Response:

We thank Kountouras et al[1] for their interest in and comment on our study.[2] We understand and appreciate the authors' opinion with regard to *Helicobacter pylori*–related metabolic syndrome and the fact that *H pylori* infection is common in patients with obesity. A sample of 227 patients who underwent EGD before bariatric surgery found *H pylori* in 27% of patiets.[3] Several studies have suggested that *H pylori* does not affect laparoscopic sleeve gastrectomy (LSG) perioperative outcomes or postoperative weight loss.[4] Additionally, a large study by Abu Abeid et al[5] showed that *H pylori* eradication does not change the postoperative course. However, LSG may lead to eradication of *H pylori*.[6] For those reasons, we believe that assessing for the presence of *H pylori* in asymptomatic candidates before LSG is unnecessary and would only add cost and patient discomfort. It is also worth noting that the American Society for Metabolic and Bariatric Surgery care pathway for LSG states that *H pylori* testing should be performed only at the discretion of the provider and based on patient history.[7] Accordingly, our propensity score–matched comparative study did not assess *H pylori* before or after LSG or endoscopic sleeve gastroplasty.[2] Further studies are warranted before a conclusion can be drawn regarding *H pylori* testing in patients undergoing endoscopic gastroplasty.

DISCLOSURE

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Influence of learning curve and perioperative factors on the clinical success of gastric peroral endoscopic myotomy

To the Editor:

We read with interest the article by Hernández Mondragón et al[1] presenting the long-term outcomes of gastric peroral endoscopic myotomy (G-POEM) for refractory gastroparesis. They identified diabetic gastroparesis, diagnosis <24 months, nausea/vomiting symptoms, Gastroparesis Cardinal Symptom Index of 1.5 to 2.5 at 6 months, and a retention percentage at 4 hours <10% at 6 months as significant predictors of long-term success.[1] However, we would like to highlight certain points related to this study.

First, it should be highlighted that the G-POEM learning curve is critical for successful clinical outcomes but was not considered in the predictive model of this study. G-POEM is a technically challenging endoscopic procedure with a specific learning curve,[2] but there are limited data for the G-POEM learning curve. A comparable treatment, peroral endoscopic myotomy (POEM), has been widely studied. Teitelbaum et al[3] found a negative correlation between case numbers and post-POEM outcomes, demonstrating that the operator's learning curve was a key predictor of clinical success. Thus, the learning curve should be considered for predicting the clinical outcomes of G-POEM.

Second, it should be mentioned that perioperative parameters crucial for successful clinical outcomes, such as intraprocedural adverse events, tunnel length, and total procedure time, were not included in this predictive model. Liu et al[4] conducted a study to create a risk-scoring system, which enrolled several perioperative factors such as intraoperative injury, operation time, and adverse events to predict POEM outcomes, indicating that intraprocedural mucosal injury was a risk factor for clinical failure. These similar parameters should also be analyzed in the study by Hernández Mondragón et al.[1]

Even though we may not yet have found a crystal ball to anticipate G-POEM outcomes, the authors of this study deserve our congratulations for their efforts in building a prediction model for the clinical success of G-POEM and for giving a foundation for further prospective work.

DISCLOSURE

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