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Letters to the Editor

Radical Treatment of Peritoneal Carcinomatosis: Times Are Changing☆

Tratamiento radical de la carcinomatosis peritoneal. Tiempos de cambio

Dear Editor:

We have read with great interest the editorial by Dr. Barrios[1] that was recently published in this journal with his reflections motivated by the results of the French phase III multicenter Prodige 7 study.[2] These results demonstrated that radical cytoreductive surgery (CRS) followed by hyperthermic intraperitoneal chemotherapy (HIPEC) do not provide greater overall survival than CRS followed by adjuvant systemic chemotherapy in the treatment of patients with peritoneal carcinomatosis of colorectal origin. In the Prodige 7 study,[2] not only were no differences found for overall survival between the study groups (41.2 months versus 41.7 months), but, more importantly, there was a clear detriment to the group of patients treated with HIPEC due to the induced toxicity, with a Clavien grade III-V morbidity rate of 24 %, compared to only 13 % in the control group.

These shockingly unexpected results have led some authors to even propose the disappearance of HIPEC from the surgical therapeutic armamentarium in an editorial article published in the prestigious European Journal of Surgical Oncology (EJSO),[3] which motivated our Letter to the Editor[4] in which we argued the transcendental value of CRS accompanied by adjuvant systemic chemotherapy.

In our letter, we discussed the 4 best publications in the medical literature to date in patients treated for peritoneal carcinomatosis of colorectal origin. The median overall survival rates range from 36.6 months reported by Ihemelandu and Sugarbaker,[5] 41.2 and 41.7 months contributed by the Prodige 7 study,[2] 47.5 months obtained by the Bergonié de Bordeaux Institute group,[6] and 62.7 months published by Elias et al.[7]

In his editorial, Dr. Barrios[1] communicated his magnificent results at the Hospital de Sant Joan Despí Moisés Broggi, with a median survival of 40.5 months.

Although the role of HIPEC can be questioned, the only thing that has been clearly demonstrated in all these experiences mentioned (including those of the Prodige 7 study[2] and Dr. Barrios[1]) is that only when the last tumor cell is eradicated from the peritoneal cavity with CRS CC0 followed by abundant lavage of detritus (with or without hyperthermia) for the treatment of residual microscopic disease, and only when these patients are treated with the best systemic chemotherapy schemes, only then can one aspire to chronization and long survival rates in this group of patients considered incurable until now.

We must aspire to surgical excellence, demanding the tutored learning of CRS CC0, the ''cornerstone'' of the treatment of colorectal peritoneal carcinomatosis, in order to offer all our patients a ray of hope, and healing in selected cases.

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Conflict of Interests

None.

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Standardizing the Treatment of Esophagogastric Junction Tumors: Centralization, Registries and Surgical Training☆

Puntualizaciones a los proyectos de estandarización del tratamiento del cáncer de la unión esofagogástrica: centralización, registros y formación

Dear Editor

We have read with interest the article published by Osorio et al.[1] We congratulate the authors for their review, but we wanted to share our comments.

We agree that centralization of certain complex procedures could improve results. However, as the authors point out, when choosing hospitals, other structure and result requirements should be met in addition to volume.[2] We believe that the basic factors for centralization should be the 90-day morbidity and mortality results and 3- or 5-year survival results, as externally audited by impartial authorities with no conflicts of interests, such as the National Healthcare Administration. However, these results are not known for any service and, therefore, the basic principles of quality are overlooked.[3] These hospitals should offer a structure that provides permanent access to interventional radiology and endoscopy teams, critical care units and, of course, trained surgeons. Only then will failure-to-rescue rates decrease. If we do not know what the actual results are, there is no 'textbook outcome'.[4]

No one questions the need for multidisciplinary cancer committees. But these should be based on scientific evidence and demonstrated protocols, and not be a 'committee of experts'. Practices with no evidence to support them should be integrated into randomized clinical trials. Without results and structure, volume is of no interest.

The auditing process should be permanent so that results improve or at least remain the same. You cannot talk about benchmarks in results —as frequently published— or 'service benchmarking' without impartial auditing.

Filling the registries with patient complications and communicating them does not imply that the results are objective.[5] National or multiregional cancer registries are objective only if their reliability is validated.[6] Therefore, it does not seem coherent that the audit to verify the veracity of the registry data is conducted by professionals who are connected to it. The registries should have 2 sources, the surgical service itself and

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