



Development of reflux after laparoscopic sleeve gastrectomy (LSG) should be evaluated from a broader perspective

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Received: 8 March 2023 / Accepted: 17 April 2023
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We have read with huge interest the article “Reflux disease following primary sleeve gastrectomy: risk factors and possible causes” by Thaher et al. [1] published online in the UPIS journal. One of the main negative aspects of laparoscopic sleeve gastrectomy (LSG), the most common done bariatric surgery in the world, is the new onset or worsened reflux symptoms following surgery. Therefore, recent studies have focused on the cause of reflux after LSG and technical maneuvers to reduce reflux. Gastroesophageal reflux disease (GERD) after LSG is already a very difficult topic to evaluate due to the lack of a standardized definition and approach, the possibility of confusion with alkaline reflux, and hiatal hernias that often accompany obesity [2, 3].

The authors aimed to conduct a significant study on de novo reflux and risk factors after LSG by excluding preoperative GERD and hiatal hernia patients with a large population of 3379 patients. The standardization of the selected cohort in terms of possible causes of reflux stands out as one of the strengths of the study. We congratulate the authors for this outstanding effort. However, we would like to make a few comments and contributions in hopes that the audience might gain further insight.

As a result of the study, it was concluded that de novo reflux patients after LSG had a longer operation time and hospital stay and a higher %EWL rate. The complex cause and effect relationship between reflux and weight loss raises a question mark in every surgeon who reads the study. Unfortunately, the question “Does reflux increase weight loss or does weight loss increase reflux?” remains unanswered. As a matter of fact, this situation is also mentioned in the discussion section.

In the study, there is no clear information about the time of postoperative de novo reflux diagnosis in 860 patients in group A. Over the 3-year follow-up period, we believe there may be a substantial difference between being diagnosed in the 2nd month versus the 2nd year. Also, it was stated that the diagnosis of patients in group A who developed reflux was based on endoscopy, manometry, reflux symptoms, and PPI use. We know that the indications for PPI (proton pump inhibitors) use are not limited to reflux. Therefore, the lack of a standardized approach when diagnosing de novo reflux and the lack of sufficient information about the duration of PPI use cause confusion in the evaluation of the results. We suggest including these conditions in the study's limitations.

When trying to clarify de novo reflux after LSG, the current literature has also focused on the effect of perioperative practices on reflux. In this context, factors such as preservation of the cardioesophageal ligament during fundus mobilization [4], prevention of anatomical or functional stricture [5], stabilization of the stomach with applications such as omentopexy/gastropexy [6], and antrum preservation [6] are known to directly affect the development of de novo reflux after LSG. These aspects, which appear to be more significant in terms of reflux, are notably absent in the current article.

Complete remission of chronic diseases such as diabetes, hypertension, and sleep apnea in Table 5 is a complex issue with varying definitions in the scientific literature. In this context, defining complete remission is critical. Different definitions of complete remission may provide varying results. Adding this definition to this article would have improved the study's objectivity.

In summary, we believe that this study brings an important contribution to the literature due to its large, standardized cohort, substantial 3-year follow-up time, and verification that de novo reflux develops in 25.5% of patients following LSG.

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Author contributions All authors have contributed to our article and agree to submit it to the ‘Updates in Surgery’ for publication.

Funding The authors have not disclosed any funding.

Data Availability Statement No datasets were generated or analyzed during the current study.

Declarations

Conflict of interest The authors have no conflicts of interest to declare regarding the publication of this article.

Ethical approval Our study does not need ethical approval or informed consent.

Human and Animal Rights This article doesn't contain any studies directly involving human participants, as it is a letter that comments on the article.

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