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Editorial

Pancreatic oncological surgery. Are the levels of excellence achievable?

Cirugía pancreática oncológica. ¿Son alcanzables los niveles de excelencia?

Pancreatic cancer is always a challenge. The surgical technique, variations and complications in operable cases are not the only aspects involved, we should also consider selection criteria for adapting treatment to each patient and achieving results that give meaning to the efforts made.

Experience gained over recent decades, advances in imaging techniques, endoscopy, interventionism and perioperative handling, have managed to streamline surgical indications, reduce mortality in specialised units, and reach 5-year survival figures of around 10%.

In Spain, most surgical departments, regardless of their resources, level of specialisation and workload, operate on patients with pancreatic neoplasms. This is why it is surprising that there is such a lack of publications presenting clinical outcomes in large series. Most of the studies are very limited examining specific technical variations, technological advances, or histopathological rarities, but do not report general results on overall experience. In fact, a recent attempt to research pancreas cancer surgery quality standards¹ proved that the results, in reality, reflect the international standards, as the Spanish studies available have a small sample size and do not give any clear conclusions as to what the quality standards for our environment are or should be. Although this would only serve as a guideline, the characteristics of our health system and the evident differences between Spain and other countries that report more cases (USA, Germany and Japan), would probably make the results differ considerably.

Another study that was very recently published in the journal *Cirugía Española*,² presents the first, although modest, attempt to change this outlook, providing results for morbidity and mortality, functionalism, and long-term follow-up in a large series of patients with pancreatic and periampullary tumours. The series recently published by Joan Fabregat in the *Hospital Universitari de Bellvitge* (Bellvitge University Hospital)^{3,4} should also be mentioned. It is the largest series published to date, with 204 cephalic duodenopancreatomes

performed between 1991 and 2007, and is sure to become a point of reference.

We should not underestimate the importance of publishing clinical results obtained in daily practice during prolonged periods. In reality, it is this type of series that most encourages improvement, since there are no external auditors, we are the ones that should compare our own results with the most important series so that we can improve and gain progress. It is difficult to establish a centralisation and accreditation system for units to provide specialised care for these patients; however, if healthcare providers with less training and specialist knowledge in this area are made aware of the results obtained by the most specialised groups, it could convince them to refer their patients to more experienced centres.

Furthermore, it is always more useful and realistic for emerging groups to be able to consult Spanish studies, instead of only having large series from English-speaking or Asian countries as reference.

Busquets et al's broad review reports postoperative complications and long-term follow-up and reflects the experience of a multidisciplinary, well-led, group of specialists that have all of the technological equipment that they need for surgery, endoscopy or conventional and interventional radiology. The good results obtained from the series must be highlighted, surely fruition of the relentless dedication and diligence that these professionals offer their patients. However, there are certain aspects that are worth special attention. Firstly, it would have been very interesting if they had included resectability rates, as this figure reflects the healthcare providers' overall quality, especially that of the radiologists and surgeons. The series includes 204 cephalic duodenopancreatomes, but it does not indicate the total number of interventions or the amount of tumours that were not resected, for one reason or another (i.e. liver or peritoneal metastasis not identified prior to the operation).

It is surprising to observe that only 4% of the subjects had retroperitoneal disorders, while this figure rises to at least 16%⁵ in studies that carefully examine this matter, and most groups present rates at around 50% or more.⁶⁻⁸ These values are important because if they were confirmed, it would mean that most of the resections that we consider relevant to oncology (R0) are in fact R1. This could be an argument that would justify applying new therapeutic strategies, such as neoadjuvant treatment in resectable cases. A third important fact is that the 5-year survival reaches 13%, a figure that is slightly higher than that obtained in another Spanish study with a long-term follow-up.² Although these values are very low in comparison with other types of tumours and could be discouraging, they are within the survival range achieved following pancreatic cancer resection in American, European and Asian series. That is why it is important to concentrate on the 2- or 3-year survival rates, as the 5-year value has little relevance to pancreatic cancer. Nonetheless, these shorter-term survival rates are clearly higher when compared to the survival achieved in patients with unresectable tumours, perfectly justifying the intervention.

The Bellvitge series is an extremely valuable clinical study because it confirms that good results are attainable when technology, humans and experience are combined. However, we must still ask ourselves several questions: Does this study reflect the general pancreatic oncological surgery situation in Spain, or does it only show the best possible results in the best circumstances and conditions? And, does it really show the best possible results, or can they still be improved?

The first question can not be answered just yet, given the apparent lack of Spanish series published. Each one of us should therefore answer it in accordance with our own experience or the results that we have access to. However, the Bellvitge results prove to healthcare providers who treat pancreatic cancer patients that levels of excellence are reachable, and that they should try to attain them. This can only be achieved by combining humans and technology capable of maintaining motivation and determination needed for this type of patient.

The second question must remain open too, awaiting the results obtained by other surgical groups and on the new innovations that are sure to develop. The only aspect that we can emphatically affirm about pancreatic treatment is that a lot still needs to be done. We are therefore confident that publications from other pancreatic surgery study groups will be added to this study, and in the near future we will really be able to establish the quality standards for pancreatic oncology surgery in Spain. We will certainly be able to progress just by understanding where we are. It is the most thorough and clearest way that we are able to

improve our results, assess units, compare results obtained with new technologies (laparoscopic approach) or therapeutic strategies (neoadjuvant treatment) and, in short, improve our patients' results and care.

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