

BIOCHEMICAL MONITORING AND MICRONUTRIENT SUPPLEMENTS FOR GASTRIC BYPASS PATIENTS

RATIONALE

- Gastric bypass prevents dietary calcium reaching the duodenum. Deficiency in fat-soluble vitamins (A & D) is a matter of concern, because previous kinds of truly malabsorptive operations did severely reduce fat adsorption. In the context of modern gastric bypass procedures the role of Vitamin D is more important in supporting residual calcium adsorption.
- Some literature suggests an increased risk of bone demineralisation during the first 7-8 years after gastric bypass. Thereafter the risk may be the age-related standard risk, because the intestinal mucosa adapts.
- After Gastric Bypass dietary iron encounters almost no gastric acid, normally involved in assuring the appropriate oxidation state of ingested iron. The bottom line of iron adsorption is Haemoglobin and MCV.
- B12 deficiency may be theoretical, but extra B12 is cheap and harmless.

PATIENTS REQUIRE THE FOLLOWING TESTS

4 weeks, 3 months and 12 months after surgery (repeated more often if abnormal, yearly thereafter if levels were normal).

- Full Blood Count
- Urea & Electrolytes
- Liver Function tests, Bone profile
- Vitamin B12, Folate
- Iron studies
- Vitamin A
- 25-OH-Vitamin D

Bone densitometry is advised 3 & 5 years after operation

AFTER THE 4 WEEK BLOOD SAMPLE

Patients are started on:

- Sanatogen Gold 1 tablet twice daily
- Pregaday or Ferrograd Folic 1 tablet twice daily
- Calcichew D3 Forte 1 tablet twice daily

The dose may be varied in the light of test results

If the **Alkaline Phosphatase** is persistently raised on Vitamin D & calcium supplementation, the Parathormone level should be measured and referral made to an Endocrinologist or Metabolic Physician