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Editorial

Obesity reflux and bariatric surgery[☆]

Reflujo obesidad y cirugía bariátrica



We often forget that gastro-oesophageal reflux (GOR), oesophagitis, and even Barret's oesophagus (BO), are common diseases in obese patients. The inflammatory process associated with obesity, excessive abdominal pressure due to truncal obesity and weakness of the diaphragmatic pillars due to a sedentary lifestyle are among the most accepted causes.^{1,2} Furthermore, due to its multifactorial origin, we should refer to it as gastro-oesophageal reflux disease (GORD) and, in addition, consider it as another comorbidity of the obese patient.

When the obese patient with GORD loses weight, as happens, for example, with type II diabetes or hypertension, the GORD can cure, improve or persist.

However, when we subject this obese patient with GORD to bariatric surgery, complications may arise, especially if we use surgical techniques that facilitate GORD per se. These techniques in these patients could generate an effect that even negatively counteracts the overall benefit of bariatric surgery in terms of weight loss, improvement in comorbidities and quality of life.

This problem has been described and is of particular concern in the most widely used surgical technique today worldwide: vertical gastrectomy (VG). GOR is highly common with this technique during the first postoperative months, subsequently progressively improving with weight loss and the patient's learning process.

However, patients with cardia dysfunction before VG have much more severe symptoms during this adaptation period, which do not always resolve over time, and result in the requirement for chronic antacid treatment.

We should also note that de novo GOR may occur over time in patients undergoing VG. This could be due, among other factors, to changes in the anatomy of the hiatus that cause sliding of the Z line,³ or to dilation of the fundus and cardia, in relation to weight gain.⁴

We can thus verify that the bariatric surgeon may have "the power" to resolve the GORD of the obese patient, but also runs

the risk of worsening it or even generating it de novo in the long term. In this context, it is evident that prior and detailed study of the patients, with functional studies in the case of GORD, will help us select an appropriate surgical technique for the patient, together with adequate long-term follow-up. Possible de novo, even asymptomatic GORD must also be taken into account.

Given the situation, we asked ourselves, how can the bariatric surgeon intervene on obesity-associated GORD? When faced with a patient with obesity and hiatus hernia (HH) associated GOR, the surgeon can surgically treat the HH, with initially high chances of cure, even using techniques such as VG.

If the obese patient has GOR due to cardia dysfunction without HH, some authors have advocated opting for a VG associated with antireflux techniques such as Nissen or associated gastropexies, although other authors state that they are a cause of worsening quality of life and poorer limitations in a possible revision surgery.⁵⁻⁷ However, this could be a necessary tool for certain patients in whom mixed or malabsorptive surgery must be avoided, and who suffer from obesity-associated GORD.

In general, when there are doubts about whether we are going to be able to resolve GORD in a patient, and in an attempt to avoid unpleasant long-term follow-ups and reductions in quality of life, we must consider Roux-en-Y gastric bypass as the safe solution and which is accepted in the literature.

Therefore, let me insist once again that it is essential to provide appropriate prior study of the patient, and functional hiatus tests (pH-metry, manometry) should be considered whenever there is oesophagitis without HH or *Helicobacter pylori* infection to justify it.⁸⁻¹⁰ The study results help us better understand the origin of GORD, and thus decide on the most appropriate technique to try not only to cure GORD, but also to prevent de novo reflux over the years.

We must not forget that obesity is a chronic disease, and bariatric surgery is not curative. It requires long-term follow-

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up and a commitment to the patient. Publications on severe oesophagitis, BO and possible oesophageal adenocarcinoma after bariatric surgery, in addition to those regarding a high rate of patients with asymptomatic postoperative acid GOR years after surgery, have alerted the scientific community and raised the need for systematic review of patients, recommending gastroscopy in all patients.^{11,12}

Finally, let us not forget the problem of bile reflux, which is not negligible in techniques such as single anastomosis bypass, SADI-S and other less accepted derivative techniques.

In this monograph, authors of great prestige in their field will provide us with illumination and knowledge on this challenge that all professionals dedicated to bariatric patients face.

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