A Guide for Patients Considering Metabolic and Bariatric Surgery

If you are reading this, you are asking one of two questions. Either "do I qualify?" or "is this right for me?"

Those are different questions, and this guide answers both.

Qualifying is about numbers and medical criteria. Being a good candidate is about readiness, safety, and whether surgery is the right tool for your situation. You can meet every number on paper and still not be ready. You can also be a far better candidate than you think you are.

Let us walk through it honestly.

First, the most important thing you should know

Obesity is a chronic disease. It is not a character flaw, a failure of discipline, or a lack of effort.

Your body actively defends its weight through hormones, hunger signals, and changes in metabolism. This is why diets so often work for a while and then stop working. It is not that you did it wrong. It is that your biology fought back, which is exactly what it evolved to do.

Metabolic and bariatric surgery is currently the most effective long-term treatment we have for this disease. It is not a shortcut and it is not cosmetic. It is a medical treatment for a medical condition.

Do I meet the criteria?

The guidelines were updated in 2022 by the American Society for Metabolic and Bariatric Surgery and the International Federation for the Surgery of Obesity. They

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are broader than the old 1991 rules that many people still hear about.

You may be a candidate if:

- **Your BMI is 35 or higher.** This is true whether or not you have any other health conditions. You do not need to be sick to qualify.

- **Your BMI is 30 to 34.9 and you have metabolic disease.** This most often means type 2 diabetes that is not well controlled, but can include other metabolic conditions.

- **Your BMI is 27.5 or higher and you are of Asian descent.** Health risks from excess weight begin at lower BMI values in Asian populations, so the thresholds are adjusted. A BMI of 25 or higher in this group already indicates clinical obesity.

- **You are older than 70.** Age alone is no longer a barrier. Older adults can be considered after a careful review of individual risks and benefits.

- **You are an adolescent** with a BMI above 120 percent of the 95th percentile for age with related medical problems, or above 140 percent of the 95th percentile.

A note on BMI. BMI is an imperfect tool. It does not distinguish muscle from fat and it does not tell us where fat is stored. We use it because it is the standard, not because it is perfect. Your evaluation will look at far more than one number.

If your BMI is below 35 without metabolic disease, guidelines recommend trying non-surgical treatment first. That does not mean the door is closed. It means we start somewhere else.

Conditions that surgery treats

Excess weight is connected to many conditions that improve, and often resolve completely, after surgery. If you have any of these, mention them at your consultation, because they matter both medically and for insurance approval:

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- Type 2 diabetes or prediabetes

- High blood pressure

- Obstructive sleep apnea

- Fatty liver disease

- High cholesterol or high triglycerides

- Osteoarthritis of the knees or hips

- Acid reflux

- Polycystic ovary syndrome or infertility

- Urinary stress incontinence

- Heart disease

Surgery is also sometimes used to make another necessary operation possible, such as a joint replacement, a hernia repair, or an organ transplant, when excess weight makes that surgery too risky.

When surgery is not the right choice

Being honest about this matters as much as anything else in this guide. Surgery may not be safe or appropriate if you have:

- **Severe heart failure or unstable heart disease.** The risk of anesthesia and surgery may outweigh the benefit until this is stabilized.

- **End-stage lung disease.**

- **Active cancer.** Treatment usually needs to be completed first.

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- **Cirrhosis with portal hypertension.** Liver disease at this stage changes the risk profile significantly.

- **Active, uncontrolled drug or alcohol dependency.** This is a timing issue, not a permanent exclusion. With treatment and a period of stability, many patients later become candidates.

- **Crohn disease.** This affects which procedures, if any, are appropriate.

- **Pregnancy now, or planning pregnancy within the next 12 to 24 months.** Rapid weight loss and altered nutrient absorption are not safe during pregnancy. We will discuss timing and contraception.

- **An inability to understand the procedure or commit to the changes it requires.**

Several of these are temporary. If one applies to you today, ask us what the path forward looks like rather than assuming the answer is no forever.

What actually makes someone a good candidate

The criteria above get you in the door. These are the things that predict whether surgery works well over the long run:

You understand that surgery is a tool, not a cure. It changes your anatomy and your hormones. It does not make decisions for you.

You are willing to take vitamins every day for the rest of your life. This is not negotiable. Skipping supplements after surgery can cause serious and sometimes permanent problems with your blood, bones, and nerves.

You will come to your follow-up appointments. Not just the first year. Long-term. Losing contact with your surgical team is one of the strongest predictors of a poor result years down the road.

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You are prepared to change how you eat, permanently. Smaller portions, protein first, no drinking with meals, and thorough chewing become lifelong habits.

You have support, or you are willing to build it. Family, friends, a support group, or all three.

Your mental health is being addressed. Depression, anxiety, binge eating, and trauma histories do not disqualify you. Untreated and unacknowledged, they make everything harder. We would much rather know.

What happens next: the evaluation

Qualifying on paper is the beginning, not the end. Every patient goes through a thorough evaluation designed to keep you safe and to match you with the right procedure.

Medical history and physical exam. A full review of your health, your weight history, previous attempts at weight loss, and all your medications and supplements.

Laboratory testing. Blood work to assess your surgical risk and to check vitamin and mineral levels before surgery. Many patients already have deficiencies before their operation, and correcting them ahead of time matters.

Nutrition evaluation. A registered dietitian will meet with you to assess your current eating patterns and start preparing you for the changes ahead.

Mental health evaluation. This is not a test you can fail, and it is not there to judge you. It is there to identify anything that would benefit from support before or after surgery.

Additional testing as needed. Depending on your history, this may include a sleep study, an endoscopy, heart testing, or evaluation by another specialist.

A discussion about pregnancy and contraception, if that applies to you.

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Insurance requirements. These vary widely by plan and may include a supervised diet program and documentation of your medical history. Our team will walk you through exactly what your plan requires.

Choosing the operation

There is no single best procedure. There is a best procedure for you.

The choice depends on your BMI, whether you have diabetes, whether you have reflux, any prior abdominal surgery, your other medical conditions, and how much lifelong nutritional monitoring your situation calls for.

You will receive a separate guide covering each procedure we perform, including our own case volumes and expected results, so you can compare them directly. That conversation happens with your surgeon, and no decision is made for you. You can also watch the YouTube Video at https://youtu.be/kDpm3cUDZrE

Things patients worry about, answered plainly

Is surgery dangerous?

Modern bariatric surgery is remarkably safe. The risk of dying from the operation is very low, in the range of a few hundredths of a percent to about two tenths of a percent, which is comparable to or lower than many routine operations such as gallbladder removal. Serious complications in the first 30 days occur in fewer than 6 percent of patients. Every operation carries risk, and we will review yours specifically. But the risk of untreated severe obesity is not zero either, and for most candidates it is considerably higher.

Is this the easy way out?

No. It is the effective way. Surgery works because it changes the biology that makes

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weight loss so difficult, not because it removes the effort. The work after surgery is real and it is lifelong.

Will I have to take vitamins forever?

Yes. Every patient, every procedure, for life.

Will the weight come back?

Some regain from your lowest weight is normal and happens to nearly everyone. Significant regain is less common and is usually manageable when caught early. This is one of the main reasons long-term follow-up matters so much.

What if I have already had bariatric surgery?

Then you may be a candidate for revision. Needing a second operation is not a failure. It is part of treating a chronic disease. Bring your prior operative report if you have it.

What if I have tried and failed at diets many times?

That history is not a strike against you. It is part of why you may benefit from surgery. Repeated cycles of loss and regain are the expected behavior of this disease, not evidence of weak willpower.

Your next step

Bring this guide to your consultation. Write your questions in the margins.

Before that visit, it helps to gather:

- A complete list of your medications and supplements, including doses

- Records of any previous weight loss attempts or programs

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- Operative reports from any prior abdominal or bariatric surgery

- Your insurance card and plan information

- A list of your medical conditions and the specialists who treat them

Questions worth asking us:

- Which procedure do you recommend for me, and why that one?

- How many of these does this center perform each year?

- What results do your patients typically achieve?

- What are the specific risks in my case?

- What will follow-up look like over the next five years?

- What will this cost me, and what does my insurance cover?

One last thing

Deciding to be evaluated is not the same as deciding to have surgery. A consultation commits you to nothing except information.

Most patients tell us they waited years longer than they needed to, usually because of shame or because someone told them they should be able to fix this on their own.

You do not have to have made up your mind. You just have to be willing to ask.

Real science. Real surgery. Real results.

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