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Press review

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Takahashi H, Okabayashi K, Tsuruta M, et al. Self-expanding metallic stents versus surgical intervention as palliative therapy for obstructive colorectal cancer: a meta-analysis. *World J Surg* 2015;39:2037–2044. doi:10.1007/s00268-015-3068-7

Background

Although self-expanding metallic stents (SEMS) are useful tools for relieving large bowel obstructions in patients with colorectal cancer (CRC), their efficacy in a palliative setting has not been validated. This meta-analysis aimed to evaluate the feasibility of SEMS as a palliation for unresectable CRC patients with bowel obstructions and to determine their contribution to the prognosis of CRC, compared with surgical intervention.

Methods

We conducted a literature search of the PubMed and Cochrane Library databases. We selected all controlled trials that compared SEMS with surgical interventions as palliative treatments in unresectable obstructive CRC patients. The primary outcome was early complications, and the secondary outcomes were mortality, other morbidities, and long-term survival rates.

Results

Ten studies met our inclusion criteria. SEMS significantly reduced the risk of early complications (odds ratio [OR] 0.34; 95% confidence interval [CI] 0.20–0.58%; $P < 0.01$), mortality (OR 0.31; 95% CI 0.15–0.64%; $P < 0.01$), and stoma creation (OR 0.19; 95% CI 0.12–0.28%; $P < 0.01$). Although SEMS placement was significantly associated with a higher risk of perforation of the large bowel (OR 5.25 95% CI 2.00–13.78%; $P < 0.01$) and late complications (OR 1.94;

95% CI 0.90–4.19%; $P = 0.03$), it also contributed significantly to better long-term survival (hazard ratio 0.46; 95% CI 0.31–0.68%; $P < 0.01$).

Conclusions

Compared with surgical intervention, SEMS could provide feasible palliation for patients with bowel obstructions and unresectable CRC, because of their acceptable morbidity rates and better patient prognoses.

Comments

1. In the absence of any controlled trial, this meta-analysis, which includes all available comparative studies, is a strong argument in favor of SEMS in the palliative setting (unresectable CRC, metastasis). Of note, the well-recognized disadvantages of SEMS (tumor perforation and increased circulating cancer cells) have little if any impact on patients with unresectable/metastatic disease.
2. One possible explanation for better long-term survival might be that, thanks to decreased morbidity and mortality, SEMS allows chemotherapy to be started more rapidly in these patients. Nonetheless, in all the studies included in this meta-analysis, it is difficult to determine if the patients having had SEMS or surgery were comparable as concerns metastatic extension; therefore, caution is warranted in the interpretation of this impact on prognosis.
3. In patients with unresectable/metastatic disease, survival is certainly important. Quality of life is also relevant; however, there are scant data on this point in the meta-analysis. Of note, in practice, while SEMS has the advantage of avoiding a stoma, it can be responsible for intestinal transit disorders and chronic pain, both of which impact the quality of life of these patients who will most likely have ongoing chemotherapy until they die.

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Fuks D, Cauchy F, Ftéliche S, et al. Laparoscopy decreases pulmonary complications in patients undergoing major liver resection: a propensity score analysis. *Ann Surg* 2016;263:353–361

Objective

To compare both incidence and types of postoperative pulmonary complications (PPCs) between laparoscopic major hepatectomy (LMH) and open major hepatectomy (OMH).

Background

LMHs are increasingly performed. Yet, the benefits of laparoscopy over laparotomy regarding PPCs remain unknown.

Methods

In this multi-institutional study, all patients undergoing OMH or LMH between 1998 and 2013 were retrospectively reviewed. Risk factors for PPCs were analyzed on multivariate analysis. Comparison of both overall rate and types of PPCs between OMH and LMH patients was performed after propensity score adjustment on factors influencing the choice of the approach.

Results

LMH was performed in 226 (18.6%) of the 1214 included patients. PPCs occurred in 480 (39.5%) patients including symptomatic pleural effusion in 366 (30.1%) patients, respiratory insufficiency in 141 (11.6%), acute respiratory distress syndrome in 84 (6.9%), pulmonary infection in 80 (6.5%), and pulmonary embolism in 47 (3.8%) patients. On multivariate analysis, preoperative hypoprotidemia [hazard ratio (HR): 1.341, 95% confidence interval (CI): 1.001–1.795; $P=0.049$], open approach (HR: 2.481, 95% CI: 1.141–6.024; $P=0.024$), right-sided hepatectomy (HR: 2.143, 95% CI: 1.544–2.975; $P<0.001$), concomitant extrahepatic procedures (HR: 1.742, 95% CI: 1.103–2.750; $P=0.017$), transfusion (HR: 2.851, 95% CI: 2.067–3.935; $P<0.001$), and operative time more than 6 hours (HR: 1.510, 95% CI: 1.127–2.022; $P=0.006$) were independently associated with PPCs. After propensity score matching, the overall incidence of PPCs (13.2% vs 40.5%, $P<0.001$), symptomatic pleural effusion (11.6% vs 26.4%, $P=0.003$), pleural effusion requiring drainage (1.7% vs 9.9%, $P=0.006$), and acute respiratory distress syndrome (1.7% vs 9.9%, $P=0.006$) were significantly lower in the laparoscopy group than in the open group.

Conclusions

Pure laparoscopy allows reducing PPCs in patients requiring major liver resection.

Comments

1. This study confirms the results originating from a cohort of the French Surgical Association study, which found that operative morbidity decreased when hepatic resection for colorectal liver metastases was performed laparoscopically [1].
2. Another recent study emanating from the French DRG-based information system (PMSI) found that 14% of liver resections, irrespective of their extent or indications, were performed laparoscopically [2]. In the current study, which included only major hepatectomies, 19% had been performed laparoscopically, and the conversion rate was 13.3%. These percentages attest to the high level of expertise of the centers participating in this study and raise the question of reproducibility of outcomes.
3. From a methodological point of view, it is regrettable that the patients undergoing laparotomy in the two “laparoscopic” centers were not included. This

would have allowed to see if decreased PPC following laparoscopy was really due to laparoscopy in itself and not because of a center effect.

4. More details concerning post-operative enhanced recovery programs would have been of interest because of their non-negligible effect on the onset of PPC.

References

- [1] *Ann Surg* 2015;262:794–802.
- [2] *Ann Surg* 2014;260:916–21.

Prytz M, Angenete E, Bock D, et al. Extralevator abdominoperineal excision for low rectal cancer-extensive surgery to be used with discretion based on 3-year local recurrence results: a registry-based, observational national cohort study. *Ann Surg* 2016;263:516–521. doi:10.1097/SLA.0000000000001237

Objectives

The aim of this prospective registry-based population study was to investigate the efficacy of extralevator abdominoperineal excision (ELAPE) regarding local recurrence rates within 3 years after surgery.

Background

Local recurrence of rectal cancer is more common after abdominoperineal excision (APE) than after anterior resection. Extralevator abdominoperineal excision was introduced to address this problem. No large-scale studies with long-term oncological outcomes have been published.

Methods

All Swedish patients operated on with an APE and registered in the Swedish ColoRectal Cancer Registry 2007 to 2009 were included ($n=1397$) and analyzed with emphasis on the perineal part of the operation. Local recurrence at 3 years was collected from the registry.

Results

The local recurrence rates at 3 years [median follow-up, 3.43 years (APE, 3.37 years; ELAPE, 3.41 years; not stated: 3.43 years)] were significantly higher for ELAPE compared with APE (relative risk, 4.91). Perioperative perforation was also associated with an increased risk of local recurrence (relative risk, 3.62). There was no difference in 3-year overall survival between APE and ELAPE. In the subgroup of patients with very low tumors (≤ 4 cm from the anal verge), no significant difference in the local recurrence rate could be observed.

Conclusions

Extralevator abdominoperineal excision results in a significantly increased 3-year local recurrence rate as compared with standard APE. Intraoperative perforation seems to be an important risk factor for local recurrence. In addition to significantly increased 3-year local recurrence rates, the significantly increased incidence of wound complications leads to the conclusion that ELAPE should only be considered in selected patients at risk of intraoperative perforation.

Comments

1. Despite initial enthusiasm, the ELAPE technique has clearly lost steam. Effectively, this technique was originally thought to decrease the risk of R1 resection and intra-operative tumor perforation, which are considered the main disadvantages of standard APE [1–2]. This was confirmed by a low-powered controlled study of 67 patients [3]. Then a propensity matched cohort study found that there was no difference in local recurrence between standard APE and ELAPE [4]. Later, another Danish national cohort study found that not only did ELAPE

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