Gallstones, Deficiencies, & Hair Loss – Oh My! Managing the Nutrition Challenges of Weight Loss

Webinar Questions Answered by Co-Presenters: Laura Andromalos, MS, RD, CSOWM, CDCES & Katie Chapmon, MS, RD

- There seems to be a big movement in dietetics now focused on "health at every size" and intuitive eating that views discussing weight loss and diets with clients negatively. How do you feel about this trend?
  K: I don't think that these two concepts have to be independent of each other. Patient collaboration and communication is at the core of patient centered care. I want to support my clients in exploring what would best for them and their bodies. I like to have compassionate conversations surrounding the knowledge that I know about weight loss if a patient wants to inquire into that, but truly supporting someone's personal health goals.
  L: I agree with Katie that these aren't mutually exclusive concepts. RDs can help someone improve their health and quality of life through weight change as well as weight neutrality. It's about practicing in a respectful & compassionate way to promote physical & emotional health. When I'm working with someone, my goal is to help them live their healthiest and happiest life which will look different for each individual person.
- Can you please share your thoughts on the ketogenic diet and gallstones?
  L: Beyond the risk factors that we discussed in the webinar (having obesity, rapid weight loss), ketogenic diets don't have specific components that would increase risk of gallstones. They do increase the risk of gout as ketone bodies prevent uric acid from excreted so not sure if that might be what you have in mind.
- Are we lacking enough effective obesity medications today?
  K: There is continued opportunity to learn about medications for intervention with obesity. As the function of obesity is better understood, medications could be developed to help target particular underlying functions.
  L: I think the bigger issue is that we are not using the medications that we do have but it will be interesting to see how medications evolve as we better understand obesity.
- Do you think the concern MDs have regarding medications for weight loss is partially due to Phen-fen side effects?
  K: MDs may be concerned of the currently available weight loss medications based on past experiences. However, some primary care physicians may not be completely educated or comfortable with weight loss medications and the lack of understanding may be part of the concern in prescribing.
- Do the weight loss medications interact with other HTN meds or heart disease meds? How long should we recommend taking?
  K: Depending upon the medication, it may interact with other medications. The MD should screen for medication interactions prior to prescribing a medication for weight loss. In addition, the medication for weight loss should be assessed for response to the intervention to determine length of time medication is recommended for.
- With topiramate, have you seen longer lasting side effects after medication is stopped?
  K: Anecdotally, I have not seen side effects continue after discontinuation of medication.
  L: I have not either.
- Do patients have to take weight loss medications for life to maintain weight loss?

K: Weight loss medications may need to be taken for an extended period of time. With any chronic condition, medication is utilized to assist with that condition. There may be a time when the medication can be discontinued and ongoing assessment would be needed to determine that.

- Is there an age restriction to Liraglutide?
  K: The dosing of liraglutide in Saxenda (up to 3mg) is not studied in patients under 18 years of age and is not recommended for pediatric patients.
  L: The dosing of liraglutide in Victoza (up to 1.8 mg) is approved for children 10 years and older with type 2 diabetes.
- What recommendations in terms of supplements can you share for a patient who is pregnant three months after a RYGBP?
  K: Pregnancy after bariatric surgery can be its own specialty. In terms of supplements, there is quite a bit of variation in vitamins. Most needs can be covered with a combination of a pre-natal vitamin and multivitamin with some additional vitamins for deficiencies. The vitamin of concern in a supplement is typically the amount of retinol, which should be under 10,000 units daily.
- Do you ever recommend wheat bran for fiber in pts with constipation?
  K: Wheat bran is not one that typically comes to mind. You may need to review what someone has tried previously and if a fiber worked better versus another. Bran could be utilized, but it also may depend how many months after bariatric surgery a patient is at.
- How do you feel about dilute prune juice, e.g., 1-2 oz in 16oz of water?
  K: This may be an option after bariatric surgery. Some people may respond to this and others may not. Typically this combination does not cause dumping syndrome, as the dilution prevents the sugar content from being too concentrated.
- For bariatric patients, what about Liquacel as a 1x a day supplement. Should this be incorporated and counted towards protein goal? Can they use more?
  L: Liquacel is collagen-based with added tryptophan. Without knowing the amount of tryptophan that is added, I'm not sure whether it would qualify as a high-quality protein based on the PDCAAS score. If it's not a complete protein, I would not encourage someone to use it as their only protein source.
- I've seen an increase in collagen supplements being promoted for hair growth, how helpful are these products?
  K: If hair loss after bariatric surgery is the body's response to stress (telogen effluvium), then hair growth is not based in a nutritional concern. If protein quality or intake is affecting hair growth, collagen may not assist with this process as collagen is typically not a complete protein source.
- Any success with hair growth for those with hypothyroid post bariatric surgery?
  K: If hair loss is related to hypothyroidism, check for nutritional deficiencies and quality of intake that may affect hair growth. Hypothyroidism may affect hair growth independently of nutritional intake.
- Do you see any bariatric patients with copper deficiencies?
  K: I have seen some copper deficiencies after bariatric surgery, though it may be years until this deficiency can occur.
  L: I have seen pre- and post-op patients with copper deficiencies. Insurance doesn't always cover copper labs so be aware of physical symptoms, such as anemia, paleness, and loss of pigment in hair. Also, with zinc getting publicity right now for immune support, remember that supplementing zinc without copper can cause a copper deficiency.

- Do obese patients with a history of bariatric surgery (not recent, maybe a good 10+ years ago) still require additional supplementation (i.e., protein shakes) even with excess/adequate dietary intake?
  K: They would still require vitamin and mineral supplementation. However, if they are able to comfortably meet their protein needs through dietary intake then a protein supplement may not be necessary.
  L: Having excess or adequate calorie intake doesn't mean that we are getting sufficient micronutrient intake, especially when the GI tract has been disrupted.
- How do you feel about use of sugar substitutes for weight loss?
  L: There is consistent evidence to support the association between sugar-sweetened beverages and obesity and that's not the case for sugar substitutes. That being said, some people dislike the taste of sugar substitutes, get GI side effects from them, or find they have cravings after eating 'diet' products. I tell my patients that neither sugar nor substitutes are meant to be consumed in excess and we work together to find more foods & beverages that they can enjoy without added sugars or substitutes.
- Regarding the study about gallstones and not following a low-fat diet, do you know what kinds of fat they evaluated? Liquid fat, animal fat, etc.?
  L: I don't have the specifics on that. In one of the studies, they used 2 liquid low-calorie diets. The low-fat version was an HMR diet using products with less than 1g fat per serving. The higher-fat version was an Optifast diet with 30g fat per day. While digging further into these studies, I learned that a 10g fat meal stimulates maximal gallbladder emptying so it doesn't need to be a very high-fat plan to reduce gallstone risk. It's more accurate to say avoid super low-fat plans.
- How do you think mindful eating and intuitive eating fit into interventions?
  K: I think both mindful and intuitive eating should be a part of the scope of weight loss interventions. Both of these practices can be a wonderful addition to the tools that someone utilizes in weight loss.
- Is there a checklist for patients considering bariatric surgery?
  L: Most bariatric surgery programs will provide a checklist or some form of guidance regarding the required appointments before surgery. These appointments will vary among programs and among patients based on medical conditions and insurance plans. The Obesity Action Coalition has a helpful guide to insurance for people considering surgery: https://www.obesityaction.org/action-through-advocacy/access-to-care/access-to-care-resources/working-with-your-insurance-provider-a-guide-to-seeking-weight-loss-surgery/
  If you're thinking of a behavior change checklist, this is a great article written by friend & colleague Melissa Majumdar: https://www.obesityaction.org/community/news/bariatric-surgery/the-checklist-top-10-ways-to-prepare-for-bariatric-surgery/
  K: There are also pre and post-procedure checklists included in the 2019 Update of Clinical Practice Guidelines for Perioperative Nutrition, Metabolic, and Nonsurgical support of patients undergoing bariatric procedures co-sponsored by AACE, TOS, ASMBS, OMA and ASA. PubMed doi:10.4158/GL-2019-0406.
- How about people who have had a cholecystectomy? Implications with weight loss and hair loss?
  L: Some people might lose weight unintentionally in the weeks after a cholecystectomy if they are asked to follow a low-fat diet or having digestion/absorption issues. It's not typically a long-term trend unless they start intentional efforts towards weight loss. Telogen effluvium can occur with any shock to the body, including a surgery or weight loss, so this would be the primary connection to any hair shedding following cholecystectomy.

- What challenges do you find with low income patients with successful weight management and/ or bariatric surgery?
  K: Some challenges may include the availability or access to food, protein supplements or vitamin supplementation.
  L: Agreed. The USDA has a nice 'healthy eating on a budget' section on their website: https://www.choosemyplate.gov/eathealthy/budget Some bariatric vitamin companies have programs to support people with financial challenges: https://www.bariatricadvantage.com/page/oac
- Do you see any signs of moving away from the BMI model due to BMI not being as culturally applicable to many communities?
  K: I am hopeful that eventually there will be several evaluation options or a grouping of evaluation tools utilized. At this time, though, BMI is still widely used as the current model.
  L: Other countries use waist circumference more frequently which is actually associated with CVD risk (while BMI is not). Unfortunately, we're slow to move in the US. The BMI-based criteria that qualifies one for bariatric surgery was determined in 1991 and despite advocacy efforts, we haven't been successful in getting the NIH to make updates.
- Do pre and probiotics also help with the distress or constipation after weight loss?
  K: Both targeted pre and probiotics can be utilized for constipation, but typically do not provide immediate relief. Prebiotics can add some fiber and create an environment for bowel formation. Probiotics take some time to change the gut environment and can be helpful if constipation has been part of the picture for a while.