

WHITE PLAINS HOSPITAL: FIGHTING AN AMERICAN EPIDEMIC

OBESITY IS A WELL-DOCUMENTED PROBLEM IN AMERICA, AFFECTING MORE THAN ONE THIRD OF THE POPULATION, ACCORDING TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC). DISEASES SUCH AS TYPE 2 DIABETES, OBSTRUCTIVE SLEEP APNEA, HYPERTENSION AND HYPERLIPIDEMIA FREQUENTLY ACCOMPANY OBESITY, FURTHER EXACERBATING AN ALREADY DANGEROUS CONDITION.

THE **BARIATRIC PROGRAM** at White Plains Hospital has the facility, expertise and structured, comprehensive plan to help eliminate many, if not all, of these problems from their root cause. In 1998, White Plains Hospital introduced its bariatric program under the leadership of William P. Homan, M.D., former Director of the Bariatric Department. Championing a multidisciplinary approach, Dr. Homan and his wife, Valerie

Homan, Ph.D., former clinical coordinator of the bariatric program at White Plains Hospital, built a comprehensive program focused on addressing patients' surgical, medical and emotional needs.

In 2000, Philip Weber, M.D., Director of Minimally Invasive Surgery and Bariatrics at White Plains Hospital, joined the team, bringing his expertise in minimally invasive laparoscopic surgery. Having earned his medical degree from Brown University, Dr. Weber completed a

residency at MCP Hahnemann University Hospital and a laparoscopic and robotics fellowship at Hackensack University Medical Center. His arrival marked the introduction of laparoscopic capabilities to the program, which helped ensure patients would receive the safest, most technologically advanced care available.

The Homans established a strong foundation for the program — enough to ensure it would continue following the couple's untimely demise in 2006. The



Philip Weber, M.D., Director of Minimally Invasive Surgery and Bariatrics, and Waheeda Mithani, M.D., bariatric surgeon, in a state-of-the-art White Plains Hospital operating room

PHYSICIAN SPOTLIGHT

WAHEEDA MITHANI, M.D., bariatric surgeon at White Plains Hospital, earned her medical degree from The University of Texas Health Science Center at San Antonio and completed residencies at the University of Illinois College of Medicine at Peoria and St. Agnes Hospital. Following her residencies, Dr. Mithani completed a fellowship in bariatric and minimally invasive surgery at Hackensack University Medical Center.

Arriving at White Plains Hospital in September 2012, Dr. Mithani feels she can connect with the overwhelmingly female patient demographic. Obesity affects women more prevalently than men globally and domestically. The World Health Organization (WHO) reports that obesity affects women at higher rates in all WHO regions, and in 2008, 35% of women in WHO regions of the Americas were obese. It follows, then, that women undergo bariatric surgery at a much higher rate than men. According to the Agency for Healthcare Research and Quality, 82% of all bariatric surgeries were performed on women in 2004.

“I think I’ve definitely seen a certain level of comfort with the patients I see in my practice,” says Dr. Mithani. “Given the high percentage of female patients, there are other weight loss-related issues they’re more comfortable talking about with a physician of the same gender, such as depression, social isolation and difficulties they’ve experienced in their sex lives. I’ve had patients tell me how glad and comfortable they are to have a female physician.”

addition of Waheeda Mithani, M.D., bariatric surgeon at White Plains Hospital, readies the program to care for increasing numbers of obese patients.

The Multidisciplinary Necessity

Because surgery is but one component of bariatric care, a nutritionist, a psychologist, a social worker and a bariatric coordinator join forces with nurses, physicians, physical therapists and surgeons to provide comprehensive care to bariatric patients.



Dr. Mithani talks to a patient as an attentive physical therapist ensures early ambulation.



Dr. Weber coordinates bariatric patient care with Mario Mitic, M.D., doctor of internal medicine.

“Surgical care for bariatric patients is not the only factor taken into account,” says Dr. Mithani. “Because the treatment plan requires a team effort, we employ a multidisciplinary approach. In addition to surgery, preoperative and postoperative care are important components of our program.”

From the Beginning

Upon referral, patients undergo a comprehensive education process that allows them to choose the right surgical option to help them meet their weight-loss goals.

Through one-on-one consultation with Dr. Mithani or Dr. Weber, or attendance at one of the bariatric program’s free monthly educational seminars, patients receive answers to their questions about the surgery, and physicians are able to gauge the extent of a patient’s motivation to lose weight.

The first criterion patients must meet, according to Dr. Mithani, is to demonstrate they have made an effort to lose weight in the past. Patients will also meet with the bariatric coordinator who, in conjunction with Dr. Mithani,



Dr. Mithani has a one-on-one consultation with a potential bariatric patient regarding her surgical options.



Dr. Weber and Dr. Mithani review a bariatric patient file.

oversees the program. The bariatric coordinator guides patients through both preoperative insurance requirements, such as meetings with psychologists and nutritionists, and postoperative rehabilitation and support groups.

“Educating patients about their surgical options is really important,” says Dr. Mithani. “An informed patient is far more likely to succeed and achieve his or her weight-loss goals. The key to our program is to make sure patients are well informed of what is required before, during and after surgery, and then confirming they have the proper support system in place.”

A Team Effort

Cultivating relationships among not only pre- and postoperative patients, but also physicians, is a point of pride at White Plains Hospital’s bariatric program. The physician who conducts the initial preoperative evaluation of a patient sees him or her through postoperative follow up, providing continuity throughout the process.

In preoperative meetings with a nutritionist, patients learn how to assess their current diets and incorporate strategies for staying on track postoperatively. Patients examine their diets with nutritionists and identify necessary

“Primary care physicians (PCPs), endocrinologists, OB/GYNs and orthopedists frequently see patients who would benefit from bariatric surgery, but it’s not always discussed because it’s a difficult subject to broach with patients. PCPs don’t always discuss obesity and its related comorbidities early enough. These specialists may see patients for obesity-related conditions, such as diabetes follow up or knee or hip replacements, and these are all avenues by which their patients’ obesity needs may be addressed.”

— Waheeda Mithani, M.D., bariatric surgeon at White Plains Hospital

changes to shed weight and create more healthful lifestyles for themselves following surgery.

Because patients considering bariatric surgery may not have always been obese, Dr. Mithani examines each patient’s weight-loss history to identify incidents that may have precipitated weight gain. In these cases, psychologists lend their expertise to pinpoint root causes and help patients work out underlying eating disorders or emotional factors tied to their eating patterns. Resolving underlying issues equips patients to succeed after surgery, says Dr. Mithani.

The Surgical Options

After clearing preoperative insurance hurdles, patients review what they’ve learned about each procedure and select the most appropriate one. Bariatric surgery is not simply a quick fix, Dr. Mithani emphasizes. Even undergoing a procedure such as gastric bypass, which studies have shown result in an average weight loss of 62% of excess body weight, requires patients to adhere to strict postsurgical diet and exercise regimens.

Patients who have less weight to lose — between 40 and 50 pounds, according to Dr. Mithani — and who are disciplined

DESIGNED TO FIT

WHITE PLAINS HOSPITAL'S dedication to the care of obese patients extends into the context of its interior design. To facilitate patient comfort, specially designed beds, chairs, commodes, wheelchairs and loungers accommodate greater weights. The operating room table bears approximately 500 pounds, and the computed tomography scanner supports as much as 350 pounds. Surgeons utilize longer instrumentation due to the increased thickness of the abdominal walls in obese patients. Specialized equipment complements the team's patient-centered philosophy of care.

enough to follow a diet and exercise program tend to do well with laparoscopic adjustable banding. According to the American Society for Metabolic and Bariatric Surgery, patients using this option lose between 28% and 65% of excess weight at two-year follow up and 54% at five years. In addition to weight loss, improvement of comorbidities such as asthma, dyslipidemia, gastroesophageal reflux, hypertension and type 2 diabetes mellitus has been demonstrated, although not to the extent observed in patients who underwent Roux-en-Y gastric bypass or sleeve gastrectomy.

During the banding procedure, surgeons place a belt around the upper part of the stomach. The upper part, into which food travels, is much smaller and restricts the amount of food patients consume in one sitting. To control satiety, physicians adjust the size of the pouch by injecting fluid into a subdermal port located around the belly button. Filling the balloon located within the band controls the speed with which food passes from the small upper pouch into the bottom section of the stomach. The upper pouch's reduced size warrants diligent portion control. Eating too much can induce vomiting and increased risk of band slippage, a complication arising from the band sliding too far down into the larger pouch of the stomach.

Laparoscopic band surgery is solely

restrictive in nature, putting responsibility squarely on patients and forcing them to exert more effort in adhering to strict diets than required by sleeve gastrectomy and Roux-en-Y gastric bypass. As a patient's weight-loss goals change, a visit to Dr. Mithani's office for band adjustment allows patients to eat more or less.

For patients challenged by portion control, laparoscopic sleeve gastrectomy may provide the best results. Surgeons restrict the amount of food patients ingest by removing approximately 75% of the stomach, leaving a banana-sized portion holding a maximum capacity of roughly 150mL, according to Dr. Mithani. Because this procedure takes only a couple of hours, the Obesity Action Coalition (OAC) notes that it may be advantageous for patients with severe heart or lung disease.

Sleeve gastrectomy executes a two-pronged attack on obesity. The excised portion of the stomach also reduces the amount of ghrelin — the hormone responsible for stimulating hunger. Patients typically see a reduction in hunger following the surgery, as well as increased satiety due to the lower volume of food held by their stomachs. Dr. Mithani notes that, although suited to patients who tend to eat large volumes, sleeve gastrectomy — like laparoscopic banding — may increase reflux postsurgically. Therefore, she doesn't recommend

these procedures for patients already suffering from significant amounts of reflux preoperatively.

The gold standard of bariatric surgery, according to Dr. Mithani, is Roux-en-Y gastric bypass. Implementing both restrictive and malabsorptive — when nutrients are not absorbed by the digestive tract — components of bariatric surgery, Roux-en-Y bypass has been an effective tool for morbidly obese patients to achieve significant weight loss since the 1960s, according to the OAC.

Surgeons divide the stomach into two parts, forming proximal and remnant pouches. Bypassing a portion of the small intestine, surgeons construct a new pathway for food, the Roux limb. The Roux limb is then attached to the proximal pouch. Food enters into the small proximal pouch, bypassing the remnant pouch and a small portion of the small intestine. The surgery lasts approximately two hours, and patients remain in the hospital for two to three days.

As with sleeve gastrectomy and adjustable gastric banding, patients who undergo Roux-en-Y gastric bypass can only eat small amounts of food — the equivalent to a shot glass, according to the OAC. However, one year after surgery, patients are able to increase food intake to the amount a 7-year-old child would consume. Although reflux is not a concern for gastric bypass,



Comprehensive postoperative care ensures successful outcomes for bariatric patients.



White Plains Hospital staff and Magnet nurses are dedicated to patient care on the hospital's designated bariatric floor.

patients must be mindful of their food choices, not only in volume, but in type, as well. Dumping syndrome, a common ailment for gastric bypass patients who eat sugary or starchy foods, may cause abdominal pain, diarrhea, dizziness, fainting and vomiting, lasting for approximately 30 to 45 minutes.

Comorbidity Resolution

Recently, researchers have realized the effects of gastric bypass on metabolic diseases such as diabetes.

“Gastric bypass is essentially an antidiabetic operation,” Dr. Mithani says. “It’s remarkable that patients with diabetes are frequently off their diabetic medication or have significantly reduced their need for it by the time they leave the hospital.”

A 2004 study published in the *Journal of the American Medical Association* shows significant reduction or elimination of comorbidities such as diabetes, hyperlipidemia, hypertension and obstructive sleep apnea as a result of bariatric surgery. The study, a meta-analysis of literature published between 1990 and 2003, observed that more than 75% of bariatric surgical patients experienced complete resolution of type 2 diabetes following surgery. The study notes that diabetes was resolved most prevalently with malabsorptive procedures such as the gastric bypass, with resolution occurring

within days of the surgery before any significant weight loss had occurred.

Recovery and Maximizing Weight-Loss Success

Postoperative recovery for most patients begins in the hospital. Because the adjustable laparoscopic band procedure is minimally invasive, patients typically return home within a few hours of the procedure and are able to return to work within a few days. For gastric bypass and sleeve gastrectomy patients, a hospital stay of two to three days is common. From the time surgeons complete the surgery until

the patient checks out of the hospital, the Magnet-certified nursing staff at White Plains Hospital provides dedicated care to patients on the bariatric floor.

Bariatric patients’ postoperative dietary requirements differ from other surgical patients. Following Roux-en-Y gastric bypass and sleeve gastrectomy, patients must consume 4 ounces of fluid each hour for the duration of their hospital stays, and, upon discharge, physicians encourage them to carry water bottles to prevent dehydration. Nurses remind patients of their nutritional requirements and facilitate postoperative ambulation, a crucial practice, Dr. Mithani says, to avoid complications such as pneumonia and blood clots.

Dr. Valerie Homan, who strongly emphasized the psychoanalytic side of bariatric patient care, established the support group structure within White Plains Hospital’s bariatric department. At inception, the program’s monthly support groups established a place for patients to gather together and voice their concerns, challenges, successes and strategies with each other. As it developed, the program, facilitated by the bariatric coordinator, nutritionist and psychologist, has incorporated educational lectures from physical therapists, nutritionists, as well as plastic surgeons, who teach patients how to manage excess skin after surgery.

Dr. Weber discusses bariatric patient care with White Plains Hospital Magnet nurses.



CRITERIA FOR WEIGHT-LOSS SURGERY

IN “**THE PRACTICAL** Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults,” the National Heart, Lung and Blood Institute notes that weight-loss surgery is a viable option for “well-informed and motivated” patients and sets forth the following criteria patients must meet to qualify for bariatric surgery:

- + Patients must have a body mass index (BMI) greater than 40.
- or
- + Patients must have a BMI greater than 35 and weight-related comorbidities, which may include heart disease, high blood pressure, sleep apnea and type 2 diabetes.

Lifelong Support

As patients enroll in the support groups, they meet other patients who have undergone bariatric procedures. Experienced members pair with pre-operative group members to share their experiences and offer suggestions and encouragement. Called “Bariatric Buddies,” these relationships provide preoperative patients a constant connection to patients who relate to their experiences. Dr. Mithani observes that, although physicians work hard to educate patients about pre- and postoperative challenges involving bariatric surgeries, patients benefit the most from developing relationships with other patients who know what they’re experiencing.

Support groups and bariatric buddies provide encouragement for patients whose adherence to postoperative diets and exercise programs is of the utmost importance — studies have shown that as much as 20% of bariatric surgery patients fail to lose significant amounts of weight. Not adhering to recommended dietary schedules following surgery sets patients up for failure in meeting their weight-loss goals, says Dr. Weber, and leads to revisional surgery or further weight gain.

Patients not achieving optimum weight loss may return to Drs. Mithani or Weber to be evaluated for revisional surgery. These candidates must follow a similarly rigorous process to what they experienced during initial bariatric surgical evaluation to ensure the procedure will help. Patients meet with the nutritionist again, and trial diets are conducted to determine if patients failed to maintain

their postoperative diet or if the challenge is due to anatomical complications.

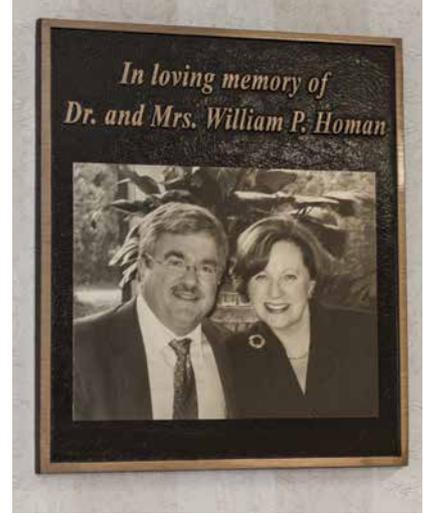
Although such cases are rare, even patients who closely follow postoperative nutrition and exercise guidelines may still fail to achieve optimal weight loss. Dr. Weber recalls in the last seven years, approximately 20 patients experienced anatomical issues related to their surgical interventions. These included ulcers and gastrogastic fistulas, a complication that can arise from Roux-en-Y gastric bypass surgery, which result from the gastric pouch reconnecting with the excluded portion of the stomach. For patients who qualify for revisional surgery, a procedure may be performed to correct complications, and the initial bariatric procedure may be repeated.

Whether patients struggle with their newly restricted diets or they have anatomical reasons for not losing weight, the expert team at White Plains Hospital is equipped to help in whatever way possible. If their struggles cannot be overcome with the encouragement and inspiration of the support groups, patients can see a nutritionist any time they need to. Once patients undergo bariatric surgery, the nutritionist is available to them, free of charge, for the remainder of their lives.

Board-Certified Physicians at the Helm

All physicians at White Plains Hospital are trained to provide the highest standard of care. This standard extends to the anesthesiologists utilized by the bariatric program.

“I have complete faith and confidence in our board-certified anesthesiologists



Plaque of dedicated leaders William P. Homan, M.D., and Valerie Homan, Ph.D., who spearheaded the bariatric program at White Plains Hospital

when I perform bariatric procedures,” says Dr. Weber. “I don’t have to look over the screen — I know who’s there, and I know patients are getting the best anesthesia care possible. A unique quality of our program is the expert care we’re able to give — a quality afforded because we have no mid-level providers caring for patients. We take pride in maintaining strong physician-patient relationships.”

Referring for Change

Because White Plains Hospital’s bariatric department includes specialists from many fields, patients may be referred at any time for evaluation. If patients do not meet the National Institutes of Health (NIH) body mass index requirements for bariatric surgery, the team will preemptively work so they never will.

“We welcome all interested patients to attend our seminars to learn more about bariatric surgery,” says Dr. Mithani. “If physicians have patients who may be good candidates for bariatric surgery based on the NIH criteria, or even if the patient is only slightly overweight, I am happy to see them in consultation. We can facilitate a referral to a nutritionist to see if patients can achieve sustainable weight loss through diet and exercise before recommending surgery.”

For more information about the bariatric program at White Plains Hospital, please visit www.wphospital.org and choose “Bariatric Surgery at White Plains Hospital” from the “Programs and Services” menu. ■