Pregnancy and Contraception After Bariatric Surgery

PREGNANCY AND CONTRACEPTION AFTER BARIATRIC SURGERY

What You Need to Know Before, During, and After Pregnancy

Patient name: _____ Surgery date: _____

Procedure: _____

Why this guide matters

Bariatric surgery dramatically improves fertility. Many women who struggled to conceive before surgery find that they can become pregnant naturally within months of their operation, sometimes unexpectedly.

This is a good thing. But it requires planning.

Pregnancy too soon after surgery puts both mother and baby at risk. Pregnancy without proper nutritional monitoring after surgery puts both mother and baby at risk. And certain contraceptive methods work differently after bariatric surgery, which means the birth control you used before may not protect you now.

This guide covers three things every woman of childbearing age needs to understand after bariatric surgery:

1. Why you should wait before getting pregnant

2. Which contraceptive methods are safe and effective after surgery

3. How to have a healthy pregnancy when the time is right

If pregnancy is not relevant to you now, keep this guide anyway. Circumstances change. And if you have a daughter, sister, or friend considering bariatric surgery, this information could matter to them.

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PART 1: WHY FERTILITY IMPROVES AFTER SURGERY

Obesity is one of the most common reversible causes of infertility in women. It disrupts the hormonal environment that controls ovulation, menstrual cycles, and conception.

How obesity affects fertility:

- Excess fat tissue produces excess estrogen, which disrupts the balance between estrogen, progesterone, FSH, and LH needed for regular ovulation

- Insulin resistance (common in obesity) increases androgen (male hormone) production in the ovaries, which suppresses ovulation

- Polycystic ovary syndrome (PCOS), the most common cause of anovulatory infertility, is strongly associated with obesity and insulin resistance

- Obesity increases the risk of miscarriage, gestational diabetes, preeclampsia, and cesarean delivery

- Obesity reduces the success rates of fertility treatments including IVF

How bariatric surgery reverses these effects:

- Weight loss reduces excess estrogen production, restoring hormonal balance

- Insulin sensitivity improves rapidly after surgery, often within days, reducing androgen production

- PCOS symptoms improve or resolve in the majority of patients. Menstrual cycles become regular. Ovulation resumes.

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- Fertility can improve within the first few months after surgery, sometimes before significant weight loss has occurred, because the hormonal and metabolic changes begin immediately

The critical point: If you were not ovulating before surgery, you may start ovulating within weeks to months after surgery. If you are sexually active and not using effective contraception, you can become pregnant much sooner than you expect.

This is why contraception planning must happen before surgery, not after.

PART 2: WHY YOU SHOULD WAIT

The recommendation: avoid pregnancy for at least 12 to 18 months after bariatric surgery.

This is the recommendation from the American College of Obstetricians and Gynecologists (ACOG), the American Society for Metabolic and Bariatric Surgery (ASMBS), and most international bariatric and obstetric guidelines.

Why waiting matters:

Nutritional stability. In the first 12 to 18 months after surgery, your body is in a state of rapid weight loss and significant caloric deficit. You are consuming 800 to 1,200 calories per day. Your vitamin and mineral stores are being depleted and rebuilt simultaneously. Your protein intake is barely meeting your own needs.

Pregnancy demands enormous nutritional resources. The developing baby needs protein, iron, calcium, folate, vitamin B12, vitamin D, vitamin A, zinc, and calories. If your own stores are depleted, the baby draws from what little you have, putting both of you at risk.

Rapid weight loss and fetal development. Active rapid weight loss creates a catabolic state (your body is breaking down its own tissue for energy). This

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metabolic environment is not ideal for fetal development. Fat mobilization during rapid weight loss releases stored toxins and metabolites into the bloodstream that may affect the developing fetus.

Micronutrient deficiency risk. Deficiencies in specific vitamins during pregnancy can cause serious birth defects:

- Folate deficiency increases the risk of neural tube defects (spina bifida, anencephaly)

- Vitamin A deficiency can cause birth defects affecting the eyes, heart, and lungs. However, excess vitamin A (more than 10,000 IU per day from retinol/preformed vitamin A) is also teratogenic and can cause birth defects. This is particularly important for duodenal switch patients who take high-dose vitamin A supplementation.

- Vitamin B12 deficiency can cause neurological damage in the developing baby

- Iron deficiency anemia reduces oxygen delivery to the fetus

- Calcium and vitamin D deficiency affects fetal bone development and increases the risk of maternal bone loss

- Vitamin K deficiency can cause bleeding complications in the newborn

Surgical complications. In the first year, there is a small but real risk of surgical complications (internal hernia, bowel obstruction, stricture) that could be dangerous during pregnancy. Allowing the surgical anatomy to fully heal and stabilize before pregnancy reduces this risk.

Accurate dating. Rapid weight loss can cause irregular menstrual cycles, making it difficult to accurately date a pregnancy. Waiting until weight has stabilized and cycles have normalized improves pregnancy dating accuracy.

What if you get pregnant before 12 months?

Do not panic. An unplanned pregnancy in the first year after bariatric surgery is not a

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catastrophe. But it does require immediate, intensive management:

- Contact your bariatric surgeon and your obstetrician immediately

- Increase your calorie intake as directed by your team. You should not be actively trying to lose weight during pregnancy.

- Increase your protein intake to at least 60 to 80 grams per day (your team may recommend more)

- Your vitamin regimen will need immediate review and adjustment, particularly folate, iron, B12, calcium, vitamin D, and vitamin A

- You will need more frequent lab monitoring throughout the pregnancy

- You will need more frequent prenatal visits

- Your pregnancy will be considered high-risk and should be managed by an obstetrician experienced with bariatric patients

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PART 3: CONTRACEPTION AFTER BARIATRIC SURGERY

Not all contraceptive methods work the same way after bariatric surgery. The changes to your digestive anatomy can affect how oral medications are absorbed, which means some methods are more reliable than others.

Most effective methods (recommended after bariatric surgery)

These methods do not depend on intestinal absorption and are the most reliable options after any bariatric procedure.

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Intrauterine devices (IUDs)

- Hormonal IUD (Mirena, Liletta, Kyleena, Skyla): releases a small amount of progestin directly into the uterus. Highly effective (greater than 99 percent). Lasts 3 to 8 years depending on the device. Reduces menstrual bleeding, which is beneficial for patients at risk of iron deficiency anemia. Does not depend on absorption.

- Copper IUD (Paragard): hormone-free. Highly effective (greater than 99 percent). Lasts up to 10 years. Good option for patients who prefer non-hormonal contraception. Does not depend on absorption.

- IUDs are considered the first-line contraceptive recommendation for bariatric surgery patients by most guidelines.

Subdermal implant (Nexplanon)

- A small rod inserted under the skin of the upper arm. Releases progestin. Highly effective (greater than 99 percent). Lasts up to 3 years. Does not depend on absorption. Excellent option after bariatric surgery.

Depot medroxyprogesterone acetate (Depo-Provera)

- Injectable progestin given every 3 months. Highly effective (greater than 99 percent with perfect use). Does not depend on absorption.

- Important caveat: Depo-Provera is associated with weight gain in some patients (average 5 to 8 pounds over the first year) and with decreased bone mineral density with long-term use. For bariatric patients who are already at risk for bone loss (especially after bypass and duodenal switch), this may not be the ideal long-term choice. Discuss with your team.

Methods with reduced reliability after malabsorptive procedures

Combined oral contraceptive pills (the pill)

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- After gastric bypass, duodenal switch, and SADI-S, oral contraceptive absorption may be reduced because the duodenum and proximal jejunum (where most oral medications are absorbed) are bypassed.

- After sleeve gastrectomy, absorption is generally not affected because the intestinal anatomy is unchanged. However, rapid gastric emptying and reduced stomach acid may theoretically affect absorption in some patients.

- If you choose to use oral contraceptives after a malabsorptive procedure, understand that the failure rate may be higher than in the general population. A backup method (condoms) is recommended.

- Many guidelines recommend against relying solely on oral contraceptives after bypass or duodenal switch.

Progestin-only pills (mini-pill)

- Same absorption concerns as combined oral contraceptives after malabsorptive procedures

- The mini-pill already has a narrower window for effectiveness (must be taken at the same time every day within a 3-hour window). Reduced absorption compounds this limitation.

- Not recommended as a sole method after bypass or duodenal switch

Contraceptive patch (Xulane)

- Delivers hormones through the skin. Does not depend on intestinal absorption.

- Effectiveness may be reduced in patients weighing more than 198 pounds (90 kg). Many bariatric patients are above this weight in the early postoperative period.

- Can be used after bariatric surgery but may not be reliable at higher body weights

Vaginal ring (NuvaRing)

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- Delivers hormones through the vaginal mucosa. Does not depend on intestinal absorption.

- Effective after bariatric surgery. A reasonable option for patients who want hormonal contraception without relying on oral absorption.

Barrier methods

Condoms (male and female)

- No absorption concerns. Effective when used correctly and consistently.

- Also protect against sexually transmitted infections

- Can be used as a primary method or as a backup to hormonal methods

- Typical-use failure rate is higher than IUDs or implants (approximately 13 percent per year for male condoms with typical use)

Diaphragm and cervical cap

- May need to be refitted after significant weight loss, as body changes can alter the fit

- Less effective than IUDs, implants, or hormonal methods

Permanent methods

Tubal ligation or bilateral salpingectomy

- Permanent sterilization. Highly effective.

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- Can sometimes be performed at the same time as bariatric surgery if requested and planned in advance. Discuss with your surgeon before your operation.

- Bilateral salpingectomy (removal of the fallopian tubes) is increasingly preferred over tubal ligation because it also reduces the risk of ovarian cancer.

Vasectomy (partner)

- Permanent sterilization for male partners. Highly effective.

- Does not affect the bariatric patient's body or medications

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Emergency contraception

- **Levonorgestrel (Plan B):** An oral emergency contraceptive. Absorption may be reduced after malabsorptive procedures. Effectiveness is also reduced in patients weighing more than 165 pounds (75 kg). May not be reliable after bariatric surgery.

- **Ulipristal acetate (ella):** An oral emergency contraceptive. Same absorption concerns after malabsorptive procedures. Effectiveness may be reduced at higher body weights, though less so than levonorgestrel.

- **Copper IUD (Paragard):** The most effective form of emergency contraception (greater than 99 percent). Can be inserted up to 5 days after unprotected intercourse. Does not depend on absorption or body weight. This is the recommended emergency contraception method for bariatric patients.

If you need emergency contraception after bariatric surgery, a copper IUD is the most reliable option. Contact your gynecologist or go to an urgent care or emergency room that can place one.

Contraception summary by procedure

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After sleeve gastrectomy:

- All methods are generally acceptable

- Oral contraceptives are likely absorbed normally, but long-acting methods (IUD, implant) are still preferred for reliability

After gastric bypass (RYGB, OAGB):

- IUD, implant, or injectable are strongly recommended

- Oral contraceptives may have reduced absorption. Do not rely on them as your sole method.

- Vaginal ring is acceptable

- Patch may be unreliable at higher body weights

After duodenal switch (BPD/DS, SADI-S):

- IUD, implant, or injectable are strongly recommended

- Oral contraceptives are not recommended as a sole method due to significant malabsorption

- Vaginal ring is acceptable

- High-dose vitamin A supplementation must be carefully managed before and during pregnancy (excess vitamin A is teratogenic)

PART 4: PLANNING A HEALTHY PREGNANCY AFTER BARIATRIC SURGERY

When you are ready to become pregnant, ideally at least 12 to 18 months after

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surgery with stable weight, the following steps will help ensure the healthiest possible pregnancy for you and your baby.

Before conception: the preconception checklist

Schedule a preconception visit with your bariatric surgeon and your obstetrician.

This visit should happen at least 3 months before you start trying to conceive. Both providers need to be involved.

Comprehensive lab work:

- CBC with iron studies and ferritin

- Vitamin B12 and folate

- Vitamin D and calcium

- Vitamin A level (critical for switch patients; must be in normal range, not excessive)

- Zinc and copper

- Albumin and prealbumin (protein status)

- HbA1c (if history of diabetes)

- Thyroid function

- Any deficiencies must be corrected before conception

Start prenatal vitamins:

- Switch from your bariatric multivitamin to a prenatal vitamin that contains at least 800 to 1,000 micrograms of folic acid (some guidelines recommend 4 mg of folic

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acid for bariatric patients due to reduced absorption)

- Your bariatric team will advise on whether additional bariatric-specific supplements should continue alongside the prenatal vitamin

- Continue calcium citrate, vitamin D, B12, and iron as directed

Vitamin A adjustment (duodenal switch and SADI-S patients):

- High-dose vitamin A supplementation (often 10,000 IU or more per day) must be reviewed and potentially reduced before conception

- Preformed vitamin A (retinol) in doses exceeding 10,000 IU per day is teratogenic and can cause birth defects

- Your team will adjust your vitamin A dose to a safe range while monitoring your blood levels to prevent deficiency

- This is one of the most important preconception steps for switch patients

Optimize your nutrition:

- Protein intake should be at least 60 to 80 grams per day before conception and will increase during pregnancy

- Ensure you are eating a balanced, nutrient-dense diet with adequate calories to support pregnancy

- If you are still actively losing weight, your body may not be ready for pregnancy. Discuss timing with your team.

Review your medications:

- Some medications commonly used after bariatric surgery may not be safe during pregnancy

- Ursodiol (used to prevent gallstones): generally discontinued before conception

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- NSAIDs (ibuprofen, naproxen): should be avoided during pregnancy, especially in the third trimester

- PPIs (omeprazole, pantoprazole): discuss with your obstetrician; some are considered relatively safe, others are not well studied

- GLP-1 medications (semaglutide, tirzepatide): must be stopped before conception. Current recommendations suggest stopping semaglutide at least 2 months before planned conception and tirzepatide at least 1 month before. These medications have not been studied in human pregnancy and animal studies have shown adverse fetal effects.

- Anti-obesity medications in general should be discontinued before and during pregnancy

- Statins: must be stopped during pregnancy (teratogenic)

- ACE inhibitors and ARBs: must be stopped during pregnancy (teratogenic)

Achieve weight stability:

- Your weight should be stable (not actively declining) for at least 2 to 3 months before attempting conception

- Pregnancy during active rapid weight loss is not recommended

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During pregnancy: what to expect

Weight gain during pregnancy after bariatric surgery

Weight gain during pregnancy is normal and necessary. The baby, placenta, amniotic fluid, increased blood volume, and breast tissue all contribute to weight gain. This is not the same as fat regain.

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Current guidelines for weight gain during pregnancy are based on pre-pregnancy BMI:

- BMI less than 18.5 (underweight): 28 to 40 pounds

- BMI 18.5 to 24.9 (normal weight): 25 to 35 pounds

- BMI 25 to 29.9 (overweight): 15 to 25 pounds

- BMI 30 or greater (obese): 11 to 20 pounds

Many bariatric patients fall into the overweight or obese BMI category even after surgery. Your obstetrician will set an individualized weight gain target.

Do not try to lose weight during pregnancy. Do not restrict calories. Do not skip meals. Your baby needs adequate nutrition to develop properly.

Nutritional monitoring during pregnancy

- Lab work should be checked each trimester at minimum. Many bariatric obstetricians check labs monthly.

- Iron, B12, folate, vitamin D, calcium, and protein status are the most critical values to monitor

- Iron deficiency anemia is the most common nutritional complication during pregnancy after bariatric surgery. You may need IV iron infusions if oral iron is insufficient.

- B12 deficiency can cause neurological damage in the developing baby. Monthly B12 injections may be recommended during pregnancy, especially after bypass and switch.

- Protein intake should be at least 60 to 80 grams per day and may need to be higher. Your dietitian will guide you.

Glucose monitoring

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- Bariatric surgery dramatically reduces the risk of gestational diabetes. But it does not eliminate it.

- Standard glucose screening (glucose tolerance test) at 24 to 28 weeks is recommended

- Important: after gastric bypass and duodenal switch, the standard 50-gram or 75-gram glucose tolerance test can trigger severe dumping syndrome and reactive hypoglycemia. Your obstetrician should be aware of this. Alternative screening methods (continuous glucose monitoring, serial fasting glucose, or HbA1c) may be used instead.

- If you had diabetes before surgery that went into remission, monitor closely for recurrence during pregnancy

Complications to watch for

- **Internal hernia:** Pregnancy increases intra-abdominal pressure, which can increase the risk of internal hernia after bypass and switch procedures. Symptoms include severe, intermittent abdominal pain, nausea, and vomiting. This is a surgical emergency. If you experience severe abdominal pain during pregnancy, go to the emergency room immediately and tell them you have had bariatric surgery.

- **Small bowel obstruction:** Related to internal hernia or adhesions. Same symptoms and same urgency.

- **Severe nausea and vomiting (hyperemesis):** Can be more challenging to manage after bariatric surgery because of the altered anatomy and reduced stomach capacity. Dehydration risk is higher. Thiamine (vitamin B1) supplementation is critical if vomiting is prolonged, to prevent Wernicke encephalopathy.

- **Marginal ulcer (bypass patients):** Pregnancy-related stress and changes in acid production can trigger or worsen marginal ulcers. Report any epigastric pain, nausea, or vomiting to your team.

- **Gallstones:** Rapid weight loss increases gallstone risk, and pregnancy

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independently increases gallstone risk. If you did not have your gallbladder removed before or during bariatric surgery, be aware of symptoms: right upper abdominal pain, especially after eating.

Delivery

- Bariatric surgery is not an indication for cesarean delivery. Vaginal delivery is appropriate for most bariatric patients.

- The decision between vaginal and cesarean delivery is based on obstetric factors, not bariatric history

- Inform your delivery team that you have had bariatric surgery so they can plan accordingly (medication absorption, IV access, anesthesia considerations)

After delivery: postpartum considerations

Breastfeeding

- Breastfeeding is encouraged after bariatric surgery. It provides optimal nutrition for the baby and supports maternal weight management.

- Breastfeeding increases your calorie and nutrient needs. You will need additional protein, calcium, vitamin D, and fluids.

- Continue your prenatal vitamin and bariatric supplements during breastfeeding

- Some vitamin supplements (particularly high-dose vitamin A for switch patients) may need adjustment during breastfeeding. Discuss with your team.

- Monitor your baby's growth closely. If your baby is not gaining weight appropriately, supplemental formula may be needed.

- Iron, B12, and vitamin D status should be monitored in breastfed infants of bariatric mothers, as maternal deficiencies can affect breast milk composition

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Contraception after delivery

- Fertility returns quickly after delivery, especially if you are not exclusively breastfeeding

- Do not rely on breastfeeding alone as contraception (the lactational amenorrhea method is unreliable after bariatric surgery due to altered hormonal patterns)

- Resume effective contraception before your 6-week postpartum visit. An IUD or implant can be placed immediately after delivery or at the postpartum visit.

- If you plan another pregnancy, discuss timing with your bariatric and obstetric teams. The same 12 to 18 month waiting period from delivery is generally recommended before the next conception to allow nutritional recovery.

Return to bariatric follow-up

- Schedule a visit with your bariatric surgeon within 3 months of delivery

- Comprehensive labs should be drawn

- Vitamin regimen should be reviewed and transitioned back from prenatal to bariatric-specific supplements (unless breastfeeding, in which case prenatal vitamins may continue)

- Body composition testing to assess postpartum status

- Weight management plan for the postpartum period

- Resume your regular annual bariatric follow-up schedule

PART 5: SPECIAL SITUATIONS

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Unplanned pregnancy after bariatric surgery

If you discover you are pregnant and it was not planned:

- Do not panic. Many healthy babies are born to bariatric surgery patients, including those who conceived in the first year.

- Contact your bariatric surgeon and obstetrician immediately

- Stop any medications that are not safe in pregnancy (GLP-1 medications, statins, ACE inhibitors, ARBs)

- Start a prenatal vitamin with adequate folic acid immediately if you are not already taking one

- Get comprehensive labs drawn as soon as possible

- Do not try to lose weight. Eat to nourish yourself and your baby.

- You will need closer monitoring than a typical pregnancy, but the outcomes can still be excellent with proper care

Pregnancy after duodenal switch

Pregnancy after duodenal switch (BPD/DS or SADI-S) requires the most intensive monitoring of any bariatric procedure because of the significant malabsorptive component.

- Vitamin A must be carefully managed (teratogenic in excess, harmful in deficiency)

- Protein malnutrition risk is highest after switch procedures

- Fat-soluble vitamin deficiencies (A, D, E, K) are more common and more severe

- Monthly lab monitoring throughout pregnancy is recommended

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- Coordination between a high-risk obstetrician (maternal-fetal medicine specialist) and your bariatric team is essential

- IV supplementation (iron, vitamins) may be needed if oral absorption is insufficient

Fertility treatments after bariatric surgery

- If you are pursuing IVF or other fertility treatments after bariatric surgery, inform your reproductive endocrinologist about your procedure

- Medication absorption may be altered after malabsorptive procedures

- Nutritional optimization before starting fertility treatments is essential

- The 12 to 18 month waiting period still applies before beginning fertility treatments

Male patients and fertility

- Obesity in men is associated with reduced testosterone, reduced sperm quality, and erectile dysfunction

- Bariatric surgery improves testosterone levels, sperm parameters, and sexual function in the majority of male patients

- Weight loss can improve fertility in men with obesity-related subfertility

- Male patients do not have the same contraception or pregnancy-related concerns, but should be aware that their partner's fertility may also be affected by the male patient's improved hormonal status after surgery

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IMPORTANT PHONE NUMBERS

Your bariatric surgeon: _____

Your obstetrician: _____

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Your registered dietitian: _____

Maternal-fetal medicine (if applicable): _____

THE SHORT VERSION

- **Bariatric surgery improves fertility rapidly.** You may start ovulating within weeks to months of surgery, even before significant weight loss.

- **Wait at least 12 to 18 months before becoming pregnant.** Your body needs time to stabilize nutritionally and reach a stable weight.

- **Use reliable contraception.** IUDs and implants are the most effective options after bariatric surgery. Oral contraceptives may not be absorbed reliably after bypass or duodenal switch.

- **Plan your pregnancy.** Preconception labs, prenatal vitamins, vitamin A adjustment (switch patients), medication review, and coordination between your bariatric and obstetric teams.

- **During pregnancy:** Do not try to lose weight. Eat protein first. Take your vitamins. Get labs checked frequently. Watch for internal hernia symptoms. Avoid the standard glucose tolerance test after bypass (discuss alternatives with your OB).

- **After delivery:** Resume contraception early. Continue vitamins. Return to bariatric follow-up within 3 months.

- **Unplanned pregnancy is not a crisis.** Contact your teams immediately, get labs, start prenatal vitamins, and stop unsafe medications. With proper monitoring, outcomes can be excellent.

- **GLP-1 medications must be stopped before conception.** Semaglutide at least 2 months before. Tirzepatide at least 1 month before.

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A healthy pregnancy after bariatric surgery is absolutely possible. It just requires planning, monitoring, and teamwork.

Real science. Real surgery. Real results.

This guide is for educational purposes and does not replace the advice of your physicians. If you are pregnant or planning pregnancy after bariatric surgery, contact your bariatric surgeon and obstetrician.

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