BRITISH MEDICAL JOURNAL

SATURDAY 5 SEPTEMBER 1987

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NO 6598 BRITISH MEDICAL JOURNAL 1987 VOLUME 295 563-616
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 295 (6598) 563-616 (1987)

CORRESPONDENCE

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- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
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- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Surgery of morbid obesity

SIR,—Mr J-C Gazet and Professor T R E Pilkington rightly point out that bariatric surgery is a well accepted procedure for otherwise intractable gross obesity (11 July, p 72), but their leading article contains inaccuracies. As well as producing considerable morbidity, persistent severe morbid obesity is a life threatening condition. This is the major reason for the explosion in the United States of surgery for a malady with no effective medical treatment and explains why this pattern will be followed in the United Kingdom and Europe.

The authors rightly point to the unacceptable morbidity of intestinal bypass—a classic example of the cure being worse than the disease. The gastric operations need to be clearly distinguished. The gastric bypass consists of a high gastric division (stapling or suture) with a Roux-en-Y or loop anastomosis to the upper small pouch. This is a major diversionary procedure with all the risks of gastrojejunal anastomosis. A vertical banded gastroplasty, on the other hand, is a reduction procedure and not a bypass. It consists of staple lines and no anastomoses, with consequent lesser risks of leakage. Gastric bypass is difficult to reverse, but a gastroplasty is easily returned to near normal by a gastrogastrostomy (proximal to distal pouch anastomosis).

Recent reviews are replete with descriptions of the complications of these gastric operations: leakage, infection, thrombosis, weight gain, and stomal stenosis.[1-5] The procedure was first described six years ago and the long term studies of large series now report results after five to six years.

The leading article does not discuss the Scopinaro procedure of biliopancreatic bypass, another procedure with promising results. Because of the long term complications of gastrectomy the authors correctly draw attention to the paucity of data on pathological changes in the stomach caused by the various gastric procedures for obesity. We must, however, question the uncritical acceptance of a paper claiming a high incidence of dysplasia and gastritis after some of these procedures.[6] In this study the preoperative incidence of gastritis among the subjects was unknown, so the postoperative incidence figures are meaningless. Furthermore, the criteria used to diagnose dysplasia are unsatisfactory.[7] Our own observations from endoscopy and biopsy of 32 patients who underwent vertical banded gastroplasty and were followed up for up to 45 months showed no cases of dysplasia and no increase in the incidence of gastritis over the preoperative incidence. Others support these findings.[8] It is unreasonable to spread disquiet about the preneoplastic complications of gastric bypass surgery on the basis of one paper that uses diagnostic criteria that are unacceptable to most pathologists. But it is certainly true that more data are needed.

The question, "When results are so poor should surgery be reserved for those in danger of dying?" is ambiguous. Non-surgical methods are little better than 10% effective. Gastroplasty has shown at least a 50-60% five year maintenance of weight loss, and our own results in 70 cases confirm this. Equally important, the successful patients are completely transformed: they become socially and sexually acceptable and are no longer unhappy freaks. True, selection is still primitive and relies too much on weight and too little on psychosocial criteria. True too is the lack of knowledge of the role in each individual of energy intake and expenditure, while body composition studies are only slowly being performed before and after surgery.

But there is still widespread medical prejudice that people bring fatness on themselves and can overcome it with a diet sheet and will power. We footsoldiers in this surgical redoubt need all the help we can get. Such experienced pioneers as your leader writers should not be resting. Their renewed efforts will be welcomed and applauded.

E R T C OWEN
A E KARK
Department of Surgery,
A C SMITH
Department of Gastroenterology,
J F FLEJOU
A B PRICE
Department of Pathology,
Northwick Park Hospital,
Harrow HA1 3UJ

1 Dietel M, Jones BA, Petrov I, *et al.* Vertical banded gastroplasty: results in 233 patients. *Can J Surg* 1986;**29**:322-4.
2 Saadia R, Schein M, Decker GAG. Anastomotic leaks and perforations after gastric surgery for morbid obesity. *S Afr J Surg* 1985;**23**:163-5.
3 Buckwalter JA, Herbst CA. Perioperative complications of gastric restrictive operations. *Am J Surg* 1983;**146**:613-8.
4 Al-Halees ZY, Freeman JB, Burchett H, *et al.* Non-operative management of stomal stenosis after gastroplasty for morbid obesity. *Surg Gynecol Obstet* 1986;**162**:349-54.
5 Owen ERTC, Kark AE. Assessment and revision of failed VBG.