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Correspondence

Comment on: Complete mesocolic excision for right colonic cancer: prospective multicentre study

Cihangir Akyol and Mehmet A. Kuzu*

Department of Surgery, Ankara University School of Medicine, Ankara, Turkey

*Correspondence to: Mehmet A. Kuzu, Ankara Universitesi Tip Fakultesi Akademik Yerleske K blok 4. Kat, Altindag, 06100 Ankara, Turkey (e-mail: ayhankuzu@gmail.com)

Dear Editor

We read with great interest the study published recently by Benz *et al.*[1], which reported the short- and long-term outcomes of complete mesocolic excision (CME) *versus* non-CME surgery. However, several points deserve further discussion.

The standardized CME concept addresses a number of crucial steps; however, only superior mesenteric vein exposure was accepted as the CME criterion in the study. Although half of the cancers were located at the caecum, which is not the most challenging site for the right colonic CME technique compared with hepatic flexure cancers, only 36.5 per cent of surgeons achieved the prespecified cut-off of at least 15 000 mm^2 mesocolic area in the study. This is far behind previously published values. Moreover, the data on length of longitudinal margins, distance from tumour to vascular tie, and closest bowel wall to vascular tie were not reported. Therefore, the quality of surgery can only be observed in terms of the local failure rate, which is missing. Furthermore, the results showed that 'the plane of surgery was characterized as mesocolic in most of the patients'. These data reveal that the majority of surgeons who continue to neglect the CME concept have modified their surgical method to adopt the new non-CME concept, which is not standardized, and follow the anatomical landmarks. In this situation, the following question must be posed: Does this study compare a CME group *versus* a near-CME group? In addition, it is difficult to understand what the authors mean by the term 'central nodes' in the non-CME group because the vessels are not ligated at their origin.

Local recurrence, an important indicator of oncological outcome, was not reported in this study and was previously documented to be a serious problem. Although there was no difference between the primary and secondary outcomes in this study, and CME did not affect survival, subanalysis of stage III describing a risk reduction should be reported with caution and interpreted in the context of overall survival and limited statistical power.

Multicentre trial heterogeneity in clinical practice among centres may be a key confounding factor in interpreting the results of this study. Furthermore, the relatively small number of patients considered for inclusion may also be a confounder. According to the results of this study, there is not enough scientific evidence to conclude that 'outside the context of expected stage III disease CME should be performed only within clinical trials or quality assurance programmes'.

Author contributions

Cihangir Akyol (conceptualization, data curation, formal analysis, investigation, methodology, project administration, resources, software, writing—original draft, writing—review and editing), and Mehmet Kuzu (conceptualization, formal analysis, investigation, methodology, project administration, supervision, visualization, writing—original draft, writing—review and editing).

Reference

1. Benz SR, Feder IS, Vollmer S, Tam Y, Reinacher-Schick A, Denz R *et al.* Complete mesocolic excision for right colonic cancer: prospective multicentre study. *Br J Surg* 2022;**110**:98–105

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