



Reply to “Laparoscopic Conversion of One Anastomosis Gastric Bypass to Roux-en-Y Gastric Bypass”

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We thank the Author(s) for their interest in our paper, cited in the final part of their Letter to the Editor. Our video submission, published in *Obesity Surgery* in 2016, describes the conversion of a One Anastomosis Gastric Bypass (OAGB) to a Roux-en-Y Gastric Bypass (RYGB) for chronic bile reflux. In our paper, we proposed to fashion a Roux-en-Y limb leaving in place the pre-existing gastro-jejunal anastomosis. We divided the afferent limb next to the previous gastro-jejunal anastomosis and a jejuno-jejunal anastomosis was performed distally at 70 cm on the alimentary limb [1].

In their Letter to the Editor, the Author(s) report(s) that the technique we previously described would result in a too large gastric pouch. Moreover, they speculated that our technique would create a too short common loop, finally leading to malabsorption.

Reading the Letter to the Editor, we think that some parts of the technique we described are not completely clear or have been misunderstood.

First, we report a specific case in which, for a technical error, the gastric pouch was too short (6 cm), not configuring, strictly speaking, a “proper” OAGB [2, 3]. This was, probably, the cause for the chronic bile reflux and this was the problem we aimed to fix with conversion to RYGB. We would like to underline that after converting the first operation to a standard RYGB, the gastric pouch, too short for an OAGB, resulted in an adequate pouch for a RYGB. However, we think that in many cases of conversion from OAGB to RYGB, a long gastric pouch does not need necessarily to be reduced in length. As a matter of fact, a long gastric pouch does not

represent an obstacle to fashion an effective RYGB. Controversies still exist, in fact, on how to construct the ideal gastric pouch in RYGB since it has been demonstrated that a long and narrow gastric pouch has less tendency to enlarge and should delay the transit of food [4, 5]. According to these observation, the gastric pouch would possibly need to be reduced only in its diameter, and not in its length, if it results too wide. This would allow to save the pre-existing pouch and gastro-jejunal anastomosis and to avoid unnecessary new sutures.

Second, we think that in cases like the one we presented, the risk for malabsorption is highly unlikely. In our paper and in the written narration of the video, in fact, it is clearly stated that before deciding to adopt the described technical solution, the efferent limb was measured and it was 650 cm. Even considering that 70 cm of the efferent limb were used to fashion the alimentary limb, the remaining common limb of 580 cm appears long enough to avoid malabsorption, in contrast to what was hypothesized by the Author(s).

Finally, we would like to point out an important technical limitation of the technique proposed by the Author(s). Watching their video submission, in fact, it appears evident that a longitudinal stapling on the omega loop is only feasible in cases of a previous end-to-side gastro-jejunal anastomosis [6]. In cases of a side-to-side gastro-jejunal anastomosis [7], in fact, the bowel involved in the omega loop would be too wide to allow a safe placement of the linear stapler and its resection would possibly result in an iatrogenic stricture.

Compliance with Ethical Standards

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

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