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Letters to the Editor

Response to "Our experience in short-term diagnostic-therapeutic management of patients with anal dysplasia"[☆]

Respuesta a «Nuestra experiencia en el manejo diagnóstico-terapéutico a corto plazo del paciente con displasia anal»

Letter to the Director:

We have read with interest the article by Galán Martínez et al.¹ on his experience in the diagnostic and therapeutic management of patients with intraepithelial neoplasia. We would like to congratulate the authors for their experience and commitment to the care of this pathology. However, we would like to add some considerations based on our experience.

In our centre, the protocol for patients with anal cytology is similar to that described, excluding transplant and haematological patients. However, the HPV serotypes present in all cytologies are indeed analysed from pathological anatomy.

It is laid down that any HSIL, regardless of which HPV genotype is present, should undergo high-resolution anoscopy (HRA). On the other hand, patients with LSIL are differentiated according to the HPV genotypes they carry. If they only show low-risk genotypes, the established protocol is to repeat the cytology in 3–6 months to assess evolution. If they present any high-risk (RA) genotype, they are included for HRA. We have laid down the same action with the ASCUS. This is due to the fact that infection with HPV-HR genotypes is associated with the presence^{2,3} or progression of AIP.⁴

In the data analysed,¹ where 112/115 patients were biopsied and 98/112 were treated, it is clear that biopsy would be considered practically unnecessary, since any patient with an altered cytology is treated. There are no clear treatment recommendations for AIP I,⁵ in fact it is not considered necessary to treat them because many of them return. What is advised is a further HRA with biopsy of the previously affected area at 6–12 months to evaluate progression.⁶

We agree on the established treatment with 80% trichloroacetic acid (TAA), however we differ on the dosage to be given. In our case, the treatment was initially applied in one single session, guided by the HRA and by means of a swab applied for 30 s to the affected quadrant, achieving results similar to those reported by Cranston et al.⁷ We consider that this should be applied selectively to the quadrants where the biopsy was taken and not with a swab inserted over the entire circumference of the anus, since this could increase deleterious effects for the patient, while not acting specifically on the altered area.⁷ The subsequent verification of the efficacy of the treatment is evaluated with HRA and occasional biopsy, since the cytology could constitute a false negative.

In summary, as reflected by Galán Martínez et al.,¹ the screening of dysplasia is complex, since there is a dilemma concerning failure to act upon treatable lesions that potentially progress to anal carcinoma,⁸ and more studies with long-term follow-up are necessary to reach a consensus on the correct diagnostic-therapeutic management in our population, in order to unify criteria and lay down protocols.

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Laparoscopic and robotic distal pancreatectomy: Outcomes and the need for patient-centred evaluation



Pancreatectomía distal laparoscópica y robótica: resultados y necesidad de una evaluación centrada en el paciente

To the Editor,

Recently, we read with great interest the work by Alvarez et al., “Laparoscopic and robotic distal pancreatectomy: the choice and the future”. We congratulate the authors for conducting a prospective study at tertiary hospitals, which analysed the results of distal pancreatectomies with laparoscopic and robotic approaches and presented the outcomes and complications of these procedures, helping us understand the safety and efficacy of each. Information pertaining to the conversion of surgery, from robotic to laparoscopic or from laparoscopy to laparotomy, has also been elucidated. The similarity of the patients involved in the study in both groups in terms of their age, sex, BMI and ASA physical status classification reduces bias, at the same time enhancing the reliability and generalisability of the study.¹

Though postoperative pancreatic fistula was assessed as a complication in this study, new-onset diabetes (which has

incidence rates varying up to 50 percent after distal pancreatectomy) can be assessed by comparing long-term outcomes in future studies.^{2,3} Though the study’s primary focus was on clinical outcomes, a more comprehensive understanding of the patients’ total well-being would have been possible by assessing subjective patient-oriented outcomes, such as postoperative pain level, which gives us insight to how the patient feels after DP. Any surgical intervention’s overall success depends on a number of important factors, including functional recovery, dietary modifications, and long-term effects on the patient’s daily activities and lifestyle choices. A more patient-centred view of efficacy can be provided by using patient-reported outcome measures, such as satisfaction levels and functional recovery. Lack of data pertaining to other short-term outcomes, including ileus, respiratory failure, pulmonary embolism, acute coronary syndrome, stroke, acute renal failure, urinary tract infection and sepsis, is yet another shortcoming.⁴