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Vertical Gastrectomy: Global Trends and Some Controversies☆

Gastrectomía vertical: tendencia global y algunas controversias

To the Editor,

We have read with great interest the editorial published by Drs. Del Castillo Déjardin and Sabench Pereferrer published in issue 96 of the journal *Cirugía Española*.[1] We would like to congratulate the authors of this editorial for the practical manner in which they have summarized the current main controversies of this surgical technique for the treatment of obesity. We would like to briefly add some comments on this subject.

Indeed, vertical sleeve gastrectomy (VSG) has been widely accepted among surgeons and patients. Even in countries like Mexico, where obesity has become a serious public health problem, this procedure has already surpassed gastric bypass in number of annual procedures.[2]

A drawback of this technique mentioned by the authors is the possibility of developing gastroesophageal reflux disease (GERD), which is an idea that is widely perceived. However, this issue has not yet been fully clarified, and a randomized controlled study evaluating this association failed to prove this claim. In comparing the results of vertical sleeve gastrectomy with the gastric band (GB),[3] after the first year of follow-up, 8.8% of patients who had received a GB developed GERD and 21.8% of the patients in the VSG group, without being statistically significant. Three years later, there were no statistically significant differences between the two groups.

To the controversies mentioned in the editorial, we should add 2 more: the enhanced recovery after surgery (ERAS) protocol and the diameter of the calibration device during the procedure.

The ERAS protocols have been shown to improve post-operative prognosis in patients undergoing colon surgery, but this territory has not been fully explored in bariatric surgery. In 2012, a randomized controlled study compared the ERAS protocol with the standard postoperative management in patients who underwent VSG.[4] The hospital stay decreased significantly in the ERAS protocol group ($P \leq .001$). Likewise, the average cost decreased in this group. The ERAS protocol seems to have favorable prognoses in VSG and could become a routine strategy.

In addition, before carrying out the gastrectomy during VSG with the linear stapler, bougie calibration is generally used along the lesser curvature to create the gastric pouch. Only one prospective randomized study has been published analyzing the size of the bougie.[5] This study determined that the caliber has no impact on short-term weight loss.

Time and scientific evidence will determine whether VSG displaces all other surgical techniques.

Last of all, we would once again like to congratulate the authors of the editorial for their accurate comments on the current trends in this surgical technique.

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