Author's Response: Anatomical Basis for the Low Incidence of Internal Hernia After a Laparoscopic Roux-en-Y Gastric Bypass Without Mesenteric Closure

Joaquin Ortega

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Dear Editor:

We thank Drs. Facchiano, Lucchese and Ianelli for their useful comments. These fine scholars have been motivated by this issue, and some of their work was referenced in our article.

We are grateful for their comments regarding our surgical results. We are very proud of the very low morbidity and good follow-up that we reported; we think that these factors support our conclusions.

Obviously, we share their opinions about the factors that reduce the incidence of postoperative internal hernia. We took these factors into account when we decided which method to implement with the laparoscopic approach. Our method was not original and did not state as such in our article [1]. We took different aspects of the procedure from several authors (which is a very common strategy for all surgeons).

We agree with Facchiano et al. that division of the omentum is not relevant in the long term. However, in our experience, it was not necessary in most of the cases. Also, an undivided omentum hinders herniation in the early postoperative period.

We agree with Facchiano et al. that the position of the mesenteric defect is dependent upon the length of the gastric pouch and site of the gastrojejunal anastomosis, being higher if the pouch is small, and if the anastomosis is side-to-side. In our experience, the gastrojejunostomy did not show tension. We think that this feature was because of the 4-week hypocaloric diet administered before surgery, which reduced the volume of abdominal fat and enlarged the mesentery.

In our method, the jejunojejunostomy was consistently above the common channel at the end of the procedure and was only slightly below the gastrojejunostomy (as can be seen

in the figures). Of course, herniation of the biliopancreatic or alimentary loops is possible but is very unlikely.

In our article, we did not advise against closing the mesenteric defect; we think that this is a good method if carried out correctly (as Facchiano et al. explained in their letter). However, we provided evidence of the very low prevalence of internal hernia in our patients without closure of the mesenteric defect. In our opinion, these results justify not closing the mesenteric defect. Of course, bowel obstructions because of internal hernias can occur in the long term, as is the case because of adhesions after any type of surgery.

We described a stapled linear gastrojejunostomy and noted that it was another factor that helped safety. Compared with a circular mechanical anastomosis, simultaneous use of this suture with the stitch that hangs to the jejunal loop from the stomach makes the rotation of the alimentary limb more difficult. However, this is our personal opinion, and experimental or bibliographic evidence is lacking.

In conclusion, we provided evidence that, after laparoscopic Roux-en-Y gastric bypass (LRYGB) is carried out with the technical details mentioned in the article, closing the mesenteric defect to avoid internal hernia is not necessary (at least at medium-term follow-up). We believe that the comments from Facchiano et al. are valuable and may help to improve outcomes. We agree that, in other versions of LRYGB, closing the mesenteric defect may be advisable as has been demonstrated.

Conflict of Interest The author declares that he has no proprietary, financial, professional or other personal interests of any nature or kind in any product or service that may influence the position presented.

Reference

1. Ortega J, Cassinello N, Sánchez-Antúnez D, et al. Anatomical basis for the low incidence of internal hernia after a laparoscopic Roux-en-Y gastric bypass without mesenteric closure. *Obes Surg*. 2013;23(8):1273–80.

J. Ortega (✉)
Unidad de Cirugía Endocrina y Bariátrica, Hospital Clínico
Universitario, Avda. Blasco Ibáñez, 17, 46007 Valencia, Spain
e-mail: joaquin.ortega@uv.es