

## OBESITY: SURGICAL INTERVENTIONS (GASTRIC PARTITIONING/ GASTROPLASTY, GASTRIC BYPASS)

Weight reduction surgery has been reported to improve several comorbid conditions such as sleep apnea, glucose intolerance and frank diabetes, hypertension, and hyperlipidemia. A number of surgical treatments for morbid obesity have been tried and discarded because of ineffectiveness or complications. The procedure of choice is vertical-banded gastroplasty, although the Roux-en-Y gastric bypass is also performed. Procedure may be performed via open abdominal incision or laparoscopy.

**Gastroplasty (gastric stapling/banding):** A small pouch with a restricted outlet is created across the stomach just distal to the gastroesophageal junction. A small opening remains, through which food passes into stomach. Vertical banded gastroplasty (VBG) is accomplished by placing rows of staples vertically in the strongest sidewall of the stomach and insertion of polypropylene band around the outlet of the resulting pouch.

**Gastric bypass (Roux-en-Y):** Anastomosis of a segment of the small intestine to upper portion of stomach that has been partitioned by a horizontal staple line or banding.

### CARE SETTING

Inpatient acute surgical unit

### RELATED CONCERNS

Eating disorders: obesity

Peritonitis

Psychosocial aspects of care

Surgical intervention

Thrombophlebitis: deep vein thrombosis

## Patient Assessment Database

### ACTIVITY/REST

**May report:** Difficulty sleeping  
Exertional discomfort, inability to participate in desired activity/sports

### EGO INTEGRITY

**May report:** Motivated to lose weight for oneself (or for gratification of others)  
Repressed feelings of hostility toward authority figures  
History of psychiatric illness/treatment

**May exhibit:** Anxiety, depression

### ELIMINATION

**May report:** Urinary stress incontinence

### FOOD/FLUID

**May report:** “Yo-yo” dieting  
Weight fluctuations  
Dysfunctional eating patterns

**May exhibit:** Weight exceeding ideal body weight by 100 lb or more or a body mass index (BMI) of more than 40 (morbid obesity)

### HYGIENE

**May report:** Difficulty dressing, bathing

### TEACHING/LEARNING

**May report:** Presence of chronic conditions (hypertension, diabetes, heart failure, arthritis, sleep apnea, Pickwickian syndrome, infertility)  
Adequate trials and failure of other treatment approaches

Desire to lose weight  
**Discharge plan** **DRG projected mean length of inpatient stay: 7.4 days (2–4 days for laparoscopic procedures)**  
**considerations:** May require support with therapeutic regimen/weight loss, assistance with self-care, homemaker/maintenance tasks  
 Refer to section at end of plan for postdischarge considerations.

**DIAGNOSTIC STUDIES**

Studies depend on individual situation and are used to rule out underlying disease and provide a preoperative workup, including psychiatric evaluation.

**NURSING PRIORITIES**

1. Support respiratory function.
2. Prevent/minimize complications.
3. Provide appropriate nutritional intake.
4. Provide information regarding surgical procedure, postoperative expectations, and treatment needs.

**DISCHARGE GOALS**

1. Ventilation and oxygenation adequate for individual needs.
2. Complications prevented/controlled.
3. Nutritional intake modified for specific procedure.
4. Procedure, prognosis, and therapeutic regimen understood.
5. Plan in place to meet needs after discharge.

**NURSING DIAGNOSIS: Breathing Pattern, ineffective**  
**May be related to**  
 Decreased lung expansion  
 Pain, anxiety  
 Decreased energy, fatigue  
 Tracheobronchial obstruction  
**Possibly evidenced by**  
 Shortness of breath, dyspnea  
 Tachypnea, respiratory depth changes, reduced vital capacity  
 Wheezes, rhonchi  
 Abnormal arterial blood gases (ABGs)  
**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**  
**Respiratory Status: Ventilation (NOC)**  
 Maintain adequate ventilation.  
 Experience no cyanosis or other signs of hypoxia, with ABGs within acceptable range.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Ostomy Care (NIC)</b>  <b>Independent</b>            Monitor respiratory rate/depth. Auscultate breath sounds.            Investigate presence of pallor/cyanosis, increased restlessness, or confusion.</p>	<p>Shallow respirations/effects of anesthesia cause hypoventilation, potentiate atelectasis, and may result in hypoxia. <i>Note:</i> Many anesthetic agents are fat-soluble, so that postoperative sedation and the potential for respiratory complications are increased.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Ostomy Care (NIC)</b></p>	
<p><b>Independent</b></p>	
<p>Elevate head of bed 30 degrees.</p>	<p>Encourage optimal diaphragmatic excursion/lung expansion and minimizes pressure of abdominal contents on the thoracic cavity. <i>Note:</i> When kept recumbent, obese patients are at high risk for severe hypoventilation postoperatively.</p>
<p>Encourage deep-breathing exercises. Assist with coughing and splint incision.</p>	<p>Promotes maximal lung expansion and aids in clearing airways, thus reducing risk of atelectasis, pneumonia.</p>
<p>Turn periodically and ambulate as early as possible.</p>	<p>Promotes aeration of all segments of the lung, mobilizing, and aiding in expectoration of secretions.</p>
<p>Pad side rails and teach patient to use them as armrests.</p>	<p>Using the side rail as an armrest allows for greater chest expansion.</p>
<p>Use small pillow under head when indicated.</p>	<p>Many obese patients have large, thick necks, and use of large, fluffy pillows may obstruct the airway.</p>
<p>Avoid use of abdominal binders.</p>	<p>Can restrict lung expansion.</p>
<p><b>Collaborative</b></p>	
<p>Administer supplemental oxygen.</p>	<p>Maximizes available O<sub>2</sub> for exchange and reduces work of breathing.</p>
<p>Assist in use of intermittent positive-pressure breathing (IPPB) and/or respiratory adjuncts, e.g., incentive spirometer.</p>	<p>Enhances lung expansion; reduces potential for atelectasis.</p>
<p>Monitor/graph serial ABGs/pulse oximetry when indicated.</p>	<p>Reflects ventilation/oxygenation and acid-base status. Used as a basis for evaluating need for/effectiveness of respiratory therapies.</p>
<p>Monitor patient-controlled analgesia (PCA)/administer analgesics as appropriate.</p>	<p>Maintenance of comfort level enhances participation in respiratory therapy and promotes increased lung expansion.</p>

**NURSING DIAGNOSIS: Tissue Perfusion, risk for ineffective: peripheral**

**Risk factors may include**

Diminished blood flow, hypovolemia  
Immobility/bedrest  
Interruption of venous blood flow (thrombosis)

**Possibly evidenced by**

[Not applicable; presence of signs and symptoms establishes and *actual* diagnosis.]

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Circulation Status (NOC)**

Maintain perfusion as individually appropriate, e.g., skin warm/dry, peripheral pulses present/strong, vital signs within acceptable range.

**Risk Control (NOC)**

Identify causative/risk factors.  
Demonstrate behaviors to improve/maintain circulation.

ACTIONS/INTERVENTIONS	RATIONALE
<b>Surveillance (NIC)</b>	
<b>Independent</b>	
Monitor vital signs. Palpate peripheral pulses routinely; evaluate capillary refill and changes in mentation. Note 24-hr fluid balance.	Indicators of circulatory adequacy. (Refer to ND: Fluid Volume, risk for deficient, following.)
Encourage frequent range of motion (ROM) exercises for legs and ankles.	Stimulates circulation in the lower extremities; reduces venous stasis.
Assess for Homans' sign, redness, and edema of calf.	Indicators of thrombus formation, but may not always be present, particularly in obese individuals.
Encourage early ambulation; discourage sitting and/or dangling legs at the bedside.	Sitting constricts venous flow, whereas walking encourages venous return.
Provide adequate/appropriate equipment and sufficient staff for handling patient.	Helpful in dealing with bulky patient for moving, bowel care, and ambulating. Reduces risk of traumatic injury to patient and caregivers.
<b>Collaborative</b>	
Administer heparin therapy, as indicated.	May be used prophylactically to reduce risk of thrombus formation or to treat thromboemboli.
Monitor hemoglobin (Hb)/hematocrit (Hct) and coagulation studies.	Provides information about circulatory volume/alterations in coagulation and indicates therapy needs/effectiveness.

**NURSING DIAGNOSIS: Fluid Volume, risk for deficient**

**Risk factors may include**

Excessive gastric losses: nasogastric suction, diarrhea  
Reduced intake

**Possibly evidenced by**

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Hydration (NOC)**

Maintain adequate fluid volume with balanced intake and output (I&O) and be free of signs reflecting dehydration.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Fluid/Electrolyte Management (NIC)</b></p> <p><b>Independent</b></p> <p>Assess vital signs, noting changes in BP (postural), tachycardia, fever. Assess skin turgor, capillary refill, and moisture of mucous membranes.</p> <p>Monitor I&amp;O, noting/measuring diarrhea and nasogastric(NG) suction losses.</p> <p>Evaluate muscle strength/tone. Observe for muscle tremors.</p> <p>Establish individual needs/replacement schedule.</p> <p>Encourage increased oral intake when able.</p>	<p>Indicators of dehydration/hypovolemia, adequacy of current fluid replacement. <i>Note:</i> Adequately sized cuff must be used to ensure factual measurement of BP. If cuff is too small, reading will be falsely elevated.</p> <p>Changes in gastric capacity/intestinal motility and nausea greatly influence intake and fluid needs, increasing risk of dehydration.</p> <p>Large gastric losses may result in decreased magnesium and calcium, leading to neuromuscular weakness/tetany.</p> <p>Determined by amount of measured losses/estimated insensible losses and dependent on gastric capacity.</p> <p>Permits discontinuation of invasive fluid support measures and contributes to return of normal bowel functioning.</p>
<p><b>Collaborative</b></p> <p>Administer supplemental IV fluids as indicated.</p> <p>Monitor electrolyte levels and replace as indicated.</p>	<p>Replaces fluid losses and restores fluid balance in immediate postoperative phase and/or until patient is able to take sufficient oral fluids.</p> <p>Use of NG tube and/or vomiting, onset of diarrhea can deplete electrolytes, affecting organ function.</p>

**NURSING DIAGNOSIS: Nutrition: imbalanced, risk for less than body requirements**

**Risk factors may include**

Decreased intake, dietary restrictions, early satiety  
Increased metabolic rate/healing  
Malabsorption of nutrients/impaired absorption of vitamins

**Possibly evidenced by**

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Knowledge: Diet (NOC)**

Identify individual nutritional needs.

**Nutritional Status (NOC)**

Display behaviors to maintain adequate nutritional intake.  
Demonstrate appropriate weight loss with normalization of laboratory values.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Weight Reduction Assistance (NIC)</b></p> <p><b>Independent</b></p> <p>Establish hourly intake schedule. Measure/provide food and fluids in amount specified following gastric stapling.</p> <p>Instruct in how to sip and eat slowly.</p> <p>Stress importance of being aware of satiety and stopping intake.</p> <p>Require that patient sit up to drink/eat.</p> <p>Determine foods that are gas forming and eliminate them from diet.</p> <p>Discuss food preferences with patient and include those foods in pureed diet when possible.</p> <p>Weigh daily. Establish regular schedule after discharge.</p>	<p>After partitioning, gastric capacity is reduced to approximately 50 mL, necessitating frequent/small feedings. Management of optimal nutrition depends on reducing the amount of food/fluid (e.g., 1 oz of fluid or 300 calories) passing through the gastrointestinal (GI) system at one time.</p> <p>Increases satiety and reduces risk of dehydration.</p> <p>Overeating may cause nausea/vomiting or damage partitioning.</p> <p>Reduces possibility of aspiration.</p> <p>May interfere with appetite/digestion and restrict nutritional intake.</p> <p>May enhance intake, promote sense of participation/control.</p> <p>Monitors losses and aids in assessing nutritional needs/effectiveness of therapy.</p>
<p><b>Collaborative</b></p> <p>Provide liquid diet, advancing to soft foods that are high in protein and bulk and low in fat, with liquid supplements as needed.</p> <p>Refer to dietitian.</p>	<p>Provides nutrients without exceeding calorie limits <i>Note:</i> Liquid diet is usually maintained for 8 wk after partitioning procedure.</p> <p>May need assistance in planning a diet that meets nutritional needs.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Weight Reduction Assistance (NIC)</b></p> <p><b>Collaborative</b></p> <p>Administer vitamin supplements and vitamin B<sub>12</sub> injections, folate, and calcium as indicated.</p>	<p>Supplements may be needed to prevent anemia because absorption is impaired. Increased intestinal motility following bypass procedure lowers calcium level and increase absorption of oxalates, which can lead to urinary stone formation.</p>

<p><b>NURSING DIAGNOSIS: Skin Integrity, actual and risk for impaired</b></p> <p><b>May be related to</b></p> <p>Trauma/surgery; difficulty in approximation of suture line of fatty tissue  Reduced vascularity, altered circulation  Altered nutritional state: obesity</p> <p><b>Possibly evidenced by (actual)</b></p> <p>Disruption of skin surface, altered healing</p> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</b></p> <p><b>Wound Healing: Primary Intention (NOC)</b></p> <p>Display timely wound healing without complication.  Demonstrate behaviors to reduce tension on suture line.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Wound Care (NIC)</b></p> <p><b>Independent</b></p> <p>Support incision when turning, coughing, deep breathing, and ambulating.</p> <p>Observe incisions periodically, noting approximation of wound edges, hematoma formation and resolution, presence of bleeding/drainage.</p> <p>Provide routine incisional care, being careful to keep dressing dry and sterile. Assess patency of drains.</p> <p><b>Skin Surveillance (NIC)</b></p> <p>Encourage frequent position change, inspect pressure points, and massage gently as indicated. Apply transparent skin barrier to elbows/heels.</p> <p>Provide meticulous skin care; pay particular attention to skin folds.</p>	<p>Reduces possibility of dehiscence and incisional hernia.</p> <p>Influences choice of interventions.</p> <p>Promotes healing. Accumulation of serosanguineous drainage in subcutaneous layers increases tension on suture line, may delay wound healing, and serves as a medium for bacterial growth.</p> <p>Reduces pressure on skin, promoting peripheral circulation and reducing risk of skin breakdown. Skin barrier reduces risk of shearing injury.</p> <p>Moisture or excoriation enhances growth of bacteria that can lead to postoperative infection.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Skin Surveillance (NIC)</b></p> <p><b>Collaborative</b></p> <p>Provide foam/air mattress or kinetic therapy as indicated.</p>	<p>Reduces skin pressure and enhances circulation.</p>

<p><b>NURSING DIAGNOSIS: Infection, risk for</b></p> <p><b>Risk factors may include</b>            Inadequate primary defenses: broken/traumatized tissues, decreased ciliary action, stasis of body fluids            Invasive procedures</p> <p><b>Possibly evidenced by</b>            [Not applicable; presence of signs and symptoms establishes an actual diagnosis.]</p> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</b></p> <p><b>Immobility Consequences: Physiological (NOC)</b>            Be free of nosocomial infection.</p> <p><b>Wound Healing: Primary Intention (NOC)</b>            Achieve timely wound healing free of signs of local or generalized infectious process.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Infection Protection (NIC)</b></p> <p><b>Independent</b></p> <p>Stress/model proper handwashing technique.</p> <p>Maintain aseptic technique in dressing changes, invasive procedures.</p> <p>Inspect surgical incisions/invasive sites for erythema, purulent drainage.</p> <p>Encourage frequent position changes; deep breathing, coughing, use of respiratory adjuncts, e.g., incentive spirometer.</p> <p>Provide routine catheter care/encourage good perineal care.</p> <p>Encourage patient to drink acid-ash juices, such as cranberry.</p> <p>Observe for reports of abdominal pain (especially after third postoperative day), elevated temperature, increased white blood cell (WBC) count.</p>	<p>Prevents spread of bacteria, cross-contamination.</p> <p>Reduces risk of nosocomial infection.</p> <p>Early detection of developing infection provides for prevention of more serious complications.</p> <p>Promotes mobilization of secretions, reducing risk of pneumonia.</p> <p>Prevents ascending bladder infections.</p> <p>Maintains urine acidity to retard bacterial growth.</p> <p>Suggests possibility of developing peritonitis.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Infection Protection (NIC)</b></p> <p><b>Collaborative</b></p> <p>Apply topical antimicrobials/antibiotics as indicated.</p> <p>Administer IV antibiotics as indicated.</p> <p>Obtain specimen of purulent drainage/sputum for culture and sensitivity.</p>	<p>Reduces bacterial or fungal colonization on skin; prevents infection in wound.</p> <p>A prophylactic antibiotic regimen is usually standard in these patients to reduce risk of perioperative contamination and/or peritonitis.</p> <p>Identifies infectious agent, aids in choice of appropriate therapy.</p>

<p><b>NURSING DIAGNOSIS: Diarrhea</b></p> <p><b>May be related to</b></p> <p>Rapid transit of food through shortened small intestine  Changes in dietary fiber and bulk  Inflammation, irritation, and malabsorption of bowel</p> <p><b>Possibly evidenced by</b></p> <p>Loose, liquid stools, increased frequency  Increased/hyperactive bowel sounds</p> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</b></p> <p><b>Treatment Behavior: Illness or Injury (NOC)</b>  Verbalize understanding of causative factors and rationale of treatment regimen.  Follow through with treatment recommendations.</p> <p><b>Bowel Elimination (NOC)</b>  Regain near-normal bowel function.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Diarrhea Management (NIC)</b></p> <p><b>Independent</b></p> <p>Observe/record stool frequency, characteristics, and amount.</p> <p>Encourage diet high in fiber/bulk within dietary limitations, with moderate fluid intake as diet resumes.</p> <p>Restrict fat intake as indicated.</p> <p>Observe for signs of dumping syndrome, e.g., instant diarrhea, sweating, nausea, and weakness after eating.</p>	<p>Diarrhea often develops after resumption of diet.</p> <p>Increases consistency of the effluent. Although fluid is necessary for optimal body function, excessive amounts contribute to diarrhea.</p> <p>Low-fat diet reduces risk of steatorrhea and limits laxative effect of decreased fat absorption.</p> <p>Rapid emptying of food from the stomach may result in gastric distress and alter bowel function.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Diarrhea Management (NIC)</b></p> <p><b>Independent</b></p> <p>Assist with frequent perianal care, using ointments as indicated. Provide whirlpool bath.</p> <p><b>Collaborative</b></p> <p>Administer medications as indicated, e.g., diphenoxylate with atropine (Lomotil).</p> <p>Monitor serum electrolytes.</p>	<p>Anal irritation, excoriation, and pruritus occur because of diarrhea. The patient often cannot reach the area for proper cleansing and may be embarrassed to ask for help.</p> <p>May be necessary to control frequency of stools until body adjusts to changes in function brought about by surgery.</p> <p>Increased gastric losses potentiate the risk of electrolyte imbalance, which can lead to more serious/life-threatening complications.</p>

<p><b>NURSING DIAGNOSIS: Knowledge, deficient [Learning Need] regarding condition, prognosis, treatment, self-care, and discharge needs</b></p> <p><b>May be related to</b></p> <ul style="list-style-type: none"> <li>Lack of exposure, unfamiliarity with resources</li> <li>Information misinterpretation</li> <li>Lack of recall</li> </ul> <p><b>Possibly evidenced by</b></p> <ul style="list-style-type: none"> <li>Questions, request for information</li> <li>Statement of misconceptions</li> <li>Inaccurate follow-through of instructions</li> <li>Development of preventable complications</li> </ul> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</b></p> <p><b>Knowledge: Disease Process (NOC)</b></p> <p>Verbalize understanding of surgical procedure, potential complications, and postoperative expectations.</p> <p><b>Knowledge: Treatment Regimen (NOC)</b></p> <p>Verbalize understanding of therapeutic needs and rationale for actions.</p> <p>Initiate necessary lifestyle changes and participate in treatment regimen.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Teaching: Disease Process (NIC)</b></p> <p><b>Independent</b></p> <p>Review specific surgical procedure and postoperative expectations.</p>	<p>Provides knowledge base from which informed choices can be made and goals formulated. Initial weight loss is rapid, with patient often losing half of the total weight loss during the first 6 mo. Weight loss then gradually slows over a 2-yr period.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Teaching: Disease Process (NIC)</b></p>	
<p><b>Independent</b></p>	
<p>Address concerns about altered body size/image.</p>	<p>Anticipation of problems can be helpful in dealing with situations that arise. (Refer to CP: Eating Disorders: Obesity, ND: Body Image, disturbed/Self-Esteem, chronic low.) <i>Note:</i> Feelings that often occur during more conventional weight loss therapies generally are not encountered in the surgically treated patient.</p>
<p>Review medication regimen, dosage, and side effects.</p>	<p>Knowledge may enhance cooperation with therapeutic regimen and maintenance of schedule.</p>
<p>Recommend avoidance of alcohol.</p>	<p>May contribute to liver/pancreatic dysfunction.</p>
<p>Discuss responsibility for self-care with patient/SO.</p>	<p>Full cooperation is important for successful outcome after procedure.</p>
<p>Stress importance of regular medical follow-up, including laboratory studies, and discuss possible health problems.</p>	<p>Periodic assessment/evaluation (e.g., over 3–12 mo) promotes early recognition/prevention of such complications as liver dysfunction, malnutrition, electrolyte imbalances, and kidney stones, which may develop after bypass procedure.</p>
<p>Encourage progressive exercise/activity program balanced with adequate rest periods.</p>	<p>Promotes weight loss, enhances muscle tone, and minimizes postoperative complications while preventing undue fatigue.</p>
<p>Review proper eating habits, e.g., eat small amounts of food slowly and chew well, sit at table in calm/relaxed environment, eat only at prescribed times, avoid between-meal snacking, do not “make up” skipped feedings.</p>	<p>Focuses attention on eating, increasing awareness of intake and feelings of satiety.</p>
<p>Avoid fluid intake <math>\frac{1}{2}</math> hr before/after meals and use of carbonated beverages.</p>	<p>May cause gastric fullness/gaseous distension, limiting intake of food.</p>
<p>Identify signs of hypokalemia, e.g., diarrhea, muscle cramps/weakness of lower extremities, weak/irregular pulse, dizziness with position changes.</p>	<p>Increasing dietary intake of potassium (e.g., milk, coffee, potatoes, carrots, bananas, oranges) may correct deficit, preventing serious respiratory/cardiac complications.</p>
<p>Discuss symptoms that may indicate dumping syndrome, e.g., weakness, profuse perspiration, nausea, vomiting, faintness, flushing, and epigastric discomfort or palpitations, occurring during or immediately following meals. Problems-solve solutions.</p>	<p>Generally occurring in early postoperative period (1–3 wk), syndrome is usually self-limiting but may become chronic and require medical intervention.</p>
<p>Review symptoms requiring medical evaluation, e.g., persistent nausea/vomiting, abdominal distension/tenderness, change in pattern of bowel elimination, fever, purulent wound drainage, excessive weight loss of plateauing/weight gain.</p>	<p>Early recognition of developing complications allows for prompt intervention, preventing serious outcome.</p>
<p>Refer to community support groups.</p>	<p>Involvement with other who have dealt with same problems enhances coping; may promote cooperation with therapeutic regimen and long-term positive recovery.</p>

**POTENTIAL CONSIDERATIONS following acute hospitalization (dependent on patient's age, physical condition/presence of complications, personal resources, and life responsibilities)**

Nutrition: imbalanced, risk for more than body requirements—dysfunctional eating patterns, observed use of food as reward/comfort measure, history of morbid obesity.

Refer to Potential Consideration in Surgical Intervention plan of care.