Letter to Editor REPLY—Response to Prof. Schiemann's Letter

Holger Karl Till

Received: 22 January 2009 / Accepted: 31 January 2009 / Published online: 15 February 2009
© Springer Science + Business Media, LLC 2009

Thank you very much, Prof. Scheimann, for your thoughtful response. We fully agree with your sincere concern about the application of bariatric surgery for children with PWS. Certainly, these patients should be treated with a supervised hypocaloric diet, exercise, and strong environmental support. Nevertheless, though, some will fail such therapy and develop life-threatening complications. Like the child we reported about, who had been in a strict PWS program since the age of 2 but gained weight dramatically until she reached a BMI of 56 by the age of 8, then requiring 24 h CPAP ventilation (besides suffering from several other metabolic co-morbidities). At that time, bariatric surgery seemed the only remaining option.

Studying the present literature carefully, we considered the laparoscopic sleeve gastrectomy (LSG) favorable, because (a) it preserves the antrum as the motor for gastric emptying [1], which may be critical in cases of PWS if they over-eat postoperatively. Furthermore, (b) the LSG achieved substantial weight reduction as a “stand-alone” technique comparable to gastric bypass in other series [1, 2]. Additionally, (c) Langer et al. [3] found a dramatic decrease of ghrelin levels after LSG, which may be relevant for PWS children. Neither effect can be attributed to the gastric banding [4] or gastric ballooning. Instead, the fundus with

the oxyntic glands (ghrelin production) would remain in place. Furthermore, in gastric banding, the pouch opens against a non-compliant band. So, for PWS patients and their eating habit, this situation could cause acute pouch dilatation or even gastric rupture, as experienced by De Peppo et al. [5]. Consequently, we refrained from either technique for children with PWS.

In summary, we agree that weight loss surgery should be considered only for those children with PWS who failed weight control therapy and developed life-threatening complications. In such a critical situation though, LSG could be a safe and effective strategy.

References

1. Deitel M, Crosby RD, Gagner M. The first International Consensus Summit for Sleeve Gastrectomy. *Obes Surg.* 2008;18(5):487–96. New York City, October 25–27, 2007.
2. Baltasar A, Serra C, Perez N, et al. Laparoscopic sleeve gastrectomy: a multi-purpose bariatric operation. *Obes Surg.* 2005;15(8):1124–8.
3. Langer FB, Reza Hoda MA, Bohdjalian A, et al. Sleeve gastrectomy and gastric banding: effects on plasma ghrelin levels. *Obes Surg.* 2005;15(7):1024–9.
4. Kotidis EV, Koliakos GG, Baltzopoulos VG, et al. Serum ghrelin, leptin and adiponectin levels before and after weight loss: comparison of three methods of treatment—a prospective study. *Obes Surg.* 2006;16(11):1425–32.
5. De Peppo F, Di Giorgio G, Germani M, et al. BioEnterics intragastric balloon for treatment of morbid obesity in Prader Willi Syndrome: specific risks and benefits. *Obes Surg.* 2008;18(11):1443–9.

H. K. Till (✉)
University of Leipzig,
Leipzig, Germany
e-mail: holger.till@medizin.uni-leipzig.de