CIRUGÍA ESPAÑOLA

www.elsevier.es/cirugia

Letter to the Editor

Letter to the Editor regarding "Highs and lows in laparoscopic pancreaticoduodenectomy"

Carta al director sobre "Luces y sombras de la duodenopancreatectomía laparoscópica"

Dear Editor,

We read with great interest the article entitled "Highs and lows in laparoscopic pancreaticoduodenectomy", by Espin F et al., [1] in the journal Cirugía Española. In this article, they evaluated the efficacy and safety of laparoscopic pancreaticoduodenectomy (LPD) compared to open pancreaticoduodenectomy (OPD) performed in a total of 54 patients, 23 and 31 respectively, after which they were able to determine that the best option is LPD in appropriately selected patients.

Pancreaticoduodenectomy (PC) is an effective treatment for pancreatic cancer, but major complications can occur, resulting in increased postoperative morbidity and mortality, such as healthcare-associated infections and pancreatic fistulas.[2] Minimally invasive surgery (MIS) has been developed with the intention of achieving satisfactory oncologic results with considerable advantages. Even so, the laparoscopic technique is not currently the technique of choice to perform PC, due to the possible complications, mainly linked to a decrease in the skill of the surgical technique.[1]

An indicator that supports the use of the laparoscopic technique is the post-surgical hospital stay. The difference between the post-surgical hospital stay for LPD (8.5 days) and OPD (15 days)[1] represents a fundamental factor in the patient's recovery, since a prolonged hospital stay restricts the capacity of the health care institutions, which generates a decrease in the availability of beds; amplifies the risk of contracting an infection associated with health care; and increases the cost of healthcare services due to the excessive and unnecessary use of supplies and labor.[3] Consequently, LPD presents a better efficiency indicator in terms of post-surgical hospital stay.

With regard to postoperative pancreatic fistulas, out of 23 LPD performed, 8.7% of the patients presented this complication, and 31 patients who underwent OPD did not present cases,[1] in comparison with another larger study that took 193 patients as a basis, where it was found that 12.3% presented pancreatic fistulas in OPD, as well as 11.8% of 58 patients who underwent LPD. We can evidence a lower prevalence of fistulas in the first study, which may be due to the fact that this is a non-randomized analysis with a smaller observed sample.[4] In view of the above, we consider that the laparoscopic technique performed by qualified personnel is the best option to reduce the probability of pancreatic fistulas.

As indicated, although the analysis concludes that LPD is safe in selected patients, randomized research should be carried out with a larger sample to guarantee conclusively that LPD is the best option, since other studies have observed a much higher risk margin.[5] In addition, we agree with the authors that adequate training of the professionals who perform LPD should be encouraged in order to reduce these risks and define it as the most appropriate.

Ethical approval

Not required.

Funding

None.

Conflicts of interest

None declared.

REFERENCES

1. Espin Alvarez F, García Domingo MI, Cremades Pérez M, Herrero Fonollosa E, Navinés López J, Camps Lasa J, et al.

Highs and lows in laparoscopic pancreaticoduodenectomy. Cirugía Española (Engl Ed). 2021;99:593–601. http://dx.doi.org/10.1016/j.cireng.2021.08.001.
2. Pang L, Kong J, Wang Y, Zhang Y. Laparoscopic versus open pylorus-preserving pancreatoduodenectomy. The first meta-analyse of retrospective matched cases. Acta Cirurgica Brasileira [Internet]. FapUNIFESP (SciELO). 2018;33:40–8. http://dx.doi.org/10.1590/s0102-865020180010000005.
3. Anand P, Kranker K, Chen AY. Estimating the hospital costs of inpatient harms. Health Serv Res. 2018;54:86–96. http://dx.doi.org/10.1111/1475-6773.13066.
4. Stauffer JA, Coppola A, Villacreses D, Mody K, Johnson E, Li Z, et al. Laparoscopic versus open pancreaticoduodenectomy for pancreatic adenocarcinoma: long-term results at a single institution. Surg Endosc. 2016;31:2233–41. http://dx.doi.org/10.1007/s00464-016-5222-1.
5. Aragón Quintana C, Guevara López JA, Casas García JC, Castillo Frausto A. Experiencia de manejo de cáncer pancreático con Whipple laparoscópico en el Hospital General y Central de Chihuahua. Cirujano General. 2017;39:152–6. http://dx.doi.org/10.35366/77028.

Lady Lorena Betancourt-Arias *,
Angello Andree Christian-Ramirez ,
Carlos Andres Gomez Arias y Gisel Alexandra Arteaga Meza

Universidad de Caldas, Facultad de Ciencias para la Salud, Manizales, Colombia

*Corresponding author.
E-mail address: lorena.medicina.bear@gmail.com (L.L. Betancourt-Arias).

https://doi.org/10.1016/j.ciresp.2021.12.005

Respuesta a «Estudios preoperatorios coincidentes para el diagnóstico de hiperparatiroidismo primario por adenoma simple: ¿podemos evitar la PTH intraoperatoria?»

Response to "Preoperative matching studies in the diagnosis of parathyroid adenoma for primary hyperparathyroidism: Can we avoid intraoperative PTH monitoring?"

Sr Director:

Hemos leído con interés el artículo de Laxague et al.[1] sobre sus resultados en el tratamiento quirúrgico del hiperparatiroidismo primario (HPP). Nos gustaría sumar la experiencia en nuestro centro, y compararla con sus resultados.

Nuestra serie consta de 273 pacientes, intervenidos de HPP causado por afectación glandular única desde enero de 2006 hasta mayo de 2021. La edad media de los pacientes fue de 59,3 años, siendo el 72% mujeres. El calcio sérico medio fue de 11 mg/dL (rango 8,8-15,7 mg/dL), y la hormona paratiroidea (PTH) media de 158,9 pg/ml. En cuanto a la medición intraoperatoria de la PTH (PTHio), se objetivó el descenso en el 94,5% de los casos tras la exéresis de la glándula considerada patológica.

En los casos en los que no hubo descenso (5,5%), en 7 fueron considerados HPP persistente. En ellos observamos que, además de no conseguir el descenso de la PTHio, en la localización preoperatoria había una discordancia entre gammagrafía y ecografía del 62,5%. El HPP persistente se debió a adenomas en glándulas ectópicas en 3 casos, en 3 por ser enfermedad multiglandular y en un caso no se evidenció otra glándula patológica y se optó por tratamiento médico con cinacalcet. Por otro lado, en el resto de los casos en los que no hubo descenso de PTHio, durante el seguimiento se objetivó descenso del calcio y de la PTH, sin precisar una segunda cirugía.

Aunque nuestro porcentaje de no descenso de PTHio sea del 5,5%, encontramos que la tasa de curación es del 97,5%. En el trabajo de Laxague et al, este porcentaje es del 4,2%, con una curación del 99%. Ante los resultados de ambas series, se apoya la idea de que, en los casos en que se sospeche un adenoma único, se podría dejar de realizar de forma sistemática la medición de PTHio, como recomienda la Sociedad Europea de Cirujanos Endocrinos[2]. En estos casos, en los que hay concordancia en pruebas de imagen, la prevalencia de enfermedad multiglandular oscila entre el 1