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Letters to the Editor

“The Paradigm of Surgical Treatment of Distal Rectal Cancer: What to Remove vs What to Leave Behind”[☆]



Paradigma del tratamiento quirúrgico del cáncer de recto del tercio distal. «Qué extirpamos vs. qué dejamos»

To the Editor,

We have read the articles published by Biondo et al.¹ and Flor-Lorente et al.² about the surgical treatment of distal third rectal cancer (0–5 cm). Both articles and the accompanying editorial³ describe the surgical aspects related with the oncologic results: avoiding tumor perforation, involvement of the circumferential margin, and integrity of the mesorectum.

In spite of technical advances, there is evidence that long-term oncologic results (local recurrence and disease-free survival) are worse in tumors of the distal third of the rectum, making these patients a high-risk group.^{4,5}

As discussed by the authors, it is still controversial whether extralevator abdominoperineal resection (ELAPR) is superior to conventional abdominoperineal resection (APR) for long-term survival.^{6,7}

In spite of neoadjuvant chemoradiotherapy (CRTx) and the significant reduction in local recurrence rates, distant metastases are common (>25%), especially in the lungs, followed by the liver.⁸ In a recent study of 593 patients (stages II/III) treated with long-course neoadjuvant CRTx and total mesorectal excision, during a mean follow-up of 44 months, 69% of the metastases were pulmonary. In addition to the distal location, other risk factors for systemic recurrence were pathological stage and perineural or lymphovascular infiltration.⁹

In an analysis at our hospital of 228 patients with locally advanced rectal cancer who had been treated with a similar neoadjuvant CRTx regime and a mean follow-up of 49 months, we observed 20.6% (47 patients) with distant recurrence and 2.6% (6 patients) with local recurrence.¹⁰ Lung metastases were more frequently associated with the distal third than in superior portions (25% vs 9%; $P=.024$). In a recent update

in 356 patients, lung recurrence continues to be higher in patients with distal third cancer (23.8% vs 10.9%).

Although anatomical factors have been argued (venous drainage), given the persistence of this pattern and based on results from our country and England,^{10–12} phase II trials have been started. These prioritize chemotherapy and select radiotherapy in non-responsive tumors. Schrag et al.¹³ have published preliminary results in 32 patients (stages II–III) treated with 6 cycles of FOLFOX-6 with bevacizumab in cycles 1–4. All patients were treated surgically, and complete pathological response was observed in 8 (25%). In the 30 patients that completed chemotherapy, local recurrence was 0%. Four patients (12.5%) developed lung metastases, and 4-year survival was 84%.

As indicated by García-Granero et al.,³ after 30 years of technical advances in the treatment of locally advanced rectal cancer, in addition to correct surgery, we should treat the systemic disease (micrometastasis, circulating tumor cells) early on in high risk cases, such as distal third rectal cancer.^{13–16}

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An Easy Acronym to Improve the Check-List: CALPE[☆]



Un acrónimo sencillo para mejorar el check-list: CALPE

Dear Editor:

According to the results of the article published in the journal entitled "Difficulties in implementing a surgical check list in operating theatres", only 27.8% of surgery checklists were followed exactly.¹ I would like to contribute a practical, simple system that I have developed mainly for short surgeries with local or regional anesthesia.

My idea is to use an acronym that makes the surgery checklist easier for physicians and nursing staff. It is based on other acronyms, such as the ABCDE (Airway, Breathing, Circulation, Disability, Exposure)² that is used in trauma patients.

The system I propose is in Spanish and uses a Spanish word that is easy to remember—CALPE:

- C is for the informed *consent*, which, when correctly filled out, covers the legal and ethical aspects of the intervention.
- A is for patient drug *allergies* in order to avoid mistakes when administering medication that could cause problems for the patient.
- L is for the *location* of the lesion, including the side for the intervention if any bilateral organs or extremities are involved, including the arms, legs, eyes, lungs, kidneys, etc., in order to avoid human errors with devastating consequences.

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