

Diagnostic value of routine preoperative esophagogastroduodenoscopy and concordance with sleeve gastrectomy specimen histopathology: a single-center retrospective study

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ABSTRACT

Aims: The role of routine preoperative esophagogastroduodenoscopy (EGD) before laparoscopic sleeve gastrectomy (LSG) remains controversial. Although EGD may identify clinically relevant pathology that influences surgical planning, its routine use and concordance with postoperative histopathological findings continue to be debated. The aim of this study was to evaluate the diagnostic yield of preoperative EGD and its concordance with sleeve gastrectomy specimen histopathology.

Methods: This retrospective, single-center observational study included adult patients who underwent primary LSG between January 2017 and June 2025 and had both preoperative EGD (with endoscopic biopsy when performed) and postoperative sleeve gastrectomy specimen histopathology available. Preoperative endoscopic findings, endoscopic biopsy results when performed, and final specimen histopathology were analyzed descriptively to assess diagnostic yield and preoperative-postoperative concordance.

Results: A total of 305 patients were included. Preoperative EGD identified reflux esophagitis in 17.4% of patients and hiatal hernia in 3.9%. Endoscopic biopsy was performed in 37.4% of patients, with *Helicobacter pylori* (*H. pylori*) detected in 50.9% of biopsied cases. In contrast, *H. pylori* positivity in sleeve gastrectomy specimens was markedly lower (12.1%). No dysplasia or malignancy was identified in either preoperative biopsy specimens or postoperative sleeve gastrectomy specimens. Intestinal metaplasia was rare in surgical specimens (0.7%).

Conclusion: Preoperative EGD may contribute to safer surgical planning in patients undergoing LSG by identifying reflux-related pathology that can influence operative decisions. However, the rarity of high-grade premalignant or malignant lesions in this cohort does not support a universal requirement for routine EGD or postoperative histopathological examination in all patients. A selective, risk-adapted approach to preoperative EGD, together with standardized management of *H. pylori*, appears to represent a balanced strategy, while the role of specimen histopathology as a potential safety measure should be considered according to institutional patient profiles and available resources.

Keywords: Obesity, upper gastrointestinal diseases, endoscopy, *H. pylori*, gastritis, bariatric procedures

INTRODUCTION

Obesity is a major global health problem associated with substantial increases in morbidity and premature mortality.¹ Bariatric surgery is widely recognized as the most effective long-term treatment for achieving sustained weight loss and meaningful improvement in obesity-related comorbidities.^{2,3} Among bariatric procedures, laparoscopic sleeve gastrectomy (LSG) is currently the most commonly performed operation worldwide.⁴

Despite the well-established benefits of laparoscopic sleeve gastrectomy, the optimal strategy for preoperative evaluation remains a matter of ongoing debate, particularly with respect to the routine use of esophagogastroduodenoscopy (EGD). While several guidelines and expert panels advocate a selective, symptom-based approach to preoperative endoscopic assessment,⁵⁻⁷ others support routine EGD to detect clinically

relevant upper gastrointestinal pathology that may otherwise remain unrecognized and potentially influence surgical planning.⁸⁻¹⁰

The rationale for routine EGD is largely based on the reported high prevalence of upper gastrointestinal abnormalities in obese patients, even in the absence of gastrointestinal symptoms.⁶ In line with these findings, reliance on symptoms alone appears insufficient to predict endoscopic abnormalities, as a substantial proportion of asymptomatic patients are found to have gastritis, esophagitis, hiatal hernia, or *Helicobacter pylori* (*H. pylori*) infection on preoperative evaluation.^{6,11} At the same time, the majority of abnormalities detected on routine EGD are mild and infrequently lead to changes in surgical management, raising questions regarding the clinical utility and cost-effectiveness of universal screening.^{10,12}

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This debate acquires an additional, procedure-specific dimension in LSG, as the resected stomach is routinely available for histopathological evaluation. Published series have demonstrated that sleeve specimens may reveal unexpected findings, most commonly chronic gastritis, less frequently premalignant lesions such as intestinal metaplasia, and only rarely malignant pathology.^{13,14} Notably, a subset of these lesions may escape detection on preoperative endoscopy, highlighting a potential discordance between endoscopic findings and histopathological assessment of the resected specimen.^{13,14} Although upper gastrointestinal malignancies are rare among candidates for bariatric surgery, professional societies recognize the limited availability of high-quality evidence and therefore recommend an individualized approach that balances potential diagnostic benefit against procedural risks, costs, and resource utilization.^{5,10}

Given the limited number of studies directly comparing preoperative EGD findings with final sleeve gastrectomy specimen pathology in routine clinical practice, the aim of the present study was to evaluate the diagnostic value of routine preoperative EGD and its concordance with postoperative histopathological findings in a single-center cohort. By systematically analyzing endoscopic findings alongside definitive pathological results, we sought to better define the clinical yield of routine EGD and clarify its role in the preoperative assessment of patients undergoing laparoscopic sleeve gastrectomy.

METHODS

This retrospective study was reviewed and approved by the Gaziantep University Non-interventional Clinical Researches Ethics Committee (Date: 05.11.2025, Decision No: 2025/397). All procedures were carried out in accordance with the ethical rules and the principles of the Declaration of Helsinki.

This retrospective, single-center observational study was conducted at the Department of General Surgery, Gaziantep University Şahinbey Research and Training Hospital. The study population consisted of adult patients who underwent primary LSG between January 2017 and June 2025 and had both preoperative upper gastrointestinal endoscopy and postoperative sleeve gastrectomy specimen histopathology available. No sampling was performed. All consecutive patients who met the predefined eligibility criteria during the study period were included in the analysis.

Patients were included if they met all of the following criteria:

- Age between 18 and 65 years,
- Underwent primary laparoscopic sleeve gastrectomy,
- Had preoperative EGD performed,
- Had a complete postoperative sleeve gastrectomy specimen histopathology report available.

Patients were excluded if any of the following criteria were present:

- Incomplete or inaccurate clinical, endoscopic, or pathological data,
- Age <18 years or >65 years,
- Absence of preoperative EGD,

- Absence of postoperative histopathological examination of the sleeve gastrectomy specimen.

Study data were retrospectively obtained from the institutional Hospital Information Management System. Collected variables included demographic characteristics, comorbid conditions, preoperative endoscopic findings, endoscopic biopsy results when available, histopathological findings of sleeve gastrectomy specimens, and operative notes.

Preoperative upper gastrointestinal endoscopy findings were recorded for all included patients. Endoscopic biopsies were performed at the discretion of the endoscopist based on endoscopic findings. In practice, biopsies were generally obtained when visible pathological findings were present during endoscopy; however, beyond this context, no predefined or standardized biopsy protocol was applied, and biopsy decisions—including whether to assess *H. pylori* status—were made according to the individual endoscopist's clinical judgment. Patients with *H. pylori* positivity detected on preoperative endoscopic biopsy routinely received standard eradication therapy in accordance with institutional clinical practice. This management strategy represents the routine approach at our center and was applied before surgery when *H. pylori* infection was identified. All sleeve gastrectomy specimens were submitted for routine histopathological examination. Pathological assessment included evaluation for *H. pylori*, chronic and active gastritis, intestinal metaplasia, dysplasia, and malignancy.

Statistical Analysis

Data analyses were performed using IBM SPSS Statistics version 22.0 (IBM Corp., Armonk, NY, USA). The primary aim of the analysis was descriptive. Continuous variables were summarized as mean±standard deviation or median with interquartile range (IQR), depending on data distribution. Categorical variables were presented as frequencies and percentages. Endoscopic biopsy findings were analyzed only in patients who underwent biopsy, and percentages were calculated using the corresponding subgroup as the denominator. No imputation was performed for missing data. Given the descriptive nature of the study, no formal hypothesis testing or multivariable modeling was performed.

RESULTS

A total of 305 adult patients who underwent primary sleeve gastrectomy were included in the study. The cohort was predominantly female (74.1%), with a median body mass index (BMI) of 44.5 kg/m² (IQR: 7.1) and most patients classified as American Society of Anesthesiologists (ASA) physical status II–III. Detailed baseline demographic and clinical characteristics of the study population are summarized in [Table 1](#).

Preoperative EGD identified reflux esophagitis in 53 patients (17.4%). Hiatal hernia was identified in 12 patients (3.9%), and duodenogastric (alkaline) reflux in 10 patients (3.3%). Gastritis was a frequent finding, most commonly involving the antrum (182 patients, 59.7%), followed by the corpus (61 patients, 20.0%), bulbus (31 patients, 10.2%), and fundus (25 patients, 8.2%). Multiple endoscopic findings could coexist in the same patient. Erosive gastritis and/or gastric ulcer was detected in 38 patients (12.5%). Gastric polyps were identified in 6 patients (2.0%), and duodenal ulcer in 15 patients (4.9%). No

Table 1. Baseline demographic and clinical characteristics of the patients (n=305)

Variable	Value
Age, years	Median: 33 (IQR: 17); Mean±SD: 34.0±10.9; Range: 18-64
Sex	
Female	226 (74.1%)
Male	79 (25.9%)
BMI (kg/m²)	Median: 44.5 (IQR: 7.1); Mean±SD: 45.8±6.5; Range: 35.9-77.4
ASA score	
ASA I	3 (1.0%)
ASA II	85 (27.9%)
ASA III	217 (71.1%)
Smoking status	
Non-smoker	181 (59.3%)
Smoker	124 (40.7%)
Length of hospital stay, days	Median: 5 (IQR: 1); Mean±SD: 4.89±1.26; Range: 4-15
Any comorbidity, n (%)	124 (40.7%)

BMI: Body-mass index, ASA: American Society of Anesthesiologists, SD: Standard deviation, IQR: Interquartile range

fundal varices or findings suggestive of portal hypertension were observed. Endoscopic biopsy was performed in 114 patients (37.4%). Detailed preoperative endoscopic findings are presented in [Table 2](#).

Table 2. Preoperative endoscopic findings (n=305)

Endoscopic finding	n	%
Reflux esophagitis	53	17.4
Lower esophageal sphincter laxity	16	5.2
Hiatal hernia	12	3.9
Duodenogastric (alkaline) reflux	10	3.3
Antral gastritis	182	59.7
Corpus gastritis	61	20.0
Fundus gastritis	25	8.2
Bulbus gastritis	31	10.2
Erosive gastritis or gastric ulcer	38	12.5
Gastric polyp	6	2.0
Duodenal ulcer	15	4.9
Fundal varices/portal hypertension findings	0	0.0
Endoscopic biopsy performed	114	37.4

Among the 114 patients who underwent endoscopic biopsy, *H. pylori* was detected in 58 patients (50.9%). Chronic gastritis was identified in 82 patients (71.9%), while active gastritis was present in 59 patients (51.8%). Atrophic gastritis was detected in 4 patients (3.5%). Intestinal metaplasia was identified in 7 patients (6.1%). Hyperplastic polyps were identified in 2 patients (1.8%). Importantly, no dysplasia or malignancy was identified in any endoscopic biopsy specimen. Endoscopic biopsy findings are summarized in [Table 3](#).

Histopathological evaluation of sleeve gastrectomy specimens was available for all 305 patients. *H. pylori* positivity was identified in 37 specimens (12.1%). Chronic gastritis was observed in 145 patients (47.5%), whereas active inflammation was present in 17 patients (5.6%). Intestinal metaplasia was

Table 3. Endoscopic biopsy findings (n=114)

Variable	Value
Endoscopic biopsy performed	114 (37.4%)
<i>Helicobacter pylori</i> positivity	58 (50.9%)
Chronic gastritis	82 (71.9%)
Active gastritis	59 (51.8%)
Atrophic gastritis	4 (3.5%)
Intestinal metaplasia	7 (6.1%)
Malignancy	0 (0.0%)
Dysplasia (any grade)	0 (0.0%)
Polyp type: hyperplastic	2 (1.8%)

detected in 2 specimens (0.7%). No cases of atrophic gastritis, dysplasia, polyp, neoplasia, or malignancy were identified in any surgical specimen. Lymphoid aggregates were observed in 4 patients (1.3%). Specimen pathology findings are detailed in [Table 4](#).

Table 4. Sleeve gastrectomy specimen pathology findings (n=305)

Pathological finding	n	%
<i>Helicobacter pylori</i> positivity	37	12.1
Chronic gastritis	145	47.5
Active inflammation	17	5.6
Atrophic gastritis	0	0.0
Intestinal metaplasia	2	0.7
Dysplasia	0	0.0
Polyp/neoplasia	0	0.0
Lymphoid aggregates	4	1.3
Malignancy	0	0.0

Across the entire cohort, no dysplasia or malignancy was identified in either preoperative endoscopic biopsy specimens or sleeve gastrectomy specimens.

DISCUSSION

Although the routine versus selective use of preoperative EGD before bariatric surgery remains controversial, the clinical relevance of reflux-related pathology appears to be more pronounced in patients scheduled for sleeve gastrectomy. In the IFSO Endoscopy Task Force position statement, Brown et al.¹² report that the existing literature demonstrates a non-negligible rate of unexpected upper gastrointestinal findings even among asymptomatic patients. The authors further emphasize that a more liberal use of preoperative EGD may be justified, particularly in patients planned for sleeve gastrectomy or one-anastomosis gastric bypass, and that endoscopic surveillance at defined intervals after sleeve gastrectomy should be considered. In our own series, the presence of hiatal hernia and esophagitis in our cohort supports the notion that the absence of symptoms does not reliably exclude clinically relevant pathology. These findings suggest that, at least in candidates for sleeve gastrectomy, preoperative EGD may provide clinically relevant information by informing surgical decision-making and guiding concomitant interventions, such as hiatal hernia repair or preoperative medical optimization.

The shared rationale of studies supporting routine preoperative EGD is the potential to identify clinically relevant

findings that may influence surgical decision-making even in asymptomatic patients, while symptom-based selection alone may fail to detect certain important lesions. Chang et al.¹⁵ reported that routine preoperative upper gastrointestinal endoscopy resulted in a change in the planned surgical procedure in 18.4% of patients. When Barrett's esophagus was identified, the choice of bariatric procedure was frequently influenced in favor of gastric bypass rather than sleeve gastrectomy. Importantly, the authors also demonstrated that symptom-based screening alone may fail to detect Barrett's esophagus, as its prevalence did not differ significantly between symptomatic and asymptomatic patients. Similarly, Praveenraj et al.¹⁶ showed that although routine preoperative endoscopy did not alter the planned bariatric procedure in the majority of cases, it led to postponement of surgery or a change in surgical approach in approximately 11-12% of patients. Owing to the lack of correlation between symptoms and clinically meaningful endoscopic findings, the authors suggested that a routine preoperative endoscopic evaluation may be considered even in the absence of symptoms. Taken together, this body of evidence helps contextualize clinical decision-making, particularly in candidates for sleeve gastrectomy, in whom reflux-related pathology and Barrett's esophagus remain clinically relevant considerations.

Conversely, studies supporting a selective approach emphasize that even when the prevalence of endoscopic findings is relatively high, the proportion of lesions that meaningfully alter clinical management may remain limited, with considerations of resource utilization becoming increasingly relevant. Salama et al.¹⁷ emphasized that in large LSG series, routine preoperative esophagogastroduodenoscopy (EGD) did not alter surgical management in the vast majority of asymptomatic patients, while its clinical impact appeared to be mainly confined to symptomatic patients or specific subgroups. The authors also highlighted that upper gastrointestinal malignancy was exceedingly rare in this setting.

Similarly, in an adolescent and young adult population, Ogle et al.¹⁸ reported that routine preoperative EGD most commonly revealed normal or only mild abnormalities, with findings rarely leading to changes in surgical or medical management. Based on the low yield of clinically actionable pathology in this age group, the authors suggested that a selective preoperative endoscopic approach may be more rational than routine screening. Elkin et al.¹⁴ reported that clinically significant gastric pathology may be identified on bariatric surgical specimens. Taken together with the broader literature, these observations suggest that the identification of such findings alone does not necessarily justify universal routine preoperative EGD for all patients, but rather supports the consideration of individualized, risk-based selective strategies. In parallel, Zidan et al.¹⁹ highlighted that real-world EGD utilization is often selective and may be influenced by institutional and economic constraints. From this perspective, our findings-demonstrating the absence of malignancy or dysplasia and a very low burden of premalignant lesions-appear to be consistent with such selective practice patterns.

The ability of preoperative endoscopy to anticipate reflux-related outcomes after sleeve gastrectomy represents a distinct area of discussion. Bellorin et al.²⁰ reported that approximately 17% of patients developed gastroesophageal reflux disease (GERD) after primary sleeve gastrectomy and

demonstrated that esophagitis identified on preoperative endoscopy-including in asymptomatic patients-was an independent predictor of postoperative GERD. The authors further emphasized that symptom-based selection alone may fail to identify patients at increased risk. This key message underscores that preoperative EGD may serve not only to detect malignant pathology but also to facilitate a more informed preoperative risk stratification and management of post-sleeve reflux risk. In line with this perspective, the observed prevalence of esophagitis and the presence of hiatal hernia in our cohort further supports the potential clinical value of EGD, when considered in the context of sleeve gastrectomy suitability and concomitant operative planning.

Heiat et al.²¹ compared preoperative endoscopic biopsy histopathology with postoperative sleeve gastrectomy specimens and reported that the negative predictive value of preoperative EGD for detecting *H. pylori* infection, gastritis, metaplasia, and atrophy was 95%, 79%, 93%, and 98%, respectively. However, when all pathological entities were considered together, the overall negative predictive value declined to 53.4%. Notably, moderate gastritis and focal intestinal metaplasia were significantly underdiagnosed on preoperative assessment ($p < 0.001$), highlighting that even when endoscopy is performed preoperatively, inherent sampling limitations and the patchy distribution of gastric mucosal pathology may lead to missed inflammatory or focal premalignant changes.

In a large single-center series, Owen et al.²² reported that 5.4% of patients undergoing sleeve gastrectomy exhibited clinically significant or potentially clinically significant postoperative pathological findings, excluding *H. pylori*. Autoimmune metaplastic atrophic gastritis (AMAG) was identified in 2.3% of patients, a notable finding given its association with a 3-5-fold increased risk of gastric cancer. Importantly, all cases of AMAG and intestinal metaplasia that were diagnosed preoperatively were identified through gastric body biopsies, indicating that antral-only sampling may be insufficient to detect selected premalignant conditions. Furthermore, the lack of preoperative detection of submucosal lesions, including gastrointestinal stromal tumors and gastric adenocarcinoma, supports the view that postoperative histopathological examination of the sleeve specimen may serve as an additional diagnostic safeguard, particularly in settings where preoperative endoscopic evaluation or biopsy sampling is limited.

The clinical value of routine postoperative histopathological examination has largely been discussed in the context of rare but potentially high-impact findings. Alessandris et al.¹³ reported an incidental neoplasia rate of 2.4% in a consecutive series of 501 sleeve gastrectomy patients, with a substantial proportion of these lesions being detected exclusively on specimen histopathology rather than on preoperative endoscopy. Taken together, these observations suggest that the combined use of preoperative upper gastrointestinal endoscopy and postoperative histopathological examination may represent a more comprehensive strategy to minimize the risk of missed clinically relevant pathology, particularly in the setting of lesions that may escape detection during preoperative assessment. Similarly, Di Palma et al.²³ demonstrated that while many sleeve gastrectomy specimens show no clinically significant abnormalities, a small but clinically meaningful subset harbors unexpected histopathological findings that

require changes in postoperative management or follow-up. Importantly, although a selective preoperative endoscopic approach was associated with a lower proportion of such unexpected diagnoses, it did not completely eliminate them, highlighting that postoperative histopathological examination of the sleeve specimen may retain residual diagnostic value even when preoperative endoscopy is selectively applied.

Against this background, our findings indicate that while postoperative histopathological examination of sleeve gastrectomy specimens may provide an additional diagnostic safeguard—particularly for rare or submucosal lesions that can escape preoperative assessment—the overall clinical yield of actionable pathology appears limited in routine practice. In our cohort, no malignancy or dysplasia was identified, suggesting that the incremental diagnostic benefit of routine postoperative histopathology may be modest in unselected sleeve gastrectomy populations. These results support a balanced interpretation in which postoperative specimen analysis is recognized as a complementary, rather than universally mandatory, component of pathological evaluation, particularly when preoperative endoscopy and clinical assessment are selectively and appropriately applied.

Conversely, a large single-center series from a high-volume United Kingdom bariatric unit, together with a contemporaneous systematic review, suggests that the clinical yield of routine histopathological examination may be limited, particularly in LSG specimens that appear macroscopically normal. In this cohort, no pathological abnormality was identified on histology in 90.4% of 404 sleeve gastrectomy specimens, and even within the small subset of macroscopically normal specimens harboring incidental pathology (approximately 2-3%), no changes in patient management were observed. Furthermore, the accompanying systematic review encompassing 26,670 patients published between 2013 and 2023 demonstrated exceedingly low rates of rare malignancy, with comparable prevalences of incidental pathology between series that did and did not perform routine preoperative endoscopy. Based on these findings, the authors recommended a selective histopathological approach limited to specimens demonstrating macroscopic abnormalities.²⁴

In contrast, the absence of dysplasia or malignancy in our own series suggests that the clinical yield of routine postoperative histopathological examination may vary according to each institution's patient profile and pathological assessment protocols. Accordingly, conclusions should be framed within a balanced perspective rather than as a mandate for universal routine practice. Although neoplastic findings are rare, their potential clinical impact when missed is substantial; therefore, decisions regarding routine histopathological evaluation should be considered in conjunction with local risk profiles, patient age distribution, access to preoperative endoscopy, and the associated pathological workload and cost.

From the perspective of *H. pylori* infection and inflammatory findings, our data highlight an important practical consideration. While the prevalence of *H. pylori* positivity was relatively high in the preoperative biopsy group, this rate declined markedly in postoperative sleeve gastrectomy specimens. Di Palma et al.²⁵ reported that preoperative *H. pylori* screening and eradication reduced the prevalence of *H. pylori* detected in sleeve gastrectomy specimens; however, this strategy did not significantly influence postoperative

morbidity. The authors further suggested that the routine clinical value of preoperative *H. pylori* screening may be limited, particularly in asymptomatic patients undergoing laparoscopic sleeve gastrectomy.

Similarly, in a small prospective series, Onzi et al.²⁶ observed no increase in gastric mucosal inflammation in the early period following sleeve gastrectomy. Instead, a trend toward improvement in inflammatory patterns was noted, which the authors suggested may be related, at least in part, to preoperative *H. pylori* eradication rather than to the surgical procedure itself. In our series, the pronounced difference between preoperative and postoperative *H. pylori* detection underscores that preoperative treatment and eradication strategies can directly influence histopathological concordance and the interpretation of follow-up findings. Accordingly, when inflammatory changes are used to assess preoperative-postoperative agreement or discordance, the impact of clinical management—particularly the administration of eradication therapy—should be explicitly taken into account.

When considered together, our findings point to two key clinical messages. First, preoperative EGD may enhance the safety of surgical planning—particularly in patients scheduled for sleeve gastrectomy—by identifying lesions such as reflux-related pathology, hiatal hernia, or esophagitis. This perspective is consistent with the IFSO position statement¹² as well as with series highlighting Barrett's esophagus and associated changes in surgical strategy.¹⁵

Second, the near absence of high-grade premalignant or malignant lesions in our cohort, together with their absence in resection specimens, does not in itself necessarily support a mandate for universal routine EGD or histopathological examination for all patients. A more pragmatic approach may involve a liberal yet selective EGD strategy in sleeve-dominant practice—one that clarifies indications based on risk profile, age, symptoms, endoscopic appearance, and biopsy criteria—alongside standardized management of *H. pylori*. Finally, given that rare neoplasms detectable only on specimen histopathology have been reported in the literature,¹³ the role of specimen examination as a potential “safety net” should be discussed in the context of each institution's patient profile.

Limitations

Several limitations of this study should be acknowledged. First, the single-center design may limit the generalizability of the findings to other institutions with different patient profiles, endoscopic practices, or pathological assessment protocols. Second, preoperative endoscopic biopsy was not performed in all patients, which may have resulted in histological prevalence estimates reflecting a selected patient population rather than the entire cohort, and the selective nature of preoperative biopsy sampling and the inherent methodological differences between focal endoscopic biopsies and whole sleeve gastrectomy specimens may have contributed to the observed discrepancies in inflammatory findings and *H. pylori* prevalence. Third, beyond sampling-related limitations, inflammatory findings identified preoperatively were frequently managed before surgery—most notably through *H. pylori* eradication—which inherently affects preoperative-postoperative histopathological concordance and limits direct comparability between biopsy and resection specimens. Accordingly, analyses based on inflammation-related parameters cannot be interpreted independently

of clinical interventions. Finally, the limited availability of long-term postoperative reflux symptoms and endoscopic follow-up data restricts a comprehensive assessment of the impact of preoperative EGD findings on long-term clinical outcomes. These limitations highlight the need for future prospective studies with standardized preoperative protocols and extended follow-up to further clarify the optimal role of endoscopic and histopathological evaluation in sleeve gastrectomy practice.

CONCLUSION

In conclusion, preoperative EGD may meaningfully support surgical planning in patients undergoing sleeve gastrectomy by identifying reflux-related pathology, including hiatal hernia and esophagitis, that can influence operative decisions. At the same time, the near absence of high-grade premalignant or malignant lesions in our cohort—both preoperatively and in resection specimens—does not justify a universal requirement for routine EGD or postoperative histopathological examination in all patients. A pragmatic approach favoring liberal yet selective use of preoperative EGD, guided by individual risk factors, age, symptoms, endoscopic appearance, and clearly defined biopsy indications, together with standardized management of *H. pylori*, appears more appropriate. Given that rare neoplasms detectable only on specimen histopathology have been reported, the role of postoperative specimen examination as a potential safety measure should be considered in the context of institutional patient profiles and available resources.

ETHICAL DECLARATIONS

Ethics Committee Approval

This study has been reviewed and approved by the Gaziantep University Non-interventional Clinical Researches Ethics Committee (Date: 05.11.2025, Decision No: 2025/397).

Informed Consent

As this was a retrospective study, formal written informed consent was not required and was therefore not obtained.

Peer Review Process

This manuscript was subject to external peer review.

Conflict of Interest

The authors declare no conflicts of interest related to this study.

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Author Contributions

Author contributions: L.Y., A.A., İ.B.; Design: L.Y.; Data collection and/or processing: L.Y.; Analysis and/or interpretation: L.Y.; Literature review: L.Y., A.A.; Article writing: L.Y.; Critical review: All authors.

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