Uvodnika

Editorals

Laparoscopic colectomy for cancer

Laparoskopska kolektomija pri raku

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The first laparoscopic colon resection for cancer was reported by Jacobs in 1991 (1). Unlike other laparoscopic procedures, such as gallbladder removal or Nissen fundoplication, minimally invasive colon resection for cancer has been adopted slowly. There were several reasons for this: the procedure is technically demanding and has a steep learning curve, there is some concern about conversion rates and clinical outcomes, as well as about port site tumor recurrences, and there is the need to strictly adhere to fundamental oncologic principles, such as complete abdominal exploration, high ligation of mesenteric vessels, nodal clearance and adequate bowel margins (2).

To address these issues and to evaluate short-term and long-term outcomes after laparoscopic versus conventional colon resection, several randomized trials were initiated in the 1990s the results of which have been published (3-5). The years 2004-2005 were particularly important

O laparoskopski resekciji kolona pri raku je prvi poročal Jacobs leta1991 (1). V nasprotju s hitro uveljavitvijo drugih laparoskopskih posegov, kot sta laparoskopska holecistektomija ali fundoplikacija po Nissnu, pri laparskopski kolektomiji zaradi raka ni bilo tako. Razlogi za to so bili: poseg je tehnično zahteven s strmo učno krivuljo, obstajali so pomisleki glede deleža preklopov in glede kliničnega izida zdravljenja, prav tako so obstajali pomisleki zaradi zasevkov na mestu vbodnih ran portov, onkoloških načel, kot so ustrezna eksploracija trebušne votline, visoka podveza mezenteričnih žil, zajem bezgavk in varni onkološki robovi (2). Zaradi teh vprašanj in pomislekov so bile napravljene nekatere randomizirane študije, ki so primerjale kratko- in dolgoročne izide zdravljenja pri laparoskopski in klasični metodi (3-5). Še zlasti pomembna sta bila v letih 2004-2005 zaradi EAES konference konsenza o laparoskopski kolektomiji pri raku (6) in po objavah treh velikih randomiziranih

after the publiccation of the EAES Consensus Conference on Laparoscopic resection of colon cancer (6) and of three large randomized controlled trials, the COST trial (7) and the short-term results of the MRC-CLASICC (8) and COLOR (9) trials.

The available data have shown laparoscopic surgery to be associated with a significantly reduced postoperative pain, faster return of bowel function and shorter hospital stay (2-9). In laparoscopically operated patients parenteral narcotics have been used for one day less than in patients after open surgery. Return of bowelfunction and resumption of oral feeding after laparoscopy occurred one day earlier than after open surgery, and as a result the length of hospital stay after laparoscopic procedures was one day less than after open surgery. The differences are small but measurable and statistically significant (2). Next, no significant difference was found between the minimally invasive procedure and conventional surgery concerning the associateed morbidity and mortality rates (2-9).

The extent to which the standards of oncologic resection were met was investigated as well. Bowel resection margins, both proximal and distal, and the median number of lymph nodes were similar for both procedures (2-9), and so were the recurrence rates. The initially reported higher incidence of port site tumor recurrences has not been confirmed by more recent studies, and local recurrence rates were similar. Survival rates of laparoscopically operated patients did not differ from those of patients undergoing open surgery. One trial (5) actually reported a survival advantage in stage III patients after laparoscopic resection, but this observation was not confirmed by other trials and needs further proof.

There are now sufficient data in the literature to support the view that laparoscopic colon resection is a valid alternative to open resection if performed by surgeons with adequate experience and mastery in oncologic, colorectal and laparoscopic surgery. Most trials (7-9) have chosen to admit surgeons who had performed at least 20 laparoscopically-assisted colorectal operations, and their surgical skill and oncologic technique were scrutinized on videotape. This stresses the need for strict adherence to surgical oncological

kontrolnih študij, COST študije (7), MRC-CLASICC (8) in COLOR (9) študij.

Na osnovi objavljenih rezultatov se je laparoskopska metoda izkazala za znatno primernejšo od klasične zaradi zmanjšanja pooperativne bolečine, hitrosti povrnitve peristaltike in krajše hospitalizacije (2-9). Parenteralni analgetiki so bili povprečno uporabljeni en dan manj pri laparoskopski kot pri klasični metodi. Povrnitev peristaltike in pričetek uživanja hrane je bil pri laparoskopski metodi zabeležen en dan prej kot pri klasični metodi. Razlike niso velike, so pa merljive in statistično značilne (2). Obolevnost in smrtnost pri obeh metodah je bila prav tako predmet analize, vendar tukaj ni bilo statistično značilnih razlik (2-9).

Prav tako je bila predmet primerjalnih analiz tudi ustreznost doseganja onkoloških operativnih načel. Resekcijski robovi, tako proksimalni kot distalni, in skupno število zajetih bezgavk so bili pri obeh metodah primerljivi. Zgodnja poročila o pogostejših zasevkih v vbodnih troakarskih ranah v teh študijah niso bila potrjena, število lokalnih ponovitev bolezni pa je bilo pri obeh metodah podobno. Stopnja preživetja je bila primerljiva pri laparoskopski in klasični metodi. Pri eni študiji (5) je bilo preživetje z boleznijo v stadiju III daljše pri bolnikih, operiranih laparoskopsko, kot pri bolnikih, operiranih klasično, a tega druge študije niso potrdile in potrebne bodo nove raziskave z dokazi za potrditev.

Sedaj je v literaturi zadosti podatkov za potrditev dejstva, da je laparoskopska kolektomija pri raku primerna alternativa klasični resekciji, seveda v rokah kirurga, izkušenega in izurjenega v laparoskopski, kolorektalni in onkološki kirurgiji. Glede slednjega je potrebno poudariti, da so bili za sodelovanje v večini študij (7-9) izbrani kirurgi, ki so opravili vsaj 20 laparoskopskih kolektomij, pri čemer se je ustrezna izurjenost in ustreznost sledenja onkološkim načelom preverjala individualno z video posnetki. Tako lahko zaključimo, da je laparoskopska kolektomija pri raku varna in primerna metoda, a le ob strogem in doslednem upoštevanju onkoloških načel operiranja. Dokler ne bo objavljenih več študij o dolgoročnem preživetju bolnikov, operiranih laparoskopsko zaradi raka širokega črevesa, je kirurgova odločitev o tem, ali on izpolnjuje ustrezno mero izurjenosti in izkušenosti in ali bo to operativno metodo

principles of the operation, which is essential for laparoscopic colonic resection for cancer to be a safe and effective alternative to open resection. Until more data on long-term results of laparoscopically assisted colon resection become available, it is up to the individual practicing surgeon to judge whether all the prerequisites are met to offer this operation to the patient as part of the routine clinical practice.

ponudil svojemu bolniku kot varno in ustrezno, pač zgolj osebna.

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