Commentary on Gastrointestinal Surgery

Cut the stomach but do not cut the gut?

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Recently, Huang *et al.* (1) present a multimedia manuscript on the technique for laparoscopic gastrectomy for gastric cancer. Laparoscopic gastrectomy is an acceptable procedure to treat gastric cancer, with outcomes that seem comparable to open conventional surgery (2) although still a very small percentage of patients are treated with this modality (3).

The authors show a video of a distal gastrectomy plus D2 lymphadenectomy focused on the digestive tract reconstruction based on an "uncut" Roux-en-Y gastrojejunostomy. The technique was described for the first time in dogs in the early 1990s (4) to prevent the Roux Stasis syndrome. I have two comments on the video: (I) the technique shown and (II) the necessity to do this type of reconstruction.

The authors show a high level of skillfulness that made the operation look easy. The technique is; however, complex and demanding, requiring a high degree of laparoscopic dexterity. Overweight and obesity found in most of the Western patients would certainly add a higher difficulty level to the operation. Although the authors emphasized that the operation should "better be performed by the experienced surgeon" (to which we agree), an experienced assistant is also mandatory. The exposure of the posterior wall of the stomach and handling the stomach after duodenal division and a heavy omentum are arduous tasks. Maintaining the stomach and the intestine in position to allow a correct stapling is also strenuous. We suggest stitching the viscera together before opening the hole to introduce the stapling device. The confection of a Braun omega-shaped anastomosis makes the handling of intestinal loops actually easier since the intestine will be exposed and the omentum will be retracted by the antecolic bowel (if the operation is done due to benign disease and an omentectomy was not added to the procedure) after the gastrojejunostomy.

My second thoughts are on the need for an uncut technique. The number of gastrectomies decreased significantly after the "golden era" of the peptic ulcer disease. Gastric cancer incidence seems to decrease along time as well. Certainly, today the majority of gastric resections or gastroplasties are linked to bariatric procedures. Interestingly, entire books were written on postgastrectomy syndromes. Even then, the uncut technique never gained a wild acceptance. Modernly, a better understanding of the pathophysiology of the postgastrectomy status and improvement in surgical technique made postgastrectomy syndromes an outdated topic. Roux stasis syndrome does not seem to be a real problem in contemporary series. Moreover, peristaltic waves can be noticed—although not in the majority of cases—in excluded intestinal limbs (5) and, on the other side, duodenal pacemaker potentials may not be transmitted through the staple line (6). Also remains the non-well studied problem of recanalization.

In conclusion, the video show a good technique to reconstruct the digestive tract after a gastrectomy but you may cut or not the bowel at your will.

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Footnote

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Comment on: Huang H, Long Z, Xuan Y. Uncut Roux-en-Y reconstruction after totally laparoscopic distal gastrectomy

with D2 lymph node dissection for early stage gastric cancer. J Vis Surg 2016;2:6.

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