Journal of Visceral Surgery (2015) 152, 61—68

Available online at ScienceDirect www.sciencedirect.com

Elsevier Masson France EM|consulte www.em-consulte.com/en

Press review

C. Mariette[a,*], S. Benoist[b]

[a] *Service de chirurgie digestive et générale, hôpital Claude-Huriez, CHRU, place de Verdun, 59037 Lille cedex, France*
[b] *Service de chirurgie digestive, hôpital du Kremlin-Bicêtre, 78, rue du Général-Leclerc, 94275 Le Kremlin-Bicêtre, France*

Available online 31 January 2015

■ Homayounfar K, Bleckmann A, Helms HJ, et al. Discrepancies between medical oncologists and surgeons in assessment of resectability and indication for chemotherapy in patients with colorectal liver metastases. Br J Surg 2014;101:550—7. doi:10.1002/bjs.9436

Background

Multidisciplinary discussion of the treatment of patients with colorectal liver metastases (CRLM) is advocated currently. The aim of this study was to investigate medical oncologists' and surgeons' assessment of resectability and indication for chemotherapy, and the effect of an educational intervention on such assessment.

Method

Medical histories of 30 patients with CRLM were presented to 10 experienced medical oncologists and 11 surgeons at an initial virtual tumour board meeting (TB1). Treatment recommendations were obtained from each participant by voting for standardized answers. Following lectures on the potential of chemotherapy and surgery, assessment was repeated at a second virtual tumour board meeting (TB2), using the same patients and participants.

Results

Overall, 630 answers (21 × 30) were obtained per tumour board meeting. At TB1, resectability was expected more frequently by surgeons. Participants changed 56.8% of their individual answers at TB2. Assessment shifted from potentially resectable to resectable CRLM in 81 of 161 and from unresectable to (potentially) resectable CRLM in 29 of 36 answers. Preoperative chemotherapy was indicated more often by medical oncologists, and overall was included in 260 answers (41.3%) at TB1, compared with only 171 answers (27.1%) at TB2. Medical oncologists more often changed their decision to primary resection in resectable patients ($P = 0.006$). Postoperative chemotherapy was included in 51.9 and 52.4% of all answers at TB1 and TB2 respectively, with no difference in changes between medical oncologists and surgeons ($P = 0.980$).

Conclusion

Resectability and indication for preoperative chemotherapy were assessed differently by medical oncologists and surgeons. The educational intervention resulted in more patients deemed resectable by both oncologists and surgeons, and less frequent indication for chemotherapy.

Comments

1. As surgery is the only treatment with curative intent for CRLM and chemotherapy has shown its value rendering resectable approximately 30% of CRLM initially thought to be irresectable [1,2], a case-by-case discussion between surgeons, oncologists and radiologists is necessary. While multidisciplinary conferences are the ideal setting for this discussion, a study of registries has shown that some patients with resectable CRLM do not undergo the best treatment [3,4].
2. This study confirms that although, individually, the resectability and the indication for preoperative chemotherapy are judged differently by surgeons and oncologists, increasing the knowledge of both groups about the current indications increases the number of patients treated with curative intent.
3. The main explanation advanced for under-treatment is the lack of reliable means to judge the resectability of CRLM, notably according to strategies based on tumor stage.
4. As expected, resectability increased between the first and second evaluations, suggesting that both oncologists and surgeons proposed surgery more often.

* Corresponding author.
E-mail address: christophe.mariette@chru-lille.fr (C. Mariette).

1878-7886/$ — see front matter
http://dx.doi.org/10.1016/j.jviscsurg.2015.01.006

5. Of note, oncologists proposed initial surgery for resectable CRLM in 69.7% of cases for the first evaluation, and in 79.7% of cases for the second, suggesting that the absence of effect on overall survival [5] is open for discussion and should lead to further studies.

References

[1] Lancet Oncol 2010;11:38—47.
[2] J Clin Oncol 2012;(Suppl. 4): abstract 540.
[3] Int J Colorectal Dis 2011;26:1475—81.
[4] Cancer 2007;109:718—26.
[5] Lancet Oncol 2013;14:1208—15.

■ Kooby DA, Lad NL, Squires 3rd MH, et al. Value of intraoperative neck margin analysis during whipple for pancreatic adenocarcinoma: a multicenter analysis of 1399 patients. Ann Surg 2014;260:494—501. doi:10.1097/SLA.0000000000000890

Introduction

During pancreaticoduodenectomy (PD) for ductal adenocarcinoma, a frozen section (FS) neck margin is typically assessed, and if positive, additional pancreas is removed to achieve an R0 margin. We analyzed the association of this practice with improved overall survival (OS).

Methods

Patients who underwent PD for pancreatic ductal adenocarcinoma from January 2000 to August 2012 at 8 academic centers were classified by neck margin status as negative (R0) or microscopically positive (R1) on the basis of FS and permanent section (PS). Impact on OS of converting an FS-R1-neck margin to a PS-R0-neck margin by additional resection was assessed.

Results

A total of 1399 patients had FS neck margins analyzed. Median OS was 19.7 months. On FS, 152 patients (10.9%) were R1, and an additional 51 patients (3.6%) had false-negative FS-R0 margins. PS-R0-neck was achieved in 1196 patients (85.5%), 131 patients (9.3%) remained PS-R1, and 72 patients (5.1%) were converted from FS-R1-to-PS-R0 by additional resection. Median OS for PS-R0-neck patients was 21.1 months versus 13.7 months for PS-R1-neck patients ($P < 0.001$) and 11.9 months for FS-R1-to-PS-R0 patients ($P < 0.001$). Both FS-R1-to-PS-R0 and PS-R1-neck patients had larger tumors ($P = 0.001$), more perineural invasion ($P = 0.02$), and more node positivity ($P = 0.08$) than PS-R0-neck patients. On multivariate analysis controlling for adverse pathologic factors, FS-R1-to-PS-R0 conversion remained associated with significantly worse OS compared with PS-R0-neck patients (hazard ratio: 1.55; $P = 0.009$).

Conclusions

For patients who undergo pancreaticoduodenectomy for pancreatic ductal adenocarcinoma, additional resection to achieve a negative neck margin after positive frozen section is not associated with improved OS.

Comments

1. Surgery remains the best therapeutic option for pancreatic adenocarcinoma. To improve the various prognostic factors, the surgeon can extend the parenchymal resection or increase the extent of lymph node resection. This study suggests that extending the resection to obtain a clear surgical margin does not improve survival.
2. We can deduct that the R1 margin is a phenotypic marker of aggressive tumor biology, notably because it is associated with lymph node involvement in multivariate analysis.
3. While these results do not extol surgery of lesser quality, they seem to plead that R1 resection is more a marker of tumor aggressiveness rather than an indication of inadequate surgery.
4. It would have been interesting to evaluate in which situations extended resection improved survival, especially for N0 patients.

■ Maggiori L, Khayat A, Treton X, Bouhnik Y, Vicaut E, Panis Y. Laparoscopic approach for inflammatory bowel disease is a real alternative to open surgery: an experience with 574 consecutive patients. Ann Surg 2014;260:305—10. doi:10.1097/SLA.0000000000000534

Objective

This study aimed to report a 14-year experience of laparoscopic approach for inflammatory bowel disease (IBD), including complicated and recurrent cases.

Background

Feasibility of laparoscopic approach for IBD surgical management has been questioned.

Methods

From 1998 to 2012, all patients undergoing colorectal resection for IBD were prospectively enrolled. Adjusted risks of conversion and severe postoperative morbidity after laparoscopic resection were computed, according to a multivariate regression logistic model.

Results

A total of 790 consecutive resections for IBD were performed on 633 patients. Laparoscopic approach was performed in 574 (73%) procedures, including 286 ileocecal resections (48%), 118 subtotal colectomies (19%), 134 ileal pouch-anal anastomoses (21%), 23 segmental colectomies (8%), and 18 abdominoperineal resections (4%). A total of 145 (25%) complex laparoscopic procedures were performed, considered as such because of iterative surgery for IBD recurrence ($n = 66$, 12%) or because of intra-abdominal-abscess or fistula ($n = 93$, 16%). Conversion to laparotomy occurred in 67 procedures (12%). Postoperative death occurred in 1 patient (0.2%). Severe postoperative morbidity occurred in 66 laparoscopic procedures (13%). Splitting the study in 5 time periods, the rate of laparoscopic procedures significantly increased from 42% in period 1 to 80% in period 5 ($P < 0.001$). With time, the rate of complex procedures performed laparoscopically significantly increased ($P = 0.023$), whereas both mean adjusted risks of conversion and severe postoperative morbidity significantly decreased ($P < 0.001$).

Conclusions

Laparoscopic approach is a safe and effective alternative to open surgery for IBD management. With growing experience, the rate of laparoscopic complex procedures increased, whereas adjusted risks of conversion and severe postoperative morbidity significantly decreased.

Comments

1. The feasibility of laparoscopic surgery for Crohn's disease has been much debated because of the intensity of inflammation, the frequency of denutrition and the therapeutic use of corticosteroids, as well as the prevalence of adhesions.
2. These results confirm the feasibility of laparoscopy, already shown in four meta-analyses and two randomized

Download English Version:

https://daneshyari.com/en/article/6110516

Download Persian Version:

https://daneshyari.com/article/6110516

Daneshyari.com