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LETTER

Role of preoperative endoscopy in bariatric surgery

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To the Editor,

The role of routine upper gastrointestinal (GI) endoscopy before surgery for obesity is controversial with opinion divided between various societies. While European Association for Endoscopic Surgery recommends it in all, Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) advocates endoscopy in patients when a gastric pathology is suspected. Such a variation in practice is also evident from National Health Service survey of bariatric units [1]. We retrospectively reviewed the prevalence and spectrum of findings on endoscopy in our patients before bariatric surgery between January 2015 and December 2016.

A total of 33 patients (19 women) underwent bariatric surgery during the period. Their mean (SD) age was 40.7 (12.2) years and mean body mass index (BMI) was 44.5. Nearly half of them had diabetes mellitus or hypertension. BMI was more than 40 in 23, 35–40 in 9, and 30–35 in 1 patient. The type of bariatric surgery included laparoscopic sleeve gastrectomy (LSG) in 18 and laparoscopic Roux-en-Y gastric bypass (LRYGB) in 15 patients. Only five patients (15.2%) had upper GI symptoms. A majority of them had one or more findings on upper GI endoscopy. They are summarized in Table 1. Four patients (12.1%) had significant findings on gastroscopy that would alter the surgical management and all were symptomatic. Five patients with hiatal hernia had concomitant laxity of lower esophageal sphincter (LES). All of them except one underwent LRYGB instead of LSG as LSG induces or worsens gastroesophageal reflux by increasing the intragastric pressure. Three patients with grade A reflux esophagitis and laxity of LES were treated with proton pump inhibitors and then underwent LSG.

The three common pathologies in endoscopy that were noted in studies to have an impact on surgical management were large hiatal hernia, severe gastritis, and peptic ulcer disease [1, 2]. LRYGB is preferred to LSG in symptomatic large hiatal hernia and patients with severe reflux esophagitis. A systematic review and meta-analysis on the role of routine preoperative upper endoscopy in bariatric surgery concluded that it should be optional in asymptomatic patients given its low probability to effect a change in surgical management [1]. However, there is no consensus on the definition of what constitutes a change in surgical management and no clear agreement amongst studies for treatment of hiatal hernia detected in preoperative endoscopy [1]. Another large systematic review and meta-analysis [2] observed an overall 7.6% influence of preoperative endoscopic findings in altering or delaying surgical treatment of obesity. However, they noted as limitations the significant heterogeneity in the studies, lack of randomization, and differing institutional protocols for preoperative endoscopy. American Society of Gastrointestinal Endoscopy (ASGE) along with SAGES has recently recommended preoperative endoscopy to be individualized in patients undergoing bariatric surgery [3].

We observed preoperative endoscopy to alter surgical management of obesity in 12%. It may be reasonable to consider preoperative endoscopy in select patients based on symptom profile and type of planned surgical procedure.

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Table 1 Findings on upper gastrointestinal endoscopy

S. No.	Finding on endoscopy	No. of patients (n = 28)
1	Hiatal hernia	5
2	Esophagitis	3
3	Gastric erosions	4
4	Duodenal erosions	2
5	Inlet patch esophagus	1
6	Laxity of lower esophageal sphincter	13

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