



Response to “Gastric Stenosis After Laparoscopic Sleeve Gastrectomy in Morbidly Obese Patients”

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It was with great interest and appreciation that we read Dr. Hussain’s and Dr. El-Hasani’s comments about our article “Gastric stenosis after laparoscopic sleeve gastrectomy in morbidly obese patients” [1]. We hope that the information below will clarify their questions:

1. All of the patients who had been subjected to a laparoscopic sleeve gastrectomy participated in a protocol that included barium X-ray studies performed on the third postoperative day. In addition to the latter, an endoscopic control was done 1 month after surgery, once the patient had been discharged. In patients who suffered from symptoms of stenosis, this upper digestive endoscopy was performed for diagnostic purposes while the symptoms were occurring. If stenosis was suspected, the patient was not discharged or was readmitted to the hospital. An upper digestive endoscopy and dilations were performed in the operating room under general anesthesia using simultaneous fluoroscopy in order to reduce risk to the patient. The procedure for the dilatation was performed according to the previously published technique [2].
2. We agree with these comments. However, in our experience, and having performed a great number of dilations for esophageal strictures (we even have classifications for this complication) [2, 3], we have found that direct endoscopic vision of balloon dilatation provides safer treatment. Furthermore, a radiological control is performed immediately after endoscopic dilatation, in order to exclude the possibility of eventual perforation.
3. Based on our study, we firmly believe that an endoscopic evaluation of all bariatric patients is essential before surgery, as included in the preoperative work up of SAGES [4]. We always perform histological studies of the stomach in order to detect beforehand *Helicobacter pylori*, intestinal metaplasia, or chronic atrophic gastritis which remains in the excluded stomach after the gastric bypass procedure. We have also diagnosed carcinoid tumors or early gastric cancer before surgery. We firmly believe that an upper endoscopy is mandatory before surgery.
4. We completely disagree with these comments, and we believe that they are wrong:
 - a. A barium study can diagnose a leak, if present, in 100 % of the cases, contrary to the hydrosoluble contrast medium employed by other authors [5].
 - b. We believe that it is very important to determine the new anatomy of the residual stomach after bariatric surgery, which we define as “zero moment” after surgery, in order to be able to conduct a comparative evaluation of this anatomy in the future. Radiological control can also demonstrate the type of stricture whether circular or ring shaped, if the stricture is twisted or longer, and its location (middle part, sub-cardial, angular). We have also demonstrated that in a significant number of patients, there is an increase in gastric volume three or more years after a sleeve gastrectomy [6, 7]. The intraoperative measurement of gastric volume is inadequate and imprecise.
 - c. Gastric emptying can be very clearly evaluated through a barium swallow, as we have seen in over 850 patients in whom this test has routinely been performed.
5. It was not the purpose of this paper to compare the importance of bougie size. We only included five symptomatic patients with severe stricture.

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6. Dilatation can be performed early after surgery, providing the special care required by the patient.

Conflict of Interest The authors do not have any conflict of interest to report.

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