



# Dose complete mesocolic excision contribute to improving the clinical outcomes of colon cancer?

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*Comment on:* Zheng M, Ma J, Fingerhut A, *et al.* Complete mesocolic excision for colonic cancer: Society for Translational Medicine expert consensus statement. *Ann Laparosc Endosc Surg* 2018;3:68.

Received: 02 November 2018; Accepted: 11 November 2018; Published: 12 November 2018.

doi: 10.21037/ales.2018.11.01

**View this article at:** <http://dx.doi.org/10.21037/ales.2018.11.01>

For new surgical procedures to become widely adopted, first of all, technical safety has to be confirmed. After that, these procedures have to be shown to be superior in long-term outcome compared with established procedure. In terms of complete mesocolic excision (CME), the technical safety seems to be almost considered acceptable. To date, there is still no conclusive data about which approach is better among open surgery or laparoscopic surgery or robotic surgery or single port surgery. Additionally, there are few reliable data in terms of long-term outcome of CME from high quality prospective study, which might confuse a lot of surgeons when deciding to perform CME or not.

When considering in terms of technical and oncological safety of CME, in the absence of conclusive evidence, present report has conducted a questionnaire survey by leading surgeons of nine countries, and each item has been thoroughly reviewed, which is very meaningful and valuable (1). In each of the eight questions, I comment about the definition of CME, the difference between CME and D3, and the perspective of CME.

Regard to CME, it is still a problem that the definition of CME is not clear. It might be better if the definition of CME could be clarified before sending the questionnaire. It is related to the core of the response of the leading surgeons of each nine countries, and the difference will affect other questions at the start point.

D3 is a common technique that is widely spread use as daily practice in Japan. It also relates to the definition of CME. Although D3 and CME with central vascular ligation (CVL) have different concepts, we can say that

both are the same in the oncological viewpoint. The difference is that the length of resected intestinal specimen in D3 is shorter, also its mesentery is less in volume, and the number of collected lymph nodes is less than CME with CVL. However, we have to know that the number of pathological metastatic lymph nodes is equivalent between both (2). This implies that the critical lymph nodes of the corresponding vessels are sufficiently dissected in D3. D3 operation is considered to be appropriate in terms of the length of resected intestinal and mesenteric specimen. It seems to be important to evaluate that what is advantage and disadvantage when leaving the length of intestinal tract and mesenteric volume as much as possible.

The results of long-term results [primary endpoint; local recurrence free survival (LRFS)] from prospective, non-randomized, double-blinded study were reported very recently, which concluded that CME improved 3-year LRFS without increasing surgical risks compared with non-CME (3). Gradually further long-term results will be reported in order to clarify the positioning of CME in the future.

In conclusion, present report about questionnaires from leading surgeons of nine countries facilitate us to make decision to perform CME with CVL or not, unless letting us know the clinical outcomes including oncological results based on high quality prospective study.

## Acknowledgments

*Funding:* None.

## Footnote

*Provenance and Peer Review:* This article was commissioned by the editorial office, *Annals of Laparoscopic and Endoscopic Surgery*. The article did not undergo external peer review.

*Conflicts of Interest:* Both authors have completed the ICMJE uniform disclosure form (available at <http://dx.doi.org/10.21037/ales.2018.11.01>). The authors have no conflicts of interest to declare.

*Ethical Statement:* The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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doi: 10.21037/ales.2018.11.01

**Cite this article as:** Akagi T, Inomata M. Dose complete mesocolic excision contribute to improving the clinical outcomes of colon cancer? *Ann Laparosc Endosc Surg* 2018;3:90.