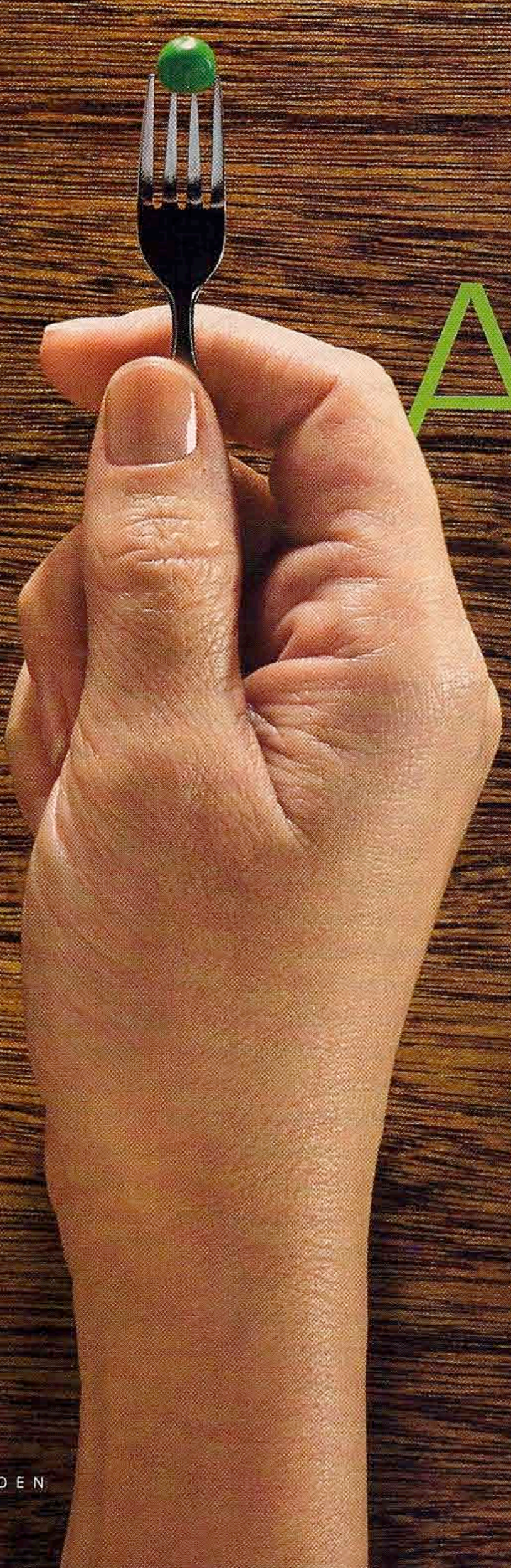
The Incredible Shrinking Stomach

Singer Carnie Wilson, weatherman Al Roker, and more than 100,000 other obese Americans cut through their weight problems with gastric bypass surgery, only to discover it's not as simple as snip snip, you're thin. **AIMEE LEE BALL** reviews the upside, downside, and outsize complications of the ultimate tummy tuck.



PHOTOGRAPHS BY FREDRIK BRODEN

A SUPPORT GROUP IS straining the capacity of a windowless conference room in a Cincinnati hospital. The subject is obesity surgery, and the people gathered here either have had the operation or are contemplating it. One post-op named Courtney takes chalk to blackboard and draws a view of her new stomach pouch, the size of an egg, while Darren, just a month after surgery, recites the mantra to chew everything 32 times before swallowing. Ashlee speaks about her sweet tooth, which has not abated much since she had the procedure a year and a half ago, and Amanda studies the nutritional label on a box of frozen chicken fingers for fat content. Sarah has only recently started walking again: After surgery she became so malnourished that she lost motor ability and developed beriberi, the result of a vitamin B1 deficiency. But despite having a Third World ›

disease in Ohio, she is thrilled with her weight loss of more than 160 pounds (her 500-pound brother is waiting in the wings) and amazed at sudden attention from the opposite sex, although she's not sure how to handle it. After all, she's still in the Girl Scouts.

That's right: Sarah, Courtney, Darren, Amanda, and Ashlee are kids who had surgery at ages 15, 19, 19, 18, and 14, respectively. Their support group, called TOOL (Teens Overcoming Obesity for Life), is meeting at Cincinnati Children's Hospital Medical Center.

The procedure under discussion is not new—it goes back about 50 years, when doctors treated cancer and ulcer patients by removing a large part of their stomach or small intestine and observed that they seemed unable to gain weight. But it has only recently become wildly popular, and for good reason: Despite the considerable prevalence of Jenny Craig, Dr. Atkins, and their many cohorts in the multibillion-dollar diet industry, nearly two-thirds of American adults have a weight problem, and almost one-third are obese, crowning us heavyweight champions of the world. Surgery has helped thousands of those for whom traditional diet and exercise failed.

In 2002, the most recent year for which the National Center for Health Statistics has records, 91,000 gastric bypasses were performed. But the real groundswell of interest has occurred since then: Membership in the American Society for Bariatric Surgery (ASBS) increased by some 40 percent in each of the past two years, while an estimated 100,000 obesity procedures were performed in 2003. Along with the evangelical fervor about a surgical solution to redress this country's collectively expanding waistline, perhaps not unexpectedly, there are abuses on the parts of both doctors and patients while basic questions about safety and efficacy remain largely unanswered.

IT WAS A 1991 CONSENSUS PANEL AT the National Institutes of Health that sanctioned surgery as a treatment for "severe obesity." To qualify, patients must have a body mass index, or BMI (a measure of weight in relation to height), of more than 40, roughly 80 pounds over ideal weight for women (normal BMI is 18 to 25). Patients are also eligible if they have a BMI of 35 with comorbid conditions such as hypertension, heart disease, or type 2 diabetes (which is related to obesity). At least 16 million Americans fulfill the requirements, and many bariatric surgeons have yearlong waiting lists of candidates eager to pay (or have their insurers pay) the average cost of each procedure: $25,000.

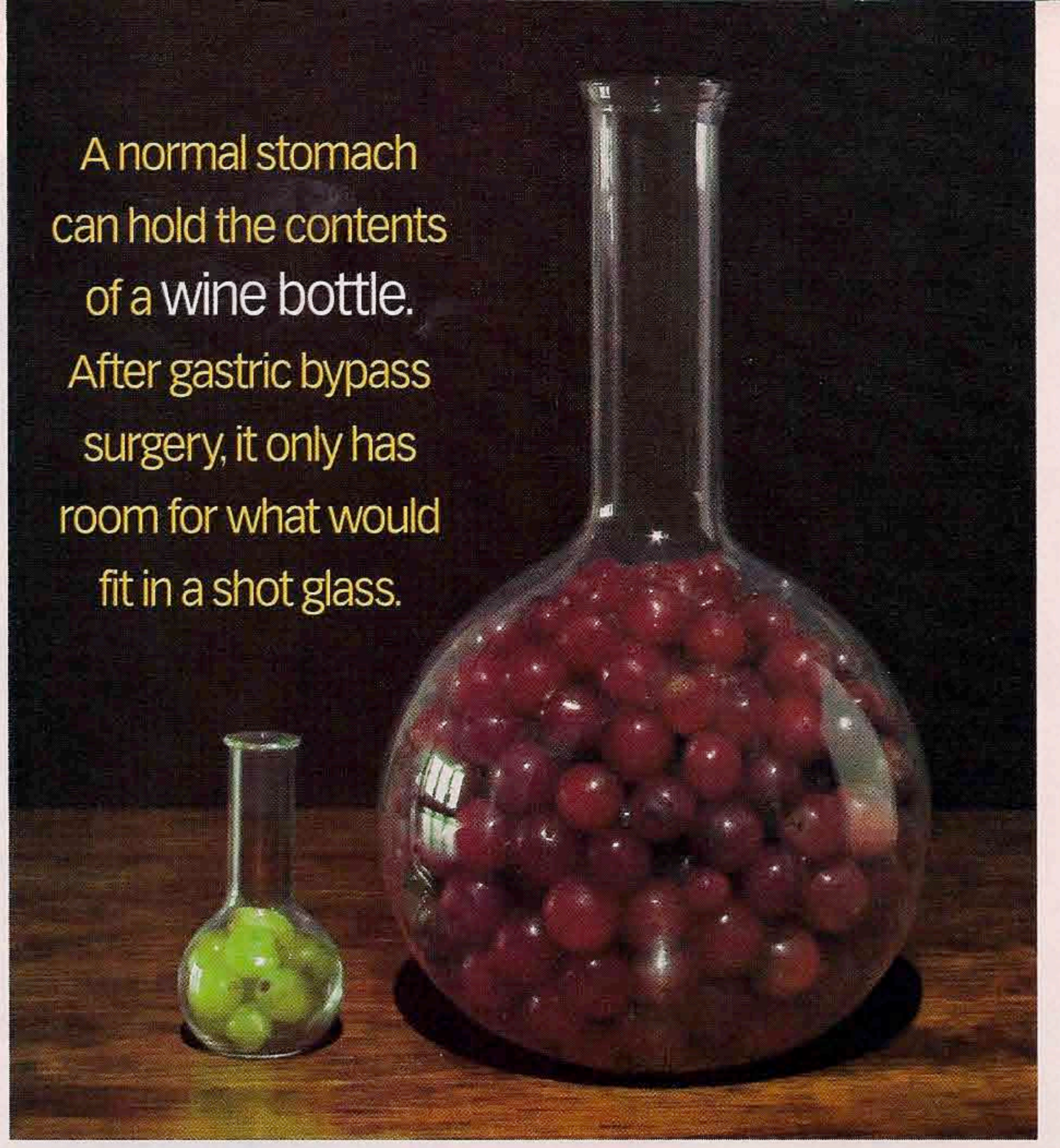
"Hunger is a biologically hardwired response that you can't suppress, even with surgery."

What they're buying, for the most part, goes by the clinical name gastric bypass, a.k.a. the more prosaic "stomach stapling" or the rather elegant "Roux-en-Y" (after Cesar Roux, the Swiss surgeon who pioneered the most common kind of bypass). Whereas earlier procedures removed much of the stomach, gastric bypass merely reduces its volume by creating a new wall with a line of staples; patients become full after eating small amounts of food that pass slowly through the tiny new outlet called a stoma. Compared to a normal stomach, which can hold the contents of a wine bottle, the post-op pouch only has room for what would fill a shot glass. In the mid-1990s, laparoscopic techniques helped reduce pain and scarring; instead of a big abdominal incision, several small cuts are made, and the surgeon works remotely, inserting instruments guided by a microscopic camera. Undoing a bypass, while technically possible, is very complex and rarely done. But in 2001, the Food and Drug Administration approved a device for a procedure that is reversible: A silicone band is placed around the upper part of the stomach to make an hourglass shape, controlling the transit of food without cutting or stapling. Gastric banding produces slower weight loss than a bypass but can be removed with few adhesions.

No one disputes the fact that obesity surgery has many satisfied customers—men, women, and adolescents who are pleased with their Faustian bargain. It's an intervention that does for the obese what Antabuse does for the alcoholic, forcing compliance by making it horribly unpleasant to resume former habits. Typically, post-op patients start with a few weeks of clear liquids sipped extremely slowly. The next stage is baby food. Meat, fish, bread, fruit, and vegetables must be pureed, and only a few tablespoons are permitted at three to six meals; eating more overtaxes the new digestive system and generally causes vomiting. After a month, as the stapled pouch expands slightly, patients can dine on four or five ounces of solid food at a time, but even then they're advised to chew each mouthful until it's mush before swallowing. Forever after, they must take vitamin and mineral supplements and wait an hour before and after meals to drink liquids (otherwise they fill up too quickly to eat enough food for nourishment).

Those who have typically "tried every diet" turn to this Draconian solution, assuming it is a permanent answer to their problem, but that isn't necessarily so. Although the new stomach pouch is smaller, the appetite doesn't necessarily decrease. And patients can sabotage themselves by reverting to old habits, steadily eating highly caloric food—albeit in small amounts—until they gain back the weight or the staples rupture. "People often don't understand what their commitment to a lifestyle afterward must be," says Madelyn H. Fernstrom, PhD, founder and director of the Weight Management Center at the University of Pittsburgh Medical Center. "Hunger is a biologically hardwired response that you can't suppress, even with surgery." Many bypass patients struggle with hunger and mourn the role that food used to play in their lives.

SUCCESS STORIES OF DRAMATIC postsurgical weight loss, with the attendant cosmetic approbation from a culture that values thinness, have been well documented. And celebrity ratification has amped up public enthusiasm. TV weatherman Al Roker proudly showed off his "after" body on the *Today* show. Actress Roseanne Barr, singer Jennifer Holliday, and *American Idol* judge Randy Jackson have new, surgically altered physiques. And while rocker mom Sharon Osbourne kept her procedure private (surprisingly, since so many of her family's intimacies have been broadcast), ›



singer-turned-*Playboy*-centerfold Carnie Wilson invited fans right into the OR, courtesy of a live feed to the Internet.

There are less superficial advantages of the surgery, too: Diabetes is often reversed within days, although doctors don't completely understand the phenomenon. But whether these benefits last remains a huge question mark. There are no long-term studies and no real answers from any of the institutions that usually track medical statistics. "The committee here decided not to report success rates because there's too much variability in defining what's a success and what isn't," says Kathleen Renquist, manager of the International Bariatric Surgery Registry (IBSR) at the University of Iowa in Iowa City. The IBSR does gather some data from its surgeon members, but there are fewer than 50 and reporting is voluntary.

Data is also lacking when it comes to the risks. No governmental agency tracks the procedure's mortality and morbidity (medicalese for "death and damage"). "It takes a real commitment on the part of surgeons to collect this information and submit it," says Renquist. "It's certainly not a marketing tool: What if they have high complication rates?"

As it is, complications are well enough known that a new acronym has found its way into the parlance: GBGB, for "gastric bypass gone bad." Up to 20 percent of patients develop an abdominal hernia, a weakness in the muscle wall, which calls for an additional operation. And successful weight loss often requires cosmetic surgery to deal with excess skin—removal of the typical overhanging belly even has its own name: a panniculectomy. Vitamin deficiencies and osteoporosis are common repercussions of limited food absorption, and many people lose their hair because they can't get enough protein from their whittled-down diet. There's also a chronic syndrome that goes by the lovely name "dumping." Since food no longer flows slowly through the gut, when a post-op eats sweets there's a sudden rush of simple sugars through the small bowel. The body reacts with massive insulin production, which can cause a shocklike state—cold sweats, pounding pulse, dizziness, cramps, and diarrhea—and there's not much to do except wait it out.

Much more threatening, a leak from the staples can lead to a severe abdominal infection, similar to a ruptured appendix; it requires immediate repair, or it can be fatal. And, as with any major surgery, there are risks of wound infections and life-threatening blood clots, made all the more urgent because obese patients, whose hearts have often been strained by their weight, are likely to suffer from problems like high cholesterol, high blood pressure, and diabetes. Based on the best data available, collected in conjunction with the National Death Index, the IBSR quotes the statistic that three out of every 1,000 patients who have obesity surgery will die within a month. Informally, doctors acknowledge that the rate of death from obesity surgery may be as high as one in 100.

If you are considering obesity surgery, ask your doctor for referrals, and shop around until you find a surgeon you trust. Make sure he or she is extremely experienced (has done hundreds of operations versus 20 or 30) and has a low incidence of complications. Information and referrals can also be found at asbs.org.

AS OBESITY SURGERY BECAME an increasingly lucrative field, general surgeons started attending Saturday and Sunday training sessions (where the guinea pig "patients" were often literally pigs) and declaring themselves qualified on Monday. "There was an explosion of weekend courses and a lot of complications, a lot of inappropriate surgery, a lot of people dying," admits Kenneth Champion, MD, an Atlanta surgeon who heads an ASBS committee to establish centers of excellence for bariatric surgery. "We want to set standards for educating and retraining surgeons. This involves lectures, lab work, a proctoring program where a surgeon would actually work with someone experienced. That is not what's happening now." Self-policing of the profession may seem like the foxes watching the henhouse, but even this minimal effort is taking a long time to implement. "We're really in the infancy stage," says Champion.

Proper qualification is definitely critical, says Elliot Goodman, MD, chief of bariatric surgery at Beth Israel Medical Center in New York City. "There's no official training, and as a surgeon all you need to do is convince the hospital that you can perform the procedure. So you can just ›

go take a course, get somebody to proctor you for a few cases, then you advertise, and all these patients are lining up at the door."

And wherever there are doctors with imperfect outcomes, the lawyers are not far behind. "It's a little Wild West out there," says Paul Simonson, partner in the New York and New Jersey law firm of Simonson Hess & Leibowitz, whose practice is labeled "Your Gastric Bypass Mal-Practice Resource" and who asserts that in most of the several dozen cases he reviews every year, the problem is in the aftercare. "There are an unprecedented number of surgeons doing this," says Simonson, "and their attitude is: Nothing to worry about—I know how to do the suturing, and I'm not going to get a leak." Simonson quotes one case in which the patient was told to take two aspirin for pain that turned out to be the unheeded warning of a leak from bypass staples. The leak killed him. "On an individual basis, it's difficult to tell a person, 'Don't do this procedure,' because the risks of being morbidly obese are so great. But when you have a union of complex surgical procedures and high-risk patients, there are going to be deaths."

Patients themselves sometimes push safety limits. There are people so desperate for the operation that they gain extra pounds intentionally in order to make the cut, or conceal metal weights under their clothes when they get on the scale at the surgeon's office. At 5'5" and 240 pounds, Paulette Zanotti went to the University of Pittsburgh Medical Center "determined that I was going to come out with an appointment for my surgery. But they told me that I was 15 pounds under the criterion. That was like putting a stake through my heart. All my life I was told I was too fat. Now I'm told I'm not fat enough. First thing I did, in tears, was go to a fast-food drive-through and order a greasy meal. I thought, *I will qualify for this surgery no matter what it takes.*"

A year's worth of bingeing did the trick: Zanotti packed on 15 pounds to qualify for gastric bypass, and since the operation she has lost about 100 pounds. "But this is not easy," says the 47-year-old nonprofit special events coordinator. "Surgery controls the amount you can eat at any one time but not the frequency. I could eat every hour on the hour—those soft carbohydrates that go down real well—and gain it all back."

WHEN 450-POUND-PLUS actor Michael Genadry decided on surgery, it was written into the story line of the NBC show *Ed,* where he plays a high school student.

Any controversy about obesity surgery is magnified when the subject is an adolescent. Bariatric surgeons often defend the procedure for teens who have failed at conventional means of weight control, claiming that it's possible to calculate precisely when a child has finished physical growth, and that obese children mature much earlier than normal-size children.

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The American Pediatric Surgical Association has basically endorsed the practice in select teens since it supported a position paper written by Thomas Inge, MD, a pediatric surgeon at Cincinnati Children's Hospital Medical Center, where the TOOL support group meets. "It's absolutely the same surgery, nothing different in the operating room, same challenges, same risks," says Inge. "The emotional well-being of the child is important. These kids are teased, ridiculed, and shunned by their peers. It's a drastic intervention. It should be the last door in the hallway after everything else has been tried, but for some no treatment other than surgery will be effective. The message has always been prevention, prevention, prevention. It's no longer applicable."

"Sure, you can tell when a child is finished growing, but there's so much more to this issue," counters Naomi D. Neufeld, MD, a pediatric endocrinologist in Los Angeles. She worries about a procedure that will dictate a young person's eating habits in perpetuity, without addressing the reasons why he or she might weigh 200, 300, 400 pounds in the first place—reasons that do not disappear with surgery. Neufeld's KidShape program aims to protect children from eating disorders through nutrition and exercise guidance in a world of Big Macs and Big Gulps. "Look at the composition of a 'supersize' meal," she says. "It's the total caloric requirement that a reasonably active adult woman should eat in a day. Why is a 4-year-old eating that meal?"

For adults, too, there's no question that surgery often misses the root of the problem. Last year a study at Montefiore Medical Center in the Bronx, New York, revealed that 25 percent of gastric bypass patients had a history of physical or sexual abuse. "We know from the more extreme examples," says Goodman, who was involved in the study, "that they began to put on weight after particularly bad episodes of abuse in an attempt to literally and metaphorically insulate themselves from the attentions of others." Before surgery, 37 percent had some psychiatric disorder, such as depression or anxiety; postsurgery it was 41 percent, despite significant slimming. "They should be happier and less depressed, but they're not. Why is that? There are two possibilities: The depression is unrelated to the weight. Or perhaps one way of dealing with depression is bad eating, and if you remove that maladaptive response to stress, it induces some other sort of emotional stress."

The psychologically vulnerable obese population is particularly susceptible to aggressive marketing and the many medical cheerleaders of gastric bypass. Susie Shumard of El Centro, California, learned about the procedure through an advertisement in her local paper. At age 45 and 212 pounds, she says she was told she was a perfect candidate for the laparoscopic procedure, which was performed in November 1995. After the surgery, Shumard fell into a coma and did not wake up until the following March: Her abdominal cavity was found to be flooded with bacteria, her temperature spiked to 107, her lungs collapsed, and her neck was broken during emergency surgery and resuscitation. After her spine was fused from the third to the eighth vertebrae, she was on pain pills for more than a year and is still confined to a wheelchair most of the time. She had to take early retirement from a high-paying job with the ›

county planning and building commission—she is considered permanently disabled. "I'm not skinny by far," she says, "but I can barely eat without rushing to the bathroom." Shumard won a settlement against the hospital (whose bill was almost $1 million), the manufacturer of the laparoscope, the assisting surgeon, and her doctor, Alan C. Wittgrove, MD, who did Carnie Wilson's surgery and is the president of ASBS. Shumard says that it wasn't until the legal action that she learned she'd flunked the presurgery test (a formal list of questions) to ensure that she understood the risks. She also discovered that she'd been mismeasured as 5'2". At her actual height of 5'4", she would not have qualified. "The video of the surgery happened to disappear and never surfaced," she says. "I went to a support group once to try to warn people what could happen. I wasn't invited back. They only want to hear good stories."

In response, Wittgrove claims that a severe untreated bacterial infection that Shumard probably brought into the hospital caused the complications. When asked if this wouldn't have been discovered before the surgery, he said no. He further maintains that Shumard, like all patients in his practice, was fully informed of the risks and that she was an appropriate candidate for the bypass.

Because of cases like Shumard's, Edward Livingston, MD, who started the bariatric surgery program at UCLA Medical Center in Los Angeles, decided he wanted out. "I was running a big university program that was the magnet for problems that occurred in other bariatric practices. Some of the most prominent members of the ASBS have some of the worst complication rates, and I know because I took care of their patients." The biggest problem among surgeons, he says, "is not knowing how to manage complications."

Livingston left UCLA for the University of Texas Southwestern Medical Center in Dallas to study the risks and outcomes of bariatric surgery. He challenges some of the rationale for having the procedure—for instance, the reversal of diabetes. "The question is, What happens five years down the road? Nobody's done that study. The diabetes may come back as patients accommodate to the bypass. And it's well known that if people lose even 10 percent of their body weight, the diabetes will either get better or go away without surgery. What bothers me is that the criteria for surgery are pretty loose, and they get stretched. People wind up having surgery for which there isn't a clear benefit."

A new five-year study by the National Institute of Diabetes and Digestive and Kidney Diseases will begin to address some of these questions. Other research is pending, the necessary answers years away.

OBVIOUSLY, GASTRIC BYPASS is (pun unintended) no free lunch. But with the ballooning popularity of the operation, it's too often viewed as an easy out rather than a last-chance saloon. "It's the way of America: We like quick fixes," says Marcelle Olfen, a psychotherapist in northern California who used to screen candidates for bariatric surgeons in San Francisco. "I'm not doing it anymore," she says. Her experience left her with the same concerns for their psychological and emotional readiness that Livingston has for their medical qualifications. Instead she has joined an ad hoc committee of the Humboldt-Del Norte Independent Practice Association (IPA), a group of 380 doctors and health professionals who have developed a multidisciplinary approach to weight loss. "It requires a lifestyle change around food, as well as dealing with eating addiction issues and emotional triggers," says the IPA's chief medical officer, Alan Glaseroff, MD. He is appalled at bariatric specialists who come soliciting new patients in his community. "They're telling people how to get around the barriers to surgery. We don't call it a barrier—we call it proper medical care. Obesity has an impact on the healthcare system equal to that of cigarettes. But where is the funding for programs like ours? We can only offer it to a small percentage of people in our county." And to all those doctors profiting off the fat of the land, Glaseroff has this to say: "If this surgery is so important to so many people, make it really available. Drop your prices." ●

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