Gastric Bypass Surgery

Even as a Last Resort it Can Change Your Life

By Chris Mercier

For most of her life, Shelley Hanson has struggled with her weight. Like many people who fall into the category of obese, she knows all too well the peaks and valleys of attempted weight loss.

"I would lose weight," she said, hesitantly. "And then I would gain it back plus five or ten pounds more."

Eating was more than a routine for Hanson; it was a way of life. Like most people, she needed an outlet during emotional crises. Some go to the gym, some go hiking, some kickbox and some even seek therapy. Hanson ate.

"Eating was my way of dealing with stress," she lamented. "I was a real binge eater."

Outside, she was and still is known for being an immensely cheerful, person — polite, thoughtful, a good listener and impeccably friendly. Yet inside Shelley Hanson resided an insecure woman, one who was tired of the inconveniences of being overweight. She never was too fond of having to buy oversized clothes. Her snoring embarrassed her.

Science supplied an excuse: *Obesity is genetic*. And sure enough, hers was a lineage of largeness: her mother, sister, grandmother and great-grandmother. But if you know Shelley Hanson, then you know a woman not too fond of taking the easy way out. And so she kept looking.

An answer was out there, somewhere.

That answer came through a few friends of hers, also struggling with their weight, who learned of bariatric surgery, and faced with few alternatives, elected to give it a shot. That shot turned out to be the Holy Grail of weight-loss — gastric bypass surgery.

"It's a miracle," Hanson said, with not the least bit of hesitation.

It is also ironic, because she had more than a few misgivings before deciding to go under the knife. Without a doubt, this surgery is not for even the partially squeamish.

"It's kind of icky," she said while providing details. "But at that time, I was getting pretty nervous about my health."

That was reason enough, and on December 29, 1999 after months of mulling it over, she went under the knife. She hasn't looked back.

Shelley Hanson weighs in at a pleasant 145 pounds these days, down quite a ways from 235 one year ago. And while post-operation life has had its own ups and downs, Hanson, along with a few other Tribal members, is convinced that *gastric bypass surgery* is *the* great hope of the future in weight-loss surgery.

Photo by Mychal Leno

DATING AGAIN – Tribal member Shelley Hanson's struggle with her weight caused her to be depressed. She lost self-confidence. Now, after her surgery, she is happy, healthier and rebuilding her self-esteem.

Bariatric surgery, to which the gastric bypass belongs, has existed for decades. Yet no single form of weight-loss surgery that existed previously worked as successfully at getting patients to lose weight and not gain it back.

"It's the only one that works for the morbidly obese," said Dr. Latham Flannagan, the Head Surgeon at the Oregon Center for Bariatric Surgery and the surgeon who performed the procedure on Hanson.

Flannagan has been working in bariatric surgery for nearly 25 years now, and he believes wholeheartedly that gastric bypass, while still evolving, is the most effective way to lose weight in history.

"I've seen a lot of people attempt various ways to lose weight...hard-core dieting, exercise, clinics," he said. "And 98 percent of them gain most or more of it back. Ninety-eight percent," he repeated.

Gastric bypass has more than one form, yet they all involve the same basic premise: partitioning off a small portion of the stomach with surgical staples, which in effect reduces the holding capacity. Following the surgery, the stomach has in effect become a small pouch, and patients have an appetite that is only a fraction of what it was before. Losing weight becomes almost arbitrary.

"Once they have this tool," Flannagan said. "They can do what they want."

Well, he said, they can't really do what they want, but the point is that patients are given the power to lose weight, provided they continue to do follow-ups with their surgeon and stick to the eating regimen.

The eating regimen, both Hanson and Flannagan agree, may be the hardest part.

The first three weeks following the operation, patients are required to stick to a liquid diet. Their "meals" consist entirely of "instant breakfast" type drinks — Slim Fast, Ensure or Resource. In between their five "meals" each day they are to drink plenty of water and supplement the new diet with vitamins.

After the first three weeks, patients move on to a high-protein, low-fat diet of pureed food, hoping not to exceed 500 calories in one day. Maintaining good hydration and continued supplement of vitamins continue. Solid foods are to be avoided at all costs. As the digestive process functions less efficiently, even a small piece of solid food runs the potential to block the stomach's outlet and induce vomiting.

Three months following surgery, patients begin the routine of "fluid loading." Because the meal sizes have increased to two to four ounces, more liquid is necessary in order to dilute the food particles and maintain a fluid balance in their system. Patients drink as much water as their new pouch can hold 15 minutes prior to each meal. Furthermore, 90 minutes after each meal they should drink more water and other low-calorie liquids.

Six months after the surgery, patients can resume some kind of a normal diet. But naturally their appetite is considerably reduced, and the few ounces of food they are permitted to eat will be predominantly meat.

One aspect of the post-op regimen not to be overlooked, however, is the addition of exercise to the daily routine. Patients are advised to begin exercising 45 to 60 minutes a day. Exercise is of paramount importance following the surgery because the body shifts into a starvation mode, and thus reduces the rate of calorie use, which contradicts the nature of the operation.

Most patients are expected to walk two or three miles a day within months of the surgery, in order to burn up what few calories they ingest and facilitate the weight-loss. No other aspect of the post-op regimen, Flannagan said, seems to pose a bigger challenge for patients.

"Some people have a hard time with that," he said, noting that many patients don't exercise at all. "But that's their decision."

"They'll still continue to lose weight," he added. "But not as much if they'd exercise."

Flannagan maintains that no great amount of discipline is needed after the surgery in order to maintain weight-loss. But he also understands why patients can stray, because the surgery, like obesity itself, can ultimately be involuntary.

Americans, as a whole, form perhaps the heaviest populations on the planet. According the U.S. Bureau of the Census, approximately 58 million Americans (22 percent of the population) can be correctly categorized as obese. According to Flannagan, five percent of the U.S. population is morbidly obese.

An uncountable number of surveys will tell you that most Americans are overweight. But there is a major distinction between overweight and obese. Clinically speaking, a person who possesses an excess of body fat that impairs their general health is considered obese. When the impairment becomes severe, that is what can be classified as morbid obesity.

During the last decade, obesity has increased so dramatically in the U.S. that the Journal of the American Medical Association has seen fit to decree it an epidemic. And considering the health implications of obesity that may not be an inaccurate term.

Since the mid 1980s, no other health problem other than cigarette smoking can be said to cause as many deaths as obesity. And that is simply because so many other diseases can spring forth from the condition. Diabetes, cardiovascular disease, hypertension, cancer and not to mention the psychological burden all combine to make obesity quite dangerous.

Causes of obesity are many — physical inactivity, excessive caloric intake and most commonly, genetics.

"I would say that most of the time, it is not psychological, not because people are lazy," Flannagan said. "It's genetic and they really can't help it."

Genetics certainly play a big role for obesity in the Native American community. A study of the Pima Indians in Arizona by the Center for Disease Control lent credence to the theory that many Natives are victims of the "thrifty gene." Geneticist James Neel first proposed the theory in 1962 after speculating why such a huge percentage of the Pimas population was morbidly obese. Neel's theory is based on the fact that for thousands of years populations who relied on farming, hunting and fishing for food, like many Native Americans, experienced alternating periods of abundance and of famine. In order to survive, their metabolism evolved in a manner so they would store fat more easily, that they might not starve during famines.

Their highly economic metabolism has still not adjusted to the ever-abundance and richness of western food. And as they no longer need to work as hard physically on a day-to-day basis, and enjoy a high fat diet, the once helpful thrifty gene has become a bane.

Flannagan knows from personal experience the validity of the thrifty gene theory. He lived on the isle of Tonga for four months, and estimates that three-fourths of the island's inhabitants are obese.

"Like Native Americans, they subsisted on a diet with very little fat — fruits, vegetables and fish," he said. "When they were introduced to Western food, especially beef, they couldn't help but become fat."

"You ask does the 'thrifty gene' affect Native Americans?" he said. "Absolutely."

Although Flannagan champions the cause of many obese Americans, he is not about to suggest that gastric bypass is advisable for everyone. In fact, he views it in many ways as a "last resort" solution.

"People should try other forms of weight-loss first, some respond quite well to medication," he said. "When all else fails, then gastric bypass surgery is the last available option."