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Supporting the bariatric patient: short-, medium- and longer-term outcomes

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About the speakers



Mr Richard Babor
General, Upper GI &
Bariatric Surgeon

As well as his private practice, Richard Babor works as a general, upper gastrointestinal and bariatric surgeon at Te Whatu Ora Counties Manukau. His interests include laparoscopic sleeve gastrectomy, roux-en-y gastric bypass and revision of complicated band surgery. Currently he is involved in research into bariatric surgery in adolescents with poorly controlled type 2 diabetes.



Mr Grant Beban
General, Upper GI &
Bariatric Surgeon

Grant Beban works in both private and public practice at Auckland Hospital. His particular interests are roux-en-y gastric bypass and laparoscopic gastric sleeve procedures, as well as other forms of laparoscopic upper gastrointestinal surgery and surgery for cancers of the upper gastrointestinal tract. He has been involved in Ministry of Health groups looking at management of morbid obesity in New Zealand and prioritisation of weight loss operations in public hospitals. Research interests include improvements in diabetes control and quality of life after weight loss surgery.

Abbreviations used in this review

BED = binge eating disorder
BMI = body mass index
BN = bulimia nervosa
BP = blood pressure
DKA = diabetic ketoacidosis
GI = gastrointestinal
GLP-1 = glucagon-like peptide-1 receptor
OAGB = Single/One Anastomosis Gastric Bypass
RYGB = Roux-en-Y Gastric Bypass
SGLT-2 = sodium-glucose transport protein 2
VLCD = very low-calorie diet

Mr Richard Babor and Mr Grant Beban, General, Upper GI and Bariatric Surgeons, provided this update at the Goodfellow Symposium held in Auckland in March 2025 to inform physicians on the short-, medium- and longer-term outcomes from bariatric surgery including risks, benefits, and costs, along with a range of weight control options for patients that are overweight, including medications and endoscopic options. A guide to managing common complications in primary care was also covered. This presentation was undertaken thanks to support by Allevia Hospitals, previously MercyAscot.

Referral criteria and prioritisation

Mr Babor commenced the session summarising that treatment pathways for weight loss need to take into consideration the patient's BMI and the presence and severity of obesity-related comorbidities and complications.

Internationally, referral criteria for bariatric surgery generally follows international guidelines which recommend surgery for patients with a BMI of 30 or higher in patients with type II diabetes; and a BMI of 35 or higher in patients regardless of presence, absence, or severity of comorbidities.¹ The private sector within New Zealand has minimal referral criteria, however is primarily guided by these international standards. In private, self-referrals from patients are common, and while there is no strict exclusion of patients based on BMI, surgery can be considered for individuals with a BMI of 30 to 34.9 who do not achieve substantial or durable weight loss or comorbidity improvement using non-surgical means. Private bariatric clinicians are happy to discuss all potential referrals especially those for complex patients with specific health concerns who do not meet the public criteria.

Mr Babor has been involved in the ongoing efforts to standardise bariatric surgery referral criteria across public hospitals in the Northern Regional Authority, which includes Auckland, Counties Manukau, Waitemata, and Northland districts. This process has involved numerous meetings aimed to improve the equity of access to bariatric surgery within the public hospital system.

In the public hospital system, although access is limited to patients with a BMI of 30 or higher and a diagnosis of type II diabetes or obstructive sleep apnoea, the process has been complicated by limited resources, leading to the development of prioritisation criteria. Category 1 prioritises patients with type II diabetes or those at a significant risk of developing diabetes, while Category 2 prioritises those who require weight management for life-extending treatments such as cancer surgery, joint replacement surgery, and corneal transplants (**Figure 1**). Obese patients without comorbidities are generally excluded from surgery within the public referral system.

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Prioritisation Criteria

Agreed on three categories:

Category 1: Admitted to Bariatric Surgery Pathway
Type 2 diabetics or those at significant risk of diabetes.

Category 2: Weight management for life-extending treatments
(Requires Further Investigation)

Patients needing weight management for life-extending treatments, such as transplantation, cardiac surgery, cancer treatment, sleep apnea with proven CPAP benefit, as well as those with **poor diabetic control and referred by endocrinologist**.

Category 3: Immediate Decline from Service
Other cases not eligible for the service.

Figure 1: Northern Regional Authority referral and prioritisation criteria.

The prioritisation criteria in the public system aims to allocate resources fairly but have led to challenges in ensuring equity. Mr Babor provided the examples of excluding patients with a BMI over 60 which can disproportionately affect Pasifika populations, while excluding smokers can disproportionately impact Māori patients. He stated that efforts have been made to address these disparities and improve access to bariatric surgery for these groups.

Medical tourism

The growing trend of medical tourism of patients traveling internationally to gain access to more affordable procedures, particularly bariatric surgery, has raised concern from healthcare professionals regarding how to support patients in the short- and medium-term post-surgery.

Mr Babor stated that New Zealand-based bariatric services cannot compete with the significantly lower prices offered by medical tourism providers in countries like Turkey and Mexico. This price disparity makes it appealing for patients who would otherwise be excluded from surgery in New Zealand due to the referral and prioritisation criteria in place. Despite being unable to match the price, New Zealand practitioners believe they offer better patient care, including more comprehensive follow-up and support lasting up to 2 years compared to medical tourism practices, which are often seen as more business-driven and less focused on patient outcomes. Mr Babor expressed that the uncertainty about the training, certification, and follow-up care provided by international surgeons was a concern.

Additionally, medical tourism providers often market their services aggressively through social media platforms like Facebook and Instagram, where they reach out directly to potential patients, offering cheaper alternatives. This is something that New Zealand-based practitioners cannot do due to professional and ethical obligations. Mr Babor also pointed out that medical tourism companies often engage in "trolling" to suppress negative reviews or comments about their services, a tactic that local providers cannot replicate.

To address the price gap, Mr Babor indicated that New Zealand providers are working on initiatives to lower the cost of bariatric surgery, such as reducing hospital stays, rationalising equipment usage, and adjusting follow-up care.

However, medical tourism often leads to a flow of patients returning to New Zealand with post-operative complications that often require intervention in the public healthcare system. These complications range from minor issues, such as difficulty tolerating fluids post-surgery, to more severe cases requiring surgery or radiological interventions. Additionally, patients who have bariatric surgery abroad often face issues related to nutritional deficiencies, which require expensive blood tests for conditions like vitamin A and vitamin K deficiencies. These tests are not typically funded by the public healthcare system in New Zealand, creating further challenges for post-operative care.

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Bariatric surgery in New Zealand Pathway

A patient being referred for bariatric surgery receives numerous consultations with a multidisciplinary bariatric team and is provided with 2 years of team oversight with a collaborative, patient-centred approach. Mr Babor's team consists of two psychologists, four dietitians, and four surgeons, all based in Auckland with extensive experience. They work together in the public hospital system, supporting one another to ensure comprehensive care for patients and provide extended care including extensive education on nutrition, psychological responses and lifestyle modifications needed for successful outcomes from surgical weight loss.

The team structure ensures continuity of care, with colleagues stepping in to support patients even if one team member is unavailable. The team prioritises a patient-centred approach, with a strong focus on collaboration and mutual support. This approach aims to provide the best possible care for bariatric patients, both before and after surgery.

The team also handles a variety of other complex upper gastrointestinal (GI) conditions, including perforated ulcers, cancer, gallbladder issues, and reflux surgery. They are skilled in dealing with a broad range of upper GI complications, which sets them apart from practitioners who may perform bariatric procedures without the same level of training in handling these complexities.

Mr Babor briefly touched on the cost of bariatric surgery in Auckland with ranges in price between \$20,000 and \$26,000, depending on the type of surgery undertaken. Follow-up consultations with dietitians and surgeons are included in the hospital charges, though some practices charge additional fees for certain services. Patients are followed for up to a year post-surgery, with some continuing to receive dietitian support for up to 18–24 months.

Bariatric Surgery Registry and surgical outcomes

The Bariatric Surgery Registry is a significant resource for tracking bariatric surgery outcomes across Australia and New Zealand, with 170,000 patients' data stored on a secure server at Monash University in Melbourne. The registry has been enrolling Australian patients since 2012 and patients from New Zealand since 2018. Each year the registry reviews the collected data to identify who is undergoing surgery, the type of initial or 'primary' surgery they had, and how the procedure was financed. The registry aims to gather data from all bariatric patients to monitor the outcomes of their surgeries. Its primary goal is to confirm that bariatric surgeries in Australia and New Zealand are both safe and effective along with helping to monitor surgical results, including complications, and provides real-world data to guide practice improvements. Most importantly, the review of data focuses on the rate of complications following surgery and the long-term impact of bariatric surgery on diabetes and weight loss.²

Mr Babor used data from the registry to outline the success of surgery which showed significant weight loss for patients undergoing the typical bariatric surgery procedures. The Single/One Anastomosis Gastric Bypass (OAGB) procedure results in approximately 40% average total body weight loss at three years while the Roux-en-Y Gastric Bypass (RYGB) and Sleeve Gastrectomy (Sleeve) procedures each on average result in around 33–31% total body weight loss at three years (**Figure 2**).

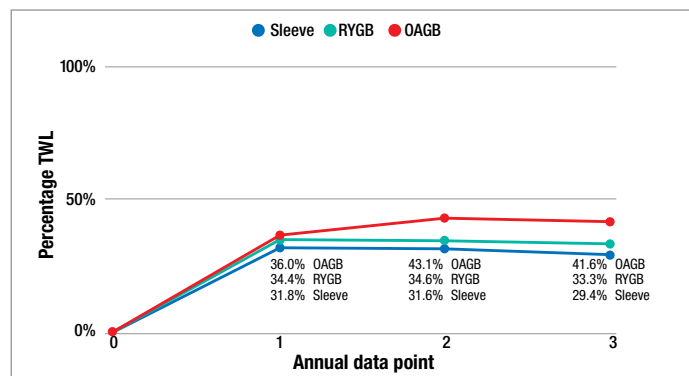


Figure 2: Average percentage total weight loss (TWL) for adult primary participants who have annual weight data for the first 3 years by procedure type in New Zealand, n=380.

Sleeve = sleeve gastrectomy; RYGB = Roux-en-Y Gastric Bypass; OAGB = Single/One Anastomosis Gastric Bypass.



For the first 90 days following surgery, the registry tracks any complications that arise, for example, where a patient requires another procedure, has an unplanned ICU admission, or needs to be readmitted to the hospital after being discharged. Using this data, Mr Babor was able to emphasise the safety of bariatric surgery, noting a very low complication rate, with mortality well under 1 in 1,000 and complications such as leaks occurring at less than 1% (**Figure 3**).

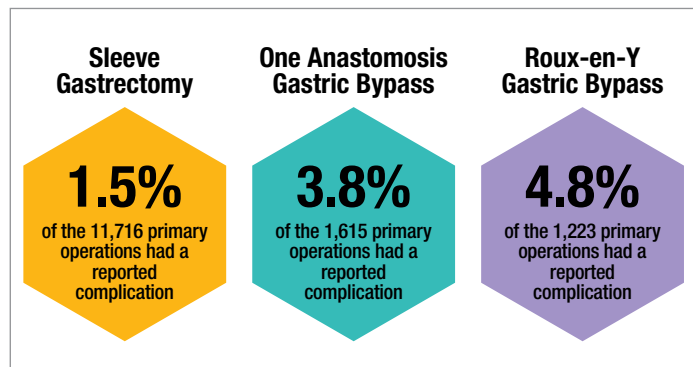


Figure 3: Australia & New Zealand Bariatric Surgery Registry: 90-day perioperative morbidity by procedure type.²

Additionally, an important research aim of the registry looks at the long-term impact of bariatric surgery on diabetes presentation and management. Data from the registry shows that diabetes remission post-surgery is significant with 66% of patients on non-insulin therapy achieving remission after one year (**Figure 4**) and data from the registry show this effect is persistent out to 5 years after surgery.

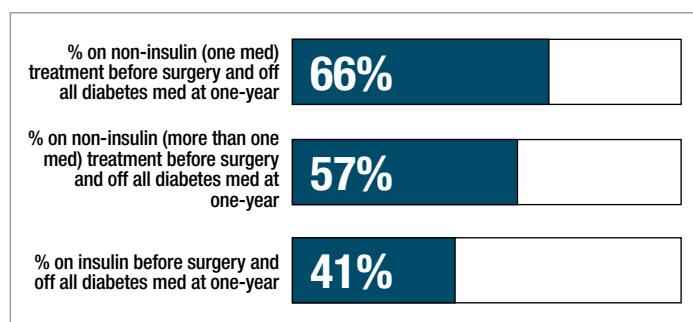


Figure 4: Percent of the primary patients who reported taking diabetes medication at time of surgery and came off all diabetes medication within one year after surgery.²

Medications that may aid weight loss

The speaker discussed the increasing availability of GLP-1 (glucagon-like peptide-1) receptor agonists such as liraglutide, semaglutide, and the newer tirzepatide (currently unregistered in New Zealand), which show potential for weight loss but are not as effective as bariatric surgery.

Liraglutide and similar medications can offer short-term weight loss benefits, but patients often stop using them due to side effects or cost, with only 25% continuing the treatment after one year. These medications are being integrated into clinical practice, especially for patients who need to lose weight pre-operatively or to prevent weight regain post-surgery. Data shows that these drugs may be more effective after bariatric surgery, helping maintain weight loss in patients who experience weight recidivism, particularly post-sleeve gastrectomy. However, weight regain typically occurs once the medication is discontinued, and Mr Babor highlighted the importance of understanding the limitations of these treatments.

Newer, more effective drugs like tirzepatide, a dual GIP (glucose-dependent insulintropic polypeptide) agonist and GLP-1 agonist, have growing potential to aid in weight management. While tirzepatide offers improved results compared to previous drugs, Mr Babor commented that it still does not reach the long-term effectiveness of bariatric surgeries such as gastric bypass or sleeve gastrectomy.

The speaker acknowledged that these medications would be particularly helpful for patients who are regaining weight post-surgery or need assistance pre-operatively to lose a significant amount of weight before surgery. However, concerns remain

regarding long-term dependence on these drugs and the fact that once patients stop taking them they will likely regain the weight.

In summary, while bariatric surgery remains the gold standard for long-term weight loss, GLP-1 agonists provide a useful adjunct, particularly for pre-operative weight loss and post-surgery weight maintenance. However, the effectiveness of these medications is limited in the long run, and they should be viewed as a temporary solution rather than a replacement for surgery.

Managing post-surgery care

Post-bariatric surgery care involves careful monitoring of hydration, nutrition, medication adjustments, and mental health. Nutritional support and supplementation are critical, as deficiencies can develop. Long-term follow-up with dietitians and regular blood testing are vital for ensuring successful outcomes and addressing potential complications early.

Nutrition care before surgery

Before bariatric surgery, patients will typically have two dietitian appointments to help establish healthy habits that will support their recovery. These sessions focus on regular eating patterns, reconnecting with hunger and fullness cues, and learning to eat and drink slowly. Patients are guided to gradually reduce their intake of high sugar and fat foods, while emphasising healthy meal planning and preparation. The importance of protein at each meal is stressed, as well as the role of physical activity, with recommendations to engage in exercise most days, including bodyweight resistance exercises twice weekly for muscle maintenance. Patients will also be provided with education on the post-operative diet progression and necessary supplements in preparation for surgery.

Surgical discharge

After bariatric surgery, patients are typically discharged with specific dietary and medication guidelines to ensure proper recovery. Patients are advised to maintain proper hydration and consume at least 1.5 litres of fluid per day. In some cases, intravenous fluids may be administered to patients presenting with symptoms like lethargy and nausea. For the first three weeks, patients should consume a pureed high-protein diet, supplemented with protein powder, followed by three weeks of soft foods, gradually transitioning to solid foods. Patients are instructed that it is important to avoid drinking water 30 minutes before and after meals. Glycaemic agents are generally discontinued, however may be restarted if blood sugar levels exceed 12mmol/L on two or more separate occasions. All patients are provided with analgesia medication, anti-emetics and Laxsol (not lactulose). A bariatric-specific multivitamin, along with thiamine, should be started, and calcium and vitamin D supplementation is recommended for gastric bypass patients.

Nutrition care after surgery

After bariatric surgery, patients typically have six follow-up dietitian appointments to ensure proper nutrition and recovery. The focus is on regular meals, avoiding non-hungry snacking, and ensuring a daily intake of 60–80g or more of protein. Portions gradually increase to 1–2 cups over time, with an emphasis on eating slowly, chewing well, and not drinking during meals. Patients are encouraged to consume more than 1.5 litres of fluids daily and are advised to take lifelong supplements to support their nutritional needs.

Supplement use after bariatric surgery

After bariatric surgery, patients are required to take a bariatric-specific multivitamin, as standard multivitamins do not contain sufficient nutrients. For those with gastric bypass and patients under 30 years of age, calcium and vitamin D supplementation is essential. Thiamine should be taken for the first three weeks post-surgery, and in cases of poor oral intake, vomiting, complications, or alcohol use, a B1 supplement may be prescribed. Due to New Zealand regulations, many over-the-counter supplements contain low levels of iron, B12, zinc, and vitamin D, which may necessitate additional supplementation, particularly for B12 and iron.

Medication management post-surgery

As mentioned above, most medications, including antihypertensives, are continued post-surgery but it is highly recommended that these are reviewed in the post-surgical period. Typically, diabetic medications like metformin can be continued, while sulfonylureas and glitazones are typically discontinued due to the risk of hypoglycaemia. Many patients on insulin will be able to cease taking it and those that remain on it will be on a much-reduced dose, usually guided by blood sugar level measurements (**Table 1**).



Table 1: Diabetes medication management plan

Medication	Management plan
Metformin	Continue
Sulfonylureas (eg. glipizide, gliclazide)	Stop. Hypoglycaemia risk
Glitazones	Stop
DPP-4 inhibitors (eg. vildagliptin)	Continue (if not combined with insulin)
GLP-1 receptor agonists (eg. liraglutide)	Stop if not tolerating full Optifast diet / too full
SGLT-2 inhibitors (eg. empagliflozin)	Stop 3 days prior to starting VLCD. DKA risk
Alpha-glucosidase inhibitors (eg. acarbose)	Stop
Empagliflozin with metformin	Stop 3 days prior to starting VLCD
Insulin	Hypoglycaemia risk. Dose review by diabetes service / primary care. Optifast complex patient protocol.

Mr Babor responded to a question from the audience regarding blood pressure medication and advised that some patients may experience dizziness and therefore may need adjustments in their blood pressure medication.

Psychiatric medications like selective serotonin reuptake inhibitors (eg. sertraline) can be continued post-surgery, with adjustments based on clinical response. Mr Babor commented that most patients experience an improvement in mood following weight loss, and some may reduce their psychiatric medications, though those on more complex regimes may require closer monitoring.

Ongoing care and monitoring after surgery

Ongoing care and monitoring after bariatric surgery involves continued support from the bariatric team for up to two years, with further care as needed. Patients are given six dietitian consultations, although many drop out after about four visits. International studies indicate that more dietitian consultations correlate with better long-term outcomes.

Regular community care includes routine blood tests to monitor blood counts, liver function, kidney function, iron studies, folate, B12, calcium, parathyroid hormone, vitamin D, B6, zinc, and copper levels (**Table 2**). Additionally, HbA1c should be checked, with extended screenings for conditions such as fat malabsorption in patients who have undergone procedures like duodenal switch or single anastomosis duodenal-ileal bypass (SADI). Depending on the individual, levels of vitamin A, E, and K may also be monitored. Calcium and vitamin D prescriptions are especially important for those who have had a gastric bypass.

Table 2: Recommended monitoring post bariatric surgery

Pre op and annual post op form	3, 6, 18 months post op
Electrolytes	Electrolytes
Creatinine	Creatinine
Renal function	Renal function
Calcium	Calcium
LFTs (incl protein and alb)	LFTs (incl protein and alb)
Lipid profile	HbA1c
HbA1c	Ferritin
Ferritin	Iron studies
Iron studies	CBC
CBC	B12
B12	Folate
Folate	PTH
PTH	Vit D
Vit D	CRP
CRP	
Vit B6	
Urate	
TSH	

Post-surgical patients are advised to refrain from alcohol consumption for at least 12 months, as alcohol is absorbed rapidly after bariatric surgery, leading to a higher risk of addiction. Even small amounts of alcohol can be highly intoxicating, so caution is highly encouraged.

Mr Babor commented that conditions like irritable bowel syndrome may respond unpredictably to bariatric surgery, with some patients experiencing improvements while others may see exacerbated symptoms. The reduction in food intake post-surgery may alleviate symptoms in some cases.

Patients are encouraged to monitor their own health, with a focus on mental health and lifestyle changes. If any concerns from the primary care team arise, patients should be referred to the bariatric surgical team for further evaluation and care.

Nutritional deficiencies post-surgery

Bariatric surgery can lead to deficiencies in vital nutrients, particularly vitamin D, folate, and iron, especially in women of reproductive age. Regular post-operative blood tests help monitor these deficiencies.

Standard multivitamin tablets are insufficient for bariatric surgery patients. Specific supplementation with multivitamins, calcium (500mg daily), and vitamin D (1.25mg weekly) is recommended long-term.

Usually, patients are given thiamine supplements for the first three weeks to prevent neurological complications, although thiamine deficiency is rare. Management recommendations for common vitamin deficiencies are provided in **Table 3**.

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Table 3: Management of common deficiencies

	Risks	Symptoms	Treatment
Thiamine (B1)	Poor oral intake Rapid weight loss Prolonged vomiting or dysphagia Alcohol	Fatigue Poor memory or "brain fog" Neuropathy Change in balance Change in vision Oedema	PO Thiamine 200–300mg daily, then 25–100mg daily Or IV Pabrinex Monitor symptoms
Vitamin B12	Vegetarian/vegan Bariatric surgery PPI therapy	Weakness Numbness Pins and needles Changes in balance and coordination	IM 1000mcg inj 2–3x weekly for 2 weeks then every 3 months Treat BEFORE folate Monitor
Iron	Vegetarian/vegan Bypasses Menstruating women GI blood loss Inflammatory bowel conditions	Anaemia Fatigue	PO 150–200mg of elemental iron daily up to as high as 300mg 2–3 times daily Monitor
Vitamin D	Obesity Darker skin tone	Decreased bone mineral density Secondary hyperparathyroidism	PO 50,000IU weekly for 4 weeks, then monthly and monitor
Zinc	Low protein intake GI malabsorption	Unexplained anaemia Change in taste Hair loss	PO zinc caps (50mg) once daily and monitor. Maintain a ratio of 8- to 15-mg zinc to 1-mg copper. Copper not on prescription.
Folate	Poor quality diet Not taking multivitamin	Fatigue Weakness Mouth sores	PO 5mg daily for 4 months and monitor

Managing complications in primary care

Post-operative complications often require intervention from primary physicians and can range from minor issues, such as difficulty tolerating fluids post-surgery, to more severe cases requiring surgery or radiological interventions. Mr Babor provided a brief summary and management plan for commonly seen complications.

Nausea

- Commonly presents in the first 4 weeks post-surgery.
- A patient may present with nausea and/or anorexia, frothy vomiting after food or fluids and poor eating patterns with regard to the volume, speed or composition of diet.
- Primary concerns are dehydration, protein intake and multivitamin compliance.
- Differential diagnosis may be bleed/haematoma, stenosis/obstruction or a leak.
- Not suitable to treat with antiemetics alone. Assessment for poor eating patterns and fluid intake is needed.
- Management:
 - Oral fluid resuscitation vs IV fluids;
 - Provide education on oral intake;
 - Hydration aim 1.5L/day orally;
 - Blood tests: FBC, Extended UEC, CRP;
 - Provide antiemetics and thiamine;
 - Liaise with surgeon and consider referral for admission.

Epigastric pain

- Presents with epigastric or right upper quartile pain (usually after fatty meals) with pain radiating to back, and nausea.
- Primary concerns are GORD, marginal ulcer, biliary stone pathology, internal hernia or obstruction.
- Up to 20% of patients develop gallstones post bariatric surgery, 8–9% are symptomatic requiring cholecystectomy (3 times higher than the general population).
- Management:
 - Clinical review;
 - Bloods – FBC, LFT, CRP +/- nutritional screen;
 - Prescribe proton pump inhibitor (stop any NSAID use);
 - Consider ultrasound or CT scan;
 - Referral for review and endoscopy, diagnostic laparoscopy, laparoscopic cholecystectomy +/- intraoperative cholangiography.

Hypoglycaemia

- Post prandial hypoglycaemia occurs 1–3 hours after eating with presenting symptoms of heart palpitations, sweating, shaking, hunger, fatigue, confusion and fainting.
- More common in patients after gastric bypass surgery and rare after sleeve gastrectomy.
- Risk factors: females, younger age, no history of diabetes prior to surgery, lower HbA1c pre-surgery, history of hypoglycaemia, greater excess weight loss.
- Management:
 - Firstly make dietary adjustments: increase protein, limit carbohydrate, choose low glycaemic index foods at meals;
 - Space meals 3–4 hours apart;
 - Avoid drinking liquids with meals;
 - Avoid caffeine and alcohol;
 - Consider the timing of exercise;
 - Consider medication or refer to Endocrinologist as next step.

Diarrhoea and dumping

- Presents with frequent loose bowel movements that are floating or smelly, morning bowel movements more common.
- Concern for pancreatic asynchrony and pancreatic exocrine insufficiency versus dumping syndrome.
- Consider a diabetes clinical referral for hypoglycaemia.
- 10 point plan for managing dumping:
 1. Control carbohydrate portions;
 2. Choose low-glycaemic carbohydrates;
 3. Avoid high-glycaemic carbohydrates;
 4. Include (heart healthy) fats in each meal or snack;
 5. Emphasise optimal protein intake;
 6. Space meals and snacks 3–4 hours apart;
 7. Avoid consuming liquids with meals;
 8. Avoid alcohol;
 9. Avoid caffeine;
 10. Maintain post-bariatric vitamin and mineral intake.

Fertility and pregnancy

Obesity is associated with oligoovulation or anovulation as well as a reduced response to fertility treatment. After bariatric surgery, the return of fertility can be rapid due to post-surgical weight loss improving multiple hormonal changes relating to polycystic ovary syndrome, such as insulin resistance and androgen levels, which lead to a reduction in anovulation and enhances the potential for conception.

Therefore, it is recommended that patients consider fertility advice before surgery if they are nearing geriatric maternal age and potentially defer pregnancy until 12–18 months after surgery or to a point of weight stability in an effort to optimise weight loss and reduce the potentially adverse effect of post-bariatric surgical nutritional deficiencies.



Consideration should be given to the type of contraceptive used in the post-surgical period due to enhanced fertility associated with weight loss as well as certain types of bariatric surgery reducing the absorption of oral contraceptives.

A bariatric specific multivitamin should be continued until conception when change to a pregnancy multivitamin is recommended, however patients should be monitored for vitamin A deficiencies as these multivitamins usually do not contain vitamin A.

During pregnancy, bloods should be monitored per trimester however an oral glucose tolerance test should not be undertaken due to the increased risk of dumping syndrome. Patients should be referred to the High Risk Maternity Bariatric Dietitian Clinic for continued monitoring and advice.

Disordered eating

Binge eating disorder (BED) and bulimia nervosa (BN) are seen at a higher rate in the bariatric population with 6.1% of patients meeting BED criteria and 1.2% meeting BN criteria post-surgery. BED is a way of coping with either physical or emotional deprivation and is linked to weight regain, low self esteem and poor quality of life. It is likely that eating disorders are more prevalent than reported and those with a history of disordered eating are often more aware of the signs and triggers post-surgery and seek support. Patients who mask issues or do not have them addressed prior to surgery may struggle more after surgery if coping strategies are not established.

While deciphering disordered eating from the post-surgical complications or restrictions is challenging, physicians should consider if there are attempts to

suppress weight below what is medically and physically stable. BED may present differently after surgery however the element of loss of control is key.

Management should start with establishing regular meals and adequate nutrition to properly fuel and avoid hunger triggered binges. Consideration should be given to working with a psychologist or Health Improvement Practitioner on emotional based triggers. Focus should be given to non-weight-related goals such as BP or blood glucose improvements, less pain, improved sleep, improved mood or ease of living. Creating a non-judgemental environment and establishing trust is an important step to helping patients open up and seek support.

Weight regain

The factors relating to the regain of weight are complex and multifactorial and may include changes in the hormonal response that have tempered over time, along with surgical or anatomical contributions and eating behaviours.

A review of dietary behaviours should be considered including snacking/grazing, soft drinks, and prolonged fasting coupled with overeating. A review of liquid and/or alcohol consumption should also be undertaken. The patient should be reminded of successful eating habits including mindful eating and keep a food diary to install good eating behaviours along with regular exercise.

Longer-term, consideration should be given to prescribing a GLP-1 agonist or referral back to the bariatric team for review and management.

TAKE-HOME MESSAGES

- In the public healthcare system in New Zealand, access to bariatric surgery is limited to patients with a BMI of 30 or higher and the existence of type II diabetes or obstructive sleep apnoea.
- Private bariatric clinicians are happy to discuss all potential referrals, especially those for complex patients with specific health concerns who do not meet the public criteria.
- Data from the Australian/New Zealand Bariatric Surgery Registry shows approximately 40% average total body weight loss at three years following a OAGB procedure compared to RYGB and Sleeve procedures which each on average result in around 33-31% total body weight loss at three years.
- The registry shows these surgeries have a very low complication rate, with mortality well under 1 in 1,000 and complications such as leaks occurring at less than 1%. Diabetes remission post-surgery is significant with 66% of patients on non-insulin therapy achieving remission after one year.
- While bariatric surgery remains the gold standard for long-term weight loss, GLP-1 agonists can provide a useful adjunct, particularly for pre-operative weight loss and post-surgery weight maintenance.
- Post-bariatric surgery care involves careful monitoring of hydration, nutrition, medication adjustments, and mental health. Nutritional support and supplementation are critical, as deficiencies can develop. Long-term follow-up with dietitians and regular blood testing are vital for ensuring successful outcomes and addressing potential complications early.

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