

Laparoscopic colorectal surgery and community hospitals

I read with interest the article from Sebjang and colleagues¹ published in the April issue of the *Canadian Journal of Surgery*. The authors report a 3-year experience of laparoscopic colorectal surgery performed in a community hospital. This is an important issue, and several papers published in the medical literature support these authors' opinions. In the conclusion section of their paper, they suggest the following:

... it is possible for community surgeons with no formal training in advanced laparoscopic surgery to transition themselves from an open to a laparoscopic approach and perform laparoscopic colorectal surgery¹

This message is somewhat self-referential and potentially dangerous. Three fundamental issues are today considered essential needs for minimal access surgery programs: training, accreditation and case load.^{2,3} Second, the authors state that the 2 surgeons involved in the program "transitioned themselves from an open to a laparoscopic approach" without any formal or informal accreditation. They report that, in the second half of their series, they experienced mentoring, tele-mentoring and telerobotic assisting. This suggests that they probably felt they needed help from a more qualified centre to improve their skill in laparoscopic colorectal surgery. From this perspective, the authors should explain in detail the importance of such mentoring. Third, the authors performed 100 laparoscopic colorectal interventions over the 3-year period, but they do not deal with their global colorectal case load. If we suppose that 100 colorectal surgeries represent their 3-year case load, then we have to affirm that it is too low to start a laparoscopic colorectal surgical program. In this sense, the importance of mentoring or telementoring may represent a valid option for hospitals without a case load and accreditation for such laparoscopic programs. This solution will be, in the near future, the concrete chance for enhancing surgical training and education. Finally, we thank the authors and the *CJS* for introducing this issue, which in

our opinion, is of utmost importance for the future of minimally invasive surgery.

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Competing interests: None declared.

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(Dr. McKinley replies)

We are pleased that our article "Can community surgeons perform laparoscopic colorectal surgery with outcomes similar to tertiary care centers"¹ has been read with interest, and we thank Professor Rulli and colleagues for their comments. We are happy to respond.

Dr. Rulli and colleagues are quite right that there are several studies in the literature that support our conclusions.² They also point out that our paper is self-referential and suggests our conclusions may be potentially dangerous. We specifically made our conclusions self-referential, for the very concern he is expressing. We feel we have demonstrated that *it is possible* for community surgeons with no formal training in advanced laparoscopy to *transition themselves* from an open to a laparoscopic approach when performing colorectal surgery. Our statement that, "it is possible," was the only conclusion we could justifiably make. Whether all community surgeons with no formal training in advanced laparoscopy can or should transition themselves is a question beyond the scope of our paper. The statement, "*transition themselves*," in no way suggests that we practise in a vacuum. No surgeon is an

island, and we are grateful to the many colleagues we have had an opportunity to learn from. These include our teachers and mentors during our surgical fellowship, the many excellent courses we were able to attend and our long collaboration and friendship with The Centre for Minimal Access Surgery, directed by Dr. Mehran Anvari. We are happy to briefly comment on other issues that are critical to our safe transition. In our series, the learning curve appeared to be the first 40 cases and was defined by a significant increase in wound infection and in the conversion rate, as well as by the use of patient selection. Our learning curve was not defined by an increased intraoperative or postoperative complication rate. As well, operating times and length of stays were not increased during the learning curve. We also note that the complication rates during our learning curve were similar to those reported by tertiary care centres for entire case series. Thus, we conclude that it is possible for community surgeons to transition themselves from an open to a laparoscopic approach safely and efficiently. We believe the the following factors are important in minimizing morbidity during our learning curve: careful patient selection; maintenance of a patient database; course attendance; 2-surgeon approach; dedicated nursing; and appropriate capitalization of the operating room. During this series, we evaluated the feasibility and use of mentoring, telementoring and telerobotic assisting as part of a larger multicentre study.³⁻⁷ During our colorectal series, this included 1 mentored procedure (case 41), 4 telementored procedures (cases 63, 66, 71 and 83) and 4 telerobotic assisted procedures (cases 70, 77, 82 and 87). Although we did not evaluate these techniques during our learning curve, we believe that they would be important enabling tools for community surgeons during their learning curves.

Dr. Rulli and colleagues also raise the important issue of colorectal case volumes. He suggests that 100 cases over 3 years may not be enough to support a laparoscopic colorectal surgical program. The first point we would the Society of American Gastrointestinal and Endoscopic Surgeons (Las Vegas, 2007) our experience with 250 laparoscopic colorectal procedures. Our mean follow-up was 36 months, and both our short-term outcomes and our longer-

term oncologic outcomes are equivalent to tertiary care centres. We therefore believe that we have created a laparoscopic colorectal surgery program with outcomes similar to tertiary care centres. Dr. Rulli and colleagues are quite right that many reports in the literature would suggest that our volumes are less than optimal, but several points need to be stated. First, many of these series involve tertiary care open colorectal surgeons transitioning themselves to a laparoscopic approach, and often these surgeons have no other laparoscopic practice. Conversely, community surgeons often have a large laparoscopic surgical practice outside their colorectal work. We respectfully suggest that the literature from academic centres may not be an appropriate yardstick when attempting to gain insight into community surgeons' practices. During the 3 years of our colorectal case series, we performed 2 Heller myotomies, 85 antireflux procedures, 3 splenectomies, 4 gastrectomies, 100 colorectal procedures, 22 ventral hernia repairs, 20 inguinal hernia repairs, 305 laparoscopic cholecystectomies and 100 laparoscopic appendectomies. Laparoscopy begets laparoscopy, and it may be that community surgeons with good outcome laparoscopic practices may be uniquely suited to adopting laparoscopic colorectal techniques. For similar reasons, the classical learning curve data published for transition from open to laparoscopic cholecystectomy may not be fruitful in understanding the transition to advanced laparoscopy from basic laparoscopy. We hope that we have sufficiently addressed the comments of Dr. Rulli and colleagues.

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Competing interests: None declared.

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Congratulations to Dr. Sebajang and colleagues for their paper "Can community surgeons perform laparoscopic colorectal surgery with outcomes similar to tertiary care centres?"¹ (published in the April issue of the *Canadian Journal of Surgery*).

We published an article on the same topic in 2005, titled, "Laparoscopic colon surgery performed safely by general surgeons in a community hospital: a review of 154 consecutive cases."² It is interesting to note that 2 groups of motivated and dedicated surgeons can reach the same conclusion regarding the introduction of advanced laparoscopic procedures in the community setting.

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Competing interests: None declared.

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Wait-lists

I must take exception to the comments of my friend and colleague, Dr. Michael Gross, regarding "Citations and wait-lists: much ado about nothing?"¹ (published in the April issue of the *Canadian Journal of Surgery*). His conclusions, based on the paper of Gaudet and colleagues,² are broad and inaccurate. Dr. Gaudet's paper is cause for the profession to feel relieved that patients are prioritized on the basis of need rather than on any other social factors. However, Dr. Gross's conclusion that this is in some way due to surgeons controlling wait-lists is completely erroneous.

With the Alberta Hip and Knee Replacement Project underway in Alberta, we have found in Edmonton, which has centralization of wait lists, that at least 30% of patients on a wait list are there inappropriately. Many patients are on multiple wait-lists, have already been operated on, are not interested in surgery or have died. The remaining patients on a wait-list also present a very heterogeneous group. Some are awaiting other medical tests or consultations before surgery may be booked. Other patients simply do not want surgery now and would rather wait until it is more convenient for them. Because of this, I feel our wait-lists need to be categorized as patients who are awaiting surgery and who are ready to come in next week and patients who wish to pick a date for surgery in the future or who are not yet ready for surgery.

It is inaccurate to accept a surgeon's office wait-list, as it requires a great deal of massaging before patients actually get to the operating room. Accurate data collection is important and will further the cause of surgery if we have centralized and standardized databases.

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Competing interests: None declared.

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