loss and metabolic healing. By changing stomach size, nutrient flow and gut–brain hormonal signalling, these procedures have a profound effect on appetite, satiety, blood glucose control, inflammation, microbiome diversity and cardiometabolic risk factors.

It is not simply a “smaller stomach” procedure—it is a whole-system metabolic reset that requires lifelong nutritional and integrative support.

The Basic What

- Bariatric surgery = metabolic surgery improving weight, diabetes and cardiometabolic risk.
- Effects include reduced ghrelin, enhanced GLP-1, microbiome shifts, bile acid changes.
- Unique requirements post-surgery for wellbeing
- The Basics or better?

Australian Epidemiology

- ~16,000 procedures annually
- SG ~80%, OAGB ~11%, RYGB ~9%
- Low mortality (~0.04%)
- Strong long term weight loss achieved.

Who Is Eligible?

Criteria

- BMI ≥ 40 OR BMI ≥ 35 with comorbidities (T2D, OSA, HTN, NAFLD, OA)
- Documented weight loss attempts
- Psychological readiness
- Medically fit for anaesthesia
- Non-smoker (surgeon dependent)

Public System

- Limited access (~5% of surgeries)
- Long waitlists
- Prioritised for severe metabolic disease

Private Pathway

- GP referral → surgeon + dietitian + psychologist
- Pre-op VLED + pathology
- Out of pocket costs are $2.5–7k with insurance; $16–22k if self-funded

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Why Patients Choose Surgery

- Most effective long-term weight-loss option (25–35% TBWL)
- Diabetes remission & major metabolic improvements
- Less hunger & better satiety
- Improved mobility, sleep, joint pain, energy
- Reduces long term risks like CVD, stroke, NAFLD, cancer
- Patients exhausted by weight cycling & failed diets
- Provides structure, support & realistic long term outcomes

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Care with Compassion

- My focus is always on health gains, not shame
- Surgery is never someone's first choice
- It’s not cheating, it’s not someone's easy way
- What is the patients' goals?
- Goals framed around energy, biochemistry, metabolic markers, inflammation, mobility and QoL
- Just like with GLP-1 therapies!

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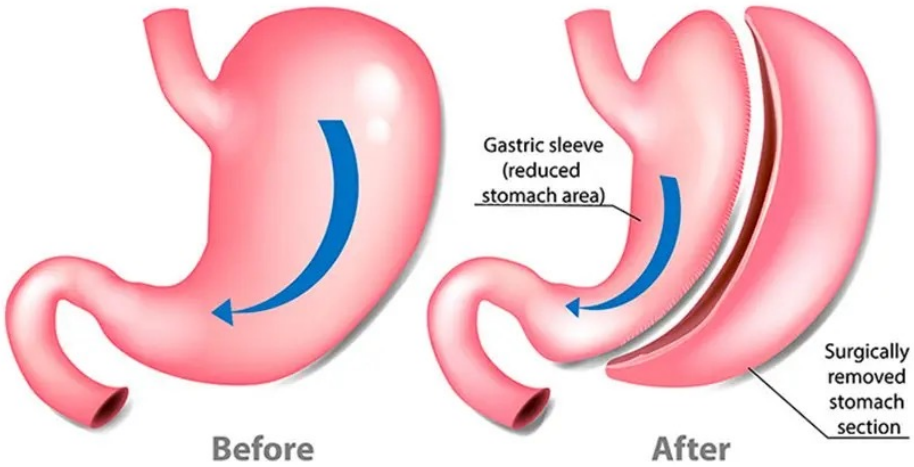
Sleeve Gastrectomy (SG)

What it is:
Removes ~75–80% of the stomach, leaving a narrow “sleeve.”
Mechanisms:
•Restrictive (smaller volume)
•Major reduction in ghrelin (hunger hormone)
•Accelerates gastric emptying
•Improves GLP-1 indirectly via rapid nutrient delivery to the small intestine
•Reduces insulin resistance
Benefits:
•Most common procedure in Australia (~80%)
•Effective weight loss similar to bypass at 5–10 years
•Lower surgical complexity
•Fewer malabsorption risks than bypass
Nutritional considerations:
•Moderate risk for **iron, B12, folate, vitamin D**
•Lower risk for fat-soluble vitamin deficiency
•Protein intake may be limited early on
Risks:
•**Reflux (up to 30%)** — key deciding factor between SG vs RYGB
•Stricture (rare)
•Staple line leak (rare but serious)
•Weight regain in some patients if sleeve dilation occurs
Who it suits:
•Patients without severe reflux
•Those preferring a lower malabsorption option



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Roux-en-Y Gastric Bypass (RYGB)

What it is:
Creates a small gastric pouch and reroutes food directly from pouch → jejunum, bypassing the duodenum.

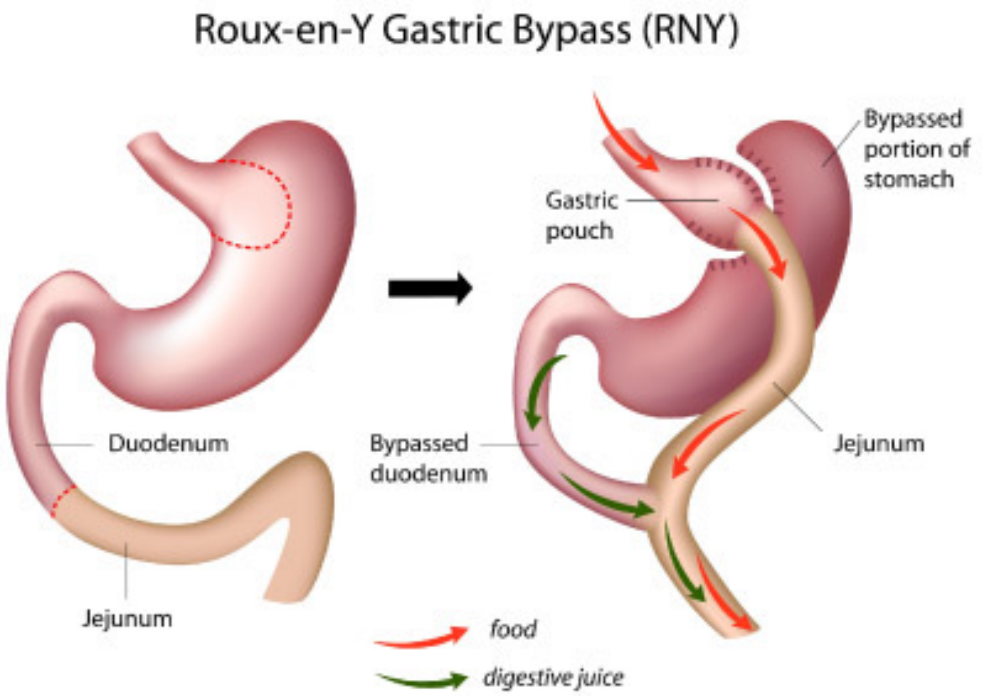
Mechanisms:
•Restrictive + mild malabsorption
•Strong hormonal effects: ↑GLP-1, ↓ghrelin
•Alters bile acids and microbiome
•Improves insulin sensitivity rapidly (often before weight loss)

Benefits:
•Best procedure for **severe reflux**, GERD, Barrett's oesophagus
•More effective for diabetes remission
•Long-term weight loss is excellent

Nutritional considerations:
High risk for:
•**Iron deficiency** (duodenum bypassed)
•**B12 & folate**
•**Calcium & vitamin D**
Medium risk for:
•**Zinc & copper**

Risks:
•**Dumping syndrome**
•Marginal ulcers
•Internal hernia (late complication)
•Anastomotic leak (early)

Who it suits:
•Patients with significant GERD
•Those with type 2 diabetes
•Those needing the strongest metabolic improvement



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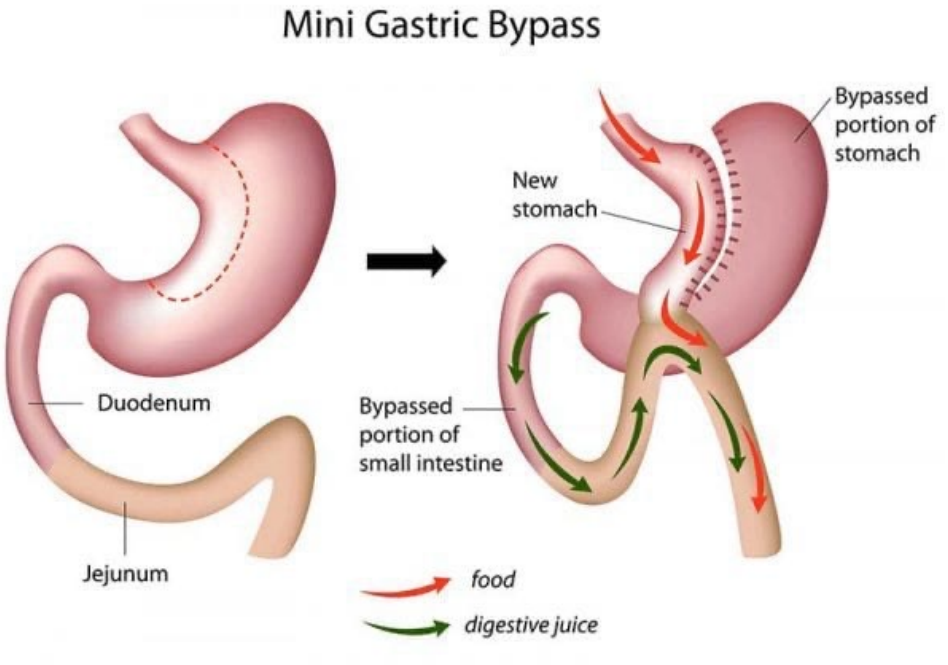
One-Anastomosis Gastric Bypass (OAGB/MGB)

What it is:
A long gastric pouch with a single anastomosis to a loop of small bowel.
Mechanisms:
•Combined restrictive and moderate malabsorptive effect
•More powerful malabsorption depending on biliopancreatic limb length
•Strong hormonal/metabolic changes (GLP-1, bile acids, microbiome)
Benefits:
•Slightly greater average weight loss vs RYGB in some cohorts
•Shorter operative time
•Effective for diabetes remission
Nutritional considerations:
Higher risk of deficiencies than RYGB:
•**Iron, B12, folate, vitamin D, calcium**
•**Zinc and copper**
•Some risk of **fat-soluble vitamins A/K** depending on limb length
Risks:
•**Bile reflux** (distinguishing risk vs RYGB)
•Marginal ulcers
•Malnutrition if limb length excessive
•Dumping syndrome
Who it suits:
•Patients needing strong weight loss/metabolic effect
•Those without significant reflux or oesophagitis



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SADI-S (Single Anastomosis Duodeno-Ileal Bypass with Sleeve)

What it is:
A sleeve gastrectomy plus a single anastomosis bypassing a large portion of the small intestine.

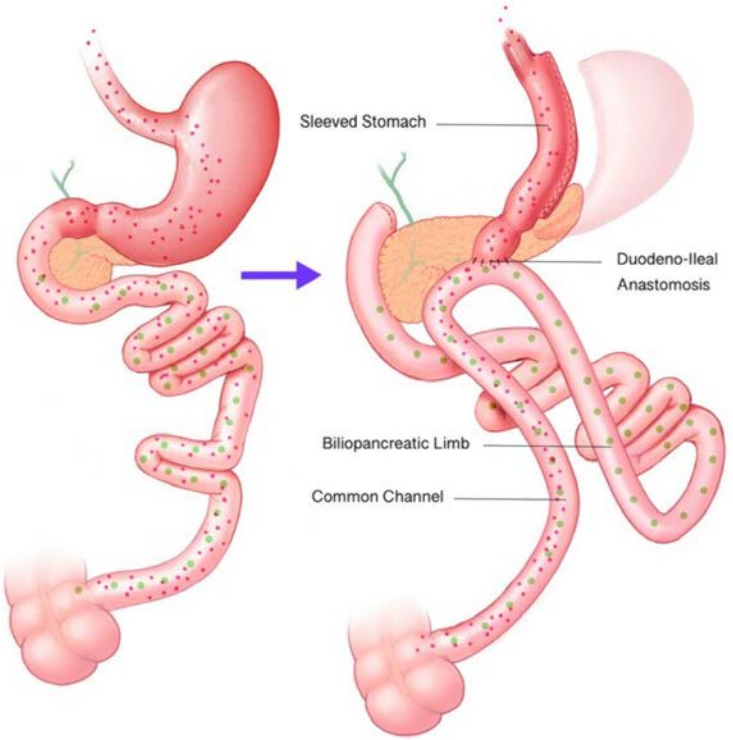
Mechanisms:
•Moderate restriction + significant malabsorption
•Strongest hormonal/metabolic effect of all four
•Major impact on GLP-1, bile acids, and insulin signalling
•Marked microbiome remodelling

Benefits:
•Highest expected total weight loss
•Most effective for severe metabolic disease
•Often used as a **revision surgery** for failed sleeve

Nutritional considerations (high-risk):
•**Fat-soluble vitamins A, D, K**
•**Calcium + PTH dysregulation**
•**Iron, B12, folate**
•**Zinc/copper**
•Protein malabsorption if intake poor

Risks:
•**Greater malnutrition risk**
•Loose stools/steatorrhoea
•Fat-soluble deficiency
•Protein malnutrition
•Lifelong intensive monitoring required

Who it suits:
•Patients with severe obesity (BMI >50)
•Those needing revisional surgery
•Patients who understand and commit to lifelong monitoring



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mercybariatrics

OBESITY SURGERY CENTRE

www.mercybariatrics.com.au

Watch Here: https://youtu.be/3lwi2mbDzWg?si=DwYhikIibFMyOsgY

Procedure Types Overview

- SG: restrictive; reflux risk.
- RYGB: mild malabsorption; dumping syndrome.
- OAGB: mixed; bile reflux risk.
- SADI-S: higher malabsorption.

Coordinated Care Map

Who & when: Surgeon, GP, bariatric dietitian, psychologist, exercise physiologist, pharmacist & Naturopath/Nutritionist

Process: Pre op optimisation → 0–6 weeks textures + symptom control → 3, 6, 12-month texture increases, symptom control + reviews → annual (forever or sooner if symptomatic).

Our CM Support Pillars

4 Key Pillars

1. **Nutrition**
2. **Supplement with Nutraceutical/Herbal Options**
3. **Movement**
4. **Lifestyle Medicine Foundations**

Integrate with prescribing team; document scope & communicate plan

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Successful Care

1. Goals - Clear & achievable
2. Food Plan - simple and varied, no orthorexia
3. Side Effect - prevention or management
4. After Care – wellbeing plan
5. Testing Schedule Post care – Pre test, 3 monthly, 6 months, annually
6. Whole Health Plan – Nutrient Optimisation, Digestive Support, Metabolism, Microbiome & Psychology

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Clinical Case Taking Plan

Weight History: trajectory, prior weight loss attempts, eating disorder history

Medications: obesogenic drugs, past/current weight-loss medications

Exercise: type, frequency, barriers to participation

Diet: overall pattern, quality, calorie-rich beverages

Sleep: quantity, quality, disturbances

Stress: physical and emotional stressors

Ethnicity and cultural background

Family History: weight-related conditions, childhood weight concerns

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Clinical Case Taking Plan

Medical: MI, CHE, CAD, COPD, asthma, PUD, hyperlipidemia, gallstones, hypothyroidism, hypertension, cancer, DVT/PE, stroke, T2DM, gout, CKD, PCOS, OSA, migraines, seizures, smoking history

Surgical: past bariatric, abdominal, gynecological procedures

Review of Systems: General, cardiac, endocrine, abdominal, pulmonary, genitourinary, psychiatric, neurologic domains

Physicals: BP, HR, neck & waist circumference, body composition, thyroid exam, hirsutism, oedema

Pathology: As outlined

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Our CM Support Pillars

CM Aims:

- Support personalised wellbeing
- Prepare for surgery
- Minimise side effects
- Maximise benefits
- If used for metabolic health, use CM to support this too
- Preserve lean mass
- Preserve/Achieve positive nutritional status
- Support improved long-term habits
- Rebuild the microbiome

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12+ Month Plan

- **Initially:** 0–6 weeks, simple diet, texture increases + symptom control
- **3 months:** symptoms, diet stage habits, adherence, pathology review
- **6 months:** weight trend, reflux/dumping, adjust iron/calcium/B12; reinforce protein/fibre for quality body composition.
- **12 months:** full pathology, discuss long term healt, plateau/maintenance, consider GLP-1 if regain occurs & is appropriate.
- **Annually:** Pathology monitoring, bone health risk; mental health screen, pregnancy counselling (generally delay 12+ months post op).

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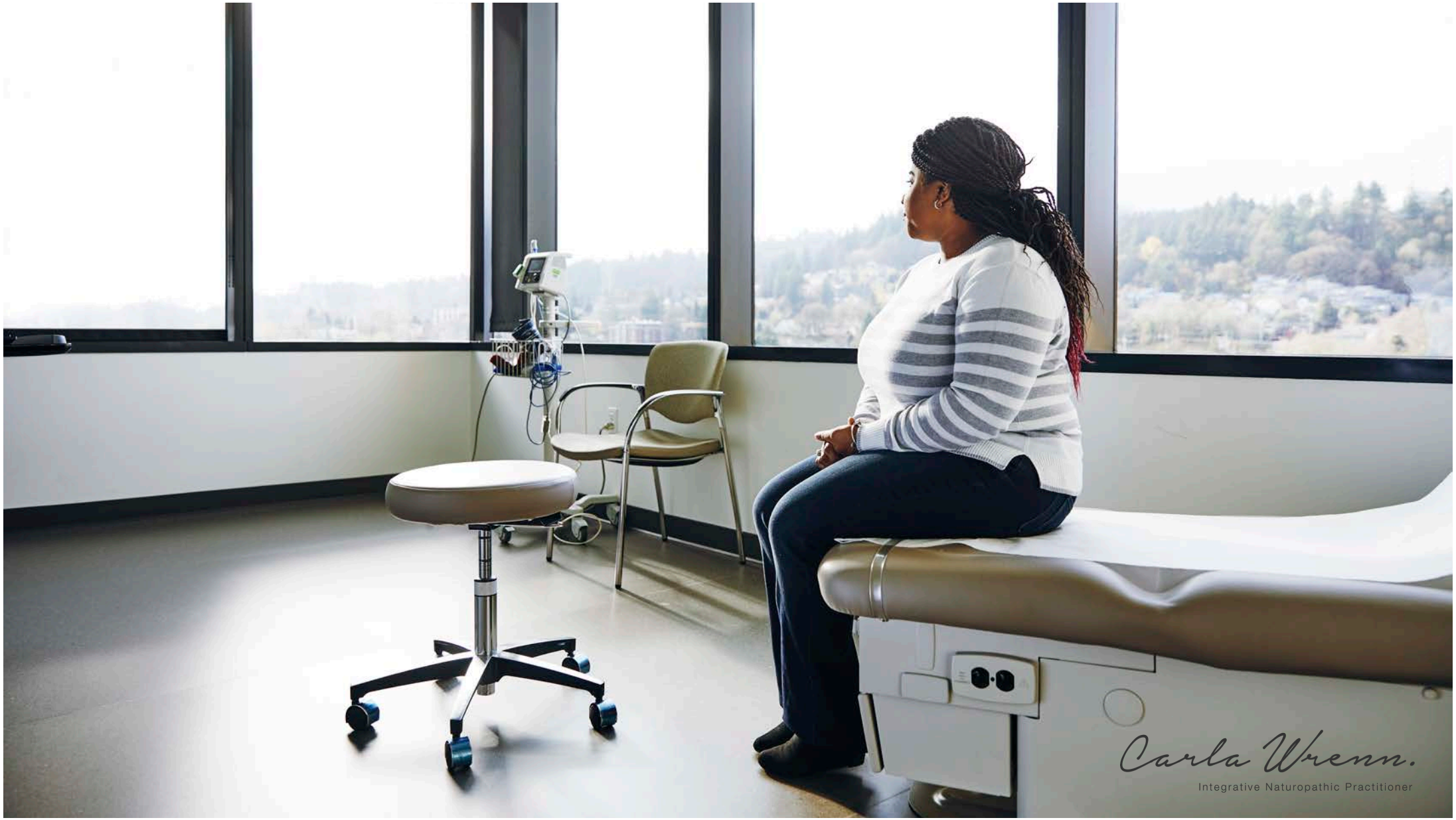
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Pre Operative Goals

1. Wellbeing
2. Marco Nutrient replete – Protein
3. Micronutrient maximized – Not just the basics
4. Pre-Surgery Plan

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Pre Operative Pathology

Most likely competed by the specialist/surgical team however I like to see:

- FBE
- GB
- HbA1c, Fasting Glucose, Fasting Insulin
- Iron, Zinc, Vitamin D, Copper, Vitamin A, Vitamin K, Folate, B12
- TSH
- ESR, hsCRP, ANA
- Homocysteine

Pre Operative Lifestyle

Teach all the lifestyle medicine steps, these are important for wellbeing pre and post surgery.

- **Nutrition/Diet – protein first eating, mindful chewing, no fluids with meals**
- **Movement**
- **Sleep**
- Rest/Relaxation/Convalescence
- Social Connections
- Spiritual Connection
- Purpose

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Pre Operative Food Plan

Australian bariatric surgery preparation, following a Very Low Energy Diet (VLED) framework commonly required by surgeons for 2–4 weeks pre-op to shrink liver size, reduce visceral fat and improve operative safety.

- Australian brands include Optifast®, Optislim®, Formulite®, Impromy®
- Wholefood Mediterranean-inspired options where appropriate
- Dietitian aligned VLED structure
- Naturopathic supportive additions
- Suitable for SG, RYGB, OAGB, SADI-S candidates
- Low-carb, high-protein, low-fat
- Bright, plant-rich, whole-food emphasis while meeting VLED rules

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Pre Operative Food Plan

Standard VLED Framework

Most Australian bariatric teams follow:

- 2–3 formulated meal replacements per day
- 1 whole-food protein + low-starch veg meal per day
- 2 cups permitted vegetables
- 1 serve fruit (optional depending on surgeon)
- 2–3 L water daily
- Electrolytes & broth allowed
- Black coffee/tea okay
- No alcohol, sugar, bread, pasta, rice, potatoes, crackers, juice

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Pre Operative Food Plan

14-Day Pre-Surgery Bariatric Food Plan

Daily Structure:

• 2–3 VLCD meal replacements

• 1 whole-food protein meal + low-starch vegetables

• 2 cups allowed vegetables

• 2–3 L water, broth, herbal teas

• No alcohol, sugar, high-carb foods, fried foods

Daily Pattern (Used Across All 14 Days):

Breakfast: VLCD shake

Lunch: VLCD shake or VLCD bar

Dinner: Lean protein (80–120 g) + non-starchy vegetables

Snacks: Broth, cucumber, celery, herbal tea

Example Whole-Food Dinners Across 14 Days:

• Grilled chicken + zucchini noodles + spinach + home made simple basil pesto

• Baked white fish + steamed green beans + lemon + cauliflower rice

• Turkey mince sautéed with tomatoes + capsicum + herbs in lettuce cups

• Tofu + bok choy + mushrooms as a stock based stir-fry

• Small portion salmon + steamed broccoli + greens

• Chicken breast + Mediterranean roasted vegetables

• Barramundi + asparagus + herb salad

Allowed Vegetables (Low-Starch): Cucumber, celery, zucchini, broccoli, cauliflower, leafy greens, green beans, asparagus, mushrooms, tomatoes.

Avoid: Alcohol, sugar, bread, pasta, rice, noodles, potatoes, sweet potato, corn, high-fat foods, takeaway, nuts, seeds, avocado.

Alternatives: Be Fit Food - Be Fit Surgery Plan *www.befitfood.com.au*

Pre Operative Food Plan

STEP 1: RAPID WEIGHT LOSS ˅ | STEP 2: GRADUAL WEIGHT LOSS ˅ | STEP 3: WEIGHT MAINTENANCE ˅ | STEP 4: HEALTHY LIVING ˅

Step 1
RAPID WEIGHT LOSS

- 820-920 calories per day
- Lose 1 – 2.5kg per week
- Replace 3 meals and 1 protein snack per day with Be Fit Food
- Add recommended extra foods and fluids

BREAKFAST | LUNCH | DINNER | SNACK | RECOMMENDED EXTRAS

PREOPERATIVE DIET

Be Rapid – Our VLCD program includes 3 meals and 2 snacks per day and is designed for rapid weight loss, with an average rate of weight loss 1-2.5kg per week. Our low carb, high protein meals are a great substitute or addition to meal replacement products throughout this phase.

SHOP 7 DAY PROGRAM | SHOP 14 DAY PROGRAM

POSTOPERATIVE DIET

There are several postoperative stages that a client must follow and Be Fit Food might be suitable in some stages (speak to our dietitians regarding meal selections)

SHOP MEAL BUNDLES

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Bariatric Essentials

- VLED Framework - Optifast®, Optislim®, Formulite®, Impromy®
- Bariatric Multivitamin - BN Multi, NutriChew, Formulite Multivitamin

(depending on surgeon preference)

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CM Bariatric Boost In Pre & Post Op

1. MediHerb Poly C
2. Protein Powder – Collagen & Biofermented Vegan
3. Orthoplex Children's Essentials

Post Op Additions:

- Orthoplex BioActive Lipids
- MultiGen Biotic Powder &/or MG Meta Control Probiotic
- MediHerb PolyPhenol Circ Support
- MediHerb Tissue Regenex (Crushed)
- Iberogast
- PHGG
- Electrolytes (LMNT or Sodii)

CM Bariatric Boost

- Iron
- Vitamin D
- Calcium
- Magnesium
- Activated B12
- Activated B9
- Vitamin B Complex with B1
- Protein Powder – Collagen & Biofermented Vegan
- Omega 3 (stop 7 days before surgery)
- Probiotic
- PHGG
- Electrolytes (LMNT or Sodii)

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Immediate post-op pathway (0–6+ weeks)

Basic dietary texture progression:

- **Stage 1 Fluids** (~2 weeks): hydration 1.5–2 L/day, protein liquids.
- **Stage 2 Purée → Stage 3 Soft** (by ~4 weeks)
- **Stage 4 Solids** (~6 weeks) with small, protein-first meals, avoid grazing & drinking with meals.
- Lifelong Plan

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Stage 1

- Days 1–7: Clear fluids only.
- Goals: hydration, electrolyte balance, gentle protein introduction.
- Dehydration, persistent vomiting, tachycardia, fever, dizziness.

Stage 1 — Clear Fluids (Days 1–7 Post-Op)

Goal: Hydration, gentle electrolytes, minimal sugar, small frequent sips only.

Daily Structure:

• Sip 50–100 mL every 15 minutes

• Aim for 1.5–2 L total fluid

• Prioritise electrolytes and clear protein waters

Day 1

• Warm weak vegetable broth (zucchini, celery, carrot strained)

• Sugar-free electrolyte drink

• Peppermint tea

• Weak ginger tea

• Water

Day 2

• Clear chicken bone broth (strained well)

• Hydralyte

• Chamomile tea

• Water

• Clear protein water (10–15 g protein total for the day)

Day 3

• Vegetable mineral broth

• Weak green tea

• Clear protein water

• Lemon-infused water

• Hydration salts

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Common Side Effects & Complications

1. Dumping (mostly bypass/OAGB) - light-headedness, palpitations, GI upset. *Plan:* small portions, protein first, limit refined sugars; consider soluble fibre with meals; discuss acarbose via GP if persistent.
2. Reactive hypoglycaemia (late dumping) - pair carbs with protein/fat; avoid liquid sugars; monitor; endocrinology input for refractory cases.
3. Reflux (SG/OAGB)- persistent cases may need endoscopy/surgical review. Gallstones/diarrhoea/steatorrhoea (malabsorptive): fat management, oxalate reduction if kidney stone risk; surgeon/gastro for meds.
4. Hair shedding (telogen effluvium) - reassure (3–6 months), ensure protein, ferritin >50–70 µg/L, zinc/B12/folate/thyroid adequate—do not add high-B6 beauty formulas.

PMID: 36441432

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Common Side Effects & Complications

Nutrient deficiency patterns:

- Iron, B12, folate, vit D, calcium across procedures;
- A, K, zinc, copper with more malabsorption;
- Thiamine (B1) during vomiting/poor intake—treat urgently.

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Red Flags (urgent referral to surgeon/ED)

- Persistent vomiting or inability to keep down fluids this risks thiamine deficiency/Wernicke's patient needs medical care to be give parenteral thiamine before glucose in an urgent review.
- Tachycardia
- Fever
- Severe abdominal pain
- Generalised pain
- Shoulder tip pain
- Dyspnoea
- GI bleeding—consider leak/bleed/PE. Neurological symptoms (confusion, ataxia, neuropathy, vision changes)
- Severe dehydration
- Intractable hypoglycaemia
- Sudden dysphagia/obstruction
- Progressive anaemia
- Pregnancy <12 months post-op
- Substance use
- Suicidality

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Stage 2

- Weeks 2–3 (day 8-21) : Purée stage.
- Goals: smooth textures, protein focus, gentle plants.
- Silky soups, blended poultry/fish, yoghurt, ricotta, lentil purées.
- Intolerances, nausea, reflux, vomiting, thiamine concerns.

Stage 2 — Purée Foods (Weeks 2–3 Post-Op)

Goal: Smooth, soft, spoon-thick foods that prioritise protein and gentle plant-based nutrition.

No lumps, skins, seeds, or raw vegetables.

Daily Structure:

• 3–6 small meals per day (2–4 tbsp each)

• Protein target: 60–80 g/day (from shakes + purées)

• Fluids between meals only (separate by 20–30 minutes)

Day 1

• Breakfast: Greek yoghurt blended smooth with cinnamon

• Snack: Smooth protein shake

• Lunch: Puréed pumpkin + white bean soup

• Snack: Ricotta purée

• Dinner: Chicken + zucchini purée (blended)

Day 2

• Breakfast: Silken tofu blended with vanilla

• Snack: Protein shake

• Lunch: Puréed lentil + tomato soup

• Snack: Cottage cheese purée

• Dinner: Puréed Mediterranean vegetables + poached fish

Day 3

• Breakfast: Yoghurt + blended stewed fruit

• Snack: Protein shake

• Lunch: Puréed roasted capsicum + cannellini bean soup

• Snack: Pureed pear + yoghurt

Longer Term Supplement Plan - Minimum

Supplementation (use TGA-listed bariatric formulations)

- Daily bariatric multivitamin to start within 1–2 wks, ideally before surgery. bariatric-formulated options.
- Cautions excess B6 neurotoxicity - >10 mg/d from extra products.
- Calcium + D typically calcium citrate in divided doses as per pathology, separate from iron.
- Iron: menstruating patients often need, dose to ferritin/TSAT and tolerance.
- Vitamin B12: oral high-dose daily or IM 3-monthly if levels/absorption issues.
- Fat-soluble vitamins (A/D/K), zinc, copper: consider with bypass/OAGB/SADI-S per labs.
- Multi - Prefer bariatric-specific, TGA-listed multis that meet bariatric nutrient needs (not generic adult multis), avoid high-B6 “hair/skin/nails” blends, separate calcium if not in the multi.

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CM Bariatric Boost In Practice

- Orthoplex Childrens Essentials
- Orthoplex Pure D Drops
- NaturoBest Calcium & Magnesium + K2
- Protein Powder – Collagen & Biofermented Vegan
- Orthoplex BioActive Lipids Liquid
- MultiGen Biotic Powder &/or MG Meta Control Probiotic
- MediHerb Wholefood Multi
- Iberogast
- PHGG
- Electrolytes (LMNT or Sodii)
- Medi Herb Fe MAX Liquid

Stage 3

- Weeks 3–6: Soft foods.
- Goals: Fork-tender textures.
- Soft eggs, lentils, slow-cooked meats, soft fish, mashed vegetables.
- Reflux escalation, dumping, poor tolerance.

Stage 3 — Soft Foods (Weeks 3–6 Post-Op)

Goal: Transition to soft, moist, fork tender foods. Prioritise protein, hydration and tolerance building.

Avoid raw vegetables, nuts, skins, bread, pasta and rice.

Daily Structure:

• 3–5 small meals/day (¼–½ cup per serve)

• Protein first at every meal (60–80 g/day target)

• Fluids between meals only

Day 1

• Breakfast: Soft scrambled eggs with ricotta

• Snack: Greek yoghurt

• Lunch: Flaked baked salmon + mashed sweet potato

• Snack: Cottage cheese

• Dinner: Slow-cooked chicken thigh + mashed pumpkin

Day 2

• Breakfast: Overnight oats (soft, soaked well)

• Snack: Protein shake

• Lunch: Soft lentil stew

• Snack: Mashed banana with yoghurt

• Dinner: White fish + well-cooked zucchini

Day 3

• Breakfast: Yoghurt + puréed stewed fruit

• Snack: Soft cheese

• Lunch: Turkey mince in soft tomato sauce

• Snack: Protein pudding

Stage 4

- 6 weeks+: Solid food reintroduction.
- Goals: Protein first; Med-style diet.
- Lean proteins, cooked then raw veg, legumes, whole grains (small amounts).
- Dysphagia, obstruction, hypoglycaemia, weight regain patterns.

Stage 4 — Solid Foods (6 Weeks and Beyond)

Goal: Transition to a lifelong whole-food Mediterranean-style diet focused on lean proteins, plants and mindful eating.

Continue small portions, chew well and prioritise protein first.

Daily Structure:

• 3–5 small balanced meals per day (½–1 cup portions)

• Fluids between meals only (separate by 20–30 minutes)

• Continue bariatric & CM supplements

Day 1

• Breakfast: Greek yoghurt + chia (1 tsp) + soft berries

• Snack: Boiled egg

• Lunch: Grilled salmon + roasted vegetables

• Snack: Cottage cheese + tomato

• Dinner: Chicken breast with lemon, oregano, and steamed greens

Day 2

• Breakfast: 2-egg omelette with spinach & feta

• Snack: Small serve soft fruit

• Lunch: Lentil & tomato stew

• Snack: Hummus with soft cucumber

• Dinner: Baked cod + roasted capsicum + zucchini

Day 3

• Breakfast: Protein smoothie (berries, yoghurt, protein powder)

• Snack: Cheese slice + a few olives

• Lunch: Turkey meatballs + tomato basil sauce

Dietary Pattern After Solids Phase (Lifelong)

Principles that work

- **Protein priority** (generally 60–80 g/day; higher if physically active lifestyle), then non starchy veg, then low-GI carbs; fluids between meals.
- **Fibre** re build for microbiome & bowel regularity, slow titration up with prebiotic veggies, oats, chia and PHGG).
- **Meal structure** 3 small meals + 1–2 planned protein snacks, avoid grazing.
- **Alcohol caution** due to rapid absorption and increased intoxication
- **NSAIDs caution** there is an increased ulcer risk in bypass surgeries.

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Successful Care

1. Goals - Clear & achievable
2. Food Plan - simple and varied, no orthorexia
3. Side Effect - prevention or management
4. After Care – wellbeing plan
5. Testing Schedule Post Care – Pre test, 3 monthly, 6 months, annually
6. Whole Health Plan – Nutrient Optimisation, Digestive Support, Metabolism, Microbiome & Psychology

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CM Toolkit - Managing Nausea

- Ginger tea/ chewable capsules - before meals
- Peppermint tea/aromatherapy
- Cinnamon aromatherapy
- M&P Nausea Relief Spray
- Iberogast®- before meals
- Digestive Enzymes
- Separate Drinks & Food
- Tiny sips or room-temp fluids

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CM Toolkit - Managing Reflux (esp. SG/OAGB):

- PPI via surgeon
- Iberogast®- before meals
- Digestive enzymes
- Eat earlier
- Smaller portions
- Avoid excess fluids before bed &/or elevate bedhead
- Elevate head of bed for reflux
- Slippery Elm

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CM Toolkit – Managing Constipation

- Fluids
- Iberogast®- before meals
- Gentle fibre progression from PHGG to Psyllium as tolerated ie. DFH Paleo Fibre – before bed
- Magnesium citrate/glycinate
- Activate Probiotics Biome Lax or preferred probiotics for bowel regularity
- Smaller portions chewed well
- Movement/exercise

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CM Toolkit – Body Composition

Orthoplex SarcoCare

BioMedica Protein Complete

Digestive enzymes

Eat proteins first

Protein with 2 meals and 1-2 snack daily

Movement

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Microbiome in Bariatrics

General Steps

1. Increase diversity with plant intake ASAP
2. PHGG
3. Probiotics
4. Poly Phenols

Testing – what's your preferred testing?

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> Obes Surg. 2019 Jul;29(7):2338-2349. doi: 10.1007/s11695-019-03863-y.

The Importance of the Microbiome in Bariatric Surgery: a Systematic Review

Josianne C H B M Luijten [1], Guusje Vugts [2], Grard A P Nieuwenhuijzen [2], Misha D P Luyer [3]

Affiliations + expand

PMID: 30982169 DOI: 10.1007/s11695-019-03863-y

Abstract

Bariatric surgery results in sustained weight loss, improvement of metabolic and hormonal changes, and reduction of comorbidities in obese patients. However, beneficial effects of bariatric surgery are not solely explained by restriction and malabsorption induced by surgery itself. Changes in the microbiome might play a role in this mechanism. A systematic review was performed in which 21 studies were included. The microbiome was affected by surgery and profound changes occurred in the first year of follow-up. An increase in Bacteroides and Proteobacteria and a decrease in Firmicutes were observed postoperatively in most studies. These changes were associated with weight loss. Bariatric surgery induces profound changes in the microbiome. This may be related to the beneficial effect of bariatric surgery on comorbidities associated with obesity.

Keywords: Bariatric surgery; Comorbidities; Gut microbiome; Roux-en-Y gastric bypass (RYGB); Sleeve gastrectomy (SG); Type 2 diabetes; Weight loss.

Comparative Study > Surg Obes Relat Dis. 2019 Nov;15(11):1888-1895.
doi: 10.1016/j.soard.2019.08.551. Epub 2019 Sep 11.

Gut microbiota adaptation after weight loss by Roux-en-Y gastric bypass or sleeve gastrectomy bariatric surgeries

Lidia Sánchez-Alcoholado [1], Carolina Gutiérrez-Repiso [1], Ana María Gómez-Pérez [2], Eduardo García-Fuentes [3], Francisco J Tinahones [4], Isabel Moreno-Indias [5]

Affiliations + expand

PMID: 31648978 DOI: 10.1016/j.soard.2019.08.551

Background: Gut microbiota could be involved in the metabolic improvement after surgery.

Objective: The aim of the present study was to evaluate the short-term evolution of the gut microbiome after different bariatric surgery procedures and their functionality and relate it with obesity resolution.

Setting: University hospital, Spain.

Methods: We studied 28 patients with severe obesity; 14 underwent a Roux-en-Y gastric bypass (RYGB) and 14 underwent laparoscopic sleeve gastrectomy (SG). All patients were examined before and 3 months after the correspondent bariatric surgery. Gut microbiome profile was assessed by the sequencing of amplicons from the 16S rDNA gene by next-generation sequencing.

Results: Gut microbiota profiles significantly differed between surgical procedures. RYGB suffered the largest changes in the microbiota population. SG and RYGB differed in their profiles with higher levels of Akkermansia, Eubacterium, Haemophilus, and Blautia for SG, while Veillonella, Slackia, Granucatiella, and Acidaminococcus occurred with greater levels in RYGB. RYGB microbiota changes were reflected also at the level of functionality, especially in pathways related to environmental adaptation. A biomarker discovery analysis revealed the genus Blautia as characteristic in SG, while Veillonella was of RYGB.

Conclusion: Our study shows a shift of the gut microbiome after a bariatric surgery in a procedure-related manner. Gut microbiome changes are related to the adaptation to the changing gut environment and could be related to the pH fluctuations.

> Arq Bras Cir Dig. 2022 Dec 19:35:e1707. doi: 10.1590/0102-672020220002e1707.
eCollection 2022.

THE INTESTINAL MICROBIOME IN PATIENTS UNDERGOING BARIATRIC SURGERY: A SYSTEMATIC REVIEW

João Kleber Almeida Gentile [1 2], Karen Danielle Oliveira [3], Júlia Guimarães Pereira [4], Daniel Yuji Tanaka [4], Giovanna Nagatsuka Guidini [4], Melissa Zanetti Cadona [4], Diego Werneck Siriani-Ribeiro [4], Mariana Tafner Perondini [4]

Affiliations + expand

PMID: 36542005 PMCID: PMC9767418 DOI: 10.1590/0102-672020220002e1707

Conclusions: The intestinal microbiota is an important influencer in the regulation of the digestive tract, and obese individuals with comorbidities (diabetes mellitus, hypercholesterolemia, and metabolic syndrome) present important alterations, with an unbalance normal state, generating dysbiosis and the proliferation of bacterial species that favor the appearance of new diseases. Patients who undergo bariatric surgery present an improvement in the intestinal microbiota imbalance as well as reversibility of their comorbidities, increasing their life expectancy.

Metabolic Health

Assessment & management with a CGM?

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Obes Surg. 2023 Aug;33(8):2573-2582. doi: 10.1007/s11695-023-06704-1. Epub 2023 Jul 6.

Use of Continuous Glucose Monitoring in Patients Following Bariatric Surgery: A Scoping Review

Yang Yu [1], Susan W Groth [2]

Affiliations + expand

PMID: 37410260 DOI: 10.1007/s11695-023-06704-1

Abstract

The objective of this scoping review was to summarize the emerging literature on the use of continuous glucose monitoring (CGM) in post-bariatric surgery patients, with a focus on its features (e.g., device, mode, and accuracy), as well as purposes and outcomes of utilization. Three databases (PubMed, EMBASE, and Web of Science) were searched to obtain relevant studies. Results suggested that most studies used CGM for 3-7 days under blinded mode. Accuracy data were available in only one study, which reported a mean absolute relative difference of 21.7% for Freestyle Libre. The primary applications of CGM were for elucidating glucose patterns and assessing glycemic treatment outcomes. No study has tested the effect of CGM as an intervention strategy to enhance glucose control.

Mental Health

Screen for depression, anxiety, substance transfer, disordered eating.

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> Front Endocrinol (Lausanne). 2023 Nov 2:14:1283621. doi: 10.3389/fendo.2023.1283621. eCollection 2023.

Bariatric surgery and mental health outcomes: an umbrella review

Saikam Law [1] [2], Shiliang Dong [1], Fuqing Zhou [1], Dexi Zheng [3], Cunchuan Wang [1], Zhiyong Dong [1]

Affiliations + expand

PMID: 38027159 PMCID: PMC10653334 DOI: 10.3389/fendo.2023.1283621

Conclusion: Bariatric surgery is beneficial for improving most mental health-related outcomes. However, we should be cautious about the increased risk of adverse mental health after surgery, such as suicide, self-harm, and AUD.

Lifestyle Medicine Steps

- Sleep – Aim for 7–9 h with consistent schedule and morning light exposure.
- Stress – Regulate with breathwork, mindfulness or nature time.
- Movement - Early walking → gradual resistance. Avoid high-impact early. Exercise Physiology is essential!
- Social support – Great for accountability
- Purpose

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“Integrative CM CARE optimises safety, results nutrients, metabolic health, wellbeing & long-term success.”

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Monitoring Framework (A Program!)

- Initial 4+ weeks Before Procedure
- Immediately Before Procedure
- 7-14 Days Post Procedure
- 30 Day Post Procedure
- 3, 6, 12 Months Post Procedure (with pathology)
- Annually (with pathology)
- Adjust based on symptom needs incl. pregnancy & co-morbidities

Longer Term Pathology Plan

Every 3–6 months in year 1, then annually

Earlier if symptomatic/pregnant/revisional surgery needs.

- FBE
- ferritin/iron studies
- B12, Folate, vitamin D, Calcium, Zinc, Copper, Vitamin A, Thiamine
- PTH
- LFTs,
- GB
- HbA1c

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Progressive Prescriptions

- Blood Glucose Regulation – Berberine, Myo-Inositol & Chromium
- GB and Liver Support
- Inflammation – SPMs & N-Regenex
- Personalised Probiotics – Gut Health, assessment?
- HMB
- Digestive Enzymes & Bitter Foods
- Adaptogens

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Take Home Messages

- Hundreds of people need our support.
- CM helps people undergoing bariatric surgery improve their health and wellbeing in the short & long term.
- Body-positive, personalised & health focussed framing is essentials.
- Clear framework for consults/program around stages and pathology review.
- Know the red flags & coordinate with prescribers.
- Collaboration is essential.

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