Invited Commentary to 'Reflux Gastritis', pp. 5-16

The paper of Rheault et al. is of considerable value because it reviews important pathophysiological events and diagnostic criteria and discusses reoperation techniques for alkaline reflux gastritis. Despite a lot of effort for many years our understanding of the pathophysiological events leading to the reflux syndrome remains incomplete. This paper gives a precise description of the physiopathological background of alkaline reflux gastritis. The clinical appearance is discussed and also the importance of psychiatric evaluation for the assessment of gastrointestinal disorders associated with the syndrome is shown. With respect to treatment the authors point out that a conservative approach is seldom successful. This is supported by the experience of Malagelada et al. [1985]. Surgical treatment with diversion of intestinal contents as the offending agent shows good results in a lot of studies. But it must be emphasized that long-term clinical outcome often demonstrates a limited effect of reflux-free reconstructive surgery. Prospective studies from Malagelada et al. [1985] and Ritchie [1986] pointed out that symptoms often reoccur and the number of patients with Visick I and II grading is reduced after a longer period of postoperative observation.

In concordance with current opinions the authors believe that gastric emptying plays an important role in reflux gastritis and the outcome of surgical reintervention. But this subject should be discussed in more detail. Recently Mackie et al. [1986] showed that bile vomiting may be a result of delayed gastric emptying. On the other hand, Pellegrini et al. [1985] stated that patients with alkaline reflux gastritis have no single emptying pattern and Roux-en-Y conversion may also result in fast, normal or delayed gastric emptying of solids. Nevertheless, it has to be emphasized that different surgical procedures have different emptying characteristics at least in the animal experiment. Emptying of fluids is always fast in a resected stomach. But emptying of solids depends strongly on the anastomized intestinal loop. The more distal the loop, the more impaired is the emptying rate, especially when the intestine is completely transected and proximal pacemakers are excluded. Therefore, in a patient with alkaline reflux gastritis Roux-en-Y conversion may solve the problem of bile vomiting but produce gastric stasis and bezoar development.

Another important fact which has been completely ignored by the authors is that reflux-preventing procedures are principally ulcer-prone. Frequency of recurrent ulcer after Roux-en-Y conversion is about 2- to 4-fold higher than after Billroth procedures. The incidence of recurrent ulcers is directly correlated to the length of the loop, i.e. the amount of alkaline reflux [Arlt, 1984]. According to this observation some reflux is necessary to prevent ulcer recurrence. These experimental data are in good accordance with clinical studies by Ritchie [1986]. They showed that a low pH in reflux-free gastric remnants may lead to recurrent ulceration.

Long-term postoperative studies show that after bile diversion symptoms reoccur. The histologic appearance of the gastric mucosa is unchanged after bile diversion [Malagelada et al., 1985].

This surgical procedure cures from bile vomiting but creates another problem: ulcer recurrence. Some new and important results are not presented in this paper but a guidance through the controversial discussion on diagnosis and therapy of alkaline reflux gastritis is given.

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