surgically and the second group was not. According to the results, the ''observation without surgery'' strategy was the optimal treatment for 87% of patients.

In the decade that has passed since this publication, laparoscopic repair of esophageal hiatal hernias has advanced immensely. Today, very good results are obtained in elderly patients. I completely agree with Braghetto and Csendes that, if these HH patients are interviewed in depth, most will report having had symptoms that have progressed for several years. As for the controversial topic of when to treat PH surgically in senior patients, I also am in agreement with them, based on reports in the literature and my own personal experience. Patients with complicated PH are sometimes difficult to diagnose, and transmural gastric necrosis is unpredictable. When this happens, patient mortality is very high. Therefore, I believe that all PH patients should be operated on after diagnosis, but not all HH patients. In my opinion, international recommendations for the surgical treatment of gastroesophageal reflux, such as those by the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES),[3] are still valid today.

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Reply to the Letter to the Editor☆

Réplica a Carta al Director

Dear Editor:

We would like to thank you for the opportunity to maintain this interesting discussion about hiatal hernias and when they should be treated surgically.

It is rather discouraging for surgeons to receive very elderly patients with severe respiratory complications secondary to recurring episodes of pneumonia or bronchitis due to the permanent aspiration of esophageal and gastric content reflux because of a hiatal hernia. And then there are those with complications from the hernia itself, such as severe anemia, active gastric ulcer, or volvulus. It is even worse when these patients were diagnosed with hiatal hernia several years earlier and were not recommended for surgery at that time. It is frustrating for surgeons because, by the time these patients are referred to us, the associated cardiorespiratory disease or the age of the patient do not make surgery recommendable, and the optimal time for surgical treatment has come and gone.

We have experienced this situation on numerous occasions throughout our careers as surgeons, so we felt it was necessary to alert surgeons when dealing with this condition.

Indeed, the article by Stylopoulos was reviewed and is mentioned in the References section. We do not agree with this article because, in addition to the methodological biases, there is a notable percentage of preventable complications derived from the patients' baseline diseases, and it does not take into account the excellent results that laparoscopic surgery currently offers these patients.

We therefore remain convinced of our point of view, and we thank you for your comments that support the concept that we have proposed.

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