emergency accesses: experience of a COVID-19 hospital. In Vivo. 2020;34:3033–8. http://dx.doi.org/10.21873/invivo.12137.
4. Chia CLK, Oh HB, Kabir T, Tan YP, Thiruchelvam N, Pang NQ, et al. Impact of COVID-19 pandemic on management of acute cholecystitis in Singapore. Ann Acad Med Singap. 2020;49:817–24

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Conversion to gastric bypass in patients with Barrett's esophagus after sleeve gastrectomy☆

Reconversión a *bypass* gástrico en pacientes con esófago de Barrett tras una gastrectomía vertical

Recently, your journal published an interesting case report by V. Lucas et al.[1] on the appearance of Barrett's esophagus (BE) in a patient 8 years after sleeve gastrectomy (SG). This patient presented high-grade dysplasia on a lesion <1 cm and was successfully treated endoscopically. This is where the controversy appears: the authors state that a gastric bypass was also performed.

As described in the letter, in recent years there has been a significant concern regarding the appearance of *de novo* gastroesophageal reflux, esophagitis and BE, with or without symptoms of gastroesophageal reflux disease (GERD), in patients after SG.[2–4] Reports of adenocarcinoma (ADC) of the esophagus in several cases within a few years of SG further added to the controversy.[5,6] This undoubtedly raises concern among surgeons treating obesity and esophageal cancer, given that SG is the most widely used bariatric technique. The IFSO has already determined the optimal endoscopic follow-up after SG,[7] but the question that remains (which they also leave open in the publication) is what to do with post-SG BE.

Regarding the patient who underwent the gastric bypass: what was her BMI? Did she report heartburn or frequent vomiting? Did she take medication for GERD?

I believe that all these data are important when making the decision to reoperate any patient with another surgery that is not without risks. This was already stated in 2020 by M. Guingand et al. in an interesting Letter to the Editor.[8] These authors proposed performing endoscopic antireflux mucosectomy (ARMS) instead of gastric bypass and presented a case with good results.

As a surgeon, and perhaps at odds with gastroenterologists,[9] I think that a patient with BE will benefit more from an antireflux operation than from chronic treatment with proton pump inhibitors (PPI), which only limits acid reflux and not bile reflux. However, a gastric bypass does not have the same morbidity as laparoscopic fundoplication.

What to do with an asymptomatic young woman with BMI <30 kg/m^2 after SG with a diagnosis years later of short-segment BE without dysplasia?

In the first case (and the reason for this letter), I agree that gastric bypass could be the best option due to the appearance of high-grade dysplasia on BE, although endoscopic treatment was effective and other important data are lacking that would help make the decision. However, in the last proposed case, I would be more inclined towards medical treatment of GERD

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and endoscopic follow-up, in accordance with international guidelines.[9,10]

REFERENCES

1. Lucas V, Luna A, Rebasa P, Montmany S, Navarro S. Degeneración del esófago de Barrett tras gastrectomía vertical. Cir Esp. 2021;99:70–1.
2. Felsenreich DM, Kefurt R, Schermann M, Beckerhinn P, Kristo I, Krebs M, et al. Reflux, sleeve dilatation, and Barretts esophagus after laparoscopic sleeve gastrectomy: long-term follow-up. Obes Surg. 2017;27:3092–101.
3. Soricelli E, Casella G, Baglio G, Maselli R, Ernesti I, Genco A. Lack of correlation between gastroesophageal reflux disease symptoms and esophageal lesions after sleeve gastrectomy. Surg Obes Relat Dis. 2019;14:751–6.
4. Sebastianelli L, Benois M, Vanbiervliet G, Bailly L, Robert M, Turrin N. Systematic endoscopy 5 years after sleeve gastrectomy results in a high rate of Barrett's Esophagus: results of a multicenter study. Obes Surg. 2019;29:1462–9.
5. Wright FG, Duro A, Medici JR, Lenzi S, Beskow AF, Cavadas D. Esophageal adenocarcinoma five years after laparoscopic sleeve gastrectomy. A case report. Int J Surg Case Rep. 2017;32:47–50.
6. Sohn S, Fischer J, Booth M. Adenocarcinoma of the gastro-oesophageal junction after sleeve gastrectomy: a case report. ANZ J Surg. 2017;87:E163–4.
7. Brown W, Shah YJH, Balalis G, Bashir A, Ramos A, Kow L, et al. IFSO position statement on the role of esophago-gastro-duodenal endoscopy prior to and after bariatric and metabolic surgery procedures. Obes Surg. 2020;30:3135–53.
8. Guingand M, Vitton V, Barthet M, Gonzalez JM. Comments on Roux-en-Y gastric bypass as a treatment for Barrett's esophagus after sleeve gastrectomy. Obes Surg. 2020;30:2415–6.
9. Shaheen NJ, Falk GW, Iyer PG, Gerson LB. ACG clinical guideline: diagnosis and management of Barrett's esophagus. Am J Gastroenterol. 2016;111:30–50.
10. Weusten B, Bisschops R, Coron E, Dinis-Ribeiro M, Dumonceau JM, Esteban JM, et al. Endoscopic management of Barrett's esophagus: European Society of Gastrointestinal Endoscopy (ESGE) position statement. Endoscopy. 2017;49:191–8.

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Response to the manuscript "Conversion to gastric bypass in patients with Barrett's esophagus after sleeve gastrectomy"☆

Réplica al manuscrito «Reconversión a *bypass* gástrico en pacientes con esófago de Barret tras una gastrectomía vertical»

We have read Dr De Tomás'[1] letter with great interest, and we fully agree with his comments. To answer the questions posed, the patient had a BMI of 27.9 with very significant GERD symptoms that were continuous and did not respond to PPI treatment. Using the visual analog scale, the symptoms were assessed as 10 out of 10. Under these conditions, we opted to perform laparoscopic gastric bypass with a 100-cm alimentary limb and a 50-cm biliopancreatic limb. Six months later, the patient was asymptomatic, with a BMI of 24.8.

Regarding the second question: what to do with an asymptomatic young woman with a BMI < 30 kg/m^2 after SG, diagnosed years later with short-segment BE without dysplasia?

We agree that the decision in this second case is more complex and controversial. Our team would be more in favor of conversion to bypass, as PPI do not control alkaline reflux. With no current solid scientific evidence on the best treatment, we accept that this case lends itself to discussion and personalized treatment.

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