



Editorial

Rectal Cancer Project of the Spanish Association of Surgeons (Viking Project): Past and Future[☆]



Proyecto del cáncer de recto de la asociación española de cirujanos (Vikingo): Pasado y futuro

Standard treatment for rectal cancer is rectal resection in conjunction with mesorectal excision. The effectiveness of this technique was demonstrated with the results of the Norwegian Rectal Cancer Project, as neoadjuvant therapy was not being used in Norway at that time and the significant reductions in local recurrence rates could therefore only be attributed to the surgery.

This project arose from the decision taken by the professors of surgery at 7 Norwegian universities to improve the poor results observed in the treatment of this disease.¹ To do so, their objectives were two-fold: to train surgeons from the 55 hospitals of their country in the surgical technique with demonstrations performed by specialists in the procedure; and, to create a registry of the results from surgically treated patients that each hospital reports annually, as well as the results of the participating hospitals, in order to identify possible deficiencies. This volunteer registry was considered obligatory by the Norwegian surgeons; 10 years later, when it started to be funded by the government, the registry did become mandatory.

Given the Norwegian results, in 2006, under the auspices of the *Asociación Española de Cirujanos* (AEC, Spanish Association of Surgeons) and thanks to the altruistic aid of the leaders of the Norwegian project, The Spanish Rectal Cancer Viking Project was initiated. Its aim was to provide training in mesorectal excision surgery for multidisciplinary groups of the public healthcare system that requested it.² In 2010, extended abdominoperineal excision was added as an objective to this project.³ In total, 104 hospitals were admitted to the project.

Although this project attempts to imitate those from Scandinavia, from the outset it has differed from them in terms of hospital inclusion, registry characteristics, funding by scientific and patient associations, and recognition by healthcare officials.

In Scandinavia,^{4,5} all surgeons participated in the training project. However, when it was demonstrated that hospitals with less than 12 rectal resection cases per year had poorer oncological results, these centres stopped operating on patients with this disease. In Spain, inclusion of the hospitals in the project was voluntary and limited to those hospitals that performed at least 12 rectal cancer resections per year.

In Norway, the patients from this project were identified in the registry with the national identification number that is unique for each citizen. This avoided inclusion biases because, when the data from the project registry were cross-referenced with those from the obligatory tumour registry, it confirmed that all patients diagnosed with rectal cancer in the country were included in the project registry. Furthermore, while the registry was voluntary, the hospitals remained anonymous; afterwards, when funded by the government, the anonymity disappeared. In Viking, both the names of the hospitals as well as the patients remain anonymous, since, as there is no tumour registry in Spain, the identification of patients in the database lacked a clear objective.

Unlike Norway, the project in Spain was not funded by scientific societies or patient associations. It was financed with the aid of the pharmaceutical industry for the training courses and with research grants awarded to participants in the project, which were sufficient to create and maintain the registry until 2014. Since then, the registry, which currently provides data on the activity of individual hospitals compared with overall hospital activity at any given time, has been financed by the AEC.

Although our results have been similar to those obtained by the Scandinavian registries, which confirms the validity and usefulness of the project,^{6,7} Spanish healthcare officials (provincial and national) have not officially recognised their value. This recognition would improve patient care by

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identifying which hospitals should be selected to treat this disease based on the registry results. This has already been demonstrated in Scandinavian countries, where less than half of hospitals are authorised to treat this disease, resulting in a progressive reduction in adverse effects and an improvement in oncological outcomes.

In several European countries (Denmark,⁸ Belgium,⁹ Netherlands,¹⁰ Ireland,¹¹ Norway¹² and Sweden¹³) national multidisciplinary projects have led to healthcare officials generating government-funded obligatory registries of the immediate and long-term results of colon and rectal cancer treatment. Furthermore, these results are published on websites that are accessible to these countries' citizens and provide detailed results for each hospital.¹¹ Moreover, these registries have tools that interact with other registries to verify the quality of the data without the need to go to each and every hospital to conduct an audit.

Currently, in Spain, it seems impossible to be able to follow in the path of these countries. Therefore, the future of this project depends in the participating hospitals that believe in it and continue to input the data of new patients as well as their follow-up data. The problem is that this additional workload provides no benefits to hospitals other than purely scientific ones. Nevertheless, the ability to analyse one's own results and to compare them with those of other participating hospitals can identify errors and provides the opportunity to correct them. This activity and the self-criticism that is involved are most important for the health of our patients.

In conclusion, maintaining the Viking Project should be based on the conviction that analysing the quality of our work is beneficial for ourselves as surgeons as well as for our patients.

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