

from the anal margin; local staging by pelvic MRI (Fig. 1A) and endorectal ultrasound was T2N0. Abdominal CT showed a mass in the left kidney suggestive of a primary neoplasm (Fig. 1B).

In coordination with the urology department, a laparoscopic approach was used with 4 trocars situated in order to serve both procedures (Fig. 1C), with the patient placed in Lloyd-Davies position. We began with complete mobilization of the splenic angle, leaving the renal fossa free in order to perform standard nephrectomy and bag extraction through a 6 cm incision in the left flank. We completed the lower anterior resection with mechanical end-to-end anastomosis and protective ileostomy (Fig. 1D). The patient progressed favorably and was discharged on the 5th day post-op. The pathology study reported a complete mesorectum with the distal margin at 2.8 cm and a free circumferential margin, with 18 isolated lymph nodes that were free of neoplastic infiltration and a clear cell renal cell carcinoma (TNMpT3).

The simultaneous laparoscopic approach is ideal in ipsilateral tumors, as indicated by the authors and coinciding with most published cases.^{2,3} Occasionally, it may be necessary to add an extra trocar or change the position to lateral decubitus to perform the nephrectomy, although this was not necessary in our case. When a contralateral (or bilateral) approach is necessary, the advantages decrease as the surgical time is longer and morbidity increases.^{1,4} The authors conclude that the simultaneous approach lengthens hospital stay; this datum needs to be confirmed statistically. In our case, hospitalization did not increase due to the combined procedures. Patient characteristics, age, comorbidities, tumor type and experience of the 2 surgical teams in advanced laparoscopic surgery can be determining factors in this regard. The reported mean hospitalization of 15 days is striking, although the conditioning factors are complex and the series is small. It would be interesting to know whether the results would be any better with an open approach.

We cannot agree with Dr. Martín when she states that this technique should be reserved for high-level hospitals and resources, as we are an experienced team that only has available the resources typical of a secondary-level hospital in the public healthcare system. We do concur, however, that an individual approach should be recommended for each patient.

Funding

The present study has received no funding.

The present study has not been previously presented at any congress.

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2173-5077/

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Indications for Anti-Reflux Surgery in Barrett's Esophagus[☆]



Indicaciones de la cirugía antirreflujo en pacientes con esófago de Barrett

Dear Editor,

In the Editorial from the May issue of *Cirugía Española*, Ruiz de Angulo et al. pose the question of whether surgical

indications should be extended in Barrett's esophagus after considering the recent publication in *JAMA* about the secondary effects of long-term proton pump inhibitor (PPI) use (particularly with regards to possible vitamin B₁₂ deficiency).^{1,2} In a very balanced manner, and based on the

[☆] Please cite this article as: Ortega Deballon P. Indicaciones de cirugía antirreflujo en el esófago de Barrett. *Cir Esp.* 2015;93:270–271.

great experience that the group from Arrixaca has in gastroesophageal reflux (GERD) surgery, the authors calm the concerns caused by the JAMA publication, and they indicate that they do not have any data about any significant undesired effects induced by PPI. In fact, given the growing proportion of long-term takers of PPI (with or without justified indications), even with high doses of PPI and the stable prevalence of vitamin B₁₂ deficiency in Europe it seems that we need not worry.³

But, there are two other arguments for not extending the indications in Barrett's esophagus: on the one hand, several robust, recent studies show that the risk for malignant transformation is much lower than what was previously believed; on the other hand, the long-term results of anti-reflux surgery are not as good as in the short term (particularly with regards to reflux control, reversal of Barrett's esophagus, or even dysplasia).^{4,5} Recent recommendations from endoscopy and digestive tract societies consider reducing vigilance in Barrett's esophagus.⁶

Thus, although we are surgeons and want to preserve our profession, I believe that today it is necessary to modify and reduce the indications for anti-reflux surgery.

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2173-5077/

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