IMPORTANT MEDICAL CARE INSTRUCTIONS

This enclosed informational packet has been created to assist you in evaluation and management of certain problems that arise in patients who have undergone bariatric surgery. Approximately 5–6 percent of patients in our bariatric program at Memorial Medical Center in Springfield will experience a complication. Most of these occur in the early postoperative days prior to hospital discharge. Some, however, occur after discharge. These patients have unique anatomy as a result of their surgery and are more susceptible to certain problems.

This document should give the treating physician, whether a primary care provider or an Emergency Department provider, some assistance in developing a differential diagnosis while evaluating and safely managing these situations. These patients are unique and are **much more prone to dehydration** in the early postoperative period. Vomiting can rapidly deplete their thiamine stores. Glucose administration intravenously will compete with thiamine uptake by the cell and this should be avoided. Placement of NG tubes is contraindicated and can readily perforate the small stomach or pouch. Oral contrast administration for imaging studies is also problematic. Abdominal CT exams are most useful when oral contrast is administrated; however, the volume should be limited to 100 cc to avoid the risk of perforation of the "neo stomach" and the risk of aspiration. IV contrast should only be given if creatinine is normal and the patient is hydrated.

THE BASICS FOR INITIAL MANAGEMENT ARE:

1. Always rehydrate with "banana bag" at 150 cc/h. No glucose in IV fluids.
    a. 1000 cc NS
    b. 1000 mcg B12
    c. 100 mg thiamine
    d. 1mg folate
    e. 1 amp MVI
2. Do not use NG tubes for fear of perforation of "neo stomach."
3. CT scan—only use 30 ml of contrast if patient is within 14 days of bariatric surgery.
4. Use IV contrast only if creatinine is normal.
5. Check CBC, electrolytes, amylase and lipase.
6. Do not ignore significant abdominal pain.
7. Ask radiologist to place CT study on a disc.

089-0075 10/16/18

Memorial BARIATRIC SERVICES

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Physician Info Packet for Bariatric Patients

Bariatric procedures employed by our program:

- Laparoscopic RNY gastric bypass
- Laparoscopic sleeve gastrectomy
- Laparoscopic duodenal switch
- Revisional bariatric surgery
- DJB-S
- Laparoscopic adjustable gastric banding

Bariatric Services at Memorial Medical Center in Springfield, Illinois, is available 24/7.

PLEASE CALL US AT:

217–788–3000 (Memorial Medical Center)

Orlando J. Icaza, MD, FACS | **217–528–7541**

Adam J. Reid, MD | **217–545–8000**

EARLY POSTOPERATIVE PERIOD:
(Discharge to six weeks)

Most common reasons for emergency room/primary care visit:

1. Dehydration
2. Abdominal pain
3. Wound/trocar site problems

Quick differential diagnosis:

1. Dehydration
    a. Persistent nausea and vomiting
    b. Inability to get 64 fluid ounces per day
    c. Weakness, lightheadedness, orthostatic blood pressure changes, tachycardia
2. Abdominal pain
    a. Persistent tachycardia (120/min or greater)
    b. Hypotension
    c. Oxygen desaturation

    R/O Anastomotic leak/abscess/free air

    R/O Small bowel obstruction

    R/O Internal hernia

    R/O Volvulus of small bowel

    R/O Trocar site pain
3. Wound/trocar site problems
    a. Cellulitis around incision
    b. Right upper trocar site is most common
    c. Consider trocar site hernia or Richter's hernia
    d. Obvious purulent drainage

LATE POSTOPERATIVE PERIOD:

Most common reasons for emergency room visit/ primary care visit:

1. Abdominal pain
2. Inability to keep meals down

Quick differential diagnosis:

1. Abdominal pain

    R/O Small bowel obstruction
    a. Small bowel volvulus
    b. Internal hernia
    c. Adhesions

    R/O Gallbladder disease

    R/O Gastric/anastomotic ulcer
    a. Clinical exam of the abdomen is marginally useful except for the obvious incarcerated hernia. Ischemic small bowel secondary to volvulus/internal hernia will have no physical findings, just unrelenting, significant pain. Do not ignore this as it can be fatal if not corrected rapidly. CT abdomen with IV contrast if abdominal pain with or without vomiting. If patient is within 14 days postoperative from bariatric surgery, add oral contrast, 30 ml maximum, to assess for leak.
2. Inability to keep meals down

    R/O Anastomotic structure or marginal ulcer

    Diagnosis established with 100 cc gastrograffin swallow or upper GI endoscopy. Gradual onset usually occurs over several weeks.

    Management is to add PPI and Carafate. Make sure PPI is tablet for solutab.

    Make sure no NSAIDS/ASA/smoking/alcohol/inhaling marijuana.