

Follow-Up advice Post Discharge after Bariatric Surgery

The following guidance is for general practitioners, practice nurses, and other health professionals who may care for patients who have undergone bariatric surgery. In particular: laparoscopic One Anastomosis gastric bypass (OAGB), Roux-en-Y gastric bypass (LRYGB) or laparoscopic Sleeve Gastrectomy (LSG) surgery, and who have completed their two year post surgery follow-up.

If you have any questions, please do not hesitate to contact me at markgrant@southernweightloss.co.nz

After weight loss surgery, we endeavour to follow our patients up for 2 years; their first follow up being at 6 weeks and subsequent visits are at 4, 8, 12, 18 months and 2 years post-operatively. However, we have found occasionally that patients, for various reasons, fail to come back to us and we are then unable to keep our routine follow up.

In general, patients who are a more than a year post bariatric surgery should be relatively stable from a nutritional and vitamin perspective. Regular vitamin supplementation and nutritional monitoring is necessary however to prevent and micronutrient deficiency. With SWL patients have worked closely with Helen Gibbs at Diet consulting to help educate them on what is required to eat appropriately after bariatric surgery

Vitamins

All patients who have undergone bariatric surgery require lifelong vitamin supplementation with a multivitamin and calcium. Most of the over counter multivitamins available in New Zealand are not sufficient for

Patients post bariatric surgery.

Our current recommendations are either **Bariatric multivitamins** at a dose of **one or two chewable/capsules daily** available through:

www.tric.co.nz

www.bnhealthy.co.nz

Barilife.co.nz

Mynewtum.co.nz

Or two tablets of **Centrum Advance multivitamin** a day. Centrum Advance does not have sufficient concentrations of vitamin B12 for most patients following Bypass surgery. All patients also require **calcium carbonate** at a dose of 500mg of elemental calcium twice a day, if their Parathyroid hormone levels are high, and your patients should take these at least 2 hours apart from any iron supplements.

Vitamin B12 is required for patients who have had LRYGB/OAGB and who are not taking a bariatric multivitamin. Alternatively, those patients with low vitamin B12 on testing. It can be given as an intramuscular injection of 1mg every 3 months, or alternatively patients can take 1000mcg B12 sublingual oral drops once daily

Iron is not given routinely, may be required by menstruating women. Iron should be given to any patient with low or falling ferritin on testing.

Maintenance dose is: **Ferro-tab** (Ferrous Sulphate 200mg/65mg elemental) once daily

Replacement therapy: **Ferro-grad** (Ferrous Sulphate 325mg/105mg elemental) once daily.

Those patients who experience constipation we recommend the **self-funded Ferro-grad C** (Ferrous Sulphate 325mg/105mg elemental containing 500mg Vitamin C).

If iron stores are not maintained despite supplementation then causes of blood loss should be investigated (GI, menstruation) and the patient should be referred for parenteral iron infusion.

In the south, **vitamin D deficiency is common** during the winter months. **Vitamin D** should be prescribed if testing reveals a deficiency.

[Why do I need to take multi vitamins after bariatric surgery? - Southern Weight Loss and Laparoscopy Limited](#)

Blood Testing

If nutritionally stable at discharge patients should only need laboratory blood testing once per year. Blood tests should be done more frequently for those with symptoms suggestive of a vitamin deficiency, pregnancy, or following supplementation of a deficiency.

Due to the potential for deficiencies post bypass surgery, periodic laboratory testing is required on a Yearly basis for:

CBC Thyroid Function tests

LIVER FUNCT. HbA1c

Na / K

Lipids

RENAL Zinc

Ferritin

B12/Folate

Ca⁺⁺/PHOS.

As of 2024 we have sent electronic repeating requests to Awanui labs for our patients, We have copied their GP into these results. We ask that you look keep an eye out for them.

Copper, selenium and zinc should also be measured if there are unexplained anaemias, neurological symptoms, taste changes, hair loss or poor wound healing.

Pregnancy

Fortunately, bariatric surgery reduces the following risks of most pregnancy complications. It can be difficult for patients who have had bariatric surgery to meet their increased nutritional requirements during pregnancy. Consequently, having undergone Bariatric surgery does represent a risk for low birth weight babies and small risks of foetal malformations related to vitamin deficiencies (e.g. folate deficiency, vitamin A toxicity). We recommend these should be referred to back to their bariatric dietitian prior to conception, and should have their pregnancy managed in conjunction with a high-risk obstetrician.

If this is not possible, recommended daily vitamin intake should be **Bariatric formulated Multivitamin OR 2 centrum advance multivitamin**. In addition to this **foliac acid 0.8mg + iodine 150mcg** is necessary to increase the folate supplementation without exceeding vitamin A daily dose limits. Alternatively, Elevit with Iodine supplement can be given instead of the foliac acid and iodine supplements, all with the bariatric multivitamin.

Thiamine deficiency needs to be considered in any patient with intractable vomiting or poor oral intake. Urgent referral for IV thiamine replacement should be made in these circumstances

As patients lose weight, they may also need their blood pressure monitored and medications such as anti-hypertensive reduced. Because of the small gastric pouch and direct entry of food into the small bowel, random blood sugars may be high. However, these patients should never have a glucose tolerance test - they will "dump" severely.

These patients are also more susceptible to ulceration if they take steroids, NSAIDS , long term Aspirin or are smokers. If you are commencing them on any of these medications, please ensure that they are given Pantoprazole as well.

Rapid weight loss is a risk factor for the development of **gallstones**. Suspicious symptoms should be investigated by ultrasound, and surgical referral indicated if diagnosed. Cholecystectomy should ideally be performed by a bariatric surgeon who can check the anatomy of the bariatric procedure at the time of cholecystectomy along with performing a cholangiogram.

It is important that any unexplained abdominal pain should ideally investigated by a bariatric surgeon. Due to the reconfiguration of the small bowel there is a three percent per annum risk of symptomatic internal hernia or intussusception resulting in an obstruction after LRYGB. This may have an atypical presentation such as left upper post-prandial abdominal pain. It may not be clear on a plain abdominal radiology.

Anastomotic ulcer can occur late after gastric bypass and present as epigastric pain in eating, rarely Meleana or haematemesis, dysphagia or perforation. These are more common in smokers and those taking NSAID's. This should be investigated by endoscopy.

Counselling regarding smoking cessation and avoidance of NSAID's is important to prevent anastomotic ulcers, which can occur at any point after surgery.

Gastro-oesophageal reflux symptoms are common after LSG. These can usually be managed with proton pump inhibitors. Persistent or severe symptoms should be investigated by a bariatric surgeon.

Vomiting after meals is not uncommon as are foamies, these are often the result of overeating or eating too fast, however can have a surgical cause. Please consider referral to a bariatric surgeon or dietitian.

Excess skin is common after significant weight loss. Patients should delay any body contouring surgery until their weight is stable, preferably two years after their bariatric surgery. After this time, referral to a plastic and reconstructive surgeon may be considered. For more information, please see:

[RECONSTRUCTIVE SURGERY AFTER WEIGHT LOSS - Southern Weight Loss and Laparoscopy Limited](#)

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