Reply to R. Vilallonga et al.

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Dear Editor,

We recently reported the management of patients presenting with staple line complications such as leak and/or stenosis after laparoscopic sleeve gastrectomy (LSG) in a tertiary referral center [1]. Patients were referred from both university and district general hospitals as well as private surgical units. Surgery was carried out by both general and bariatric surgeons. We believe that Vilallonga and colleagues belong to an expert surgical team, trained in bariatric surgery. However, in France, as in many other countries, bariatric surgery is often performed by general surgeons, which may result in high rates of challenging complications during the early phase of surgical experience with these procedures. However, in the particular case of LSG, the learning curve does not seem to influence the morbidity and mortality rates, as high-volume surgeons have been shown to experience similar potentially severe complications as low-volume surgeons [2].

A surgical procedure may be adopted, even though it carries a risk of life threatening and disabling complications, as long as prompt management of these complications is available. We agree with the authors that the gold standard of treatment for LSG leakage is conservative management with endoscopic intervention. In our experience, there was often a considerable delay between diagnosis of the complication and tertiary center referral. This delay renders the further management more difficult as chronic local inflammation

increases the failure rate of stent placement and may make safe gastro-jejunostomy formation impossible. The high failure rate of nondedicated endoscopic devices has recently led to the development of covered self-expandable and retrievable stents such as HANAROSTENT® (diameter from 18 to 30 mm, length from 170 to 240 mm; M.I. Tech., Seoul, Korea) [3]. HANAROSTENT consists of a membrane with gold radiopaque markers, an antireflux valve at the distal end, and a retrievable lasso attached to the proximal end. Stenting is performed by endoscopy and fluoroscopy under general anesthesia. It has been advocated that early stent placement (within the first 3 weeks for 6 weeks) is associated with a shorter healing time [4]. As described by the authors, the same applies to covering the leak with a Roux limb, which should not be carried out any earlier than 3–6 months after the initial operation [5].

Autologous adipose tissue-derived stem cell injection has been described for the management of digestive fistulae, e.g., Crohn's fistulae, and is currently studied for the closure of chronic gastric leakage after LSG [6].

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