Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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SURGERY FOR OBESITY AND RELATED DISEASES

Letters to the editor

Comment on: Bariatric surgery in patients with previous COVID-19 infection

We read with great interest the interesting and timely paper by Nedelcu et al. [1]. Although we share the authors' conclusions, a 4-week interval between a coronavirus disease 2019 (COVID-19) infection and bariatric surgery is probably not safe. Herein, we report 2 cases of unexpected and asymptomatic pulmonary abnormalities discovered during the preoperative assessment of patients with recent infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

The first patient was a female aged 44 years with a body mass index (BMI) of 47.7 kg/m^2 with laparoscopic adjustable gastric band scheduled for removal and conversion to 1-anastomosis gastric bypass/mini gastric bypass (OAGB/MGB). Unfortunately, the patient was diagnosed with a COVID-19 infection and the intervention had to be cancelled. She did not develop severe clinical symptoms (only mild fever and cough) and did not start any therapy. A nasopharyngeal swab tested negative after 10 days and she was rescheduled for surgery after an interval of 2 months. A preoperative chest computed tomography (CT) angiography (Fig. 1) showed sequelae of bilateral pneumonia with ground glass opacities; a CT with ventilation/perfusion scintigraphy demonstrated multiple areas of hypoperfusion bilaterally (Fig. 2) with signs of thromboembolism.

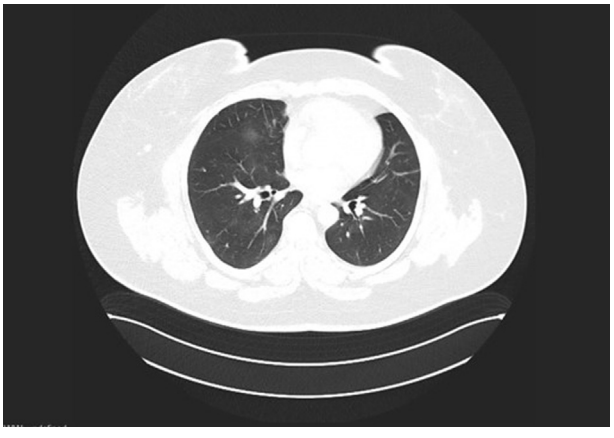

Fig. 1. Preoperative chest computed tomography angiography of patient number 1.

The second case was a male patient aged 46 years with a BMI of 60.8 kg/m^2 scheduled for an OAGB/MGB. The patient had a COVID-19 infection 3 months before the planned surgery, with bilateral pneumonia requiring oxygen therapy and azithromycin by mouth. However, admission to a hospital was not required. Symptoms resolved in 10 days and a nasopharyngeal swab tested negative after 20 days. The subject was rescheduled for surgery at 3 months after complete recovery, but a preoperative chest CT showed residual bilateral abnormalities.

Even if 30-day morbidity and mortality rates following bariatric surgery did not change during the COVID-19 epidemic [2], asymptomatic patients may present focal unilateral or diffuse bilateral opacities that progress within 1–3 weeks.

Patients with a recent history of symptomatic or asymptomatic COVID-19 infection that are scheduled for bariatric surgery should undergo a full preoperative pulmonary evaluation with chest CT angiography [3]. Adequate therapy with low–molecular weight heparin is recommended to avoid risks of intraoperative desaturation and postoperative thromboembolism.

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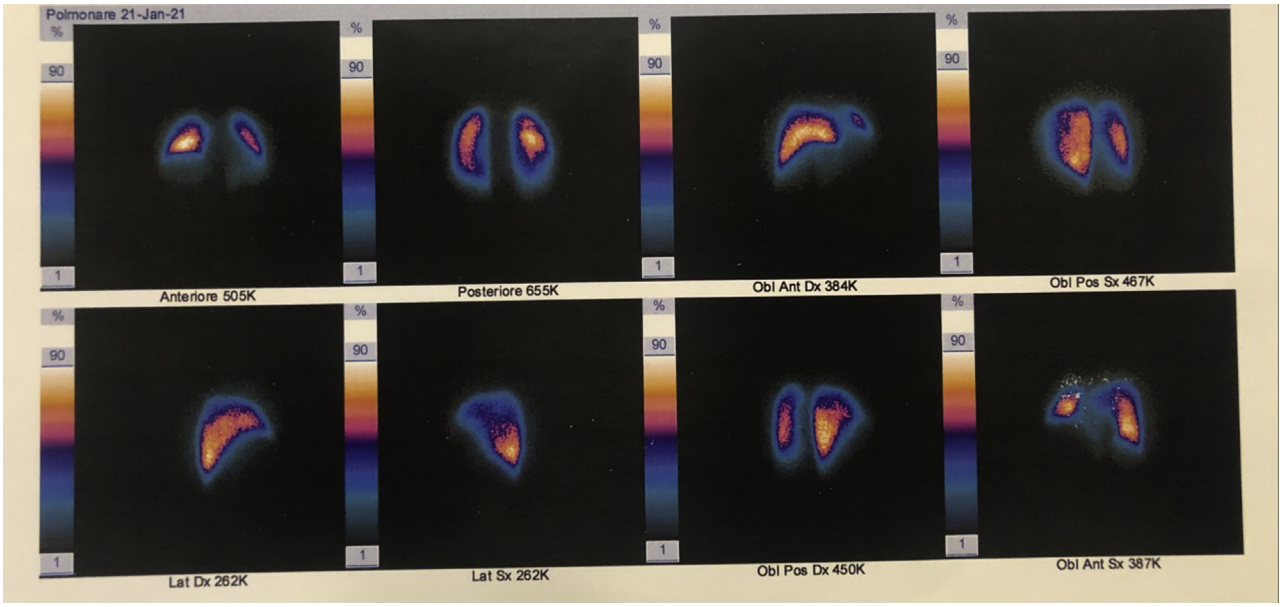

Fig. 2. Preoperative computed tomography with ventilation/perfusion scintigraphy of patient number 1.

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When to perform bariatric surgery after COVID-19 infection

In the current letter [1], the authors reported 2 cases of patients with previous COVID-19 infection scheduled for bariatric surgery, as a reply to our initial manuscript [2]. They should be commended for inciting bariatric professionals to progress in order to better address the history of COVID and future bariatric surgery, but their letter is lacking important information about these 2 cases, especially regarding their clinical status and preoperative pulmonary functional tests. The attitude against this COVID-19 pandemic was distinctive among different countries at different periods for the last 15 months. However, a patient with bilateral pneumonia who requires oxygen therapy and azithromycin per os but not hospitalization should alert us during bariatric preoperative work-up. The authors' letter suggest that this was a benign evolution (with no need of hospitalization) of the COVID -19 infection, which is highly debatable in a case with azithromycin and oxygen therapy.

Our main criticism of the Vitiello et al. letter [1] is related to a presumed recommendation of our manuscript supports a 4-week interval between the infection and bariatric surgery. Vitiello et al. have misunderstood our conclusion and completely neglect our use of the term "minor." Our manuscript [2] reported 35 patients who underwent different procedures of bariatric surgery after previous COVID-19 infection. We remind the authors that the mean interval time from COVID infection to the bariatric surgery in our manuscript was of 11.3 weeks (3–34 wk) and not 4 weeks. The purpose of our current letter is to explain better the interval between COVID-19 infection and bariatric surgery. The management should be different for completely asymptomatic cases and the 2 cases reported in your letter that could not be considered minor cases (azithromycin and oxygen therapy). For such cases, equally in our practice, bariatric surgery would be performed after a longer period and further investigations (e.g., CT scan or pulmonary functional tests) which should be considered mandatory. It is legitimate for any bariatric team to propose these new tools which should also be evaluated in larger prospective clinical trials.