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LETTER TO EDITOR/LED REPLY

A Rocambolesque Metafiction

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I respectfully disagree with most comments elucidated by Musella et al. [1] Interestingly, a recent presentation during the latest ASMBS annual meeting in Nashville on November 15 by Dr Maud Robert and co-authors presented a level 1 evidence comparing one-anastomosis gastric bypass, OAGB, versus Roux-en-Y gastric bypass, RYGB [2]. The strength of this trial is reflected on the fact that it is a multicentric randomized controlled trial of non-inferiority, with OAGB performed according to the majority of those who are proponents, and the RYGB performed the classical way, all laparoscopically, from high volume centers in France. Both groups had 128 patients followed up to 2 years, with the same indications according to NIH criteria, excluding severe GERD, Barrett's esophagus, and/or esophagitis. Baseline characteristics were similar.

Although not significantly different, 21% of OAGB patients had at least one serious adverse event (SAE), and 21% had nutritional problems, none in RYGB, $p < 0.0034$. Seven had malnutrition, and two of those had to be converted to RYGB due to encephalopathy and/or severe malnutrition, with additional two patients with severe symptomatic biliary reflux. Recent reports attest to these kinds of conversions and or reversals [3, 4]. Gastroscopies performed at 2 years had revealed 4 times more gastritis in OAGB, 3 times more esophagitis, with 2 cases of dysplasia, 1 gastric and 1 esophageal, none in RYGB. Additionally, 14% had diarrhea-anal fissures, and steatorrhea was significantly more present in OAGB.

The authors' conclusions, which include one surgeon of your letter (Dr JM Chevallier), are asserting that comparable weight loss and metabolic effects are seen with both interventions, but a severe warning is given regarding OAGB for nutritional complications and higher SAE. There is no definite answer yet on the risk of biliary reflux in the long term, but warnings are also extended as dysplasias may develop into neoplasias. Following these preliminary deductions, the majority of surgeons in this trial have abandoned OAGB to simply perform RYGB when indicated. Like a rocambolesque metafiction, more internal hernias are reported [5], and the nutritional serious complications, steatorrhea, diarrhea-anal fissures, and liver deteriorations, mirror the profile of a biliopancreatic diversion (BPD) [6].

Compliance with Ethical Standards

Conflict of Interest Dr Gagner reports speaking honoraria from Ethicon, from Medtronic, from GORE, and from Valeant, and is a consultant in Lexington Medical, outside the submitted work.

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