

The LIGHTHOUSE

A NEWSLETTER BY IRAQI HEALTH PROFESSIONAL ASSOCIATION AUSTRALIA



Iraqi
Health
Professionals
Association
Australia



جمعية المهنة الطبية العراقية في استراليا



INSIDE THIS ISSUE

PAGE 2

MESSAGE FROM THE PRESIDENT

PAGE 4

**RAMADAN IFTAR FOR WOMEN,
OUR POP-UP ACTIVITY**

PAGE 5

**ARABIAN NIGHT AT
MERRYLANDS WEST, A
FULL HOUSE AND A BARREL OF
LAUGHS**

PAGE 6

**PERSPECTIVE: M IS FOR MAY &
M IS FOR MOTHER'S DAY:
CHALLENGES FACING HEALTH
PROFESSIONAL MOTHERS**

PAGE 7

**SERIES: BLASTS FROM THE
IRAQI MEDICAL HERITAGE**

PAGE 9

**SHINING LIGHTS: GETTING TO
KNOW OUR MEMBERS**

PAGE 10

**THE EDUCATIONAL CORNER
ARTICLE: OBESITY IN ADOLESCENTS
AND SURGERY**



Welcome to our Newsletter . IHPAA is a non-for-profit, non-governmental professional organization concerned with social and professional networking for Australian-Iraqi health professionals . IHPAA was established to encourage and facilitate scientific, educational, and social activities between its members .

Message from the president

Saif Hayek BDS, Grad Dip Ortho (Lond), MBA, Fellow of IADFE and ICCDE

Dear colleagues,

This is our second edition for this year, and what a year it has been so far, full of exciting events.

First, I would like to welcome three new members to our board and subcommittee.

- Dr Atika Balasem
- Dr Muhaya Hazim
- Miss Mina Al-Tawel- Medical student

I thank all board members for their tireless work and amazing contributions.

Our first event for this year was such a successful, colourful, and fun event. Make sure to see the pictures of the Arabian Night event in our social media feed. Tickets were sold out prior to the date and we had a full house.

We encourage our members and all the Iraqi Health professionals in Australia to try to attend our events as they will enrich your senses and broaden your network. There are three more events coming up soon and I urge you to book as soon as possible to secure your place:

1. July 2023: A webinar on university education in medical schools across Iraq and Australia facilitated by doctors and medical students.
2. August 2023 City2Surf charity run.
3. November 2023, our highly sought after Gala event- Luxury Cruise Luncheon.

Just a reminder for all to join as active members of the association, just visit www.Iraqihealth.com.au and hit on the register now button. Membership fees help us cover the costs of the association, we are an all-volunteers board but we still have website, legislatives, and tax costs to cover. Annual membership fee is \$50 per member and it gives you exclusive access to our upcoming events and educational activities. We appreciate your support.

Sincerely,

Saif Hayek



SUBSCRIBE:

Website:

www.iraqihealth.com.au

CORRESPOND:

Email:

ihpanewsletter@gmail.com

THE EDITING TEAM

Dina Mahmood *MBChB, FRANZCP, CertCAP*

Faiq Issa, *MBChB, PhD*

Hiba Aal-Yaseen, *BDS, MHLM*

George Damuk, *BPharm, AACPA, ACP*

Sam Sohaily, *MBChB, FRACP, PhD*

Important events

<https://iraqihealth.com.au/events/>

July 2023 Webinar: University education in medical schools across Iraq and Australia.

Coordinated by Mina Al-Tawel-University of Newcastle, school of
Medicine .

Facilitated by Dr Atika Balasem, Dr Dina Mahmood-Sydney & Dr Umniah
Khajori-Baghdad .

Follow us on social media for details and registration link .

August 13th City2Surf charity run.

Put your sports shoes on and join us with your family and friends for the
biggest and most fun run in the world . We are running City2Surf 2023 to
raise funds for the Sydney Children 's Hospitals Foundation . Visit our
website or social media for links to join .

November 5th Gala Luxury Cruise Luncheon

Enjoy the best scenery Sydney has to offer with 5 stars food and
entertainment on board the most luxurious ship in Sydney .

Tickets available and will sell fast, for more details follow us on social media
or visit our website .

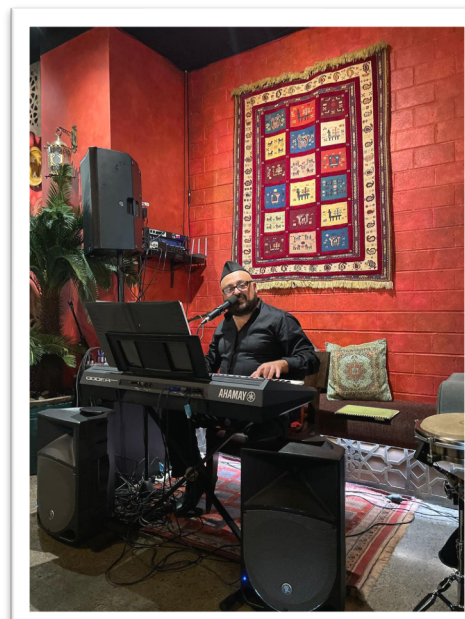


Ramadan Iftar for women, our pop-up activity

At the Iraqi Health Professionals Association Australia, we are never satisfied with standard plans, our board members constantly have their eyes on any opportunity to connect and appreciate each other as health professionals. This is how Ramadan Iftar for women in health and medical sector was a quickly executed idea that paid off well. Meeting over Iftar provided a space for our health professional females to come together and celebrate a joint Iftar experience, also demonstrated a commitment to inclusivity. Such events not only provide an opportunity for networking but also allow for sharing of experiences, insights, and support among professionals.



Arabian Night at Merrylands West, a full-house and a barrel of laughs



The IHPAA had the pleasure of organising an event that gathered our elite Iraqi health professionals attending a magical Arabian Night at The Middle Feast restaurant in Merrylands West.

An exquisite night of entertainment and delicious food; The night included a dazzling performance by the Iraqi singer Bashar Hanna and a spectacular belly dancer show.

The event was met with enthusiasm and interest from the community and tickets were quickly sold out. It was delightful to see everyone beautifully showing off their traditional Iraqi and Arabian attire!

Perspective: M is for May & M is for Mother's Day: Challenges facing health professional mothers

This month, as we celebrated Mother's Day, we took a moment to appreciate and honour the incredible mothers in our lives. Being a mother is often regarded as one of the toughest jobs in the world, but have you ever considered the unique challenges faced by mothers working in healthcare? These brave women have been on the front lines of the ongoing pandemic, grappling with staffing shortages, resource limitations, and an increased volume of complex cases. The aftermath of COVID-19 has further exacerbated the challenges faced by health professionals, resulting in higher rates of burnout both personally and professionally.

In addition to the challenges they face at work, women in healthcare are also burdened with increased stress as they tend to the emotional well-being of their entire household. This emotional labour, professionally known as mental loading, refers to the responsibility women bear for worrying about the worries of others in her household and beyond. Even in our post-modern society, women continue to shoulder the majority of the family's mental load.

When we specifically focus on health professional mothers in the balance of life, the challenges they

face are taken to the next level, adding an enormous moral burden. Many mothers can relate to waking up to a sick child and being torn between caring for their child and fulfilling their professional responsibilities. These lose-lose situations have become increasingly common since the pandemic, as mothers are caught in a dual role dilemma, feeling the desperate need to be present for their team and patients while also being there for their children. At first glance, this dilemma may seem outdated, as women have long been part of the workforce, but upon further reflection, it becomes clear that it has become an increasingly demanding task, with heavier stressors at either side of the scale.

As we bid farewell to the month of May, let us reflect on ways to show ongoing kindness and acknowledgment to the fierce fighters in our workforce—the health professional mothers.

Let's recognize their immense dedication, resilience, and sacrifices, not only on Mother's Day but every day. Whether it's offering support at work, advocating for policies that address their unique needs, or simply showing gratitude for their unwavering commitment, let's strive to create an environment that supports these extraordinary individuals in their dual roles as healthcare providers and mothers.

With warm regards,
The editing team

Series: Blasts from the Iraqi medical heritage

Dina Mahmood / MBChB, FRANZCP, CertCAP / Sydney Children's Hospital Network



A series of articles placing spotlights on the Iraqi medical culture in its wild, weird, and wonderful aspects across history. The article references published materials and firsthand testimonials.

EPISODE TWO: HEALTH CARE SITUATION IN IRAQ DURING THE OTTOMAN RULE

After the glorious scientific renaissance brought forth by the Arabs during the prosperous ruling times of the Abbasids, the Far East found itself languishing in the dark corridors of decay across all aspects of life. With Iraq's inclusion in the Ottoman Empire, the general conditions began to deteriorate, taxes escalated, and a decline in health and medical services ensued. In this vacuum, myths, deception, and sorcery became widespread, plaguing the people. Despite attempts at reform, hospitals were neglected, leaving them as havens for the poor and homeless. 'Al-Ghuraba' Hospital, established in 1872 AD, exemplified this plight. Preceding World War I, Baghdad became a fertile ground for imposters and sorcerers who capitalized on limited medical resources, corruption, ignorance, and public desperation.

Imposters and Sorcerers of the era:

Among the notable imposters in the healthcare domain was Hakeem Khadada, an individual of unknown qualifications from Hamedan, Iran, who arrived in Baghdad in 1885 AD. Khadada settled near Al-Kadhumiya and began practicing medicine, quickly gaining a significant reputation and becoming the personal physician of many prominent families. Dressed in traditional Iranian attire, he jovially received patients in his courtyard, where wooden benches were often



Iraqi medical students of the Astana medical school pre WWI-
Sitting from the rt: Dr Dawod Al-Dobooni, Dr Jalal Al-Azawi.
Standing from the rt: Dr Faiq Shaker, Dr Abdulla Al-Damaluji,
& Dr Yahya Nazhat.

crowded with those seeking his services. Khadada prescribed mixtures of herbs, combined with Western drugs and other unknown substances. Interestingly, he did not charge for examinations in his clinic but accepted gifts from patients upon recovery. His affluent life continued for approximately 20 years until his demise from the plague.

Like Khadada, other imposters wreaked havoc on public health, perpetrating numerous health crimes with devastating consequences. Doctor Lazar, believed to hold a fake medical degree, Sayyid Ahmed, Sayyid Aristotle, and Farah Khatoun, who specialized in eye disease treatments, were among those who exploited the vulnerable state of medical affairs during this era.

Establishment of Medical Schools under Ottoman Rule :

During the Ottoman era, a cluster of medical schools was established in the central region of governance in Turkey. The most prominent of these was the "Tabakhane" School, founded in 1827, where a significant number of graduates served as doctors for the military force. In the same year, the School of Surgery, also known as "Jarraht khane," was established. Eventually, both schools merged to form the Military Medical School. In 1875, the Royal Medical School emerged, aiming to make Turkish the official language of instruction instead of French. These schools were subsequently merged in 1910 and relocated to a unified building known as "Haydarpasha College" on the coast of Sea of Marmara. It was from this school that several Iraqi medical pioneers graduated.



Iraqi doctors after returning to Iraq upon WWI-from rt: Dr Hashim Al-Witri, Dr Faiq Shakir, Dr Sami Shawkat, Dr Skakir Al-Sewedi, Dr Ismail Al-Saffar, Dr Saib Shawkat, & Dr Shawkat Al-Zahawi.

Reference: *History of Medicine in Iraq with the establishment and progress of the Iraqi Royal School of Medicine*. Dr Hashim Al-Witri; Dr Muamar Khalid Al-Shabandar, Government printing press-Baghdad 1939

Shining stars: Getting to know our members



Congratulations Dr Dina Mahmood, IHPAA secretary for being elected as the Psychiatry Councillor for the Australian Medical Association (AMA) NSW for the period May 2023–May 2026. Dr Dina will continue advocating for optimising access to mental health care and for the support of doctors in training and IMGs.



Congratulations Dr Ettihad Amash for the remarkable accomplishment of her sons: Dr Ausama (Sam) Tharwat Alhayo and Dr Marwan Tharwat to graduate from the Royal Australasian College of Surgeons during college ceremony, April 2023. We wish them all the best in their careers as surgeons as they carry on their late father's legacy with pride.



Congratulations Dr Aulla Mahdi for attaining her medical degree from Western Sydney University and starting a career as doctor following an inspiring journey. Dr Aulla initially started studying medicine at Erbil 2014 but had to drop out halfway through her study to join her husband in Australia and start a family. Filled with determination it took close to a year to meet the Australian requirements, pass the ISAT, and language tests following which she was accepted to start medical studies in 2018, two weeks after giving birth to her first baby boy. She graduated in 2022 and encourages all females to not give up on their dreams.

The Educational Corner



Khalid Ahmed / MBChB, MSC, FRACS / General Surgeon-Bariatric

Obesity in Adolescents and Surgery

Obesity has become one of the most important public health problems.

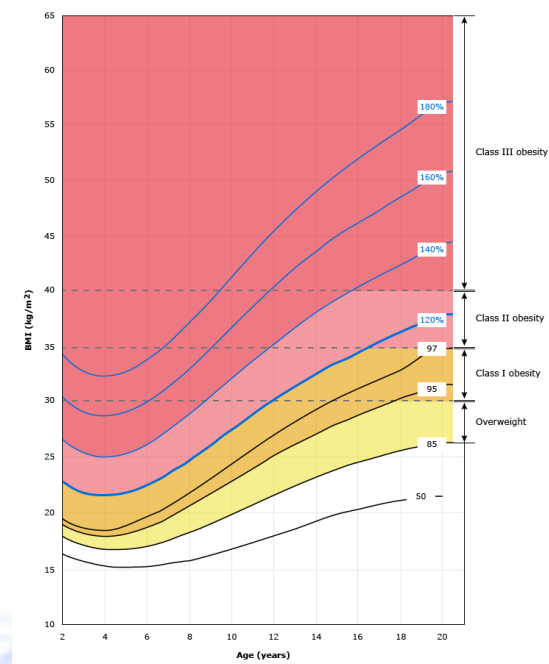
As the prevalence of obesity in children and adolescent increases, so does the prevalence of metabolic syndrome associated conditions including (but not limited to) diabetes, cardiovascular disease, fatty liver, and chronic liver disease. Management of obesity and associated conditions results in an enormous burden to the health system worldwide.

For this reason, it is imperative that clinicians identify children with overweight and obesity so that counselling and treatment can be provided.

Obesity in children and adolescents is classified by severity, using the following thresholds (figure 1A-B):

- Class I – BMI $\geq 95^{\text{th}}$ percentile for age and sex or BMI ≥ 30 (whichever is lower).
- Class II – BMI ≥ 120 percent of the 95th percentile values or a BMI ≥ 35 kg/m² (whichever is lower). This corresponds to approximately the 98th percentile.
- Class III – BMI ≥ 140 percent of the 95th percentile values or a BMI ≥ 40 kg/m².

Severe (class II or III) obesity affects approximately 10 percent of girls and 13 percent of boys 12 to 19 years old in the United States.



During the past 40 years, weight loss surgery has clearly been shown to produce significant and sustained reductions in body mass index (BMI), diabetes, and hypertriglyceridemia in adults. It also reduces mortality, as highlighted in a 24-year follow-up of patients undergoing Roux-en-Y gastric bypass (RYGB), adjustable gastric banding (AGB), or vertical banded gastroplasty in the Swedish Obese Subjects Study

Alternatives to surgery — Non-invasive approaches should always be the first-line treatment for any child or adolescent with obesity. The best-established approaches are multidisciplinary, using family-based behavioural techniques to support changes in diet and physical activity, with goals of reducing caloric intake, improving the quality of the food intake, and increasing energy expenditure. Recommendations from the American Academy for Paediatrics and other professional organizations advocate for early intervention with dietary and lifestyle changes for children with excessive weight gain.

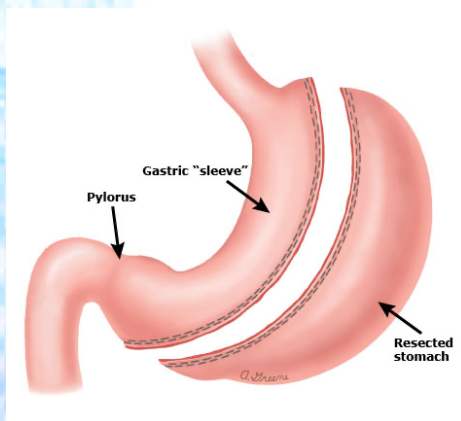
An increasing number of drugs are available for the management of obesity in adolescents.

TYPES OF SURGERY

Sleeve gastrectomy — The SG (also known as vertical sleeve gastrectomy) is a partial gastrectomy, in which the majority of the greater curvature of the stomach is removed, creating a tubular stomach (figure 2). The frequency of this procedure for weight loss surgery has been rapidly increasing, and it accounts for more than 80 percent of bariatric procedures in adolescents. It is typically used as a standalone procedure. If patients regain weight in the long term, the SG can be converted to a RYGB, but this is uncommon.

Because SG is less complex than RYGB and has a lower theoretical risk of micronutrient deficiencies, it is an appealing option for adolescents. In a study from the United States with five-year follow-up, SG was associated with reduced frequency of emergency department visits (53.3 versus 59.9 percent) and hospitalization (36.9 versus 52.1 percent) compared with RYGB.

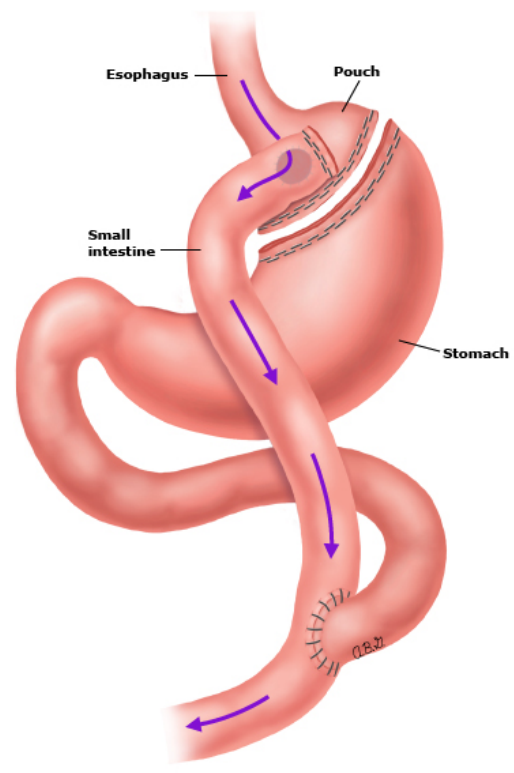
SG may be a particularly appropriate choice for individuals with cognitive deficits, younger age, or other issues that might increase risk for postoperative nutritional deficiencies.



Roux-en-Y gastric bypass — RYGB creates a small (less than 30 mL) proximal gastric pouch that is divided and separated from the distal stomach and anastomosed to a Roux-limb of small bowel 75 to 150 cm in length (figure 3). The surgery was the most commonly performed bariatric procedure in the United States until approximately 2012 but now accounts for less than 20 percent of procedures in adolescents.

The long-term outcomes for weight loss and comorbidity improvement are well established for RYGB, based on more than 25 years of experience with this procedure in adults. In

addition, it has particularly dramatic benefits on glycaemic control, which may offer some advantage for patients with type 2 diabetes. On the other hand, there are probably more risks for nutritional deficiencies compared with SG. In particular, iron deficiency and long-term outcomes for bone health after RYGB are not well studied.



Other — Endoscopically placed intragastric balloons are approved by the FDA for short-term use (up to six months) in severely obese adults but have only been studied in a few single-centre, small case series of adolescents. In a two-year cohort study of 12 severely obese adolescents, clinically significant, modest improvements in weight (mean 5 percent loss) and some measures of glucose metabolism (insulin area under the curve and glycated haemoglobin) were seen at six months, while the intragastric balloon was in place. However, after device removal, weight loss and cardiometabolic benefits were not sustained for most participants at two-year follow-up.

MECHANISMS OF WEIGHT LOSS AFTER BARIATRIC SURGERY

Reduction of caloric intake plays an important role in the dramatic weight loss produced by bariatric surgery. However, this is only partially attributable to a reduced capacity of the stomach or pouch. Many patients report a subjective decrease

in appetite and increase in postprandial satiety after surgery, which help them maintain lower intakes of food. This experience suggests that the effects of bariatric surgery on weight loss and comorbidities may have neuroendocrine mechanisms and are not entirely attributable to mechanical restriction of food intake or to malabsorption.

Emerging data suggest that alterations in neuroenteric hormones that regulate appetite and energy expenditure could contribute to changes in satiety after surgery. Several studies have demonstrated an increase in postprandial peptide YY (PYY) concentrations after Roux-en-Y gastric bypass (RYGB) compared with lean or obese nonoperative controls. This postprandial increase in PYY is not reported after an adjustable gastric banding (AGB). However, a single series of 12 patients undergoing the vertical banded gastroplasty (also purely restrictive) reported an increase in fasting and postprandial PYY concentrations after surgery to levels comparable with concentrations measured in lean controls.

In addition, bile acid signalling, mediated through the farnesoid X receptor (FXR), appears to be integral to achieving the weight loss and beneficial metabolic effects of sleeve gastrectomy (SG) in rodent models of bariatric surgery. Studies in adults have also demonstrated a rise in circulating total bile acids after RYGB and to a lesser degree after SG; however, no significant change was demonstrated after AGB. Bile acids have also been shown to rise significantly in adolescents as well during the rapid weight loss phase in the first three months after SG.

PREOPERATIVE EVALUATION AND SCREENING

Screening — Recommended screening prior to surgical weight loss procedures includes evaluation for the presence and severity of coexisting diseases, as well as assessment of the patient's and family's understanding and readiness for a life-changing and often permanent procedure.

A multidisciplinary approach is recommended when offering weight loss surgery to adolescents. At a minimum, the team evaluating and caring for the candidate should include an experienced bariatric surgeon, paediatric obesity specialist, nurse, dietician, and paediatric psychologist or psychiatrist. One of these providers or an additional team member should have responsibility for coordinating each patient's care and ensuring follow-up and adherence to the prescribed medical regimen. The program also must have ready access to relevant paediatric subspecialties, including endocrinology, cardiology, gastroenterology, pulmonology, gynaecology, and orthopaedics, for further evaluation and/or management of specific comorbidities as needed.

Contraindications for surgical weight loss procedures in adolescents include:

- Medically correctable cause of obesity
- An ongoing substance abuse problem (within the preceding year)
- A medical, psychiatric, psychosocial, or cognitive condition that prevents adherence to postoperative dietary and medication regimens or impairs decisional capacity
- Current or planned pregnancy within 12 to 18 months of the procedure
- Inability on the part of the patient or parent/guardian to comprehend the risks and benefits of the surgical procedure

POSTOPERATIVE MANAGEMENT

Average hospital stay after laparoscopic Roux-en-Y gastric bypass (RYGB) or sleeve gastrectomy (SG) ranges from one to three days, during which strict measurement of intake and output, and gradual advancement of diet is done.

Diet — Dietary management after discharge varies with the type of surgery. After RYGB and SG, the patient advances through several stages, from high-protein shakes to gradual introduction of greater volumes and more textured and solid foods. The advancement to regular foods is slow, occurring over the first six months after surgery. For best results, the patient is encouraged to eat three to four small, high-protein meals per day and to avoid high-fat and carbohydrate foods as these may provoke malabsorptive or dumping side effects. Supplemental fluids are encouraged to avoid dehydration (64 to 92 ounces per day of sugar-free, noncarbonated beverages). Drinks should be sugar-free to avoid dumping syndrome and weight regain through overconsumption of liquid calories. Patients also are advised to avoid drinking during meals to avoid nausea and vomiting. Some patients experience greater degrees of nausea in the first postoperative month after SG as compared with RYGB, requiring addition of antiemetic medications. Typically, however, this resolves over time.

Follow-up visits are typically performed at two weeks postoperatively, then 1, 3, 6, 9, and 12 months after surgery. After that, annual follow-up is recommended for monitoring of anthropometric measurements, nutritional status, residual comorbidities, and general health. Follow-up for adjustable gastric banding (AGB) patients typically is more frequent due to the need for band adjustments. Some patients require visits every four to six weeks during the first one to two years.

General recommendations for long-term weight maintenance include:

- Drinking 8 to 12 8-ounce (we use ml than ounce) servings of sugar-free liquids per day. Some providers encourage the patient to avoid or limit caffeinated or carbonated beverages, based on theoretical concerns

that these substances may be detrimental after surgery, although there is little evidence to support this concern.

- Exercising 30 to 60 minutes daily.
- Eating protein first at each meal (1 g/kg of ideal body weight).
- Three to four portion-controlled meals per day, with minimal snacking between meals.
- Taking daily vitamin and mineral supplementation.

These guidelines may need to be tailored to meet an individual patient's needs if significant weight regain or too much weight loss has occurred.

Nutritional supplements — After RYGB or SG procedures, lifelong supplementation with vitamins and minerals is recommended to avoid development of nutritional complications secondary to reduced intake and/or mild malabsorption. Although SG and AGB may be associated with reduced risk for nutritional deficiencies compared with RYGB, long-term data on nutritional outcomes are still lacking. Therefore, the same supplementation is prescribed for all patients regardless of the bariatric procedure. As long-term data on outcomes in adolescents are collected, these initial recommendations may be modified.

After RYGB, patients should conscientiously adhere to a supplementation regimen because of risks for malabsorption of micronutrients; the recommended doses and preparations vary somewhat among practices and may be adjusted based on laboratory measures.

The following supplements are recommended for all patients (table 2):

- Standard multivitamin with folate and iron, or prenatal vitamin if female (once or twice daily).
- **Vitamin B12**, 500 micrograms sublingually daily, or 1000 micrograms intramuscularly monthly. In those with satisfactory levels at annual monitoring, a single semiannual dose of 3000 micrograms intramuscularly can be considered.
- Calcium, 1200 to 1500 mg daily (measured as elemental calcium), with 800 to 1000 international units of vitamin D.

Additional supplementation may be necessary during pregnancy or as indicated by laboratory testing. If postoperative vomiting is severe, vitamin B1 (thiamine) deficiency also can rapidly develop. Vitamin B1 deficiency is particularly important to recognize early as lasting neurologic sequelae can result if rapid replenishment of vitamin B1 is not initiated. In the author's program, vitamin B1 supplementation (50 mg orally daily) is provided during the first six months after surgery as a prophylactic measure.

Recommended nutritional supplementation after bariatric surgery in adolescents

Gastric bypass
Standard multivitamin with folate and iron, or prenatal vitamin if female*
Vitamin B12 500 micrograms orally/sublingually daily, or 1000 micrograms intramuscularly monthly
Calcium 1200 mg to 1500 mg daily with 800 units vitamin D [†]
Supplemental iron if iron deficient*
Adjustable banding
Standard multivitamin with folate and iron* or prenatal vitamin if female*
Vitamin B12, iron, calcium with vitamin D as indicated clinically

* Additional iron and folate may be necessary in pregnant females.

[†] Calcium citrate may be better absorbed.

REFERENCES

- [QuickStats: Prevalence of Obesity* and Severe Obesity† Among Persons Aged 2-19 Years - National Health and Nutrition Examination Survey, 1999-2000 through 2017-2018. MMWR Morb Mortal Wkly Rep 2020; 69:390.](#)
- [QuickStats: Prevalence of Obesity* and Severe Obesity† Among Persons Aged 2-19 Years - National Health and Nutrition Examination Survey, 1999-2000 through 2017-2018. MMWR Morb Mortal Wkly Rep 2020; 69:390.](#)
- [Hampl SE, Hassink SG, Skinner AC, et al. Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents With Obesity. Pediatrics 2023; 151.](#)
- [Carlsson LMS, Sjöholm K, Jacobson P, et al. Life Expectancy after Bariatric Surgery in the Swedish Obese Subjects Study. N Engl J Med 2020; 383:1535.](#)
- [Jackson WL, Lewis SR, Bagby JP, et al. Laparoscopic sleeve gastrectomy versus laparoscopic Roux-en-Y gastric bypass in the pediatric population: a MBSAQIP analysis. Surg Obes Relat Dis 2020; 16:254.](#)
- [Paulus GF, de Vaan LE, Verdam FJ, et al. Bariatric surgery in morbidly obese adolescents: a systematic review and meta-analysis. Obes Surg 2015; 25:860.](#)
- [Eisenberg D, Shikora SA, Aarts E, et al. 2022 American Society for Metabolic and Bariatric Surgery \(ASMBS\) and International Federation for the Surgery of Obesity and Metabolic Disorders \(IFSO\); Indications for Metabolic and Bariatric Surgery. Surg Obes Relat Dis 2022; 18:1345.](#)
- [Fullmer MA, Abrams SH, Hrovat K, et al. Nutritional strategy for adolescents undergoing bariatric surgery: report of a working group of the Nutrition Committee of NASPGHAN/NACHRI. J Pediatr Gastroenterol Nutr 2012; 54:125.](#)