ischemia or peritonitis is controversial and is considered a relative contraindication by certain groups.[3,4]

As stated by the authors, the main argument against this procedure has been the increase in iatrogenic injuries that go unnoticed during adhesiolysis. Nonetheless, different groups[4,5] have recently published percentages that are similar to open surgery (3%–17%), which demonstrates the safety of this approach in the hands of expert surgeons. Dissections must be done delicately, while avoiding traction on the intestinal loops and restricting the use of electrocoagulation. It is essential to avoid the placement of trocars over previous incisions. Likewise, during pre-op it is necessary to define the cause of the obstruction. If this were not possible with laparoscopy, conversion to laparotomy is required.[3,5,6]

Laparoscopy plays a fundamental role in these cases because it prevents future adhesions, which would cause intestinal obstructions to recur, resulting in additional socioeconomic costs. There have been no national reports on this factor here in Spain; in the United States; however, these costs have been estimated at some 1.3 billion dollars per year.[6]

In short, we agree with the authors about the positive results provided with laparoscopic treatment of intestinal obstruction. However, even when its use is justified, we must remember that laparotomy is still considered the treatment of choice in intestinal obstructions, and laparoscopy should be reserved for selected cases.

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Hiatal Hernias or Paraesophageal Hernias?☆

¿Hernias de hiato o hernias paraesofágicas?

Dear Editor,

Braghetto and Csendes are two prestigious authors in the world of esophagogastric surgery. They have recently published in your journal an article about when and why hiatal hernias (HH) should be treated surgically.[1] Their results are from a prospective study of 121 patients who had undergone HH hernias, who were divided into 2 groups according to age (younger and older than 70). Their conclusions support an interventionist approach to HH, and they believe that all patients should be treated surgically as soon as they are diagnosed. Elderly patients do not need to be excluded from surgery due to the low mortality rate (<1.5%) of elective laparoscopic procedures compared with the mortality rate in cases requiring urgent surgery (>5%).

Although they present a complete series of patients operated on for HH with a predominance of type I HH with gastroesophageal reflux, I believe the article and the final conclusions mainly refer to HH in seniors, which are usually paraesophageal hernias (PH). In 2002, Stylopoulos published an article in *Annals of Surgery* that had a thought-provoking title: ‘‘*Paraesophageal hernias: operation or observation?*’’.[2] They concluded that the initial treatment for asymptomatic PH patients, or those with few symptoms, should be conservative and non-surgical. To this end, they designed a study with 2 cohorts of patients with PH. The first group was treated

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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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