



Your guide to weight loss surgery

Information Pack

WVA WEIGHT LOSS
CENTRE

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Thank you for your enquiry. You have made a huge step towards improving your overall health and life expectancy.

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Obesity in Australia

Did you know that 2 out of 3 Australians are overweight or obese? If the current trend continues, more than 40% of the Australian population will be living with obesity in the next ten years.

Body mass index (BMI) is a calculation based on your height and weight to place you in a weight category: underweight, normal weight, overweight, or obese.

BMI can be a useful starting measure to identify your weight classification and risk of comorbidities.

IN AUSTRALIA,
4.5 MILLION
ADULTS HAVE
OBESITY

EVERY YEAR
189,333
AUSTRALIANS
DEVELOP
OBESITY

OBESITY KILLS
3 MILLION
PEOPLE
EACH YEAR
WORLDWIDE

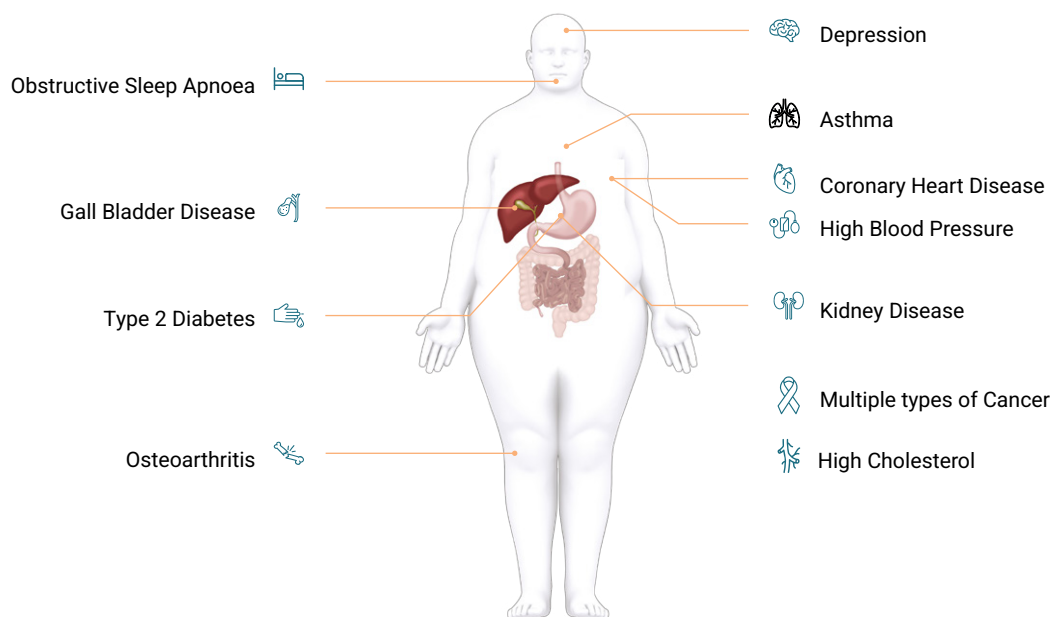
BMI	Classification	Risk of Comorbidities
Less than 18.5	Underweight	Increased
18.5 – 25	Normal weight	Low
25-30	Overweight	Increased
30-35	Obese I	Moderate
35-40	Obese II	Severe
40 or greater	Obese III	Very severe

How to calculate BMI = weight in kg/(height in m)²

The Obesity Challenge

Obesity is now recognised in Australia and internationally as a chronic disease with severe health and quality of life consequences.

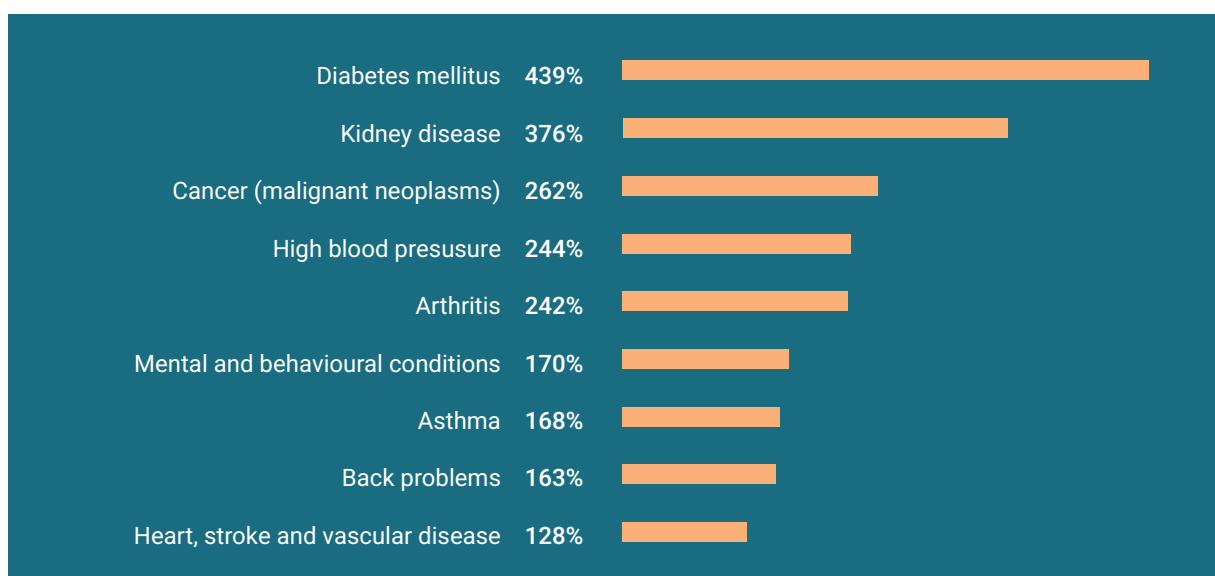
Below you can find some of the consequences associated with obesity.



The graph below compares the risk of incurring a certain disease between people with obesity (BMI >30) and people with normal weight (BMI 18.5-24.9).

Example:

People with obesity are 4.39 times (or 439%) more likely to have or develop diabetes when compared to people with a normal weight.






Obesity treatment options

Is weight loss surgery right for you?

Your BMI together with any obesity related illnesses are the most important criteria to determine whether weight loss surgery is the appropriate choice.

Surgery for obesity is considered an appropriate choice for patients:

- ✎ With a BMI greater than 40
- ✎ With a BMI greater than 30 and one or more obesity-related illnesses
- ✎ Who have tried non-operative weight loss solutions without long-term success
- ✎ In certain circumstances, patients with lower BMI may be candidates

Surgical treatment	Metabolic & Bariatric surgery 	BMI \geq 30-34.9 + comorbidities BMI \geq 35-39.9 + comorbidities BMI \geq 40
	Pharmaceutical treatment 	BMI \geq 25-29.9 + comorbidities BMI \geq 30
Conservative treatment	Change in lifestyle 	BMI \geq 25-29.9

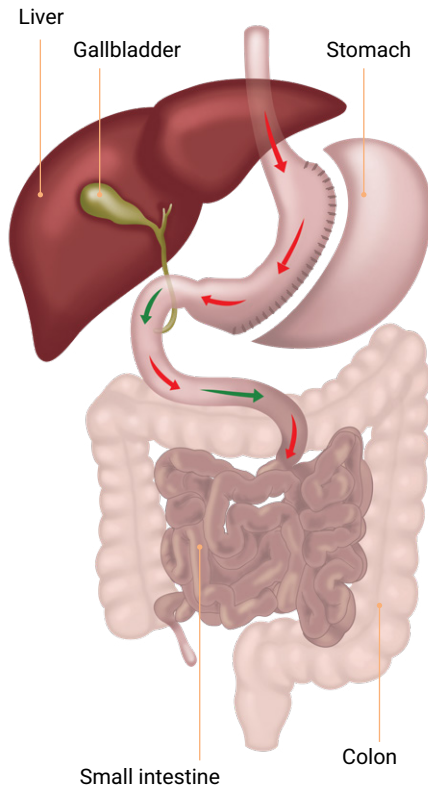


Can you think of other complex chronic diseases where you would expect to treat yourself without qualified medical help?

Think of obesity like asthma; which also has genetic, physiological and environmental causes.

Would you try to treat your asthma without help from your doctor? Would you feel ashamed or guilty just for having asthma or for asking your doctor for help?

Types of Surgery



Sleeve Gastrectomy

This operation involves minimally invasive or key hole (laparoscopic) access to remove a large portion of the stomach roughly amounting to 70%, reducing its capacity from about 1500ml to 200 – 250 ml. This is a permanent and irreversible effect.

In this operation stomach loses more distensible outer portion while retaining the control of both inlet and outlet valves. Remaining stomach also has smaller volume of all the cell types represented in the large stomach. (acid, enzyme and hormone secreting) and has its nerve supply undisturbed.

It's not the size of the stomach that causes weight loss after a specific type of bariatric surgery, but rather a change in the gut metabolism, say researchers. There is an increasing body of evidence now showing that effects of bariatric surgery is beyond smaller meals and caloric restriction. Changes in the gut hormone response to a meal, bile acid and gut bacterial changes after surgery are all thought to have a wider effect on body metabolism that may have a stronger effect on weight loss and weight maintenance.

Reversible: No

Average hospital stay:

1-3 nights

Operating time: 1-1.5 hours

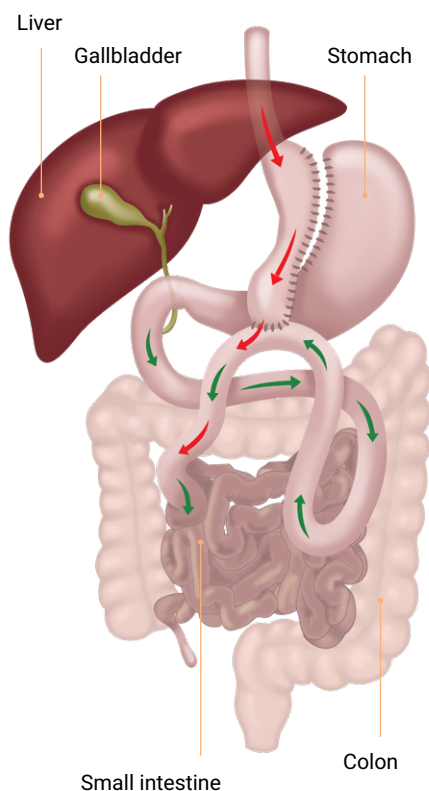
Average time off work:

1-3 weeks

Average weight loss:

60-70%
excess weight

Types of Surgery



One Anastomosis Gastric Bypass (Mini Gastric Bypass)

OAGB is a keyhole (laparoscopic) procedure. First step is using stapling device to create a long and narrow stomach tube in continuation with the oesophagus and disconnect the rest of the stomach from food stream. Operation is completed by joining the lower end of the newly created stomach tube to a loop of small bowel (Jejunum) 2 meters from the start.

With OAGB anatomy the small stomach leads to portion control (restriction). After passage through the small stomach tube, food enters the small bowel with a 2 meter lead, bypassing the first 2 meters of the intestine from food stream. This reduce the total intestinal length available for digestion and absorption from an average of 6 meters down to 4 meters (malabsorption).

The first Gastric bypass was a one anastomosis gastric bypass carried out by Dr. Mason in 1966 (mason loop). Initially it consisted of an horizontal stomach pouch with a loop small bowel Join (anastomosis). Due to severe bile reflux the reconstruction was changed to a "Roux-en-Y" configuration, which diverts the bile from the stomach and oesophagus. Over the next few years Roux-en-Y gastric bypass became more established and later became the surgical standard. After the first laparoscopic gastric bypass was performed by Alan Wittgrove in 1994, the exponential growth of bariatric surgery started.

Reversible: Yes

Average hospital stay:

1-3 nights

Operating time: 1-2 hours

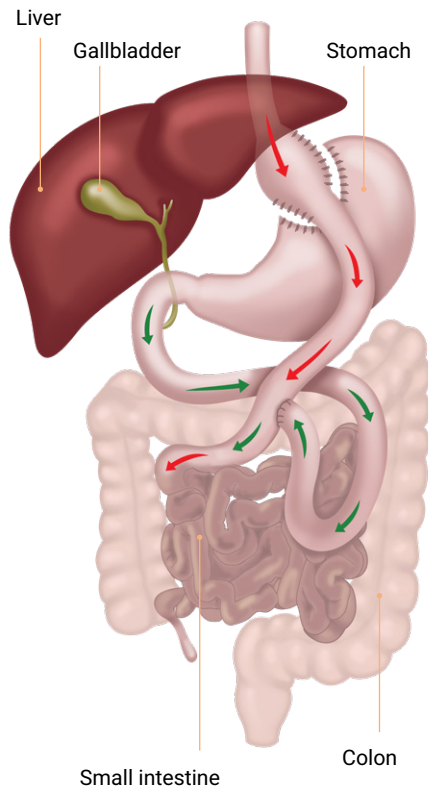
Average time off work:

1-3 weeks

Average weight loss:

70-80%
excess weight

Types of Surgery



Roux-en-Y Gastric Bypass

Historically the gastric bypass was based on the weight loss observed among patients undergoing partial stomach removal for cancer and peptic ulcer disease. In 1966 Dr Mason, a surgeon from the University of Iowa, described the first gastric bypass, consisted of an horizontal stomach pouch with a loop small bowel configuration (Mason loop). Due to severe bile reflux the initial bypass surgery underwent modification which resulted in the "Roux-en-Y" gastric bypass.

Over the years several modifications to the technique was proposed to increase the weight loss and durability of the effect. Modifications to pouch size and limb lengths and using a ring to prevent expansion of the aperture between the stomach and the small bowel loop are most notable.

Currently the most common technique involves the creation of a small 30ml stomach pouch, a biliary limb of 70 cm and a roux limb of 150 cm. An exponential growth of this operation was noted since the adoption of laparoscopic (Key hole access to the abdominal cavity) approach to the gastric bypass in 1994.

Reversible: Yes

Average hospital stay:

1-3 nights

Operating time: 1-2 hours

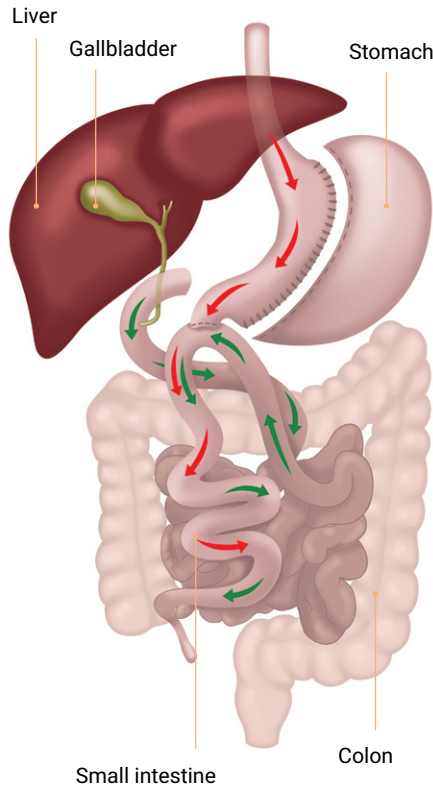
Average time off work:

1-3 weeks

Average weight loss:

70-80%
excess weight

Types of Surgery



SADI-S (SIPS)

Weight loss surgery is a relatively new discipline that is still evolving. Most significant change in the last 20 years is being able to perform procedures using minimally invasive keyhole (laparoscopic) approach. With the use of laparoscopic method, two established key weight loss surgical procedures are undergoing changes aimed at simplification of technique and reduction of complications while achieving similar or better results.

One anastomosis gastric bypass (OAGB) is emerging as an alternative to Roux-en-Y gastric bypass which for many years considered to be the gold standard by many. Single anastomosis duodeno-ileal bypass with sleeve (SADI-S) is coming up in place of Bilio-Pancreatic diversion with duodenal switch.

In both cases simpler modern version has got a single anastomosis (single bowel join) in place of two in the older version making the newer operation easy to perform with less complications. However novel single anastomosis operations are proving to be as effective weight loss and metabolic procedures.

Reversible: NO

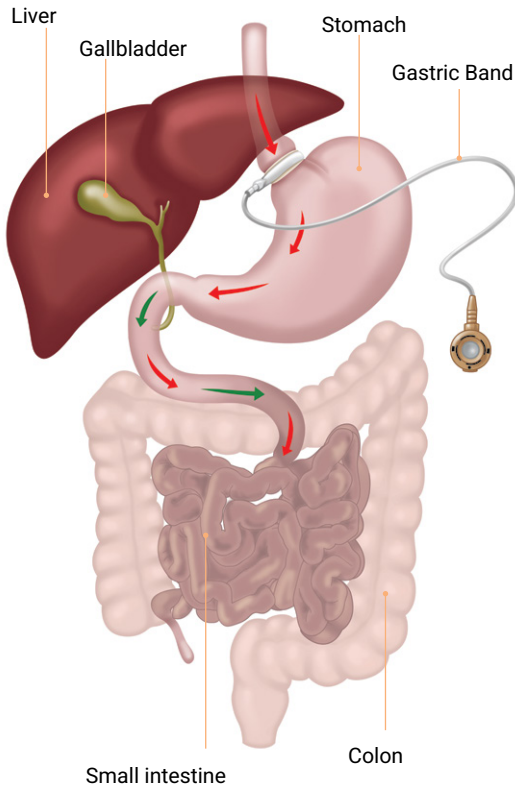
Average hospital stay: 2-3 nights

Operating time: 1-2 hours

Average time off work: 3-4 weeks

Average weight loss: 60 - 70%
excess weight

Types of Surgery



Gastric Band

Gastric band surgery involves implantation of a foreign material to create a tight ring around the upper part of the stomach. This is unique to gastric band surgery which leads to increase of complications over a long period of time.

In addition inadequate weight loss and medium and long term weight regain are more common problems of gastric band surgery compared to other bariatric procedures. Due to complication or inadequate weight management, many patients with gastric bands need to have a second operation, and most requiring band removal. Although gastric band was marketed as a less invasive and a safe option, the cumulative risk over a long period and risk of subsequent surgery add up making it probably a riskier choice.

Because of the long term concerns associated with the gastric band and availability of better and more reliable operations, at Southwest bariatrics we have not offered gastric band as an option over the last 8 years.

Reversible: NO

Average hospital stay: 2-3 nights

Operating time: 1-2 hours

Average time off work: 3-4 weeks

Average weight loss: 60 - 70%
excess weight

Types of Surgery

Revisional Bariatric Surgery (RBS)

After primary (first time) bariatric surgery further operations (revisional surgery) may be considered due to long term weight regain or as corrective surgery to address a complication.

The most common reason for RBS is weight regain after a previous operation (or lack of adequate weight loss from the first operation). This highlights the chronic and relapsing nature of the causes of obesity. There is some degree of individual variability of the results after bariatric surgery.

In the long term some weight regain is almost universal with every bariatric operation. When the weight regain exceeds a certain limit it is considered as failure of the procedure.

Studies have demonstrated that RBS in general leads to less maximum weight loss compared to the results of the same operation in the primary setting and carries a higher rate of complications. Due to these reasons goals of further surgery must be carefully considered as a part of life time health and weight management strategy. Any potential benefit must be weighed against the risks of further surgery.

Before considering further surgery it is important to have an honest reflection as to the reasons for failure of previous surgery and be prepared to correct patient related factors if any. You must satisfy yourself of having determination and a mindset to comply with the after surgery requirements of further surgery.

Adjustable Gastric Band Revision Surgery

Adjustable gastric band was the most popular weight loss surgery until year 2011. In 2008 about 14000 gastric bands were implanted in Australia which accounted for 94% of weight loss surgeries performed that year. However at present less than 1500 bands are implanted a year and the numbers are declining. This is mainly due to long term failure and complications compelling a high proportion to have revisional surgery.

You may consider gastric band removal and another weight loss surgical option due either for failure of the band or due to a complication of the band. Failure of weight loss and weight regain are common long term issues after gastric Band.

Common complications lead to symptoms of over restriction. Gastric band slippage usually lead to night time symptoms including reflux, regurgitation, cough, aspiration and vomiting after meal. Reflux is also a common problem after gastric band which can lead to dilatation of the oesophagus and disruption of the lower oesophageal valve mechanism that prevents reflux. Rarely band erosion and device leak and port problems also leads to further surgery.

Pharmacotherapy for Weight Loss

Obesity is a chronic, relapsing disease and should be managed as such. Along with lifestyle intervention, pharmacotherapy (medications) can be a useful tool in effecting and maintaining clinically meaningful weight loss.

Pharmacotherapy should be considered in those with BMI $>30\text{kg}/\text{m}^2$ or those with BMI $>27\text{-}30\text{ kg}/\text{m}^2$ with obesity related complications. Pharmacotherapy can be used in both patients that have never had weight loss surgery, as well as those that have. In those that have had weight loss surgery, the use of medications may be useful in cases of insufficient weight loss, as well as those that have experienced weight regain.

The use of medications for weight loss

To date (2022), the Therapeutic Goods Administration of Australia has approved the use of 5 different medications for weight loss – phentermine, orlistat, bupropion/naltrexone, liraglutide and the recently approved semaglutide. There are also other medications that have been proven to be successful weight loss medications, that are not TGA approved for weight loss in Australia. They are therefore sometimes prescribed “off label” for weight loss.

The use of medications for weight loss is not a ‘one size fits all’ process. Treatment is individualised to the patient and results will vary from person to person. The average weight loss achieved in patients taking weight loss medications is 5-10% of total body weight. For some people it is less than this, for some it is more (20% or greater). New medications are currently being developed and tested that show even better results to the ones we currently have available, making this a very exciting area of medicine.

Weight loss medications currently available in Australia

Phentermine

Phentermine is a sympathomimetic agent that suppresses appetite. It has been available in Australia for decades. Common side effects include dry mouth, disturbed sleep, irritability/ agitation, increased blood pressure and increased heart rate. Given the effects of phentermine on the cardiovascular system, it should not be used in people with a history of cardiovascular disease. It should also not be used in patients with significant anxiety disorders, over-active thyroid, a history of drug or alcohol dependence, pregnancy, or breast-feeding.

Pharmacotherapy for Weight Loss

Weight loss medications currently available in Australia

Orlistat

Orlistat inhibits the production of pancreatic and gastric lipase and therefore reduces absorption of dietary fat. Side effects are due to fat malabsorption and may include diarrhoea, flatulence, faecal incontinence, and fat-soluble vitamin deficiencies. These side effects may be limited by adhering to a low fat, high fibre diet.

Naltrexone/Bupropion

The combination of an opioid antagonist (naltrexone) and a dopamine and noradrenaline re uptake inhibitor (bupropion) works centrally on the brain to reduce hunger and cravings. Common side effects include nausea with or without vomiting, headache, dizziness, and constipation. Serious side effects may include seizures, allergic reactions and change in mood.

Liraglutide

Liraglutide is a glucagon-like peptide 1 (GLP-1) agonist initially developed to treat Type 2 diabetes, but now approved in Australia for weight loss. Liraglutide is self-administered by once daily subcutaneous injection. It effects gut hormones resulting in reduced hunger and increased satiety. This class of medication is generally well tolerated. Side effects may include nausea, abdominal cramps and change in bowels. Liraglutide-induced weight loss may be associated with increased incidence of symptomatic gallstones, and more rarely, pancreatitis.

Semaglutide

Semaglutide is also a GLP-1 agonist developed to treat Type 2 diabetes. It has a longer half life than liraglutide and therefore only needs to be injected once a week. The side effect profile and tolerability are similar to liraglutide. It has been used in low doses "off Label" in Australia for quite some time now. It has recently been approved at a higher dose for weight loss, but supply issues have limited accessibility.

Topiramate

Topiramate is an anti-convulsant used to treat seizures and help prevent migraines. It has been used off label to treat obesity. In the US, it is available as a combination tablet with phentermine. Such a combination does not exist in Australia. Dose-related side effects may include dry mouth, altered taste, constipation, disturbed sleep, dizziness, decreased concentration and attention, and memory impairment. Rare but serious side effects include closed angle glaucoma and increased suicidal thoughts. Topiramate should not be used in patients with a history of renal stones or glaucoma, or in pregnancy.

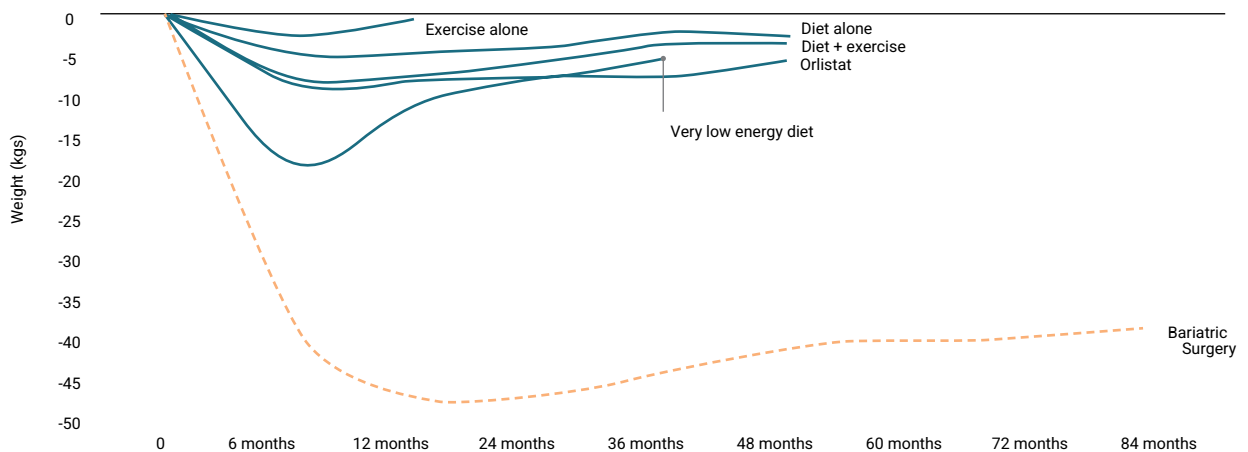
What to expect from surgery

With support from your GP and a team of allied health professionals, including dietitians, exercise specialists and psychologists, weight loss surgery is a safe and effective solution to losing and keeping off excess weight.

Losing weight and keeping it off can feel like a hopeless endeavour because the truth is, 95% of people can't lose weight and keep it off with diet and exercise alone.

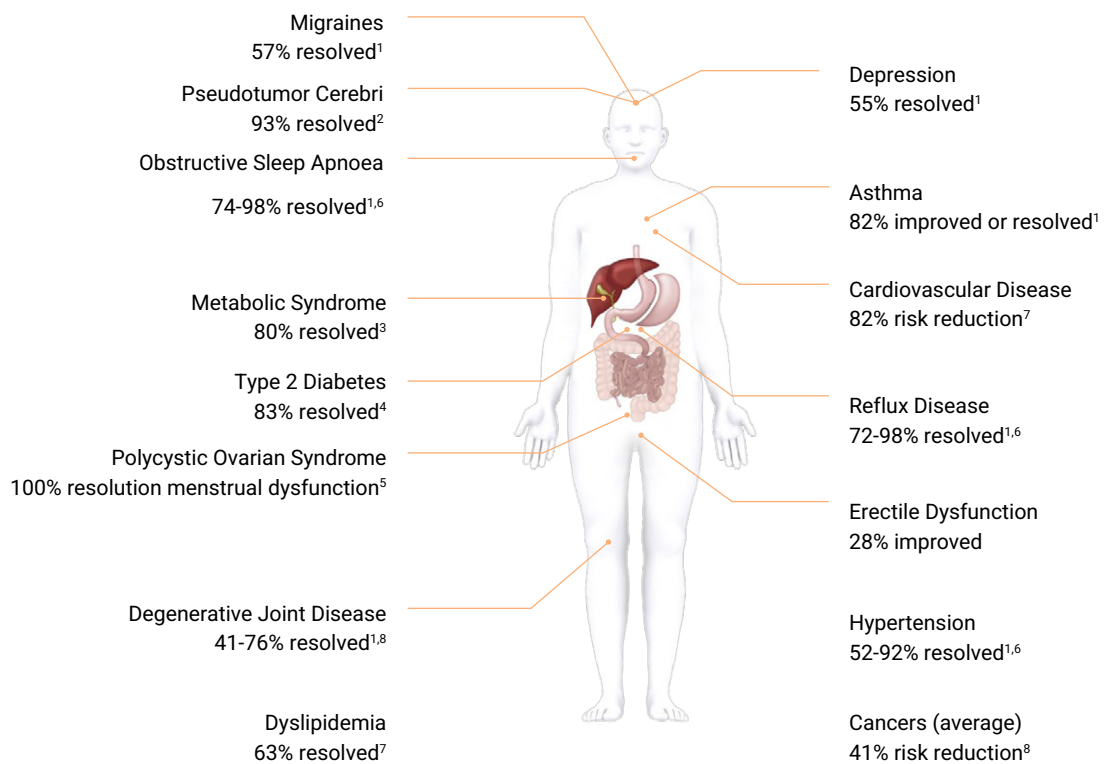
Bariatric or metabolic surgery changes the metabolism, resetting the body's 'set point' to a lower weight. It has significantly higher long term efficacy rates than diet and exercise alone because the body self-regulates at that lower weight. Up to 90% of patients maintain at least 50% of their initial weight loss after surgery. Bariatric surgery has been shown to decrease the risk of heart disease, high blood pressure and some cancers, as well as improving diabetic control.

Weight loss (kgs) following lifestyle change, pharmaceutical therapy and bariatric surgery



What to expect from surgery

The overall benefits of weight loss surgery extend much further than simply losing weight.



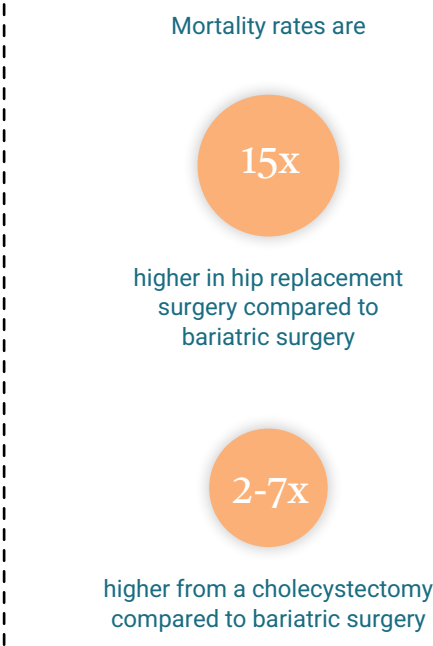
Risks of Surgery

Like any medical intervention, weight loss surgery has risks, including the risk of surgical failure, complications, and in rare cases, death.

Out of 70,000 patients in Australia and New Zealand who have had weight loss surgery and for whom data has been collected (starting in 2012), only 0.8% have had to have another operation to fix a problem and less than 1% have been re-admitted to hospital with a complication.

In 2018-19, the rates of adverse events after the most common forms of primary surgery ranged from 1.6% (Sleeve Gastrectomy) to 6.3% (Roux-en-Y Gastric Bypass).

Surgical complications	Likelihood
Leak	1-2%
Anastomotic Stricture	<1%
Dehydration	0.14%
Abdominal Pain	0.11%
Bleeding	<1%
Vomiting	0.11%
Bowel Obstruction	1-2%
Dysphagia NOS	0.06%
Wound Infection	0.06%



Patient pathway

01 Preparation for weight loss surgery

Initiating the process

- ↘ **Consultation with your GP** – You will need to obtain a referral form from your GP.
- ↘ **Contact our practice** – We will book you in for your first consultation.
- ↘ **Complete questionnaire** – We will send you a 2 page questionnaire that you will need to complete before your consult.

Pre-op Consults

- ↘ **Consultation with Surgeon** – You will discuss with the Surgeon the best treatment option for you.
- ↘ **Consultation with Bariatric Nurse** – Coordinating consultations with our dietician, psychologist and physician if needed.
- ↘ **Consultation with dietitian**
- ↘ **Consultation with psychologist**
- ↘ **Consultation with physician**

Consult with Surgeon

- ↘ A consult with your surgeon again prior to surgery to discuss the details of your surgery (consent).

Pre-operative diet

- ↘ A low calorie diet may be commenced in some cases, this will be discussed with the dietitian.

Medical examination

- ↘ After a surgery date is given, blood and diagnostic tests may be required to prepare for surgery.

02 Before your surgery

- ↘ The hospital will contact you to discuss pre-op requirements and admission details.

03 Post Weight Loss Surgery

- ↘ **Daily consultation with Surgeon** – You will be reviewed daily by the surgeon to ensure your recovery is going well.
- ↘ **2-3 weeks post surgery** – You will have a consult with our dietician and surgeon to review how your recovery is progressing.

Bariatric Nutrition Plan

To optimise weight loss before and after surgery, you will be required to change your eating style significantly. Our dietitians, will provide you with detailed, individualised information and resources prior to your procedure. This will help you in all stages of your journey.

Before surgery:

You will be given an overview of the nutrition following your surgery, what to expect and how your eating patterns will change. Most patients will undertake a period of pre-operative VLCD (Very Low Calorie Diet).

Weight loss before surgery will improve your overall health status and in particular shrink your liver, making surgery easier. Therefore reducing the risks of operation. In most cases a 2-6 week period on Optifast is recommended.

Week 1: Fluid Diet

Your stomach is swollen after surgery and it needs to heal. During this period you need to follow a fluid diet. Fluids that can pass through a large straw are acceptable. Remember to slowly sip and stop when full.

From Week 2: Puree Diet

At this stage the swelling is slowly settling down. To prevent symptoms such as nausea, vomiting and pain, it is important to avoid dry, lumpy or doughy foods that may get stuck easily.

From Week 3-5: Soft Diet

Now you can slowly have soft foods. Remember you need to chew food well. The dietitian will discuss common problem foods and will suggest alternatives to these foods.

From Week 6: Solid foods

If you are tolerating soft foods well, you can start introducing solid foods. Generally you can include most foods you had before surgery but in smaller quantities.

Long-term

You can slowly experiment with returning to a full diet. The aim is a well balanced and varied diet, tailored to your needs. You will need to take a Bariatric Multivitamin daily.

Meet the team

A holistic team approach

Our multidisciplinary team offers a holistic approach to your weight loss journey.

With a team consisting of your bariatric surgeon, Dr Werapitiya, along with Dr Tanya Coulson, bariatric practitioner, Lisa Moore our bariatric dietitian, and anaesthetists as well as hospital staff, we form an experienced team offering personalised and comprehensive care to ensure your ongoing long-term health.



Dr Werapitiya

M.B.ChB F.R.A.C.S.

Dr Werapitiya is an Australian trained surgeon. He completed his medical degree in his native Sri Lanka. He moved to Australia in 1999 and subsequently completed his surgical training, becoming a Fellow of the Royal Australasian College of Surgeons. In 2006, he became the first graduate of the Bariatric Surgery program through Sir Charles Gardiner Hospital, Perth, Western Australia. He is now one of the leading bariatric surgeons in Australia, having performed over to 5000 weight loss procedures.

Dr Werapitiya started One Anastomosis Gastric Bypass (OAGB) surgery 8 years ago and has performed over 1000 of them. He has a research interest in OAGB, mainly in refining the operative technique and the management of post-operative issues. He is a leader in one anastomosis gastric bypass surgery in Australia, publishing research in the field as well as participating in the teaching of other surgeons.

His Bariatric surgery practice is based at St John of God Hospital Bunbury. He provides public service at Bunbury Regional Hospital, Busselton Hospital and Bridgetown Hospital.

Outside his busy working schedule, he likes to show off his culinary skills, mainly Sri Lankan cuisine. He has hosted big crowds at community fund raising activities. Appreciating the vast country we live in, he has developed a keen interest in four wheel driving.

Costs

Are you covered by your private health insurance?

This is a breakdown of costs payable by you; including the "out of pocket fees" relating to your surgery.

All out of pocket fees must be paid in full, at least one week prior to your procedure. Dietitian and Counselling fees can be claimed if you have extras cover on your health insurance or with an EPHC Plan from your GP – not both.

Description of costs
Surgeons Fee: (includes surgical assistant fee).
Private Health Insurance Excess Fee
Anaesthetic Fee: Gastroscopy**
Anaesthetic Fee: Bariatric Surgery**
Clinical Labs Pathology Fees: **
Nestle-Optifast VLCD as per Dietitian
Barriatric Multivitamin Costs
Physician Initial Consultation: (~\$220 Medicare rebate)
Dietitian Subsequent Initial Consultation:
Dietitian Subsequent Consultations:
Counselor Consultations:
Out Patient Rehab Program - 6 weeks (optional)

**dependant on individual fund and level of cover

Costs

Out of Pocket Costs

Consultation and associated follow up fees:

Weight loss surgery patients require detailed and extensive assessment, education and preparation. They also require strict long-term follow up for successful results and to minimise complications. This process involves multiple visits for office consultations. Typically, you will see the doctor at least three times prior to surgery and three times in the first year after surgery. You will then usually see the doctor once a year after that. You will pay consultation fees up to \$ 3500 in total.

Please note that Private Health Funds do not cover any outpatient consultation fees and regardless of the level of cover, you will be required to pay these fees.

For outpatient consultation associated fees, you will be eligible for a Medicare rebate.

- **Initial Consultation**
(Item No. 104) \$120.00 (Medicare Rebate – \$75.05)
- **Subsequent Visits before Surgery**
(Item No. 105) Total cost up to \$3200.00 out of pocket (Medicare Rebate – \$36.55 per visit)
- **Review Consultations Post Surgery**
(Item No. 105) Bulk bill – no cost to patient

Please note that you will have no further out of pocket costs payable to Dr Senarath Werapitiya for regular follow-up visits after surgery or attending to a direct complication following surgery.

Effective and efficient delivery of patient care is a team effort. Please note that sometimes other team members (specially trained doctors) may be involved in part of the pre surgery assessment process and after surgery follow-ups, with no extra cost to you.

Procedure associated fees:

As a no gap doctor procedure associated costs are fully paid by your health fund and billed directly to your health fund

- **Gastroscopy** (
Item Number: 30473)
- **Laparoscopic Gastric Band Removal**
(Item Number: 31584)
- **Laparoscopic Sleeve Gastrectomy**
(Item Number: 31575)
- **Laparoscopic Gastric Bypass/Omega Loop**
(Item Number: 31572)

Please confirm cover status with your health fund using the appropriate item number/s and be aware of any 'waiting period' if your policy is new.

Please note the fees listed do not include hospital charges and anaesthetic services and are to be paid at the time of consultation. Payment for this can be made by:

- Cash
- Savings/Cheque Accounts
- Direct Deposit – BSB: 086554 ACC: 869 903 564 (invoice number as a ref.)
- Unfortunately, we are unable to accept Credit Card payments.

Costs

Superannuation for payment

If you are accessing your superannuation for payment, we will provide you with the required Superannuation Access Forms and a quote at your initial consultation.

Employee Gap Schemes

If you are employed by a company that offers to cover GAP payments for surgery, please ensure you speak to our reception staff about this at your initial consult.

Medicare Safety Net

The Medicare Safety Net is an additional rebate scheme introduced by the Federal Government for the benefit of patients and represents an arrangement between patient and the Federal Government. The Medicare Safety Net provides for reimbursement of 80% of the gap between the rebate and the charge for non-inpatient services once the relevant threshold has been met. Please check with Medicare with regards to your Medicare Threshold.

BSR Registry

Our practice is proud to contribute to the National Bariatric Surgery Registry.



This registry initiative of the Obesity Surgery Society of Australia and New Zealand along with the Monash University, School of Public Health and Preventive Medicine follows the progress of all patients who have undergone a bariatric procedure in Australia.

You will receive a letter inviting you to participate in this process allowing your operation. This letter will include a detailed explanation of what is involved in participating in the registry. You will be given the opportunity to indicate that you do NOT want to be involved.

If you do decide to be involved, the hospital will provide the registry with information about your weight, height, diabetes status and the operation you had performed. Following the operation information on any problems arising from the surgery will be collected, and you may be contacted annually to check on your weight, diabetes status and about any issues arising from the surgery.

Participation is entirely voluntary and you should be reassured that your care here in the clinic will in no way be affected by your decision to participate. You should also be reassured that you will not be individually identified in any report arising from the Registry.

If you would like more detailed information about the Registry at this point we would be happy to provide you with the information sheet now, and you can contact the Registry project officer:

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