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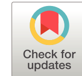
Editorial

Fashions in General Surgery☆



Las modas en la Cirugía General

I won't lie. This Editorial was inspired by recently reading *Vida cotidiana y velocidad* ('Everyday Life and Speed'), the posthumous essay by Lluís Duch, anthropologist and Montserrat Abbey monk who recently passed away. Duch wrote, ''Fashion is the imitation of models constructed by specialists who, in one way or another, are faithful servants to market desires and interests. (...) Fashion followers limit their behavior to mere examples of a rule (fashion), which is granted unlimited authority and infallibility.'' I encourage everyone to read the entire essay, even if this involves some effort. Duch's writing style is not simplistic, but the core of his argument, questioning the supposed progress of our culture in the 21st century, should not be disregarded.

At this point, I do not believe that anyone can reproach me for implying that surgery is influenced by fashions, much like clothing, popular music or organic food. The evidence is too obvious. But, just in case, I will provide examples for the consideration of readers of Cirugía Española who desire to keep up-to-date.

Let us start from the beginning, as it should be. I must admit that at the onset of my professional career I was intrigued by the rise and fall of a number of procedures that became fashionable in supposedly academic circles at the hand of star surgeons, only to last just a few years in surgical forums. Those that come to mind are sigmoid myotomy for diverticulosis,[1] anal dilatation for hemorrhoids[2] and Angelchik's ring for the treatment of gastroesophageal reflux[3] back in the 1970's and 80's. These were passing fashions that fell out of vogue faster than the miniskirt, leaving behind very bad memories. Not to mention certain ephemeral proposals I closely witnessed that seemed to me, even then, truly questionable savageries, not only from a scientific standpoint but simply in terms of ethics. These included the Teflon esophagus, silicone tracheas or removing the pancreas in cases of severe pancreatitis. To make matters worse, in the years of the secular transition, Longo described hemorrhoid stapling,[4] to which a cohort of 'updated' surgeons adhered without any critical analysis, causing an epidemic of pelvic and anal cataclysms. Some of these cases were very honestly reported[5] but, as with so many innovations, many were hidden. Even so, the *El País* newspaper (17.12.2002) echoed the advent of an ''automatic machine that (...) avoids conventional surgery.''

The phenomenon of fashions in surgery was not limited to the last decades of the twentieth century, when surgical innovations were justly scrutinized in *The Lancet*.[6] While theoretically the criteria for the introduction of new surgical procedures have been toughened,[7,8] fashions continue to appear and disappear, driven by a symbiosis between the vanity of surgeons, social hypochondria and industrial interests. Laparoscopy, for example, was a notable advance in adrenal surgery, but it became a death sentence for patients with potentially curable adrenocortical carcinoma, many of whom have died from peritoneal carcinomatosis at the hands of fundamentalism.[9] When single-port surgery appeared, laparoscopists who did not hop on the bandwagon were virtually scorned in more fashionable circles, but today there is hardly any trace left of this procedure. Of course, the gallbladder can be removed through the mouth, or the colon or the spleen through the vagina, and all of these procedures have even made newspaper headlines. However, everything currently indicates that natural orifice surgery is in danger of extinction.

In my subspecialty of Endocrine Surgery, fashions have come and gone at a dizzying speed in the last 30 years, especially regarding access to the thyroid gland. In one of the courses organized by Professor Moreno González at the Hospital 12 de Octubre in the late 1990s, Michel Gagner presented an endoscopic hemithyroidectomy with 3 trocars performed on a 28-year-old woman who was in the operating room for 4 h.[10] I was part of a round-table discussion with him, and, when I was asked for an opinion, I suggested that this type of surgery should be prohibited. Gagner replied that ''general surgeons are very conservative.'' Twenty years later, Inabnet, his most outstanding disciple —who supposedly has

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considerable experience— attempted a transaxillary hemithyroidectomy at a hospital in Barcelona that culminated after more than 5 h with a revision of the internal jugular vein. Henry defended endoscopic parathyroidectomy,[11] a technique that has died with his retirement except in the hands of some recalcitrant epigone. After Gagner and Henry, Paolo Miccoli came along with open endoscopic access (MIVAT) for the thyroid gland, which seduced many unsuspecting professionals. As with the proposals for supposedly disruptive methods, the Pisa group never presented a credible audit of permanent complications after hundreds of MIVAT thyroidectomies, many of them probably unnecessary due to the peculiar Italian funding system. But these are not exceptional occurrences in the world of passing fashions: either they are not discussed, or they are mentioned in passing at rates of less than 1% (or both).[12]

In 2003, at the request of Agustín del Valle, I was the moderator of a round table in Seville during the 3rd MIR Training Course in Endocrine Surgery, during which two simultaneous retransmissions of live surgeries were viewed: a hemithyroidectomy by Miccoli himself to remove a 4 cm thyroid nodule through a 2 cm incision, and an endoscopic parathyroidectomy of a Spanish colleague. When Miccoli had barely finished a dirty job, I asked him to measure the wound, which at that time already reached 4 cm (since then, my relations with the surgeon in Pisa have cooled). After almost an hour without finding the parathyroid adenoma (located, by the way, on scintigraphy), the endoscopist colleague asked the audience if they felt it necessary to ligate the middle thyroid vein. Understandably, after these experiences in Madrid and Seville, I have systematically rejected other similar invitations.

But in spite of everything, fashions continue. South Korean surgeons have recently massacred the healthy thyroid glands of thousands of compatriots with screening, overdiagnosis and robotic surgery, who deserve to be banned by the highest academic organisms.[13] Something similar has happened with the latest rage in remote access to the thyroid gland through the lower lip. The Thai 'technostar' Angkoon Anuwong has popularized this approach after the failure of the sublingual access proposed by German authors and their confessions of serious complications.[14] Luckily, the latter did not reach the category of 'fashion' and remained circumscribed to Essen. Anuwong and his followers have never provided reliable data on the complications derived from this approach or, as in the examples mentioned, they report figures below 1%.[15] This is very odd for a technique that combines the complications inherent to conventional thyroidectomy and those of an atypical access that, like other remote accesses, gives way to a greater possibility of complications, such as pain, mental nerve injury or soft tissue infections. In all these instances, we should contemplate whether 'glam' surgeons prioritize the well-being and safety of their patients or would rather see their name (albeit in small print) in the annals of endocrine surgery.

Surgical fashions represent a health threat when they attempt to incorporate into the technical arsenal of our specialty procedures with a higher risk than those already being used, which are more expensive, take longer, and have unjustifiable learning curves due to the limited benefit they provide. Antonio Machado, who was far from being a conservative, wrote that, "Out of every ten new developments, nine are not, and one not so much." Without a doubt, we must not put a spoke in the wheel towards progress in our discipline, but we do have a moral and scientific duty to question what we actually mean by 'progress.'

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