

# Follow-up and a shared care model of chronic disease

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Shared care arrangements with surgeons/physicians and primary care need to be in place so that diabetes and hyper tension medications and dosage can be appropriately reduced as weight is lost. Every patient with diabetes needs at least an annual review . Although sleeve gastrectomy , short-limb forms of gastric bypass and gastric banding do not cause protein-calorie malabsorption, bariatric surgery can cause severe vitamin and mineral deficiencies, amplifying pre-existing deficiencies caused by obesity . All patients should have lifelong routine metabolic and nutritional monitoring ( Table 68.7 ). Patients need regular multivitamins/trace element supplements ( Table 68.8 ). The minimum frequency of assessment is 3–6 monthly in the first postoperative year, 6–12 monthly in the second year and at least annually thereafter. Folic acid supplementation should be considered in all sexually active women of childbearing age because of the risk of neural tube defects. This is especially important as fertility often improves after surgery . The MDT also needs to support the small number of patients who develop severe mental health issues after surgery as there is a slightly increased risk of suicide after gastric bypass. - - -

Mortality Late 0.1% Gastro-oesophageal reflux Barrett's oesophagus Weight regain 0.1% Internal hernia Chronic abdominal pain Malnutrition if long limb bypass Anastomotic ulcer/stricture Weight regain 0.05–0.1% Band infection Tubing leak Slippage Erosion into stomach Band intolerance Failure to lose weight/weight regain TABLE 68.7 Summary of British Obesity and Metabolic Surgery Society (BOMSS) biochemical guidance after bariatric surgery. Blood tests all patients should have at baseline Full blood count, including haemoglobin, ferritin, folate and vitamin B12 levels, urea and electrolytes, liver function tests, vitamin D, 2+ Ca , parathormone, HbA1c, lipid profile Postoperatively After gastric banding: Annual full blood count, urea and electrolytes, HbA1c, fasting glucose, lipids as appropriate After sleeve gastrectomy, forms of gastric bypass, BPD/DS, SADI-S: As for banding + liver function tests, ferritin, folate, vitamin D, 2+ Ca , parathormone at 3, 6, 12 months then annually; vitamin B12 at 6, 12 months then annually; zinc, copper annually; vitamins A, E, K, selenium if concern (e.g. steatorrhoea, night blindness, unexplained fatigue, anaemia, metabolic bone disease, chronic diarrhoea, heart failure) BPD, biliopancreatic diversion; DS, duodenal switch; HbA1c, glycated haemoglobin; SADI-S, single-anastomosis duodenoileal bypass with sleeve gastrectomy.

## Summary box 68.6 Shared care model of chronic disease

Surgery Society (BOMSS) nutritional and micronutrient guidance after bariatric surgery. After gastric banding Multivitamin and mineral supplement, thiamine if vomiting, vitamin D, iron After sleeve gastrectomy, forms of gastric bypass, BPD/DS, SADI-S As for banding + selenium, copper, zinc, folic acid, vitamins B12, A, E, K BPD/DS, SADI-S may require higher doses BPD, biliopancreatic

diversion; DS, duodenal switch; SADI-S, single- anastomosis duodenoileal bypass with sleeve gastrectomy. Close collaboration between surgeons, physicians and primary care doctors is needed to enable seamless follow-up before and after surgery with a focus on the long-term care of patients Patients should be committed to lifelong vitamin and micronutrient monitoring and replacement

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Revision #1

Created 2025-12-31 15:25:21 UTC by Omar Ayman

Updated 2025-12-31 15:25:21 UTC by Omar Ayman