



# One swallow does not make a summer

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The article by Shimizu *et al.* (1) is a genuine attempt to address the feasibility and safety of laparoscopic colorectal resection after self-expandable metallic stent (SEMS) placement for cancer-related large bowel obstruction. The authors should be commended for sharing their experience and suggesting to the surgical community that this approach is apparently reasonable and harmless in expert hands. However, the results might remain anecdotic for several reasons: first, laparoscopic colorectal resection, even in the setting of elective surgery and in highly selected and renowned academic centres does not exceed 35–50% of the cases (2); second, a 24/7 endoscopic facility must be available to perform a timely SEMS placement in patients presenting with large bowel occlusion and this is uncommon; third, the time needed for a team to get sufficient expertise to safely complete a laparoscopic colon resection in a challenging scenario such as after SEMS placement. The learning curve of elective laparoscopic colorectal resection needs at least 25 consecutive cases in a short period of time (three months) to be completed (3). As emphasized by the authors, this surgical procedure should be performed by skilled surgeons. However, evaluating the data reported by Shimizu and colleagues, two surgeons performed 55 elective laparoscopic resections over a period of 4 years (January 2012–January 2016; 13 cases/year; approximately 7 cases/surgeon/year). This figure is somehow surprising and may suggest that the control cohort has been assembled with very selected cases.

Another concern is about the true similarity of the experimental group (laparoscopy after SEMS) and the control group (elective laparoscopy without previous

occlusion). Despite the P values did not demonstrate any significant difference, the two populations differ for many variables (age, sex, site of tumour, and disease stage). This lack of statistical significance may be easily attributed to a type II error due to the small sample (4).

Lastly, this series report a near zero complication rate in the most challenging and high risk patients as those operated after SEMS placement (one minor complication such as paralytic ileus). As surgeons, we know quite well that we might be lucky enough to have small series of patients without any significant postoperative morbidity. Nevertheless, when evaluating large and unselected cohorts the overall complication rate is close to 20% for elective colon (5) and 40% for rectal resections (6). Therefore, it is highly probable that by increasing the number of patients of their series, this favourable outcome will not be confirmed.

In conclusion, “one swallow does not make a summer”. We strongly need large randomized clinical trials to accept the hypothesis of laparoscopic resection after SEMS placement as a safe and effective operation in this scenario. Even though such studies will confirm these preliminary results, reproducibility, transferability, and applicability of this approach will remain major concerns.

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