

# GP Guidance for managing patients post Gastric Bypass

## Dunedin | Otago | Southland General Practice

What is a Gastric Bypass?

Gastric Bypass (GB) is a combined **restrictive and malabsorptive** bariatric procedure.

The operation involves:

- Creating a small gastric pouch (30–50 mL)
- Dividing the small intestine
- Connecting the pouch to a small bowel limb
- Bypassing much of the stomach, duodenum, and proximal jejunum

### **Mechanism of action**

- Restriction of intake
- Altered gut hormones (GLP-1 rise)
- Reduced ghrelin signalling
- Mild–moderate macronutrient malabsorption
- Significant improvement in insulin sensitivity

Compared with sleeve gastrectomy, a bypass produces **greater metabolic effect**, particularly for type 2 diabetes and severe reflux disease.

For GPs in Dunedin and across Otago, structured long-term follow-up is essential due to the malabsorptive component.

# Expected weight loss after Gastric Bypass

**How much weight should patients lose after gastric bypass?**

Weight loss is measured as % **Total Body Weight Loss (TBWL)**.

<b>Time post-op</b>	<b>Expected TBWL</b>	<b>Clinical interpretation</b>
1 month	10–15%	Rapid early phase
4 months	22–30%	Strong metabolic response
8 months	30–38%	Ongoing loss
12 months	32–40%	Plateau common

Most patients achieve **65–75% excess weight loss** at 12 months.

### **Concerning patterns**

- <15% TBWL at 6 months
- Ongoing vomiting
- Rapid unexplained weight loss
- Failure of diabetes improvement

## **Early and late complications after Gastric Bypass**

### **Early (<30 days)**

- Anastomotic leak
- Intra-abdominal collection
- Bleeding
- Pulmonary embolism

### **Late complications**

- Internal hernia
- Marginal ulcer
- Small bowel obstruction
- Iron deficiency anaemia
- Vitamin B12 deficiency
- Calcium deficiency
- Hypoglycaemia (late dumping)
- Protein malnutrition

Internal hernia risk is unique to bypass and must be considered in any patient with intermittent abdominal pain.

## **Red flag symptoms after Gastric Bypass**

**Urgent same-day referral required if:**

- Persistent tachycardia >100 bpm
- Severe abdominal pain (especially colicky/intermittent)
- Fever
- Persistent vomiting
- Haematemesis or melaena
- Severe dysphagia
- Chest pain or dyspnoea
- Unexplained hypoglycaemia
- Signs of dehydration

Intermittent severe abdominal pain in a post-bypass patient should raise suspicion for **internal hernia**, even if CT imaging is initially normal.

If unstable in Otago → refer to Dunedin Hospital ED.

## When to refer to public hospital

Immediate referral if:

- Suspected leak
- Suspected internal hernia
- Small bowel obstruction
- GI bleeding
- Severe symptomatic anaemia (Hb <90 g/L)
- Neurological symptoms of deficiency
- Intractable marginal ulcer
- Severe malnutrition

Internal hernia is a surgical emergency.

## Recommended supplementation after Gastric Bypass (NZ)

**Are lifelong vitamins mandatory after bypass?**

Yes: absolutely.

Due to bypass of the duodenum and proximal jejunum, micronutrient deficiency risk is higher than sleeve.

### Core regimen

- Bariatric multivitamin (daily, high potency)
- Vitamin B12 (oral high dose or IM 3-monthly)
- Calcium citrate 1200–1500 mg/day

- Vitamin D 2000–3000 IU daily (adjust to levels)
- Iron supplementation (routine in menstruating women)
- Consider additional thiamine if vomiting risk

## NZ Bariatric supplement providers

- BariLife
- BNHealthy
- My New Tums
- TRIC

Calcium citrate is preferred over carbonate due to improved absorption in low-acid environments.

## Post-Bypass blood test monitoring schedule

What blood tests should GPs order after gastric bypass?

Time Point	Tests to Request	Clinical Purpose
<b>1 month</b>	FBC, U&E, LFT, Iron studies, B12, Folate, Vitamin D	Early anaemia, hydration, baseline nutrition
<b>4 months</b>	FBC, Iron studies, B12, Folate, Vitamin D, HbA1c, Lipids, LFT	Monitor metabolic improvement and emerging deficiencies
<b>8 months</b>	FBC, Iron studies, B12, Folate, Vitamin D, Calcium, PTH, Albumin	Detect iron depletion, calcium imbalance
<b>12 months</b>	FBC, Iron studies, B12, Folate, Vitamin D, Calcium, PTH, HbA1c, Lipids, Zinc, Copper, Thiamine	Comprehensive annual nutritional review
<b>After 2 years (Annually)</b>	FBC, Iron studies, B12, Folate, Vitamin D, Calcium, PTH, HbA1c, Lipids, Zinc	Lifelong surveillance

Increase frequency if:

- Pregnancy
- Vegetarian diet
- Recurrent vomiting
- Ongoing PPI use
- Symptoms of neuropathy

# Dumping syndrome and hypoglycaemia

Bypass patients may experience:

## **Early dumping (10–30 mins post-meal):**

Tachycardia, flushing, diarrhoea.

## **Late dumping (1–3 hours):**

Reactive hypoglycaemia.

Management:

- Small frequent meals
- Protein first
- Avoid refined carbohydrates
- Dietitian referral

## Medication review

- Avoid NSAIDs (marginal ulcer risk)
- Reduce insulin early post-op
- Review antihypertensives
- Avoid extended-release medications

## Key GP summary for Dunedin and Otago

- Expect 32–40% TBWL at 12 months
- Lifelong micronutrient supplementation mandatory
- Structured blood monitoring at 1, 4, 8, 12 months, then annually
- Intermittent abdominal pain = consider internal hernia
- Tachycardia + pain = emergency referral
- Annual lifelong nutritional surveillance essential

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