We appreciate the thoughtful letter to the Editor regarding our article describing the steps and outcomes of performing revision of a poorly emptying gastric conduit after esophagectomy. Our study focused on the technical aspects of approaching this complex surgical situation, with less detailed descriptions of the appropriate presurgical evaluation to ensure that a potentially morbid reoperation is an appropriate management step for patients where benefits outweigh risks. We agree that the preoperative workup requires a set of relatively subjective assessments, including detailed history-taking, dynamic imaging studies, and endoscopic interventions. However, there are constant themes, even accounting for the subjectivity required to interpret the aforementioned workup, that can lead a surgeon to suspect an anatomic cause for patients’ failure to thrive. The preoperative workup is best conducted by the surgeon who performed the index operation and who has intimate knowledge of the re-created gastrointestinal configuration. The significance of having reliable and long-term follow-up with patients postesophagectomy cannot be understated.

The letter’s author has brought up many important things to consider when postesophagectomy patients have issues with resuming an oral diet after surgery. We agree that many factors can influence a patient’s upper gastrointestinal function after esophagogastrectomy, and that reoperation cannot and will not address all of them. However, we urge the author, as well as all surgeons, to always keep in mind that the postsurgical anatomic configuration can also play a role, often with no medical or endoscopic options that can provide adequate palliation. Simply assuming that the inherent physiologic changes that occur after an esophagectomy are responsible for poor oral intake, regurgitation, or aspiration can lead to prolonged and ultimately unnecessary patient suffering, as we observed in 2 of the patients in the series who underwent surgery at other facilities and then were no longer followed by their original esophagectomy surgeon despite never actually being able to eat postsurgery.

Although our study included a relatively small sample size, it is pertinent to remember the rarity of severe conduit complications, evidenced by the fact that the existing literature mostly consists of case series of individual patients. There is a wide range of postoperative dysphagia presentations after esophagectomy and we focused solely on the most complicated patients. The patients we described experienced recurrent hospitalizations secondary to aspiration and delayed gastric emptying, and some were completely dependent on tube feeding, which not only worsens quality of life, but places a huge cost burden on both the patient and the health care system at large. Therefore, although we agree with the letter’s author that considering whether or not symptom severity warrants a major reoperation is critically important to optimizing a patient’s care, we also urge all esophageal surgeons to always consider that surgical revision may be necessary for some patients with poor gastric emptying due to postoperative anatomic issues.

Lye-Yeng Wong, MD
Mark F. Berry, MD
Department of Cardiothoracic Surgery
Stanford University Medical Center
Stanford, Calif

Conflict of Interest Statement
The authors reported no conflicts of interest.

The Journal policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

https://doi.org/10.1016/j.xjtc.2024.01.011