

## Patient outcomes: The only size that eventually matters in dealing with colonic neoplasia



We read with great interest the editorial by Pioche et al. on overutilizing surgery to resect benign colorectal lesions [1]. We strongly agree that referral to either surgery or endoscopic intervention is a multifactorial/dimensional process that has to be well-orchestrated and executed for optimal outcomes. In fact, the chosen methods often reflect tradition and availability rather than the optimal balance between best outcome, patient convenience, and side effects. We hope that multidisciplinary educational tutors and on-the-spot endoscopic meetings will become available soon, with the advent of artificial intelligence and tools for real-time consultations such as the EndoConf [2]. To confirm or stage benign/malignant is a complex matter. The question one should ask is, "What is the prognostic advantage of those who have a 'complete resection' after endoscopic submucosal dissection (ESD) compared to those who have a primary surgical resection?" To our knowledge, the answer is none [3]. To date, there is limited European expertise in the resection of early malignant lesions with ESD. Conversely, a right hemicolectomy is neither a complex nor a major operation and the complication rate after right hemicolectomy is not high [4].

However, with all the intricacies involved in what is next, we should never lose our primary focus or overinterpret our understanding of what the patient wants. For sure, a great deal of pressure is brought to bear on clinicians to deliver precise and individual care for all, which remains a utopian view. The reasons that goal cannot be achieved are not due, but simply due to failure of good and straightforward decisions taken one step at a time. Very few patients would mind undergoing a repeat (reassessment) colonoscopy, but this should not steer us away from the main aim, that is, to get it right and get it right the first time. The pan-European explosion in co-

lonoscopy procedures has led to "fast track" education of young doctors to become qualified endoscopists [5]. This may explain the lack of support and essential skills at the EU-wide level, as well as for training in complex procedures, such as ESD. Our goal should be not to lobby further for this or the other approach but to find ways to intensify the collaboration between gastroenterologists and surgeons in open-minded, multispecialty-inclusive units geared to the task of dealing with complex cases. In a proper collaborative environment, we could have access to many techniques, such as endoscopic mucosal resection, ESD, TEM, endoscopic full-thickness resection, hybrid techniques, and hemicolectomies. For example, the preoperative staging with endoscopic ultrasound of early rectal cancers T1 sm1, sm2 and sm3 has low accuracy with a risk of understaging in around 15% to 20% of patients. The optimal treatment is to offer completion surgery if pathology reveals that a more advanced cancer has been resected than what was believed to be T1 sm1 disease. The past errors with too much surgery should not be followed by a new era with too much non-evidence-based therapeutic endoscopy; after all, the surgeons are the ones to deal with the completion procedures and sometimes hybrid techniques, if indicated.

### Competing interests

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### The authors

**Thomas Bjørsum-Meyer<sup>1,2</sup>, Anastasios Koulaouzidis<sup>3</sup>, Gunnar Baatrup<sup>1,2</sup>**

- 1 Department of Surgery, Odense University Hospital, Denmark
- 2 Department of Clinical Research, University of Southern Denmark, Denmark
- 3 Department of Social Medicine & Public Health, Pomeranian Medical University, Szczecin, Poland

### Corresponding author

**Thomas Bjørsum-Meyer**

Odense Universitetshospital – Department of Surgery, Winsløvsvej 4, Odense 5000, Denmark  
 Fax: +65413035  
 thomas.bjoersum-Meyer@rsyd.dk

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