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Chronic Fistula After Laparoscopic Vertical Gastrectomy[☆]



Fistula crónica tras gastrectomía vertical laparoscópica

Dear Editor

We have found interesting the recent article by Ferrer Márquez, in which the authors analyzed a patient with chronic fistula after vertical gastrectomy (VG) and a serious chronic postoperative leak.¹ However, we would like to comment on other considerable treatment methods.

At our high-volume university bariatric center, the leak rate is 2.7% for primary VG and around 7% for corrective VG as a second procedure.^{2,3} We have made a special effort to implement a leak treatment algorithm based on our experience of more than 1100 cases, and we believe that leak treatment should be uniform and a combination of medical, radiological, endoscopic and surgical treatments. In our experience, we have obtained a primary cure rate of more than 85% of resistant leaks after VG, and almost 100% after surgical treatment.⁴

As described by Eisendrath et al., we believe that conservative medical/radiological treatment with drain placement and endoscopy should be the first step in the therapeutic algorithm. This method of treatment has successfully resolved 75% of leaks in these patients (overall success rate, including all patients, was 81%).⁵ Self-expanding stent placement is a good option for reducing the need for revision surgery and for improving patient results.⁶ Nonetheless, we have found no efficacy in using more than 2 attempts at stent placement. As for the radiological application of percutaneous glues, we have not found them to be useful, and the leak area can become even worse with their use as it can become a fibrous tissue that is difficult to heal. Thus, we believe that our success rate is related with the Roux-en-Y loop, which provides drainage proximal to the leak and resolves the eventual distal stenosis that favors chronic leakage.⁷

In our opinion, many medical and surgical modalities have been described for the treatment of stenosis after VG. These

include observation, endoscopic dilation, seromyotomy and wedge resection of the stomach sleeve included in the stenosis.⁸

The placement of a Roux-en-Y loop above the VG defect can be useful. We believe that when a proximal leak has persisted for more than 4 months, a Roux-en-Y loop should be inserted laparoscopically above the defect.⁵ Baltasar et al. described the technique in open surgery.⁹ Careful, extensive dissection of the proximal stomach, hiatus and mediastinal esophagus is essential to safely debride the defect and offer tissue quality that provides safe and effective suture of the small bowel loop over the stomach.⁵ The conversion rate reaches 11.1% in some centers.¹⁰ This technique should only be done when systemic signs of infection have completely disappeared, which is generally at least 3 months after the initial process.² Likewise, we do not believe that total gastrectomies are the only or best surgical option for managing leaks, as has been reported.²

We hope that these comments provide other relevant surgical options in addition to what was mentioned in the article by Ferrer Márquez et al.¹

Conflict of Interests

The authors have no conflict of interests.

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Perioperative Immunonutrition[☆]



Inmunonutrición perioperatoria

Dear Editor:

We have read the systematic review of the literature by Morán López et al. with interest. Throughout the article, the authors emphasize the importance of perioperative nutritional support and its proven beneficial impact on the incidence of infectious complications and, especially, hospital stay.¹ They also insist on some basic concepts that were scientifically proven years ago (such as the greater efficacy of enteral over parenteral nutrition, or the need for preoperative immunonutrition in patients scheduled for major gastrointestinal surgery). Nonetheless, these practices have not become generalized among surgeons.

In 2005, after a systematic review on perioperative management of surgical patients, the *Société Française de Chirurgie Digestive* (SFCD) published very specific clinical practice guidelines in which they insisted on the importance of systematic nutritional status assessment and perioperative nutritional support.² Specifically, in accordance with the high-level of scientific evidence that existed at that time, the administration of preoperative immunonutrition was recommended for 5-7 days in all patients scheduled for digestive tract cancer surgery (not only upper digestive tract surgery, but also

colorectal procedures), even in well-nourished patients. Immunonutrition is then continued during the postoperative period only in those patients who presented malnutrition before surgery. This explicit and formal recommendation "obligated" the Health Ministry to assume the cost of preoperative immunonutrition (approximately 175€ for one week of preoperative treatment) in a decree one year later, providing the product was prescribed by a surgeon, oncologist or anesthetist for a patient undergoing gastrointestinal cancer surgery.³

The recommendations made by the SFCD in 2005 were then re-examined and confirmed by the corresponding nutrition (SFNEP) and anesthesia-reanimation (SFAR) scientific societies.⁴ This process meant that, in just 5 years, these practices went from total unawareness in the world of surgery to a level of prescription of 65% in oncological patients; today, this percentage is certainly higher thanks to the many communications on this subject.⁵

Therefore, the reason for this letter is to encourage the Spanish Association of Surgeons (*Asociación Española de Cirujanos*) to initiate a similar process to transmit to surgeons, responsible health care administrators and ministries that these practices are not only in the patients' best interest, but also result in proven medical and economic benefits.⁶⁻⁸ The

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