Updated ASMBS Nutrition Guidelines

Written by Brian Hoyle

Julie Parrott, MS, RD, LD, Central Jersey Bariatrics, Freehold, New Jersey, USA, discussed the formulation process of the latest American Society for Metabolic and Bariatric Surgery (ASMBS) nutrition guidelines.

The update to the 2008 version of the nutrition guidelines [Aills L et al. *Surg Obes Relat Dis.* 2008] included all of the previously identified micronutrients but was also broadened to include new information for sleeve gastrectomy– and bariatric surgery–related nutritional considerations. Macronutrients will be addressed in subsequent updates. The micronutrition update incorporates information from a systematic review of the pertinent literature with evidence-based recommendations, which followed the clinical practice guideline standards set by the Institute of Medicine, with the first 5 of the 8 standards having been accomplished to date. The 5 standards are as follows: establishing transparency of funding and process; disclosing conflicts of interest; establishing a balanced, multidisciplinary group composition; executing high-quality systematic reviews; and establishing an evidence foundation for and rate of strength of recommendation.

The profession-based tools used included those of the Academy of Nutrition and Dietetics and the American Association of Clinical Endocrinologists.

Questions posed for each nutrient addressed known pre- and postoperative risks of nutrient deficiency for planned or performed bariatric surgery, recommendations for preoperative screening, and recommendations to prevent and treat nutrient deficiencies after bariatric surgery.

REPORT OF THE INTEGRATED HEALTH SUPPORT GROUPS COMMITTEE

Kellie Armstrong, RN, MS, Center for Bariatric Surgery at the Miriam Hospital, Providence, Rhode Island, USA, described the efforts of the Integrated Health Support Groups Committee to develop a manual directed at support groups for bariatric surgery patients. The process that began in 2012 has culminated in a draft document that was internally approved and is now being prepared for submission for publication.

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The manual is not intended to be static. Rather, the intent is to produce a resource document that will continue to change to reflect ongoing research and developments in support programs and patient needs. The development of the manual was driven by the recognition of the paucity of support group research specific to bariatric surgery patients, particularly the benefits that can be derived from support groups by patients. The hope is that the document will help stimulate research interest in the value of support groups for these patients.

Suggestions include support groups focused on patients before and after bariatric surgery, as well as combined pre- and/or postsurgery support. Support groups that involve alternative approaches are encouraged. Suggested support group topics include physical health, emotional health, nutrition-related health, and health derived from social interactions and relationships.

Support groups rely on patient involvement and continued enthusiasm. Multiple efforts were suggested to promote and nurture these aims. These efforts include providing information and promoting discussion of emerging technologies, facilitating active involvement of patients in the groups, respecting patient privacy and confidentiality, defining the role of the support group facilitator, incorporating special events into group activities, anticipating and taking steps to ensure a productive group dynamic, considering the group size that is most conducive to participation, accounting for the physical location and design of the room housing the group, and facilitating productive utilization of survey information.

Current research considerations include psychotherapy vs support groups, patient benefits separate from the perspective of weight, patient self-reported information, and research on the support group process.

Table 1. The RESPECT Model of Patient Care

R	Rapport	Establish a foundation of trust, confidence, and collaboration
E	Environment/ equipment	Use appropriately sized equipment, gowns, lifting devices, etc.
S	Safety	Build a culture of safety and security
P	Privacy	Protect patient privacy and dignity
E	Encouragement	Offer support and reassurance
C	Caring/ compassion	Avoid blaming the victim
T	Tact	Be aware of nonverbal signs, body language, tone of voice, etc.

Source: Bejciy-Spring SM. *Bariatr Nurs Surg Patient Care*. 2008.
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UPDATE ON THE GUIDELINES

Pam Davis, RN, CBN, MBA, TriStar Centennial Center for the Treatment of Obesity, Nashville, Tennessee, USA, provided a more general overview of the guideline development process considering those guidelines currently being formulated, with the hope of stimulating involvement in guideline formulation by the ASMBS community.

A guideline begins with an idea, a perception of the absence of guidance, and the need for the particular guideline. The next step is the submission of the suggestion to the Integrated Health Executive Council or Integrated Health Clinical Issues and Guidelines Committee (IHCIGC). An IHCIGC review determines whether the submission has merit. If so, the submission is further investigated ad hoc or by a subcommittee, which involves a literature review and summary, identification of the best strategy for the particular issue, and solicitation of expert opinion.

As the document is formulated, a review process involves a continuing back-and-forth exchange, first between the formulation committee and the IHCIGC. The next step is submission to the chair of the Clinical Issue Committee of the full committee, followed by legal input. After review by the Executive Council, the views of the full membership are sought. All steps involve exchanges with the formulation committee and revisions of the document as needed.

As an example, Ms Davis described one guideline that concerns guideline sensitivity training. The process began with a survey of the membership that yielded approximately 400 responses. Respondents were queried on the how, who, when, and where aspects of sensitivity training. Germane issues included the frequency of follow-up training, how long the sensitivity training should be to adequately cover all topics while not overwhelming the audience, the core content, the presenter (a person with direct clinical experience treating obese patients), the target audience, and the presentation format (eg, in person, web based).

It was agreed that the core content should involve definitions of overweight, obesity, and severe obesity, as well as comorbidities associated with obesity, prevalence of obesity, causes of and/or contributing factors to obesity, role of the health care provider, and the RESPECT model of patient care devised by the National Association of Bariatric Nurses (Table 1) [Bejciy-Spring SM. *Bariatr Nurs Surg Patient Care*. 2008].

Guideline development is followed by implementation. This involves identifying aspects needed with existing programs, with adjustments made in terms of staff and team delivery. Education of core and ancillary staff will be necessary. Patients will also need to be educated on how the guideline pertains to them before and after surgery. Criteria to ensure proper implementation and ongoing evaluation of the guideline will need to be put in place.

The goal is to formulate and implement procedures that benefit patients, with the ability to evolve with the accrual of evidence and experience. As such, guideline development is necessarily arduous and detailed.