



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.

Moreover, the current letter does not report any bariatric surgery with outcome analysis. Did the authors operate on these 2 patients? After which interval, and what are the recorded outcomes? We considered that this type of information was essential for the initial letter. The authors are to be commended for reporting these 2 clinical cases, but the relation with our previous manuscript is extremely limited.

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Comment on: Sleeve gastrectomy versus Roux-En-Y gastric bypass in patients aged ≥ 65 years: a comparison of short-term outcomes

We read with great interest the results of the study “Sleeve Gastrectomy versus Roux-en-Y Gastric Bypass in Patients Aged ≥ 65 years: A Comparison of Short-term Outcomes” [1]. This represents one of the largest sample sizes from a single center comparing the outcomes of SG and RYGB in elderly patients. Previous publications focusing on this population were limited mainly by small series or databases from administrative data. The authors included 565 patients, representing 22.7% of the number of bariatric surgeries in their institution, and reported surgical complications and clinical outcomes up to 24 months of follow up.

The authors had a surprisingly similar rate of SG (43.1%, $n = 244$) and RYGB (56.8%, $n = 321$), despite a growing preference for SG by the American surgeons, where RYGB represented only 17.8% of the estimated number of bariatric surgeries in 2019 [2]. Although there was a difference in preoperative BMI between groups (40.5 ± 5.5 for