Positioning Trocars for Performing Sleeve Gastrectomy. Points of Controversy

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Dear editor,

As the number of trocars used for performing sleeve gastrectomy is variable [1, 2], the location of some ports should have already been standardized as it determines the angle between the stapler and the major axis of the stomach, which could influence the complication rate.

We read with great interest the letter of Kassir et al. [3] about positioning trocars in sleeve gastrectomy and we would like to make some observations. We think that the two first cartridges are important because they affect the incisura angularis and guide the rest of the gastric section. We think it would be difficult to start the gastric section without using a 12-mm trocar on the patient's right side, as the gastric antrum is normally found slightly to the right of the midline. Maximum articulation of the stapler head is required when we begin the section from the midline or the patient's left side. In this case, the surgeon has to cross the instruments in order to pull out the surgical specimen to the left side; the stapler usually points directly to the incisura, creating an acute angle, which could result in complications such as stenosis [4, 5]. On the other hand, it is easier to continue the section upward from the patient's right side as it allows for pushing the gastric tube with the stapler to the right while the surgeon pulls the specimen to the left at the same time. Finally, when the stapler is introduced from the patient's right side, its direction makes the surgeon to get away from the angle of His, while the contrary occurs when the stapler is introduced from the patient's left side.

Conflict of Interest David Ruiz de Angulo has no conflicts of interests to declare in relation to this article. Vicente Munitiz has no conflicts of interests to declare in relation to this article. M. Ángeles Ortiz has no conflicts of interests to declare in relation to this article. Luisa F. Martínez de Haro has no conflicts of interests to declare in relation to this article. Pascual Parrilla has no conflicts of interests to declare in relation to this article.

Statement of Informed Consent Informed consent was obtained from all individual participants included in the study.

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References

1. Baltasar A, Serra C, Pérez N, et al. Laparoscopic sleeve gastrectomy: a multi-purpose bariatric operation. *Obes Surg*. 2005;15:1124–8.
2. Arru L, Azagra JS, Goergen M, et al. Three-port laparoscopic sleeve gastrectomy: feasibility and short outcomes in 25 consecutives super-obese patients. *Cir Esp*. 2013;91:294–300.
3. Kassir R, Lointier P, Breton C, et al. Positioning trocars for performing sleeve gastrectomy. *Obes Surg: Points of Controversy*; 2014.
4. Burgos AM, Csendes A, Braghetto I. Gastric stenosis after laparoscopic sleeve gastrectomy in morbidly obese patients. *Obes Surg*. 2013;23:1481–6.
5. Lalor PF, Tucker ON, Szomstein S, et al. Complications after laparoscopic sleeve gastrectomy. *Surg Obes Relat Dis*. 2008;4:33–8.

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