As our colleagues Dr. González and Dr. Franch Arcas have indicated, it is not possible to carry out randomized prospective studies that would resolve all these uncertainties. Above all, because central lymph node dissection is not harmless and entails morbidity.[6] Also, there is currently no solid evidence to recommend prophylactic central lymph node dissection in papillary microcarcinomas with a good prognosis (quite the opposite).[7] What is important is to be able to select that small percentage of cases that could benefit from therapeutic central lymph node dissection. Despite its limitations, our study tried to address this objective.[1]

For all these reasons, we consider that the comparison of the groups performed in the study is useful.[1]

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Response to «Management of Splenic Injuries Utilizing a Multidisciplinary Protocol in 110 Consecutive Patients at a Level II Hospital»☆

Respuesta a «Resultados en el tratamiento de traumatismos esplénicos utilizando un protocolo multidisciplinar en 110 pacientes consecutivos en un hospital de nivel II»

Dear Editor,

We have read with interest the article by Zurita Saavedra et al.[1] about their experience in splenic trauma management at a level II, hospital. We congratulate the authors for their experience, commitment to the care of splenic trauma patients. However, we would like to add some considerations based on our experience.

Like the authors, we believe that non-operative management (NOM) of blunt splenic trauma is the treatment of

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choice, except in patients with hemodynamic instability or the presence of other injuries that justify surgery. Success rates up to 90% have been obtained with conservative treatment.[2]

What we find controversial in the article by Zurita Saavedra et al. is the direct surgical treatment of patients with grade IV splenic trauma (American Association of Trauma Surgery AAST[3]), regardless of hemodynamic status. In 2017, the World Society of Emergency Surgery (WSES)[4] published its recommendations for the management of patients with splenic trauma injuries, establishing hemodynamic stability as a key aspect of NOM in patients with grades IV–V splenic trauma. Angioembolization (AE) was also introduced as the most appropriate initial technique in these patients.

Despite the absence of randomized studies to support the recommendation (in 2017, the prospective randomized multicenter study SinE qua NOM trial was initiated but had to be canceled due to slow recruitment[5]), there is sufficient evidence based on retrospective studies and meta-analyses that support this indication with good results.[6]

Based on this, and given the proximity of the referral center at only 300 m, we believe that hemodynamically stable patients with grades IV–V splenic trauma should be referred for AE at that center, as the success rate of NOM in these patients is higher when AE is performed.[4] We also encourage the authors to conduct propensity score matching of the results of both techniques.

In addition, we have also noticed the high number of spleen-preserving surgeries performed. Even though we would have liked to see an analysis of their results, it is somewhat contradictory with the trend in the literature, as the use of this approach has decreased over time with the increased use of NOM and the poor initial results of this technique (although with little evidence).[7] This surgery is complex, and we find its accumulated volume very interesting, which we also consider a subject that merits being published alone.

Finally, we are uncertain whether excessive professional zeal or the absence of embolization, as well as the high rate of conservative surgery, could justify the long hospital stay reported by the authors.

In short, we believe that the prevailing general management strategy for blunt splenic trauma allows us to used NOM in hemodynamically stable patients, even those with grades IV–V lesions accompanied by AE. Moreover, until new studies show otherwise, spleen-preserving surgery in this context should only be performed by experts or under clinical trial protocols.

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