



Letters to the Editor

Intraoperative Ultrasound: Is it the Method of Choice for the Detection of Breast Lesions?[☆]



Ecografía intraoperatoria: ¿método de elección en la detección de lesiones de la mama?

We have read with interest the publication by Medina Fernández et al.¹ about resection margins in conservative surgery for breast cancer. The paper is a synopsis of the problem posed in conservative breast surgery and the presence of positive margins in between 20 and 40% of surgical specimens that are removed. This confirms that our objective should be to achieve free resection margins and absence of residual tumor. The authors describe it as “rigorous conservative breast cancer surgery”, and we could not agree more.

The authors analyze the literature on predictive factors for positive margins in resection specimens. They comment on an experimental study, emphasizing the impact of formalin preservation of the surgical specimen, which could alter the measurement of the tumor margins. Last of all, they analyze the different intraoperative methods for locating tumors. Harpoons, radioguided occult lesion localization (ROLL) and intraoperative ultrasound (IOUS) are currently the 3 basic pillars with extensive, corroborated studies. They also mention other methods such as the cryoprobe and manual probes for positron detection, both of which are unthinkable in our hospital for financial reasons. The results of IOUS, ROLL and harpoons are similar, although IOUS and ROLL seem to be superior in comfort of use, positive margin rate and re-operations.¹

In our hospital, we started using IOUS 18 months ago because of its availability, easy handling, non-invasive nature and reliability in the hands of surgeons dedicated to breast pathologies in collaboration with the radiologist from the Breast Unit. The surgeon also reviews the surgical specimen *ex vivo* with the ultrasound before it is sent for further ultrasound and mammography studies by the radiologist. The harpoon technique that we used previously has been relegated to use in lesions that are not visible on ultrasound, as well as

microcalcifications due to non-calcified ductal carcinoma *in situ* or multifocal invasive carcinoma. Ultrasound-guided surgery can significantly reduce the rate of resection margin involvement by reducing the need for re-excision.²

The ROLL technique requires our patients to go to another hospital with a Nuclear Medicine Unit either the day before or the same day of the procedure, with consequently higher costs and involvement of a greater number of specialists.³

We have recently published our data with IOUS in non-palpable lesions and, although the series is still small, there has been a re-intervention percentage of malignant lesions of 15.4%.⁴

The breast ultrasound starts in the breast consultation and turns into IOUS with the breast surgeon. In small hospitals like ours that lack “cutting-edge” technology, we should continue to offer the diagnostic-therapeutic options upheld by the literature.

REFERENCES

1. Medina Fernández FJ, Ayllón Terán MD, Lombardo MS, Rioja Torres P, Bascañana Estudillo G, Rufián Peña S. Los márgenes de resección en la cirugía conservadora del cáncer de mama. *Cir Esp.* 2013;91:404-12.
2. Krekel NM, Haloua MH, Lopes Cardozo AM, de Wit RH, Bosch AM, de Widt-Levert LM, et al. Intraoperative ultrasound guidance for palpable breast cancer excision (COBALT trial): a multicentre, randomised controlled trial. *Lancet Oncol.* 2013;14:48-54.
3. Ripoll Orts F, Morera Ocon F, Olagüe de Ros R, Bernal Sprekelsen JC. Técnica del ganglio centinela en la cirugía del cáncer de mama en un hospital sin servicio de medicina nuclear. *Cir Esp.* 2007;82:312-3.
4. López García J, Escudero de Fez MD, González-Moncayo S, Bernal Sprekelsen JC. Ventajas de la ecografía intraoperatoria

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en el manejo quirúrgico de las lesiones no palpables de la mama. *Rev Senol Patol Mamar.* 2013;26:115-6.

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Single Port Cholecystectomy. Glove Port[☆]

Colecistectomía por incisión única. Glove port



We read with great interest the article by Dr. Noguera about single-incision cholecystectomy.¹ We agree with some of his observations, but disagree with his comments on the use of glove ports.

With regard to the supposed cosmetic benefit (which is starting to become doubtful in the mid to long term),²⁻⁵ the few systematic studies performed with large numbers of procedures and hospitals have demonstrated that single-port cholecystectomy leads to double the amount of bile duct injuries, more incisional hernias⁶⁻⁸ and higher hospital costs. In the American study of a total of 193 000 cholecystectomies in 428 hospitals, the cost of the single-port technique was 964 dollars higher per procedure compared with that of conventional laparoscopic cholecystectomy.⁹ However, the *glove port* technique was developed with the idea of minimizing these disadvantages: its high added cost versus conventional laparoscopy.

As a member of our team has spent time working in the Surgery Department with Dr. Mortensen at the John Ratcliffe Hospital in Oxford, where there is much experience in the use of these devices, we have had the opportunity to learn the technique and implement it in our surgery unit. We have seen that it enables surgeons to use all types of trocars, straight or curved instruments, fiber optics of any and all diameters and the same or even better angulations and maneuverability as commercially available devices.

We do not agree with the author's statements that its use entails "inadequate patient selection and a lack of self-criticism", "greater concern for the individual case than for the advancement of the technique" or that it is associated with the concept of "anything goes". We feel these proclamations are unjustified and harsh. Several groups, including Mortensen's at Oxford, Asakuma's at the University of Osaka and others,¹⁰⁻¹⁶ have published positive results with the use of *glove ports* in different types of interventions, and our initial experience (which includes cholecystectomies, appendectomies and hepatic segmentectomy II-III) support these results.

We therefore believe that this technique should at least be considered a valid alternative to be evaluated in the future. This is especially true in today's day and age where we have to be more concerned about the efficacy of our surgeries, which of course includes costs. Perhaps this is the most obvious disadvantage of glove ports: they are just too inexpensive. This means that neither the companies that market other much more expensive devices nor the surgeons who consult with them (and are sponsored by them) show any interest in the evaluation or diffusion of this technique. We believe such unjustified criticism should be avoided so that one's objectivity is not discredited, especially in cases where there may be a clear conflict of interests.

REFERENCES

1. Noguera JF. Colecistectomía de única incisión: ¿una innovación segura? *Cir Esp.* 2013;91:401-3.
2. Ma J, Cassera MA, Spaun GO, Hammill CW, Hansen PD, Aliabadi-Wahle S. Randomized controlled trial comparing single-port laparoscopic cholecystectomy and four-port laparoscopic cholecystectomy. *Ann Surg.* 2011;254:22-7.
3. Bignell M, Hindmarsh A, Nageswaran H, Mothe B, Jenkinson A, Mahon D, et al. Assessment of cosmetic outcome after laparoscopic cholecystectomy among women 4 years after laparoscopic cholecystectomy: is there a problem? *Surg Endosc.* 2011;25:2574-7.
4. Garg P, Thakur JD, Raina NC, Mittal G, Garg M, Gupta V. Comparison of cosmetic outcome between single-incision laparoscopic cholecystectomy and conventional laparoscopic cholecystectomy: an objective study. *J Laparoendosc Adv Surg Tech A.* 2012;22:127-30.
5. Saad S, Strassel V, Sauerland S. Randomized clinical trial of single-port, minilaparoscopic and conventional laparoscopic cholecystectomy. *Br J Surg.* 2013; 100:339-49.

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