WESTERN ZONE

BARIATRIC SURGERY PRE-OPERATIVE CHECKLIST

(see quick reference guide for details)

Initial Evaluation	Preparing for Surgery	Post Surgery
CLASSIFICATION & ASSESSMENT Weight: _____ □ lbs □ kg Height: _____ □ in □ cm BMI: : _____ kg/m² Class: □ I □ II □ III □ IV□ V EOSS Stage: □ 0 □ 1 □ 2 □ 3 □ 4 ***MENTAL HEALTH*** □ Binge Eating □ Depression □ Anxiety □ Alcohol Dependence □ Smoking, Vaping □ PTSD or trauma history □ Realistic expectations discussed ***MEDICATIONS*** □ Anti-obesity medications? □ NSAIDs use? ***ROUTINE CANCER SCREENING*** □ Pap smear □ Mammogram □ Colonoscopy / FOBT-FIT ***REFERRALS*** □ Registered Dietitian □ Psychiatry/Psychology □ Sleep study □ Addiction services □ Eating disorder specialist □ Kinesiology	***DIETITIAN & NUTRITION*** □ RD assessment completed □ Total Meal Replacement Education □ WZON Nutrition Guide □ WZON Bariatric Surgery Guide ***LIFESTYLE & CESSATION*** □ Smoking cessation ≥3-6 mo □ Alcohol use addressed □ Mental health stable □ BED stabilized pre-op (if applicable) □ Encourage Movement. ***INITIAL BLOODWORK*** □ CBC, lytes, Cr, eGFR, fasting glucose, HbA1c, Lipid panel, Liver panel (AST, ALT, ALP, GGT, bili, albumin), TSH, iIron studies (ferritin, Fe, TIBC, transferrin sat) □ B12, folate, 25-OH Vit D, calcium, PTH □ Vitamin A, E, Zinc, Copper (esp. if RNY) □ INR/PT □ HBsAg, Anti-HCV, HIV □ H. Pylori Stool Ag ***INVESTIGATIONS*** □ EGD (esp. if RNY planned) □ H. pylori treated if + □ ECG □ +/- Abdominal ultrasound □ Chest X-ray □ Sleep study / CPAP initiated □ DEXA scan (if osteoporosis risk)	**Follow Up Month:** □ **Family Doctor:** 1, 3, 6, 12 □ **Dietitian:** 1, 2, 6, 12 □ **Surgeon:** 1, 6, 12 *see dietitian 1 week post op. **Consider**: psychology, kinesiology, other allied health support. ***POST-OP LABS at 3, 6, and 12 mos then annual:*** □ CBC, electrolytes, Cr, random glucose, HbA1c, lipid panel, liver panel, ferritin, iron studies, B12, folate, 25-OH Vit D, Ca, PTH, albumin □ If RYGB, add: Vit A, E, Zinc, Cu, thiamine (B1)

Western Zone Obesity Network's Referring Physician Quick Reference Guide for Bariatric Surgery

Sleeve Gastrectomy (SG) & Roux-en-Y Gastric Bypass (RYGB)
Physician-facing reference for pre-operative patient preparation and post-operative follow-up.

SECTION 1: PRE-OPERATIVE ASSESSMENT & PREPARATION

A. Obesity Classification (WHO/Obesity Canada)

Class	BMI (kg/m²)	Health Risk
Class I	30.0–34.9	Increased
Class II	35.0–39.9	High
Class III	≥40.0	Very High

B. Edmonton Obesity Staging System (EOSS)

Stage	Description
0	No obesity-related risk factors or symptoms
1	Subclinical risk factors (e.g., borderline HTN, impaired fasting glucose, elevated liver enzymes)
2	Established obesity-related chronic disease (T2DM, OSA, GERD, PCOS, HTN, dyslipidemia, OA)
3	End-organ damage (MI, heart failure, diabetic complications, disabling OA)
4	Severe/end-stage disability or life-threatening conditions

Surgical candidacy generally considered at EOSS Stage 2–3. Stage 4 may require careful risk–benefit analysis.

C. The 4 M's Framework (Obesity Canada)

Assess each patient across all four domains prior to referral:

Domain	Key Considerations
Mental Health	Depression, anxiety, PTSD, binge eating disorder (BED), emotional eating, body image, history of trauma/abuse. Screen with PHQ-9, GAD-7, and BED screener (see Section 1G).
Mechanical	OSA, OA, GERD, urinary incontinence, mobility limitations, chronic pain, functional impairment.
Metabolic	T2DM/insulin resistance, dyslipidemia, NAFLD/NASH, PCOS, HTN, metabolic syndrome.
Monetary/ Milieu	Socioeconomic barriers, food insecurity, access to follow-up, insurance/coverage for medications, support systems, cultural considerations.

D. Surgical Criteria & Interventions

Indications for Bariatric Surgery (Obesity Canada Guidelines):

- BMI ≥40 kg/m² (Class III), OR
- BMI ≥35 kg/m² (Class II) with at least one obesity-related comorbidity (T2DM, OSA, HTN, NAFLD, GERD, dyslipidemia, PCOS, OA), OR
- BMI 30–34.9 kg/m² with poorly controlled T2DM (consider on case-by-case basis)

Procedure Options:

Procedure	Mechanism	Key Considerations
Sleeve Gastrectomy (VSG)	Restrictive; ~80% stomach removed	Lower malabsorption risk; may worsen GERD; simpler anatomy
Roux-en-Y (RNY)	Restrictive + malabsorptive	Better for GERD and T2DM; higher micronutrient deficiency risk; dumping syndrome possible

E. Medications to Consider Pre-Operatively

Medication	Notes
Liraglutide (Saxenda) 3.0 mg SC daily	GLP-1 RA; may assist with pre-op weight loss; stop on day of surgery
Semaglutide (Wegovy) 2.4 mg SC weekly	GLP-1 RA; superior weight loss efficacy; stop 2–4 weeks pre-op per anesthesia/surgical team guidance
Naltrexone/Bupropion (Contrave)	Useful if concurrent depression/cravings; CI in seizure disorder, opioid use, uncontrolled HTN
Orlistat (Xenical)	May assist modestly; GI side effects; rarely used pre-operatively
Topiramate (off-label)	May reduce BED behaviors; CI in pregnancy; monitor for cognitive side effects
Metformin	Continue if T2DM/insulin resistance; adjust post-op as glucose improves

Significant Concerns & Contraindications: GLP-1 RAs — risk of aspiration (delayed gastric emptying); discuss timing of discontinuation with anesthesia. Contrave — avoid with seizure history, bulimia, opioid use. All anti-obesity medications should be reviewed by the surgical team pre-operatively.

F. Pre-Operative Workup

Routine Bloodwork:

- CBC, electrolytes, Cr, eGFR, fasting glucose, HbA1c
- Lipid panel (TC, LDL, HDL, TG)
- Liver panel (AST, ALT, ALP, GGT, bilirubin, albumin)
- TSH
- Iron studies (ferritin, serum iron, TIBC, transferrin saturation)
- Vitamin B12, folate, 25-OH Vitamin D, calcium, PTH
- Vitamin A, Vitamin E, Zinc, Copper (especially if RNY planned)
- INR/PT if liver disease suspected
- Fasting insulin (optional, if assessing insulin resistance)
- HbsAg, Anti-HCV, HIV (per institutional protocol)

EGD (Esophagogastroduodenoscopy):

- Recommended pre-operatively, particularly if RNY planned (stomach will be inaccessible post-op)
- Assess for Barrett's esophagus, hiatal hernia, ulcers, gastritis, H. pylori
- Biopsy for H. pylori — if positive, treat with eradication therapy and confirm clearance prior to surgery

H. pylori Testing:
- Test all patients pre-operatively (serology, stool antigen, or biopsy via EGD)
- If positive: eradication therapy (e.g., PPI + clarithromycin + amoxicillin × 14 days, or bismuth quadruple therapy)
- Confirm eradication with urea breath test or stool antigen ≥4 weeks after treatment completion

Additional Investigations:
- ECG (baseline, especially if cardiac risk factors)
- Sleep study / polysomnography if OSA suspected — initiate CPAP pre-op if positive
- Abdominal ultrasound (cholelithiasis, NAFLD assessment)
- Chest X-ray (per anesthesia requirements)
- DEXA scan if osteoporosis risk factors present

G. Binge Eating Disorder (BED) Screening

Screen all bariatric surgery candidates for BED prior to referral. Untreated BED is associated with poorer surgical outcomes and higher risk of weight regain.

Screening Tools:
- Binge Eating Scale (BES) — score ≥17 suggests moderate BED; ≥27 severe
- QEWP-5 (Questionnaire on Eating and Weight Patterns-5)
- Clinical interview: frequency of binge episodes, loss of control, distress, compensatory behaviors

If BED identified:
- Refer to psychiatry/psychology with expertise in eating disorders
- Consider CBT, DBT, or interpersonal therapy pre-operatively
- Pharmacotherapy: lisdexamfetamine (Vyvanse) — Health Canada approved for moderate–severe BED; topiramate (off-label); SSRIs may help with comorbid depression
- BED does NOT necessarily preclude surgery, but should be stabilized pre-operatively
- Consider role of GLP1a or GIP/GLP1 for other obesity complications and monitor symptoms of BED.
- Evidence suggests BED may resolve after bariatric surgery or BED may arise post surgery in those that did not have it in the past.

H. Routine Cancer Screening (Ensure Up to Date)

Screening	Guideline
Pap smear	Per provincial guidelines (q3yr ages 25–69, or as indicated)
Mammogram	Ages 40/50–74 per provincial guidelines; q1–2yr
Colonoscopy	Age ≥50 (or ≥45 if high risk); q10yr if average risk
FOBT / FIT	q1–2yr if not undergoing colonoscopy
Iron studies	Baseline iron studies mandatory — rule out occult GI malignancy if iron deficiency present pre-operatively

Rationale: Post-surgical anatomy (especially RNY) may limit future endoscopic evaluation. Complete all age-appropriate cancer screening prior to surgery.

I. NSAID Avoidance

- Discontinue all NSAIDs (ibuprofen, naproxen, ASA, diclofenac, celecoxib) pre-operatively
- Post-operatively: NSAIDs are PERMANENTLY contraindicated — risk of marginal ulcers, anastomotic ulcers, perforation, and GI bleeding (especially post-RNY)
- Alternatives: acetaminophen, tramadol, topical analgesics, PPI if gastroprotection needed
- Educate patient and update medication list / allergy alerts in chart

J. Smoking & Alcohol Cessation

Smoking:

- Complete smoking cessation required minimum 3–6 months pre-operatively
- Confirm with urine cotinine testing if needed
- Smoking increases risk of anastomotic leak, marginal ulcers, DVT/PE, and impaired wound healing
- Offer NRT, varenicline (Champix), bupropion, and smoking cessation counseling

Alcohol:

- Screen with AUDIT-C or CAGE questionnaire
- Post-bariatric patients are at increased risk of alcohol use disorder (AUD) due to altered metabolism (faster absorption, higher peak BAC, reduced first-pass metabolism — especially post-RNY)
- If current AUD or heavy use: refer for addiction support; surgery may be deferred until stable sobriety demonstrated
- Counsel on lifelong moderation/abstinence post-operatively

K. Mental Health Assessment

- Screen with PHQ-9 (depression), GAD-7 (anxiety)
- Assess for PTSD, history of trauma, self-harm, suicidality
- Evaluate relationship with food, emotional eating, night eating syndrome
- Screen for BED (see Section 1G)
- Ensure patient has realistic expectations regarding surgical outcomes
- Psychiatric/psychological clearance required per bariatric program protocol
- If active untreated psychiatric illness: stabilize before proceeding with surgery
- Post-bariatric patients have elevated suicide risk — ensure ongoing mental health follow-up

L. Dietitian Referral

- Refer to Registered Dietitian (RD) with bariatric expertise at time of surgical referral
- Pre-operative RD assessment: nutritional status, eating patterns, food security, disordered eating, supplement review
- Pre-operative diet education: total meal replacement (TMR) protocol, post-op dietary stages (clear liquids → full liquids → pureed → soft → regular)
- Review WZON Nutrition Guide for Bariatric Surgery with patient
- Post-operative RD follow-up recommended at 4 weeks, 8 weeks, and 6 months post-surgery

SECTION 2: POST-OPERATIVE FOLLOW-UP LABS

A. Post–Sleeve Gastrectomy (SG) Lab Schedule

Timing	Labs
3 months post-op	CBC, electrolytes, Cr, fasting glucose, HbA1c, lipid panel, liver panel, ferritin, iron studies, Vitamin B12, folate, 25-OH Vitamin D, calcium, PTH, albumin
6 months post-op	Repeat above
12 months post-op	Repeat above + Vitamin A, Zinc, Copper if clinically indicated
Annually thereafter	CBC, ferritin, iron studies, Vitamin B12, folate, 25-OH Vitamin D, calcium, PTH, HbA1c, lipid panel, liver panel, albumin

B. Post–Roux-en-Y Gastric Bypass (RYGB) Lab Schedule

Timing	Labs
3 months post-op	CBC, electrolytes, Cr, fasting glucose, HbA1c, lipid panel, liver panel, ferritin, iron studies, Vitamin B12, folate, 25-OH Vitamin D, calcium, PTH, albumin, Vitamin A, Vitamin E, Zinc, Copper, thiamine (B1)
6 months post-op	Repeat above
12 months post-op	Repeat above + DEXA scan if osteoporosis risk
Annually thereafter	CBC, ferritin, iron studies, Vitamin B12, folate, 25-OH Vitamin D, calcium, PTH, Vitamin A, Vitamin E, Zinc, Copper, thiamine (B1), HbA1c, lipid panel, liver panel, albumin, INR if on anticoagulation

RYGB-Specific Note: Higher risk of fat-soluble vitamin deficiencies (A, D, E, K), B12 deficiency, iron deficiency anemia, calcium malabsorption, and thiamine deficiency. Monitor more frequently if symptomatic. Thiamine (B1) deficiency is a medical emergency — suspect in patients with persistent vomiting, neuropathy, or encephalopathy (Wernicke's).

C. Key Post-Operative Reminders

- NSAIDs: Permanently contraindicated post-bariatric surgery (see Section 1I)
- Alcohol: Strongly discourage; altered metabolism post-surgery increases AUD risk (see Section 1J)
- Smoking: Lifelong cessation recommended; ongoing increased risk of ulcers and complications
- Mental health: Ongoing monitoring essential; elevated suicide risk post-bariatric surgery; ensure continued follow-up
- Pregnancy: Avoid pregnancy for 12–18 months post-operatively; ensure reliable contraception; monitor nutrition closely if pregnancy occurs
- Dumping syndrome (RNY): Educate on avoidance of high-sugar/high-fat meals
- Supplement adherence: Lifelong bariatric-specific multivitamin + calcium citrate + Vitamin D + B12 (sublingual or IM if malabsorptive) + iron as needed
- Dietitian follow-up: RD at 4 weeks, 8 weeks, 6 months, and as needed thereafter

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Based on Obesity Canada Clinical Practice Guidelines (2020; updated 2024).
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