Anchorage Bariatrics Weight Loss Seminar Video Transcript

Section 1

{Dr. Clark}
Welcome to Anchorage Bariatrics! I'm Dr. Justin Clark. It's our pleasure to have you in the office today to inform you about all of your weight loss options. We take pride in being able to offer you a comprehensive approach to weight loss. I hope you enjoy the presentation today and I hope to see you personally in the office at a later date.

{Voice over Presentation}
Dr. Clark was born and raised in San Diego, California. He stayed in San Diego for college and attended the University of California at San Diego. He also spent one year studying at Oxford University in England where he played on the tennis team and rowed crew. Dr. Clark then attended medical school at Northwestern University in Chicago before attending the University of Hawaii for general surgery residency. Dr. Clark was then fortunate enough to secure one of the nation's top fellowship positions in bariatric and advanced minimally invasive surgery at Duke University. He then entered active duty as a major in the United States Air Force and served at Joint Base Elmendorf Richardson as the Director of Bariatric Surgery from 2012 to 2016. Dr. Clark is now the owner of Anchorage Bariatrics, Alaska's most comprehensive weight loss practice and is the Director of Metabolic and Bariatric Surgery at Providence Alaska Medical Center.

Dr. Lee was born in the Seattle suburb of Kirkland, Washington and went to high school in Redmond, Washington. He then attended Cornell University in Ithaca, New York, where he graduated Cum Laude in 2000. He then moved to Connecticut where he attended Yale University School of Medicine, achieving his M.D. degree in 2005. Following his time at Yale, Dr. Lee was fortunate to match into the general surgery residency program at Duke University Medical Center. Dr. Lee spent five years there working in the hospital and another two years doing medical research. Following his residency, Dr. Lee stayed at Duke for his fellowship in bariatric and minimally invasive surgery. Upon the completion of his surgical training, Dr. Lee took a position at the medical college of Georgia in Augusta. In 2016, Dr. Lee was promoted to be the head of bariatric surgery there and was able to lead their program to obtain Bariatric Surgery Center of Excellence status. In 2017, Dr. Lee joined Dr. Justin Clark as co-owner of Anchorage Bariatrics and as co-director of the Metabolic and Bariatric Surgery program at Providence Alaska Medical Center.

Section 2

{Obesity Presentation}
The first step in identifying a problem is defining it. Obesity is measured using your body mass index or BMI. It is the ratio of your weight to your height. BMI calculators are available online or on our website. A normal BMI is from 18 ½ to 25, overweight is 25 to 30. Above this, we get into different classes of obesity as you can see from the chart. What your BMI is will help us determine what weight loss interventions you qualify for.

{Obesity Graphic}
As you can see from this graphic, it is clear that obesity has a significant negative impact on many systems of our body. You may suffer from one or several of these. Of particular importance is the impact on the pulmonary system with obstructive sleep apnea; the metabolic system with high blood pressure, high cholesterol and diabetes; and increased risk of certain kinds of cancers. In fact, in 2013, the American Medical Association classified obesity as a chronic disease.

When dealing with your weight, you should know that you are not alone. This graphic from the CDC shows obesity rates across the country. In 1995, we see rates of obesity at less than 20% nationwide.

If we fast forward to 2010, we see a dramatic rise in obesity. Not even one state stayed less than a rate of 20% and many states are above 30% obesity. The most recent data shows that 35% of Americans are obese and 68% are obese or overweight. The projections show that by 2050 over 42% will be obese and one in every 3 people will have diabetes. This is truly an epidemic.

The causes of obesity in the obesity epidemic are diverse. Certainly, there are many things that contribute to it, but on the simplest level, we see that there are genetic, behavioral and environmental factors. Each of these plays a role, but it's the interplay of these that has really caught the attention of new research that is helping us to understand this epidemic.

Section 3

There's exciting new research and a new theory on why this epidemic is occurring. I would like to introduce you to this concept of the “set point” by showing you a portion of the TED talk by neuroscientist Sandra Aamodt.

{Sandra Aamodt}
Three and a half years ago, I made one of the best decisions of my life. As my New Year's Resolution, I gave up dieting, stopped worrying about my weight, and learned to eat mindfully. Now, I eat whenever I'm hungry and I've lost 10 pounds.

This was me at age 13 when I started my first diet. I look at that picture now and I think, ‘you did not need a diet, you needed a fashion consult.’ But, I thought I needed to lose weight and when I gained it back, of course I blamed myself.

For the next three decades, I was on and off various diets. No matter what I tried, the weight I had lost always came back. I'm sure many of you know the feeling. As a neuroscientist, I wondered, why is this so hard? Obviously, how much you weigh depends on how much you eat and how much energy you burn. But, what most people don't realize is that hunger and energy use are controlled by the brain, mostly, without your awareness.

Your brain does a lot of its work behind the scenes and that is a good thing. Because your conscious mind is easily distracted. It's good that you don't have to remember to breathe when you get caught up in a movie. You don't forget how to walk because you're thinking about what to have for dinner. Your brain also has its own sense of what you should weigh, no matter what you consciously believe. This is called your “setpoint” but, that's a misleading term because it's actually a range of about 10 or 15 pounds. You can use lifestyle choices to move your weight up and down within that range, but it's much, much harder to stay outside of it.

The Hypothalamus is the part of the brain that regulates body weight. There are more than a dozen chemical signals in the brain that tell your body to gain weight and more than another dozen that tell your body to lose it. The system works like a thermostat responding to signals from the body by adjusting hunger, activity and metabolism. This is to keep your weight stable as conditions change - that's what a thermostat does, right? It keeps the temperature in your house the same as the weather changes outside.

Now, you can try to change the temperature in your house by opening a window in the winter. But, that's not going to change the setting on the thermostat, which will respond by kicking on the furnace to warm the place back up. Your brain works exactly the same way. Responding to weight loss by using powerful tools to push your body back to what it considers normal.

If you lose a lot of weight, your brain reacts as if you were starving. Whether you started out fat or thin, your brain's response is exactly the same. We would love to think that your brain could tell whether you need to lose weight or not, but it can't. If you do lose a lot of weight, you become hungry and your muscles burn less energy.

Dr. Rudy Leibel of Columbia University has found that people who've lost 10% of their body weight burn 250-400 calories less because their metabolism is suppressed. That's a lot of food! This means that a successful dieter must eat this much less forever than someone of the same weight who has always been thin.

From an evolutionary perspective, your body's resistance to weight loss makes sense. When food was scarce, our ancestors survival depended on conserving energy. And, regaining the weight when food was available, would have protected them against the next shortage.

Over the course of Human History, starvation has been a much bigger problem than overeating. This may explain a very sad fact that “set points” can go up, but they rarely go down. Now, if your mother ever mentioned that life is not fair, this is the kind of thing she was talking about.

Successful dieting doesn't lower your setpoint. Even after you've kept the weight off for as long as 7 years, your brain keeps trying to make you gain it back. If that weight loss had been due to a long famine, that would be a sensible response.

In our modern world of drive-thru burgers, it's not working out so well for many of us. The difference between our ancestral past and our abundant present is the reason why Dr. Yoni Freedhoff of the University of Ottawa would like to take some of his patients back to a time when food was less available. And, it's also the reason that changing the food environment is really going to be the most effective solution to obesity. Sadly, a temporary weight gain can become permanent. If you stay at a high weight for too long - probably a matter of years for most of us - your brain may decide that that's the new normal.

{Voice over Presentation}
Now, I want to show you a video that really elaborates on this concept in a more detailed way.

{Animation}
Let me introduce you to Amanda. You're just meeting her for the first time, but chances are, you're already making assumptions about how much she eats and how little she exercises because she's obese. But, I'm about to show you that there's much more than meets the eye when it comes to obesity. There are lots of Amandas out there and they need treatment. Maybe, you're one of them, or maybe you know an Amanda.

It's time to act on obesity but, in order to do so effectively, we need to understand obesity. It's generally accepted that body weight is determined by a pretty simple formula. We call it the “energy balance equation” and it works like this: If the number of calories that you consume equals the number of calories that you burn, your weight remains the same. If you consume more than you burn, you gain weight. And, if you burn more than you consume, you lose weight.

Most people think that those of us who properly manage our energy balance remain lean, whereas those of us like Amanda who eat too much and exercise too little, become obese. We view obesity as a lifestyle choice and the cure for it is simple - eat less and exercise more.

This may sound logical but, it is wrong. Let me explain. First, let's talk about “set point.” No, I'm not talking about the point in a tennis match when one player is about to beat the other. I'm talking about a theory that says that, no matter what you consciously want your weight to be, your brain has its own sense of how much body fat it should have onboard and it has a complex system in place that very precisely regulates your energy intake and expenditure to keep you within a so-called “set point” range for body fat. The whole energy balance equation is not something that you control voluntarily. Your brain regulates your calories in to your calories out for you.

For your brain to do this, it needs to know how much energy you have onboard at all times. And it knows by listening to hormones like Leptin which is made in your body fat. You can think of it like a car. Leptin is the gas gauge that tells your brain how much gas is in your tank. Leptin is just one piece of the puzzle. You've got a whole bunch of other hormonal signals and senses. These involves your bones, muscles, pancreas, liver, GI tract and sensory organs. They all play a role, communicating with your brain to give it the information it needs to do its job. But, that's more detail than we need for this conversation.

The point is that you have a complex system in place that regulates you to within a set point range for body fat. So, what happens if Amanda decides to lose weight by going on a diet? After all, people with obesity should eat less, right?

Here's what happens, she loses weight but her hormone levels change. Her brain hears this and starts acting to restore whatever body fat she's lost. She feels hungrier and although she doesn't know it, she's also burning fewer calories than before. You see, setpoint is usually a one way street, and once it's been elevated, the brain works to defend it just as vigorously as it would a lower setpoint. Amanda's brain doesn't know that she needs to lose weight, it only knows to defend her current setpoint.

Back to our car analogy. Amanda can't help but look for a gas station to refuel when she sees that her gas gauge is low. At the same time, she becomes more fuel efficient, burning less energy than before. This might explain why treating obesity with diet and exercise so

often fails to produce the desired result. It's sort of like telling Amanda that she needs to be a more careful driver when the real problem is she needs a mechanic to fix her car.

Okay, so if we've all got this complicated system in place that prevents us from us losing weight, why doesn't it also protect us from gaining weight and developing obesity in the first place? How can we explain the obesity epidemic?

Getting back to Amanda, why did she develop obesity? The answer is that it takes a perfect storm to cause an obesity epidemic like the one we're seeing now. And it's our modern environment that places us, and Amanda, directly in the path of that storm. While there's no single cause for the rising rate of obesity, changes to the chemical and nutrient content of our food, the so-called "Western diet," a decrease in physical activity, increased levels of stress, inadequate and disrupted sleep, and more widespread use of medications that promote weight gain, all play a role.

Our unique genetics, and developmental histories cause each of us to respond differently to these elements of the modern environment. And some of us, like Amanda, respond by sending hormonal signals that elevate our set point for body fat. It's not that Amanda's system has stopped working, it's just that its working to regulate her to a set point that's too high. So you can think of obesity as a biological response to the modern environment. A disease where the body dis-regulates to a body fat set point that is too high. Back to our car analogy, the size of Amanda's gas tank has expanded, so she carries around too much fuel.

Section 4

{Voice-over Presentation}
As this video explains, GI hormones play an important role in your weight. So, I want to spend a minute on the hormones we know most about. Ghrelin is a hormone secreted in the fundus of the stomach and it increases appetite. CCK is a hunger suppressant from the duodenum. PYY and GLP-1 are secreted by the small bowel just before your colon. PYY reduces appetite and GLP-1 increases fullness, and more importantly, increases the body's response to its own insulin which can help improve diabetes.

What we see after bariatric surgery, specifically the gastric sleeve, gastric bypass, and the duodenal switch, is a change in these hormones. Ghrelin decreases which decreases appetite. This lower level can last for a year or more. CCK, PYY and GLP-1 all increase after surgery, which helps reduce appetite and helps the body respond better to its own insulin. These hormones play a crucial role in weight loss.

We are now going to move on to discuss the different options we offer for weight loss. As you can see from the slide, your BMI will direct us as to what you may qualify for. For those of you with a BMI less than 30, we may be able to offer you a monitored diet and/or

medication assistance weight loss. If your BMI is between 30-35, we can add in the Orbera Intragastric Balloon as an option. And finally, if your BMI is above 35, we may be able to offer more invasive options like different kinds of bariatric surgeries.

Let's talk first about Physician Monitored Diets. The program we use is New Directions and it is manufactured by the Robard Corporation. You can review details at https://www.robard.com if interested.

In general, we offer two diets. The first is a very low calorie diet with under 800 calories a day. Your BMI must be above 30 or down to 27 if you have weight-related medical problems. This is an engineered diet that is Ketogenic, or fat-burning. We aim for a weight loss of 3 to 5 pounds a week. You have several visits with me and we review your EKG and lab work, and you have weekly group visits with our dietitian. As you lose the weight, we begin incorporating regular foods back into your diet until you reach a stable level.

We also offer a low calorie diet which uses meals supplemented with regular foods from the start. It's non-Ketogenic, and provides 1,000 to 1,500 calories a day. This may be appropriate for lower BMI patients, or if you are not medically approved for the very low calorie diet.

Medication assisted weight loss is also something we offer in certain cases. I think it can be a useful tool when added to other treatments. While some medications can be used long-term, I typically use them only short-term to offer a jumpstart. There are many different medications approved for weight loss, but each has its own set of restrictions and side effects. In my experience, weight loss on these medications for most people is rather limited but, we strive for a 5-10% weight loss. Also, many times these medications are not covered by your insurance. But, most of the medication companies do offer discounts and coupons.

We can now transition to our procedural options. The Orbera Intragastric Balloon is a newly FDA approved device. However, while it is new in the United States, it has been used in over 220,000 patients in over 80 countries. This is a non-surgical option. A balloon filled with saline is placed into the stomach using a camera that goes into your mouth and down your throat. The balloon is about the size of a grapefruit and takes up space. It basically makes you feel full so that you don't eat as much. It stays in the stomach for 6 months and is then removed the same way it is placed. You may qualify for this if your BMI is between 30 and 40.

The studies show that when you compared people who had the balloon to those that did not have it, but still did diet exercise, the patients with the balloon lost three times as much. It's also important to know that the balloon is only part of the program. You are also enrolled in a 12 month coaching program with one-on-one and group sessions with a registered dietitian to work on changing your eating habits so that you can maintain your weight loss after the balloon is removed.

Orbera has a proven track record of good results and safety worldwide. Serious side effects, like ulcers or a hole in the stomach, are very rare. Minor side effects are more common. Most people experience nausea, vomiting, and abdominal bloating with this procedure. It can be quite severe the first week, but the body does adjust and most people do well once they get through this period. Some restrictions apply and we don't place a balloon if you have a history of stomach surgery, stomach ulcers, or a large hiatal hernia. For a full description of the balloon, the restrictions, the side effects and the complications, please visit the Orbera website at orbera.com or the link on our website.

Now, here's a short video that shows how the Orbera is placed and removed.

Now, we're going to discuss a few of the more invasive options. These are what we traditionally describe as bariatric surgery. Before we move on though, I want to show you the last part of the set point video that helps explain why we think surgery works.

{Presentation}
For Amanda to lose weight and keep it off, she needs to find a way to lower her set point. That is, rather than declaring war on her own biology, she needs to find a way to make her body regulate itself to a new, lower weight.

One option for Amanda to consider is bariatric surgery. In study after study, it's been shown to be the most effective, long-term treatment of obesity. But, how bariatric surgery works is often misunderstood. Most people, even many doctors, think of bariatric surgery in terms of restriction or malabsorption. It's a reasonable assumption that surgery would work in these ways. After all, the procedures usually consist of some combination of altering stomach anatomy to be smaller, which you'd think would restrict the amount of food that you'd be able to eat, and rerouting the GI tract in a way that you'd think would make you fail to absorb the calories that you do eat.

But, new research suggests that certain types of bariatric surgery, for example gastric bypass, sleeve gastrectomy, and duodenal switch, affect the signals between the brain and the body to decrease appetite, increase feelings of fullness, increase metabolism and even encourage preferences for healthier food.

Surgery may change the set point for body fat. It's like the anti-diet. Instead of fighting the set point like a diet does, surgery may recalibrate it, and the hormones that stimulate weight gain when a person diets do the exact opposite after surgery as the body regulates itself to the new, lower set point.

So, here are three things you can take away from all of this. One, energy balance is complex and highly regulated. Two, obesity is a disease where the complex system that regulates body fat may dis-regulate to a set point that is too high. Three, bariatric surgery may work by changing the signals that regulate body fat set point enabling patients to successfully lose weight and keep it off. It's time to reshape the conversation about obesity.

{Voice-over Presentation}
Another way to think about this concept is with this diagram. Dieters can easily get caught in this circle of dieting and gaining the weight back to the body's old set point. Surgery is one way to break the cycle and help reset your set point to a new, lower level.

Section 5

The first surgery I want to talk about is the Laparoscopic Sleeve Gastrectomy. This is now the most common bariatric operation in the country, with over 50% of all procedures being the sleeve. In this procedure, about 85% of the stomach is removed. I remove the portion of the stomach that stretches when you eat and also the part that secretes ghrelin which usually results in less appetite after surgery for the first year or more. The stomach you're left with is about the size of a small banana. It works by restricting how much you can eat and also by altering the GI hormones like we talked about before. To qualify, you must have a BMI over 40, or we can accept down to a BMI of 35 if you are being treated for high blood pressure, high cholesterol, diabetes, or obstructive sleep apnea. Here's a short animation about the laparoscopic sleeve gastrectomy.

{Animation}
To access the abdominal cavity, small incisions are created. Trocars are placed to serve as passageways for surgical instruments. The surgeon examines the abdomen using a laparoscope or video camera. The average human stomach can expand to hold around 1 to 1.5 liters of food. While in the stomach, food is combined with digestive enzymes. These help break the food down into a simpler form so it can be digested more easily and absorbed in the small bowel. During a sleeve gastrectomy, a thin, vertical sleeve is created by using a stapling device. This sleeve will typically hold between 50-150 milliliters and is about the size of a banana. The resected portion of the stomach is removed. By altering the anatomy of the gastrointestinal tract, sleeve gastrectomy changes signals in the body resulting in decreased hunger and increased feelings of fullness after meals. Bile and pancreatic fluid from the liver and pancreas mix with food and allow it to be completely digested and absorbed in the bowel. There is no re-routing of the small bowel or post-operative adjustments needed for the sleeve gastrectomy.

{Voice-over Presentation}
The next most common surgery is the Roux-en-Y Gastric Bypass. This is the surgery we have done the most over the last 20 years so we know the most information about it. But as the sleeve has gained in popularity, the bypass has gone down a bit and now is about 25 to 30% of all bariatric operations. In this surgery, I make a new, small stomach pouch about the size of an egg. Then the small intestine is rerouted to the small pouch and the rest of the stomach, and about 25% of your small intestine, is bypassed. The old stomach is left in place and still makes digestive juices. These juices and the bile meet up later in your intestine to help digest your food.

The surgery works in three ways. It restricts how much you can eat. It doesn't allow you to absorb food in the bypassed segment of the intestine, and of course it also significantly alters the GI hormones. The qualifications for the Roux-en-Y gastric bypass are the same as the sleeve. Here's a short animation about the Laparoscopic Roux-en-Y gastric bypass.

{Animation}
During a gastric bypass, a small pouch is created in the stomach using a stapling device. The small stomach pouch, about the size of an egg, limits the amount of food you can eat before feeling full. The small bowel is separated into two sections; the lower portion of the small bowel is attached to the newly created stomach pouch. This allows food to pass directly into the second portion of small bowel, where digestion continues. The upper portion of the small bowel is reconnected to the lower. Bile and pancreatic fluids from the liver and pancreas allow food to be digested completely. By altering the anatomy of the gastrointestinal tract, gastric bypass changes signals in the body resulting in decreased hunger and increased feelings of fullness after meals.

{Voice-over Presentation}
The Laparoscopic Loop Duodenal Switch is a modification of the traditional duodenal switch with bilio-pancreatic diversion. Essentially, a sleeve gastrectomy is performed first, and then the duodenum is cut and a new connection is made to the intestine about 300 centimeters from your colon. Just like the gastric bypass, it works in three ways. It restricts how much you can eat, it doesn't allow you to absorb food in the bypassed segment of the intestine, and it also significantly alters the GI hormones. This operation, however, has a more profound impact on your absorption of food than the other operations. Some people can get nutritional deficiencies and have chronic diarrhea. However, the weight loss with this operation is usually greater and has really great results in resolving diabetes. I tend to offer this operation to patients who have a BMI greater than 50, or who have severe diabetes. Here's a short animation about the loop duodenal switch.

{Animation}
The single anastomosis duodenal switch, or loop D.S., begins with a sleeve gastrectomy in which a thin vertical sleeve is created using a stapling device. This sleeve will typically hold between 100-150 milliliters and is about the size of a banana. The resected portion of the stomach is removed. The small bowel is divided approximately 3 centimeters beyond the stomach, preserving the pyloric.

The end of the small bowel is located and about 3 meters of small bowel are measured. At this point, a loop of the small bowel is brought up to the duodenum and joined as shown. By altering the anatomy of the gastrointestinal tract by creating the gastric sleeve and altering the path and anatomy of the small bowel, the single anastomosis duodenal switch changes signals in the body, resulting in decreased hunger and increased feelings of fullness after meals.

{Voice-over Presentation}
These three operations have a similar postoperative course in terms of your diet and recovery. Most patients stay in the hospital just one night. You are then on a liquid diet for 3 weeks after surgery. You are then advanced to a soft food diet until 3 months after surgery, at which point you are allowed a normal, healthy diet. I see you in the office at 3 weeks, 3 months, 6 months, 9 months, and a year after surgery. You are then followed every year for 5 years. You will also be required to take a multivitamin and other supplements for the rest of your life. This is extremely important, since with less stomach you will absorb less of these vitamins and minerals. I will provide you with recommended vitamins and we also have some available for purchase in the office for your convenience.

I also want to mention a few other surgical options that are considered less invasive but they do not permanently alter your anatomy.

The first is the lap band. This was a very common operation in the past, but, it's now not done much. There are many reasons for this, but mostly because the long-term results have not been great, especially compared to the sleeve. In this operation, a small plastic band is placed around the upper stomach and the port is placed under your skin to allow me to put fluid in or take fluid out, to make the band tighter or looser. It works by restricting how much you can eat, but has no significant hormonal impact. The qualifications are the same as the previous surgeries. I do not routinely perform this operation anymore, but if you have a lap band, I can assist with managing it and adjusting it.

Finally, the vBloc is a new device that targets the hormonal pathways from the stomach to the brain. The vagus nerves run from your stomach to your brain and impact many GI functions. In this operation, we use laparoscopic surgery to place two small leads around the vagus nerves and put a pacemaker-like device under the skin. We can then manage adjustments to the device electronically. The pacemaker can be turned off and on to help block hunger signals to the brain. It is usually turned on for about 12 hours a day. There's no specific diet after surgery except guidelines for a healthy, well-balanced diet. BMI required is 40 to 45 or 35 to 40 if you have weight-related medical conditions discussed earlier. Here's a short animation about the vBloc.

{Animation}
Surgery involves the placement of two thin leads on to the vagus nerve trunks at the gastro-esophageal junction through small incisions created as part of a minimally invasive laparoscopic procedure. The leads are connected to a subcutaneously implanted neural regulator that delivers high-frequency electronic pulses to intermittently block vagus nerve activity. The device is designed to be non-invasively adjusted, deactivated, or reactivated.

{Voice-over Presentation}
As with any surgical intervention, there are potential complications. Each of these procedures and operations have specific possible complications. As we get ready for surgery, if that is the course you decide on, we will review this in great detail. Luckily, serious

complications are rare. Here's a list of some of the complications we watch closely for. Please take a moment to review this and make a note of any you wish to know more about and we can go over them in your consultation.

Section 6

I want to talk next about the results after surgery. Many of my patients report excellent results at losing weight on various diets. But, very few people can maintain that, and most gain all the weight back and more. For people who are overweight or obese, it can be very challenging to maintain weight loss. In fact only 2-5% of obese patients can sustain weight loss with diet, exercise, and behavioral modification. However, if we add in surgery, we can attain an 85% success rate.

It is important to realize though, that this is not just due to surgery. It is surgery combined with diet, exercise, and behavioral modification. The surgery alone is not a cure, but rather a tool to be used in resetting your set point. It's your lifestyle change that will sustain your weight loss.

A common question is, ‘how much weight will I lose?’ This is not an exact science, but we do have some national averages. These are recorded in percent of excess weight loss. Everyone will have a different excess weight. But to make it easy, let's say that based on your height, you should weigh 140 pounds but, you weigh 240 pounds, so your excess weight is 100 pounds. You can see from this graphic what the averages are for the different procedures. So for this patient, based on the averages, they would lose 28 pounds with the vBloc, 40 pounds with the Orbera, about 50 pounds with the lap band, and 65-75 pounds with either the sleeve or the gastric bypass, and probably more than 75 pounds with the duodenal switch. Of course, these are averages and some people may do better, while some may do worse. From my own data, our practice has an average of 73.8% excess weight loss after the sleeve and the gastric bypass, so we are fitting in well with the national averages.

This is a wonderful slide from the ASMBS or American Society for Metabolic and Bariatric Surgery. It shows the average resolution of various medical conditions after bariatric surgery. These numbers apply to the sleeve, the bypass, and the duodenal switch. Take a few moments to review the slide and think about how this may apply to you. Of particular interest to me, is the improvement in obstructive sleep apnea, diabetes, and the overall improvement in quality of life.

While overall, most people measure success based on weight loss, it's actually the fourth most important aspect, in my opinion. If I were to rank the most important aspects of surgery, it would be first and foremost that your quality of life is improved. Second, that we get your metabolism to change from a fat storing to a fat burning metabolism. Third, that we improve or even eliminate your weight-related medical issues and medications, and finally, how much

weight you lose. Moreover, even if you don't lose as much weight as you or I expect, if you are happier, healthier, and off some medication, I consider this a success.

People have many different reasons for wanting to have surgery. I have heard lots of these reasons, like improve your overall health, decrease the number of medications, have more energy, live longer to see kids or grandkids grow up, feel better about yourself, have a baby, or even have another surgery like a joint replacement. But in the end, the decision to have surgery is yours and no one can make it for you. It's our job to educate you so that you can make an informed decision and ensure that you are physically, mentally, and emotionally ready for surgery.

I want to make a quick note about pregnancy after surgery. Fertility can improve rapidly after surgery, even within weeks. Also, oral contraceptives are not always absorbed as well after surgery. It is really important to take appropriate precautions and avoid pregnancy for 12 to 18 months after surgery, otherwise it could impact the baby. When you do get pregnant, you will need your vitamins and minerals checked regularly.

A common question I get is, how to choose which surgery to get? Again, this is a personal decision. I encourage each patient to choose their own surgery. However, I will suggest a particular one if I think your medical or surgical history requires it. Some factors that may impact your decision are things like how much weight you want to lose, your medical problems or medications, and your expected lifestyle after surgery.

Please take some time and decide if you want to join our program. If you decide you want a personal consultation with Dr. Clark, you will need to get a referral from your primary care doctor or another health care provider and complete our application form and return it at least one week before your appointment. Joining our weight loss program costs $200. This is separate from your insurance.

During your consultation, we will go over your application in detail and formulate a weight loss plan. Additional studies will likely include labs, EKG, chest X-ray, an EGD, which is a camera into your stomach to look at the anatomy for any ulcers or infections, nutritional and dietary assessment, a sleep assessment, a psychological assessment, and any other consults that I think may be necessary.

During your work up, we will be working on getting your insurance approved, if required. Please be aware that most insurance companies require 6 months of documented weight monitoring by your primary care physician prior to approving surgery. This whole process can sometimes last 6 to 9 months. Of note for those interested in the physician monitored diets, medication assisted weight loss or the Orbera Balloon, these are not covered by insurance and you will need to explore cash pay options.

Thank you for coming in today and congratulations on taking this first step for a new beginning! I hope you found the seminar today educational and helpful. All of us at Anchorage Bariatrics are excited to begin this process with you. Have a great day!