



Letter to the Editor Concerning: Conversion of One Anastomosis Gastric Bypass (OAGB) to Roux-en-Y Gastric Bypass (RYGB) for Biliary Reflux Resistant to Medical Treatment: Lessons Learned from a Retrospective Series of 2780 Consecutive Patients Undergoing OAGB

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Published online: 17 April 2020

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Dear Editor,

We read the interesting article of Kassir et al. regarding the conversion of one anastomosis gastric bypass (OAGB) to Roux-en-Y gastric bypass (RYGB) in patients with bile reflux resistant to medical treatments [1]. They evaluated 2780 patients who underwent OAGB. Thirty-two (1.2%) patients with bile reflux that fulfill the criteria underwent conversion of OAGB to RYGB to treat bile reflux. They reported the method which they used to convert OAGB to RYGB and the long-term results of this conversion with a mean length of follow-up of 47.6 months. While we were reading the article, some concerns rose that based on their method, some complications may develop for the patients.

The length of the gastric pouch has an important role in developing postoperative complications in both OAGB and RYGB surgeries. While a short gastric pouch in OAGB surgery may lead to developing bile reflux, a long gastric pouch in RYGB surgery may lead to other complications such as

developing marginal ulcer. Musella et al. reported a positive correlation between gastric pouches shorter than 9 cm and developing bile reflux [2]. Also in different studies, a longer gastric pouch was correlated to more risk of developing a symptomatic marginal ulcer [3, 4]. In the Kassir's study, the authors did not mention the length of the gastric pouch. Also, they left the gastrojejunal anastomosis unchanged. If they used a short gastric pouch, it could be the reason for developing bile reflux, and if they used an appropriate gastric pouch length in the first surgery, it was critical to change the size of the gastric pouch when converting OAGB to RYGB to prevent developing marginal ulcers.

Besides, due to the anatomical structure of the gastrointestinal (GI) system after OAGB surgery, we have two major concerns with OAGB patients. One is about the high risk of bile reflux and the other is developing malnutrition due to malabsorption. In the Kassir's study, in the first surgery, 150 cm of the small bowel was bypassed and in the second surgery, they bypassed another 100 cm to convert it to RYGB. So, the total length of the bypassed part of the bowel after conversion of OAGB to RYGB was increased to 250 cm. With this increase in the bypassed part of the bowel, patients are more prone to develop malnutrition especially if they have a short bowel [5]. So, it was crucial to measure the total length of the bowel before performing the conversion surgery. Also, the authors did not mention the malnutrition status of the patient before the conversion of OAGB to RYGB. If a patient had comorbid bile reflux and malnutrition after OAGB surgery, it should be considered to convert it to normal anatomy rather than RYGB, due to the high risk of complications [5].

Therefore, we think this study needs to be more explained and we would be happy to hear the comments of the authors on our opinion.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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