



Invited Response Letter to the Letter “Our Experience Regarding the Association between Gastrointestinal Stromal Tumor and Bariatric Surgery. A Response to a Letter “Gastrointestinal Stromal Tumor After Laparoscopic Sleeve Gastrectomy: Be Awake Before, During, and After a Bariatric Procedure”

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Published online: 14 December 2018

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Dear Editor,

Thank you for the opportunity to comment on the letter to the editor entitled “Our Experience regarding the association between Gastrointestinal Stromal Tumor and Bariatric Surgery. A response to a letter “Gastrointestinal Stromal Tumor After Laparoscopic Sleeve Gastrectomy: Be Awake Before, During, and After a Bariatric Procedure.”

We read this letter with great interest and we are grateful to the authors for their interest and thoughtful comments regarding our former letter [1]. In their letter, the authors shared their experience regarding the gastrointestinal stromal tumor (GIST) as a bariatric surgery incidental finding [2]. The authors presented 12 cases which were retrospectively analyzed from a group of 50 European laparoscopic surgeons. In their case series, the demographics of the patients and anatomic tumoral localization and pathological characteristics (size, margins, CD117 marker, and mitotic index) were similar with other studies in the literature [1, 3–5].

The preoperative diagnosis of GISTs is difficult in obese population since these tumors are located usually on the serosal side of the stomach without any mucosal involvement as well as usually have low-grade malignant potential [3]. In the authors’ study, all patients underwent preoperative esophagogastroduodenoscopy (EGD) and they reported that a suspicious submucosal gastric lesion was determined in

only two cases before surgery. However, no biopsy was made for both patients. If possible, we suggest histological analysis to confirm for any incidental tumor in such cases before bariatric surgery. The authors reported that the other gastric lesions were perioperatively detected in majority of cases (87.8%) as reported similarly in global literature [1, 3–5]. By these means, we suggest that a bariatric surgeon should inspect the stomach thoroughly including both the anterior and the posterior surface before initiation of resection. During bariatric surgery, in case of a suspicious gastric mass, the surgeon should consult with other members of surgical team. Although GISTs cannot be differentiated from other spindle cell tumors of the stomach in intraoperative frozen section examination, an experienced pathologist may help the surgical team for the best management of patients.

Anatomic tumoral localization of gastric GISTs is frequently described in the fundus and cardia, which is in accordance with the distribution of interstitial cells of Cajal throughout the stomach [3, 5, 6]. The localization and the size of the tumors are critical for the operative strategy during a bariatric procedure. Tumors near to the gastroesophageal junction or on the lesser curvature as well as larger than 2 cm in size may necessitate changing of the surgical strategy or aborting the procedure [4]. When a GIST is suspected during a bariatric procedure, it is mandatory to achieve negative microscopic margins. For these reasons, we suggest that a written consent should be taken from all patients describing all alternative bariatric strategies such as LSG, RYGB, and BPD in unexpected situations.

In a conclusion, we agree with the authors that every surgeon should be aware of any incidental findings that may be discovered during bariatric surgery. We suggest our colleagues to inform their patients for alternative strategies before surgery in case of incidental findings.

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Compliance with Ethical Standards

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

Ethical Statement and Consent Statement Not required.

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