



## Editorial comment on: Laparoscopic resection for colorectal diseases: short-term outcomes of a single center

Erdoğan Kamer

Dear Editor,

I read the article on "Laparoscopic resection for colorectal diseases: short-term outcomes of a single center" by Attaallah et al. (1) with great interest. I wanted to draw attention to certain details in order to avoid misunderstanding by future readers. First, liver metastasis was detected in 2 (6%) patients. One of these patients underwent metastasectomy with abdominoperineal resection while there is no information on the other patient (Table 2) (1). I believe a brief information on laparoscopic metastasectomy (e.g. if there was a requirement for an additional port, bleeding amount, surgical drainage of the site, operation time, energy device used) in the material method section would enlighten the reader on the subject. The authors stated their conversion rates as "low" in the discussion section. I think that it would be informative to the readers if the authors presented their conversion rate and the reasons for converting in the results section.

The authors cited a study by Ertem and Baca (2) to specify the relative indications for laparoscopic colorectal surgery in the discussion section (1). However, the article by Ertem and Baca (2) has identified major cardiac disease, severe pulmonary disease, portal hypertension, coagulopathy, pregnancy, tumor obstruction or perforation, and T4 tumor as absolute contraindications. This section should be corrected in order not to mislead the reader.

In addition, this is a descriptive study in which the authors present their experience on 33 cases. There was no comparison group, and no statistical analysis was performed. I believe that it would not be right to reach the definite results mentioned in the conclusion section in such study designs.

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### REFERENCES

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2. Ertem M, Baca B. Current status in laparoscopic colorectal interventions. *Ulus Cerrahi Derg* 2006; 22: 116-119.

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Department of General Surgery,  
Katip Çelebi University İzmir  
Atatürk Training and Research  
Hospital, İzmir, Turkey

**Address for Correspondence**  
Erdoğan Kamer  
e-mail: erdinc.kamer@gmail.com

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### Author's Reply

To the Editor,

We appreciate the commentary of Dr. Kamer.

First, liver metastasis was detected in 2 (6%) patients. Our comment on the interpretation of one patient undergoing metastasectomy with abdominoperineal resection is that the patient underwent a simultaneous resection while the other patient had liver metastasectomy at a second operation (two-stage approach). The practice in our center is to apply simultaneous resection to patients with synchronous liver metastasis if the condition of the patient is appropriate (absence of irresectable metastases outside the liver, no serious comorbidities) (1).

We did not provide much detail on laparoscopic metastasectomy, since it has been performed in a single patient (a bleeding rate cannot be determined based on one case), but the author's question is in place. Depending on the localization of the liver metastasis, an additional port may be required. The bleeding rate depends on factors such as the location and size of the metastases. We routinely place surgical drains to the metastasectomy site due to probable bile leakage. Ligasure was used as an energy device in our patient who underwent laparoscopic metastasectomy.

The rate of conversion to open surgery was expressed numerically in the results section (3 out of 36 patients) and as a rate in the discussion section (8%). Laparoscopically un-controllable bleeding was the reason for conversion.

In answer to Dr. Kamer's righteous criticism, the study published by Ertem M and Baca B. in 2006 stated major cardiac disease, severe pulmonary disease, portal hypertension, coagulopathy, pregnancy, tumor obstruction or perforation, and T4 tumor as definite contraindications. However, due to the rapid technologic progress and the increase in experience in laparoscopic surgery, contraindications in colorectal surgery are entirely relative and vary according to the experience of the surgeon and the protocols of the centers. As a matter of fact, T4 tumor is no longer considered as a contraindication (2, 3).

Wafi Attaallah

Department of General Surgery, Marmara University School of Medicine, İstanbul, Turkey

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