Response to: "Comment on "Does Sleeve Gastrectomy Expose the distal esophagus to Severe Reflux?". So what? Keep the big picture in perspective."

Accepted Version

Dear Editor in Chief,

Thank You for the opportunity to respond and we thank Dr. Gagner for his insights.

We are encouraged that this paper(1) has led to discussion with the community. In conclusion to our original paper, we felt the decision making and consent process behind procedures needed to be considered alongside its weight loss and metabolic effects. We focused on discussing a highly debated aspect of sleeve gastrectomy (SG) but by no means advocating one over another. From the study, we also highlighted that the data available was heterogenous and that there was a distinct lack of any global diagnostic criteria as well as pre & post-operative screening consensus.

We agree that patients who undergo Roux-En-Y Gastric bypass (RYGB) can also suffer from new or recurrence of gastro-esophageal reflux disease (GERD). Reviews have found remission of GERD after RYGB higher when compared to SG(2) but there is still variability in literature. There is also evidence to suggest revisional RYGB for GERD after SG is effective(3, 4). RYGB also seems to lead to a significant improvement of Barrett's esophagus (BE) and associated GERD(5).

We do agree with Dr Gagner's view that perhaps post-operative gastroscopy should be considered for all bariatric surgery patients.

Many suggest a morbidity advantage for SG over RYGB(6, 7),but this view is not universal within the literature and does not necessary in turn lead to higher readmission, re-operation or higher mortality rates(8).

We entirely appreciate the point made over relative late cancer risk versus the positive effect of SG on morbid obesity and its associated comorbidities. However, there is also a quality of life element that patients should be counselled for.

There continues to be rapid scientific progress in the field, studies such as those using high resolution manometry(9) will allow us to further understand the underlying mechanisms of post-operative GERD. We will then be able to develop techniques to mitigate again such risks. The study mentioned to objectively measure the esophageal gastric insertion angle's effects on GERD (10) is a great example of this.

Is GERD a reason not to perform SG? No, but perhaps with an agreed surveillance protocol which takes into account both the latest evidence and expert consensus such as the recommendations from "Gastroesophageal Reflux and Laparoscopic Sleeve Gastrectomy: Results of the First International Consensus Conference(11)".

Nevertheless, there is no correct universal approach. A precision approach aiming to tailor each patients' preference, medical requirements and risk profile is what we all aim for. SG remains an important operation to help combat morbid obesity and its associated comorbidities.

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