Zinc absorption and zinc status are reduced after Roux-en-Y gastric bypass: a randomized study using 2 supplements

Manuel Ruz, Fernando Carrasco, Pamela Rojas, Juana Codoceo, Jorge Inostroza, Karen Basfı-fer, Attila Csendes, Karin Papapietro, Fernando Pizarro, Manuel Olivares, Lei Sian, Jamie L Westcott, Leland V Miller, K Michael Hambidge, and Nancy F Krebs

ABSTRACT

Background: Micronutrient deficiencies are common in patients undergoing gastric bypass. The effect of this type of surgery on zinc absorption and zinc status is not well known.

Objective: The objective was to evaluate the effects of Roux-en-Y gastric bypass (RYGBP) on zinc status and zinc absorption at different stages after surgery. We hypothesized that zinc status would be significantly impaired after surgery and that this impairment would be less severe in subjects receiving increased supplemental zinc. We also hypothesized that zinc absorption would be lower after surgery.

Design: Anthropometric and body-composition variables and dietary and biochemical indexes of zinc status and zinc absorption were determined in 67 severe and morbidly obese women [mean (±SD) age: 36.9 ± 9.8 y; BMI (in kg/m₂): 45.2 ± 4.7] who underwent RYGBP. The subjects were randomized assigned to 1 of 2 vitamin-mineral supplementation groups. Measurements were made before and 6, 12, and 18 mo after surgery. Fifty-six subjects completed the 18-mo follow-up.

Results: Mean plasma zinc, erythrocyte membrane alkaline phosphatase activity, and the size of the rapidly exchangeable zinc pool decreased after RYGBP. Percentage zinc absorption decreased significantly from 32.3% to 13.6% at 6 mo after RYGBP and to 21% at 18 mo after surgery. No effect of supplement type was observed.

Conclusions: Zinc status is impaired after RYGBP, despite the finding that dietary plus supplemental zinc doubled recommended zinc intakes in healthy persons. Zinc absorption capacity is significantly reduced soon after RYGBP, with no major changes until 18 mo after surgery. Am J Clin Nutr 2011;94:1004–11.

INTRODUCTION

Several surgical alternatives are available to treat morbid obesity, such as RYGBP, gastric banding, sleeve gastrectomy, and biliopancreatic diversion (1–3). RYGBP has shown highly satisfactory results, including long-term maintained weight loss and improvements in medical conditions and quality of life (3, 4). Surgical complications associated with this procedure include anastomotic leakage (2.5%) and postoperative bleeding of the gastric staple line (0.75%) (4). In terms of adverse nutritional consequences, anemia is relatively common, mainly iron-deficiency anemia, which has been reported in 15–60% of patients who undergo gastric bypass (5–8). Recently, we showed that iron absorption from both a standard diet and from a standard dose of ferrous ascorbate was significantly decreased 6 mo after RYGBP to 32.7% and 40.3% of their initial values, respectively. No further significant modifications were noted until 18 mo after surgery (9).

Knowledge of the effects of gastric bypass on other minerals, zinc for example, is very limited (10, 11). Of the potential causes of zinc deficiency, a reduced zinc absorption capacity has frequently been mentioned, but the experimental evidence to support this is not available. In the current study we determined zinc status and zinc absorption before and 6, 12, and 18 mo after RYGBP. We hypothesized that, compared with presurgical measurements, zinc status would be significantly impaired after surgery and that this impairment would be less severe in subjects who received increased supplemental zinc. A secondary hypothesis was that zinc absorption would be lower after surgery and that the level of absorption would persist.

SUBJECTS AND METHODS

Subjects

Sixty-seven menstruating women were enrolled in this study [mean (±SD) age: 36.9 ± 9.8 y; age range: 18–55 y; mean weight: 115.1 ± 15.6 kg; weight range: 88.4–156.4 kg; mean BMI (in kg/m²): 45.2 ± 4.7]. The patients were enrolled between August 2004 and December 2006. The subjects were evaluated before and 6, 12, and 18 mo after RYGBP.

1 From the Department of Nutrition, Faculty of Medicine, University of Chile, Santiago, Chile (MR, FC, PR, JC, JI, and KB); the Department of Surgery, University of Chile Clinical Hospital (AC and KP), and the Institute of Nutrition and Food Technology, University of Chile, Santiago, Chile (FP and MO); and the Section of Nutrition, Department of Pediatrics, University of Colorado Denver, School of Medicine, Denver, CO (LS, JLW, LVM, KMH, and NFK).

2 Supported by FONDECYT Research Projects 1040765 and 1080576. The calcium and vitamin D supplements were donated by Andromaco Laboratories, Santiago, Chile. The mineral and vitamin supplements were provided at a reduced price by Farmacias Ahumada, Santiago, Chile.

3 Address correspondence to M Ruz, Department of Nutrition, Faculty of Medicine, University of Chile, Independencia 1027, Correo 7, Código Postal 8380453, Santiago, Chile. E-mail: mruz@med.uchile.cl.

4 EZP, exchangeable zinc pool; RDA, Recommended Dietary Allowance; RYGBP, Roux-en-Y gastric bypass.

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inclusion criteria considered women with a BMI ≥40 or a BMI ≥35 with comorbidities and who had a medical indication to undergo RYGBP at the Department of Surgery of the University Clinical Hospital. Fifty-six subjects completed the 18-mo follow up (Figure 1). Main initial anthropometric and biochemical characteristics of the individuals who abandoned the study were not significantly different from those who remained (data not shown).

All patients who accepted enrollment into the study signed an authorized consent form. The study was approved by the Ethics Committee for Human Investigation of the Faculty of Medicine of the University of Chile.

Experimental design

Details regarding the experimental design were provided previously while reporting the effects of the protocol on iron status and iron absorption (9). Briefly, the study was intended to produce the minimal interference to the standard medical management of patients undergoing RYGBP while simultaneously testing an improved vitamin and mineral supplement to reduce potential nutritional adverse consequences. All patients followed routine standard procedures after surgery. During the first month, they were fed a 500-mL liquid diet daily, which consisted of chicken breast, egg white, spinach, carrots, and potatoes that provided 2.9 mg Zn. A full medical evaluation was conducted at the end of this month. At this time, 1 unit of vitamins (TOL12; Saval Laboratories SA) was prescribed to all patients to be administered intramuscularly. This preparation contained 200 mg thiamine chloride, 100 mg pyridoxine chloride, and 10 mg hydroxycoabalamin. In addition, a solid diet divided into 5 or 6 meals was also prescribed. It provided ~1000 kcal, 60 g protein, and 6.5 mg Zn. If any nutritional-related signs (including zinc deficiency, such as alopecia or dermic lesions) were present at the medical evaluation conducted 3 mo after surgery, additional supplements of the corresponding nutrient were prescribed and used during distinct periods of treatment. These procedures were repeated 6 mo after surgery and every 6 mo thereafter until 18 mo after surgery.

At the evaluation scheduled 1 mo after surgery, the subjects were randomly allocated (using a random numbers table and carried out by a member of the Department of Nutrition not related to this study) into 2 groups: group A received the “standard vitamin and mineral supplement” and group B received the “improved vitamin and mineral supplement.” The study was blinded to the participants only. The “standard vitamin and mineral supplement” consisted of the routine vitamin and mineral supplement established at the University of Chile Clinical Hospital, which considered the use of a vitamin-mineral supplement (Larotabe; Bayer Laboratories) and 2 tablets daily of a calcium and vitamin D supplement (Elcal D; Andromaco Laboratories) to prevent the development of nutritional deficiencies. The “improved vitamin and mineral supplement” consisted of a specially designed vitamin-mineral supplement that provided at least the RDA of selected nutrients (12, 13) and 2 tablets daily of a calcium and vitamin D supplement (Elcal D-PLUS; Andromaco Laboratories).

![Flow diagram of volunteer recruitment and progress throughout the study.](https://academic.oup.com/ajcn/article-lookup/64/4/1004/4598071)
Laboratories). The total contents of the vitamins and minerals supplied by these supplements are described in detail elsewhere (9). In terms of elemental zinc, the standard vitamin and mineral supplement provided 7.5 mg/d and the improved vitamin and mineral supplement provided twice as much, 15 mg/d. A careful record of the amount of zinc-containing supplements consumed was kept throughout the study in a monthly register, and the number of pills remaining in the container was counted by study personnel. Also, a periodic evaluation for any indication of additional zinc supplements registered in the medical record was made. If this situation occurred, the subject was contacted by telephone to determine the extent to which the indicated supplement had effectively been consumed.

Sample size was calculated to detect postsurgical differences between plasma zinc (minimal number required: 21 subjects/group) and zinc absorption (minimal number required: 10 subjects/group). A series of anthropometric, body-composition, dietary, and hematologic evaluations were conducted in all patients before the surgical procedure and 6, 12, and 18 mo after RYGBP. In a subset of 26 individuals randomly selected within each group, zinc absorption tests and the size of the rapidly EZP were carried out during the same evaluation periods.

Surgical procedure

Details of the surgical technique are available elsewhere (4). Briefly, it consisted of a 95% distal gastrectomy and resection of the excluded stomach, which left a small gastric pouch of 15–20 mL. The length of the Roux-en-Y loop was 125–150 cm, in agreement with the current practice of clinical centers in Chile expressed in the 2005 panel of experts’ consensus (14).

Anthropometric and body-composition evaluations

Weight (kg) was measured to the nearest 0.1 kg on a digital scale (Seca; Vogel & Halke GMBH & Co), and height (m) was measured to the nearest 0.1 cm with a scale-mounted stadiometer according to standardized procedures (15). From these measurements, BMI (in kg/m²) was calculated. Body fat mass and fat-free mass were measured by dual-energy X-ray absorptiometry with a Lunar DPX-L densitometer (Lunar).

Dietary evaluation

Before and 6, 12, and 18 mo after RYGBP, the patients were interviewed by a dietitian, and a 3-d record that corresponded to 2 weekdays and 1 weekend day was completed. The data registered was analyzed by using a computer program (Food Processor II; ESHA) to calculate energy and nutrient intakes by using a database that contained locally generated nutrient composition data and information from the literature (16).

Zinc status evaluation

Fasting blood (7 mL) was collected by antecubital puncture and maintained in trace element–free containers until analyzed. Blood was obtained immediately before the administration of the stable isotopes used to determine percentage zinc absorption and the size of the rapidly EZP. Plasma was separated within 2 h of sample collection.

Plasma zinc concentrations were measured by atomic absorption spectrophotometry according to the method of Smith et al (17) with a Perkin-Elmer Analyst 100 atomic absorption spectrophotometer (Perkin-Elmer Corporation). Erythrocyte membranes were prepared as indicated by Steck et al (18), and alkaline phosphatase activity (E.C.3.1.24) was determined by the method of Ruz et al (19). Enzyme activity was expressed as nmol of product formed per mg membrane protein per min. Protein was determined according to the method of Markwell et al (20). Erythrocyte metallothionein concentrations were measured by using the method of Eaton and Toal (21), and the results were expressed as nmol/g protein. Hair was collected from the proximal centimeter of the occipital scalp. It was washed with nonionic detergent, dried, digested with an HNO₃-H₂O₂ mixture, diluted with deionized water, and analyzed by atomic absorption spectrophotometry (17). The results of the zinc status indexes were also presented as the percentage of cases below selected cutoffs, which were obtained from literature if available, ie, plasma zinc <70 μg/dL (22) and hair zinc <100 μg/g (23). The limit for erythrocyte membrane alkaline phosphatase, (<0.20 U/mg protein) was obtained from previous results obtained in our laboratory. Erythrocyte metallothionein and EZP cutoffs were arbitrarily set at the 5th percentile of the corresponding distribution of cases before surgery.

The accuracy of zinc determinations was assessed by analyzing a reference standard (Huma Trol N, from Human Gesellschaft für Biochemical und Diagnostica GmbH). The values found were between the confidence limits of the reference data. Precision was evaluated by repeated determination of a plasma pool, and the CV was 2.6%.

Zinc absorption and size of the rapidly exchangeable zinc pool

Percentage zinc absorption and EZP were determined by extrinsic labeling with enriched zinc stable-isotope preparations by using a dual isotope tracer ratio technique (24) according to the following protocol: an accurately weighed quantity (~0.45 mg) of 70Zn was administered intravenously (before the oral administration of oral dose of 67Zn) with a 10-mL syringe (via 3-way stopcock and scalp vein needle placed) in a superficial vein in the forearm over a 5–10-min interval. The syringe was flushed twice with normal saline via the 3-way stopcock. An accurately weighed quantity of 67Zn solution (~0.7 mg) was combined with 100 mL of the liquid diet used during the first month after the surgery. The container with the labeled meal was rinsed with deionized water twice, and these rinses were also ingested. Oral and intravenous isotope administration was carried out between 0830 and 0930 under fasting conditions. The subjects suspended taking their assigned vitamin and mineral supplements 3 d before isotope administration. This protocol was repeated at each testing point.

Preparation and administration of zinc stable-isotope solutions

Accurately weighed quantities of enriched zinc oxide (67Zn or 70Zn) preparations (Traces Sciences International) were dissolved in 0.5 mol H₂SO₄/L to prepare a stock solution. For preparation of the orally administered dose of 67Zn, the stock
solution was diluted with triply deionized water and titrated to pH 3.0 with metal-free ammonium hydroxide. For the intravenously administered $^{65}\text{Zn}$, the pH of the stock solution was adjusted to 6.0 with ammonium hydroxide, and the stock solution was diluted with sterile isotonic sodium chloride to a zinc concentration of 1.5 mmol/L. Oral and intravenous solutions were filtered through a 0.2-μm filter. The zinc concentrations of these solutions were measured by atomic absorption spectrophotometry with mass correction factors applied (25). The intravenous doses were tested for pyrogens and sterility immediately before use.

Sample collections and analyses
Timed 30–50-mL urine samples were collected daily in acid-washed bottles from 4 to 9 d after administration of the tracers. Urine was transferred to tempered glass beakers, dried at 100°C, and then ashed twice for 24 h in a muffle furnace at 450°C each time. Between the 2 ashings, a few drops of concentrated nitric acid were added to the sample and then the sample was dried on a hot plate. After digestion, each sample was dissolved in 2.5 mL ammonium acetate buffer (pH 5.6). Zinc in the dissolved samples was extracted according to the method of Veillon et al (26). All glass tubes used in the extraction were acid washed in aqua regia and rinsed in deionized water before use. All procedures were conducted at the Department of Nutrition, Faculty of Medicine, University of Chile.

Zinc stable-isotope analyses
$^{65}\text{Zn}/^{66}\text{Zn}$ and $^{70}\text{Zn}/^{66}\text{Zn}$ ratios were determined by inductively coupled plasma mass spectrometry in the Section of Nutrition Laboratory, Department of Pediatrics, School of Medicine, University of Colorado, Denver, according to the following protocol: 8 mL of a 50-μg Zn/L solution in 2% (vol: vol) nitric acid was prepared from each sample. The solution was introduced into an inductively coupled plasma mass spectrometer (PlasmaQuad 3; VG Elemental) for measurement of zinc stable-isotope ratios ($^{65}\text{Zn}/^{66}\text{Zn}$ and $^{70}\text{Zn}/^{66}\text{Zn}$). Ratios were converted to percentage enrichment by using a mathematical matrix that takes into account the abundance of each isotope in the doses. The samples were introduced through an autosampler (ASX-500, model 510; CETAC) with a peri-pump (Perimax 12; CPETEC). Instrument parameters were as follows: argon gas flow, 13 L/min; intermediate gas flow, 1.40 L/min; nebulizer gas flow, 0.82 L/min; forward power, 1350 W; temperature of pneumatic nebulizer, 4°C; sample flow rate, 1 mL/min. Data acquisition parameters were set as follows: dwell times, 3 min for $^{66}\text{Zn}$, 4 min for $^{65}\text{Zn}$, and 5 min for $^{70}\text{Zn}$; one point per peak, 1800 sweeps; 10 replicates; and 50-nS dead time. A natural zinc standard was run every 6 samples and 2% HNO₃ every 12 samples. Counts per second of nitric acid were subtracted from counts per second of all samples. The precision of this method with the use of natural abundance standards is <0.3% relative SD for $^{65}\text{Zn}/^{66}\text{Zn}$ and <0.6% relative SD for $^{70}\text{Zn}/^{66}\text{Zn}$.

Compliance
A member of our team (JC) provided a new container with a known number of vitamin and mineral pills at the beginning of every month throughout the study. At the time of distribution, the number of remaining pills from the previous month was counted. Compliance was assessed by comparing the total pills provided and those consumed during any given period.

Statistical analyses
Two-factor repeated-measures ANOVA with treatment group as a between-subjects factor and time as a within-subjects factor, followed by a Bonferroni test for multiple comparisons, regression and correlation analyses, and the Wilcoxon’s signed rank test (27) were performed by using SPSS 15.0 statistical software (SPSS Inc). Because zinc absorption data have skewed distributions, the values were converted to logarithms before performing any statistical analysis. The results were then transformed into antilogarithms to recover the original units and are expressed as geometric means and range of ±1 SE.

RESULTS
Details on compliance and main anthropometric changes are presented elsewhere (9). Briefly, compliance, defined as the number of vitamin and mineral pills consumed related to the total provided was well above 80% (as median) throughout the study. No adverse effects related to the administration of the vitamin and mineral supplements or to the procedures carried out to determine zinc status and zinc absorption were observed. Body weight decreased by 27.9% 6 mo and by 35.2% 18 mo after RYGBP. Fat mass (in kg) decreased by 38.1% and 52.3% at 6 and 18 mo after surgery, respectively. Fat-free mass (in kg) decreased by 17.7% at 6 mo after RYGBP, after which it remained stable.

The mean supplemental zinc intakes during the 0–6-mo period were 6.5 ± 2.7 mg/d for group A and 11.1 ± 3.9 mg/d for group B, during the 6–12-mo period were 6.9 ± 1.8 mg/d for group A and 13.2 ± 2.7 mg/d for group B, and during the 12–18-mo period were 7.0 ± 2.1 mg/d for group A and 12.7 ± 2.8 mg/d for group B. Dietary intakes of energy and protein were described elsewhere (9). Dietary zinc intakes were 9.1 ± 3.5, 5.4 ± 2.0, 6.4 ± 2.0, and 7.2 ± 2.8 mg/d before and 6, 12, and 18 mo after RYGBP, respectively. All postoperative zinc intakes were significantly different from preoperative intakes (Bonferroni test after repeated-measures ANOVA). No effect of supplementation type was observed.

Two-factor repeated-measures ANOVA was conducted to test the effects of time and type of supplementation (standard compared with improved) on a series of indexes of zinc status: plasma zinc, hair zinc, erythrocyte membrane alkaline phosphatase activity, erythrocyte metallothionein, and EZP (Table 1). None of the results indicated an effect of supplementation type. Thus, further analyses are presented and discussed considering both supplementation groups combined. Of the 5 indexes of zinc status, 3 (plasma zinc, erythrocyte membrane alkaline phosphatase activity, and EZP; the latter expressed as total mass and by kg fat-free mass) were significantly lower 12 or 18 mo after RYGBP. Erythrocyte metallothionein remained unchanged during the study. Hair zinc, contrary to expectations, was higher 6 and 12 mo, but not 18 mo after surgery.

The percentages of cases below the selected cutoffs are shown in Table 2. With the exception of hair zinc, the percentage of cases below the selected cutoffs significantly increased by the end of the experimental period. Percentage zinc absorption was...
Subjects with zinc status indexes below selected cutoffs before and after Roux-en-Y gastric bypass

<table>
<thead>
<tr>
<th>Month</th>
<th>Plasma zinc &lt;70 µg/dL</th>
<th>Hair zinc &lt;100 µg/g</th>
<th>Erythrocyte membrane alkaline phosphatase &lt;0.2 U/mg protein</th>
<th>Erythrocyte metallothionein &lt;1.85 nmol/g protein</th>
<th>EZP &lt;155 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>36/71 (4.5)</td>
<td>6/64 (9.4)</td>
<td>5/65 (7.7)</td>
<td>2/55 (3.6)</td>
<td>1/26 (3.8)</td>
</tr>
<tr>
<td>6</td>
<td>5/58 (8.6)</td>
<td>2/56 (3.6)</td>
<td>7/56 (12.5)</td>
<td>3/55 (5.5)</td>
<td>5/26 (19.2)</td>
</tr>
<tr>
<td>12</td>
<td>12/56 (21.4)</td>
<td>3/54 (5.6)</td>
<td>11/51 (21.0)</td>
<td>1/55 (1.8)</td>
<td>4/25 (16.0)</td>
</tr>
<tr>
<td>18</td>
<td>12/56 (21.4)</td>
<td>2/52 (3.8)</td>
<td>11/49 (22.4)</td>
<td>9/45 (20.0)</td>
<td>6/25 (24.0)</td>
</tr>
</tbody>
</table>

1 EZP, exchangeable zinc pool.
2 Significantly different from month 0, P < 0.05 (Wilcoxon’s signed rank test).
risk of having a mild zinc deficiency after RYGBP. Additional interpreted our results to indicate that subjects had (or were at zinc, percentages increased during the study up to 20–24%. We below selected cutoffs showed that, with the exception of hair contamination from shampoo, it could not be completely ruled out. (31, 32). Besides, despite care being taken to avoid zinc con- zinc is not considered to be a very sensitive index of zinc status (39, 40). Hair zinc showed a trend contrary to expectations. Hair zinc variations in previous studies, was almost unaffected in ours cyte metallothionein, which had been shown to respond to dietary were consistently decreased after RYGBP. In contrast, erythro- as total mass and relative to kg fat-free mass (data not shown) EZP increased after 6 mo of supplementation with 15 and 30 mg zinc depletion-repletion study (19), also decreased after surgery. EZP represents the mass of zinc that interchanges with plasma in a relatively short period of time (34). EZP was reduced in cases of severe acute zinc deficiency (35) but not in cases of moderate zinc deficiency (36). EZP at birth was smaller in small-for-gestational-age than in appropriate-for-gestational-age preterm infants (37). EZP increased after 6 mo of supplementation with 15 and 30 mg Zn/d in adult men (38). In our study, EZP values expressed both as total mass and relative to kg fat-free mass (data not shown) were consistently decreased after RYGBP. In contrast, erythrocyte metallothionein, which had been shown to respond to dietary zinc variations in previous studies, was almost unaffected in ours (39, 40). Hair zinc showed a trend contrary to expectations. Hair zinc is not considered to be a very sensitive index of zinc status (31, 32). Besides, despite care being taken to avoid zinc contamination from shampoo, it could not be completely ruled out. The results of zinc indexes expressed by the proportion of values below selected cutoffs showed that, with the exception of hair zinc, percentages increased during the study up to 20–24%. We interpreted our results to indicate that subjects had (or were at risk of having) a mild zinc deficiency after RYGBP. Additional activity, erythrocyte metallothionein, and size of the EZP. Despite the host of factors that can affect plasma zinc concentrations (31, 32), a consistent and significant decreasing trend was observed in our subjects. Similarly, erythrocyte membrane alkaline phosphatase activity, which had responded accordingly in a previous zinc homeostasis (50). Whereas endogenous zinc losses increase pancreatic secretions (33). This component is vital to maintain activity, erythrocyte membrane alkaline phosphatase activity, which had responded accordingly in a previous zinc depletion-repletion study (19), also decreased after surgery. EZP represents the mass of zinc that interchanges with plasma in a relatively short period of time (34). EZP was reduced in cases of severe acute zinc deficiency (35) but not in cases of moderate zinc deficiency (36). EZP at birth was smaller in small-for-gestational-age than in appropriate-for-gestational-age preterm infants (37). EZP increased after 6 mo of supplementation with 15 and 30 mg Zn/d in adult men (38). In our study, EZP values expressed both as total mass and relative to kg fat-free mass (data not shown) were consistently decreased after RYGBP. In contrast, erythrocyte metallothionein, which had been shown to respond to dietary zinc variations in previous studies, was almost unaffected in ours (39, 40). Hair zinc showed a trend contrary to expectations. Hair zinc is not considered to be a very sensitive index of zinc status (31, 32). Besides, despite care being taken to avoid zinc contamination from shampoo, it could not be completely ruled out. The results of zinc indexes expressed by the proportion of values below selected cutoffs showed that, with the exception of hair zinc, percentages increased during the study up to 20–24%. We interpreted our results to indicate that subjects had (or were at risk of having) a mild zinc deficiency after RYGBP. Additional research is needed to determine the potential functional effects of this finding. Mild zinc deficiency in adults has been associated with alterations in immune function (41), dermic lesions (42), and cognitive function (43). Presumably, without at least the level of supplementation used in this study, the patients would have been at risk of even further compromising their zinc status. When this study was designed, no evidence indicated the need for preventive zinc supplementation greater than 1–2 times the RDA. One group, the standard vitamin and mineral supplementation group, received the routine supplementation being used by the bariatric surgery team from the University Clinical Hospital at that time; this value was approximately equivalent to the RDA for zinc, the “improved vitamin and mineral supplementation” doubled it. These differences in the supplementation level were not accompanied by changes in the indexes of zinc status. Thus, data suggest justification for routine supplementation, but at a higher dose, probably in the range of 40 to 60 mg/d.

Three major factors can determine zinc status in humans: reduced zinc intake, reduced zinc absorption, and increased intestinal losses. Gastric capacity is dramatically reduced in RYGBP; as a consequence, dietary nutrient intake is also reduced. In our study, total dietary zinc was significantly reduced after surgery. In addition to a decrease in total zinc intake, zinc intake from red meat—a highly available zinc source—also decreased. The magnitude of the reduction of red meat in our patients was nearly 50% after surgery (9). Low tolerance to read meat is frequently observed after gastric bypass (5). In addition to dietary zinc, the patients received an average of ~9.5 mg Zn/d as supplements during the entire experimental period.

Zinc absorption takes place mainly in the duodenum and initial portions of the jejunum (44). These portions of the intestine are bypassed during RYGBP. The main consequence is a substantial reduction in intestinal absorption surface and, in turn, less absorption capacity. To the best of our knowledge, no previous studies have evaluated zinc absorption after RYGBP. We assessed zinc absorption using a widely accepted method involving stable isotopes (45). In our study we found a significant reduction in zinc absorption from a standard diet. The level of zinc supplementation did not have a differential effect on the magnitude of absorption. Zinc absorption is a complex process and involves the participation of many transporters from both the ZIP (solute-linked carrier SLC39) and the ZnT (solute-linked carrier SLC30) families (46–48), the most prominent of which are ZIP4 and ZnT1. ZIP4 is the primary regulator of zinc uptake at the intestine, and ZnT1 is crucial to the zinc efflux from the enterocyte (46–49). Zinc transporter expression is regulated by cytokines, hormones, and zinc itself (46). Changes in the expression of zinc transporters have important effects on zinc homeostasis. For instance, in ileostomy patients, supplementation with 25 mg Zn/d for 14 d resulted in decreased ZnT1, ZnT5, and ZIP4 proteins in the intestinal mucosa (47). This may explain, at least in part, why we did not observe differences in zinc absorption between our 2 groups.

Zinc is mainly excreted by the intestine through intestinal and pancreatic secretions (33). This component is vital to maintain zinc homeostasis (50). Whereas endogenous zinc losses increase with diarrhea (51), they are rapidly reduced when facing dietary zinc restrictions (33, 52). We did not determine intestinal zinc losses in our subjects. Because we did not observe major changes in transit time, zinc losses presumably did not increase. In addition,
E2P has been shown to be directly related to endogenous fecal zinc, among other variables (53). Thus, far from being increased, endogenous zinc lost by the intestine probably decreased.

In conclusion, we found that zinc deficiency occurred in many patients after RYGBP. According to our data, average supplemental zinc of ~9.5 mg/d would not be enough to prevent an impairment of zinc status. Zinc absorption capacity is markedly reduced 6 mo after RYGBP, and this impairment persists at least until 18 mo after surgery.

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The authors’ responsibilities were as follows—MR, FC, MO, FP, JC, and JJ: participated in the study design and data interpretation; NFK, KMH, LVM, JLW, and LS: participated in the data interpretation; PR, JC, JJ, and FC: implemented the study; PR: carried out enrollment and group assignment of patients; KB: conducted and analyzed the dietary intake component; AC and KP: performed the surgical procedures and postsurgical controls; and MR had principal responsibility for the data analysis. None of the authors had any conflicts of interest related to this study.

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