

Table 3 Endorsed statements

	Responses	Strongly Agree (A)	Agree (B)	All positive (A+B)	Neutral	All negative (C+D)	Disagree (C)	Strongly disagree (D)
Definitions								
• Information regarding symptoms of failure is more useful in determining management after previous fundoplication than use of the all-encompassing term 'failed fundoplication', as recommended treatments will differ according to symptoms	27	48%	48%	96%	0%	4%	4%	0%
• Patients should have their management directed towards symptoms. (For example, the diagnosis of recurrent heartburn after fundoplication will guide management more than simply the presence of a recurrent hiatal hernia.)	27	63%	30%	93%	7%	0%	0%	0%
• The goal of treatment is resolution of the patient's symptoms and not necessarily normalization of physiologic or anatomic parameters.	27	48%	33%	81%	11%	7%	7%	0%
• The goal of fundoplication of is an excellent anatomic result and normalization of physiologic parameters.	23	30%	65%	96%	4%	0%	0%	0%
• Some symptoms result from common side-effects of fundoplication even though surgical anatomic outcomes are acceptable, such as nausea, bloating and rectal flatulence	27	33%	56%	89%	4%	7%	4%	4%
• Some troublesome postfundoplication symptoms may persist from preoperatively and may not necessarily be related to the fundoplication, e.g., cough, burning in throat	27	48%	44%	93%	4%	4%	0%	4%
• Many cases of troublesome symptoms after fundoplication arise due to underestimated malfunctions which existed prior to surgery.	33	21%	64%	85%	0%	15%	15%	0%
• Anatomical problems (for example, hiatal hernia, tight hiatus) are not necessarily the cause of all postfundoplication symptoms.	31	32%	65%	97%	0%	3%	3%	0%
Investigations								
• Investigations should be guided by the presenting complaint	27	59%	41%	100%	0%	0%	0%	0%
• The investigation of symptoms after previous fundoplication is a complex undertaking which should only be undertaken at centers offering access to the full range of options (including esophageal manometry, contrast esophagram, endoscopy) and which include experienced clinicians.	32	84%	16%	100%	0%	0%	0%	0%
• There are some diagnostic investigations which are universally required to be performed for every symptomatic patient with problematic symptoms after previous fundoplication	27	41%	41%	81%	15%	4%	4%	0%
• Common bloating side-effects of fundoplication are common in the postoperative period, and therefore investigation thereof should not occur until three months postoperatively.	32	41%	53%	94%	0%	6%	6%	0%
Dysphagia								
• Investigation of mild dysphagia (defined as able eat a normal diet or at least able to swallow some solid or pureed food) requires contrast imaging, either contrast esophagram or CT with oral contrast, prior to re-intervention	27	41%	48%	89%	4%	7%	4%	4%
• Mild dysphagia (still able eat a normal diet or at least able to swallow some solid or pureed food) is common after fundoplication and therefore investigation thereof should not occur until three months postoperatively	23	43%	52%	96%	4%	0%	0%	0%

(Continued)

Table 3 Continued

Responses	Strongly Agree (A)	Agree (B)	All positive (A + B)	Neutral	All negative (C + D)	Disagree (C)	Strongly disagree (D)
<ul style="list-style-type: none"> Mild dysphagia (defined as able eat a normal diet or at least able to swallow some solid or pureed food) should always be investigated with either endoscopy and/or contrast imaging (either contrast esophagram or CT with oral contrast) prior to re-intervention Mild dysphagia (defined as able eat a normal diet or at least able to swallow some solid or pureed food) should always be investigated with endoscopy prior to re-intervention. Severe dysphagia (unable to swallow anything) must always be investigated within 24 h of report Severe postfundoplication dysphagia (defined unable to swallow anything) at any time, always requires endoscopy Endoscopic esophageal dilatation may be attempted before revisional surgery is considered to treat severe dysphagia (defined as unable to swallow anything) The investigation and management of symptoms after transoral incisionless fundoplication (TIF and TIF 2.0) should be identical to the investigation and management of symptoms after laparoscopic fundoplication Prior to undertaking further investigation of the postfundoplication patient, the patient's preoperative history and preoperative investigations should be reviewed 	32	56%	28%	84%	0%	16%	0%
<ul style="list-style-type: none"> Heartburn symptoms in a postfundoplication patient should not be investigated until three months postoperatively. Acid suppressant medications should be trialed prior to investigating postfundoplication heartburn Investigation of postfundoplication heartburn requires endoscopy prior to re-intervention Investigation of postfundoplication heartburn requires pH testing (capsule or wireless), prior to re-intervention Postfundoplication heartburn should always be investigated with either endoscopy and/or contrast imaging (either contrast esophagram or CT with oral contrast) prior to re-intervention. If re-operation is being considered for postfundoplication heartburn, then esophageal manometry must be performed now (even if it was performed before the original fundoplication operation). Reoperation for heartburn and abnormal pH-metry does not also require multichannel intraluminal impedance assessment prior to re-intervention. Endoscopic delivery of radiofrequency energy to the gastro-esophageal junction (Stretta) is not an acceptable treatment for postfundoplication heartburn. 	32	25%	63%	88%	0%	13%	0%
<ul style="list-style-type: none"> Revisional surgery Revisional fundoplication must be performed in a high-volume center At revisional fundoplication, the wrap should be tailored to preoperative symptoms. After two previous fundoplication operations, it is sometimes acceptable to re-attempt another fundoplication at the third operation (that is, three fundoplications in total). It is not reasonable to consider magnetic sphincter augmentation as the reoperation of choice when reoperating to address dysphagia after previous fundoplication. 	27	59%	33%	93%	7%	0%	0%
	31	29%	52%	81%	0%	19%	0%
	31	16%	74%	90%	0%	10%	0%
	31	58%	35%	94%	0%	3%	3%

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