



# Oversewing and Gastropexy in Laparoscopic Sleeve Gastrectomy – Two Futile Steps of the Procedure? An Observational Case-Control Study

Mohit Bhatia<sup>1</sup>  · Elia Azir<sup>1</sup> · Shamsi El-Hasanii<sup>1</sup>

Received: 28 August 2023 / Revised: 28 August 2023 / Accepted: 25 September 2023 / Published online: 10 October 2023  
© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2023

We read with great interest the article from Sala et al. [1] and we praise them for their efforts.

Over the years, laparoscopic sleeve gastrectomy (LSG) has gained acceptance among the bariatric community for treating morbidly obese patients with favorable post-operative outcome [2].

Gastro-esophageal reflux disease (GERD) has been considered a problematic implication after LSG, and many authors have suggested gastropexy, calibrating the bougie size to avoid features of GERD [3, 4].

Vage et al. concluded incidence of GERD and reflux symptoms was low in patients who underwent gastropexy as compared to the ones who did not have gastropexy [5].

In principle, we agree with the contents of the article and, to complement the scientific value, we would like to share some technical points that we use for the benefit of the bariatric community.

We have always used a 36 F bougie to calibrate the sleeve. We have always used 0 Ethibond (non-absorbable stitch) to oversee the sleeve: basically, invaginating the whole staple line. We use the same stitch for the gastropexy while we are doing the oversewing. The gastropexy is simply three bites in the gastro-splenic omentum and the sleeve itself—usually, we do it in the body of the sleeve proximal to the incisura.

We take extra care to align the staple line on the left side of the sleeve not spiralling anteriorly; otherwise, oversewing will disfigure the sleeve.

Also, we have a very low threshold for hiatal dissection to make sure we get at least 3 cm of the esophagus into the abdominal cavity, and we perform hilar repair whenever required.

We find these technical points to be very valuable to prevent future complications of the sleeve.

It is our observation that when it comes to revisional surgery, sleeves which have been oversewn with Ethibond are less dilated, and it is possible that the fibrosis induced by the Ethibond (non-absorbable stitch) may be a factor in preventing dilatation and distention of the sleeve.

## References

1. Sala DT, Fodor SR, Voidăzan S, et al. Oversewing and gastropexy in laparoscopic sleeve gastrectomy – two futile steps of the procedure? An observational case-control study. *Obes Surg*. 2023;33:2420–7. <https://doi.org/10.1007/s11695-023-06681-5>.
2. Griffin SB, Ross LJ, Burstow MJ, et al. Efficacy of a dietitian-led very low-calorie diet (VLCD) based model of care to facilitate weight loss for obese patients prior to elective, non-bariatric surgery. *J Hum Nutr Diet*. 2020;34(1):188–98.
3. Kahrilas PJ, McColl K, Fox M, et al. The acid pocket: a target for treatment in reflux disease? *Am J Gastroenterol*. 2013;108(7):1058–64.
4. Hawasli A, Jacquish B, Almahmeed T, et al. Early effects of bougie size on sleeve gastrectomy outcome. *Am J Surg*. 2015;209:473–7.
5. Vage V, Behme J, Jossart G, et al. Gastropexy predicts lower use of acid-reducing medication after laparoscopic sleeve gastrectomy. A prospective cohort study. *Int J Surg*. 2020;74:113–7.

✉ Mohit Bhatia  
drbhatia711@gmail.com

<sup>1</sup> Princess Royal University Hospital, King's College, Orpington, London, UK