LETTER TO THE EDITORS

Adjusting the Focus of Transoral Robotic Surgery

Dear Editor:

We read the article by Esteban et al. "Critical analysis of robotic surgery for laryngeal tumours," with interest. We applaud the authors’ initiative and essentially share their critical spirit. However, evidence is rapidly accumulating to endorse robotic surgery for minimally invasive approaches in head and neck cancer.

There has been discussion for a long time on the indications for transoral robotic surgery (TORS), and in many cases the balance has already been swayed by the weight of evidence. Where we disagree, however, is on the focus of the review. An overall critique is apparently made of robotic surgery on the head and neck, focussing on laryngeal tumour indications, when what should be being discussed is its essential usefulness in the oropharynx. The fact that a different department surgically treats oropharyngeal tumours without the aid of the robot is a superfluous argument, since this very status quo is perhaps what the authors should be questioning.

Certainly, under current circumstances, no centre would acquire a “da Vinci” to treat laryngeal cancer. Not even for an integral TORS programme. However, why not use it where it exists? The cost of specific consumables for a TORS procedure (VAT included) is €1027.87: a “lifetime” of the Maryland dissector, or of the spatula tipped monopolar cautery and the set of sterile covers for the stretcher. For the oropharynx, it clearly outstrips any alternative, (not minimally invasive) surgical approach. For the larynx it is simply reasonable from a financial point of view, bearing in mind that the fixed costs of the apparatus (depreciation and maintenance) are unaltered and there are strong arguments in its favour: surgery is easier and faster, more reproducible and it contributes to the surgical experience (and the rapid learning curve) of the TORS programme. In our opinion, the most reasonable argument in favour of laser would be the time the robotic surgery procedure takes.

Our centre initiated the TORS programme in July 2013. Case selection is based on an appropriate exposure and the calculation of the transoral resectability of oropharyngeal, hypopharyngeal, and supraglottis lesions: to date no case has been rejected. Of the first 17 patients treated only 2 presented with first stage tumours. Seven of the surgical procedures involved the larynx. Robotic instrumentation in the supraglottis has obvious technical advantages. All the procedures were completed as planned. None of the programme patients required tracheotomy at any time during treatment. None of the patients had a permanent feeding tube. Oncological safety was supervised by the Head and Neck Tumour Committee and the institutional quality control system. Transoral laser microsurgery was reserved for the initial glottic tumours.

The robot is merely a surgical instrument. In surgery we should avoid media chatter and surgical fashions. Technology will of course progress and robotic surgical systems will change. It is, however, our duty to offer our patients the best treatment we can. If the current robot is proved to be beneficial then there is no excuse to wait for it to improve, especially if one is available in the operating theatre next door.

References

Reply to the Article ‘‘Adjusting the Focus of Transoral Robotic Surgery’’

Respuesta al artículo ‘‘Ajustar el enfoque en cirugía robótica transoral’’

Dear Editor:

We have carefully examined the letter sent to the journal by Granell et al. regarding our article ‘‘Critical analysis of robotic surgery for laryngeal tumours’’. In their view, the fundamental disagreement lies in the focus of the article, since they consider that the document criticising robotic surgery is apparently a generalisation, ‘‘what should be being discussed is its essential usefulness in the oropharynx’’.

Unfortunately, the editor considered this ‘‘partial’’ laryngeal view acceptable, and we only deal with the oropharynx superficially in our article. We would love to be able to review the subject of oropharyngeal robotic surgery and we will thus refer this suggestion to the Editorial Board. It is true that in the case of laryngeal oncology there are comparative series on both open surgery and transoral laser surgery, whilst in the case of robotic oropharyngeal surgery, where basically a transoral resection of the tumour is made with monopolar electro-dissection, there are insufficient comparisons with series on minimally invasive transoral approaches. The rapid transition in oropharyngeal oncology from open surgery with major morbidity to a transoral procedure with robotic electro-dissection, with apparently similar published results, is surprising. We would, in any case, repeat that our article focuses on laryngeal surgery, and their opinion that its usefulness in oropharyngeal tumours should be discussed is interesting and, therefore, also subject to systematic review.

Secondly, their argument regarding using the robot that is available on the premises is at the very least questionable, in the cost-restrictive environment in which we now find ourselves. An immediate counter-argument could be made, in other words, that the robot’s availability might lead to overuse in order to justify or amortise its cost. In this regard, in a very recent review of robotic surgery on oropharyngeal and tongue cancer in the USA, it was stated that 25% of robotic procedures on the oropharynx were carried out for non oncological indications, the most frequent of which was tonsillectomy due to hypertrophy! A very expensive piece of apparatus, with limited material and designed for other specialties, with, among other examples, astronomical annual maintenance contracts, an indefinite return value for when it needs to be updated, would require a value which compares extremely well with other alternatives in order to justify its use. Their affirmation that the cost of consumables for a TORS procedure (VAT included) is €1027.87 is demonstrably untrue: this does not include depreciation costs, maintenance costs; the total cost of consumables is undervalued, without engaging in further discussion on the useful lifetimes of each instrument or whether they have included other necessary investments such as the specific Fehy-Kastenbauer retractor which is basic to oropharyngeal surgery. It is highly significant that the use of the robot is being questioned for indications for which it was being used rapidly, based on financial criteria, without dismissing the doubts which are being raised regarding its safety.

However, it is not just financial considerations which motivate us as surgeons: in our environment, with the very widespread use of CO2, the lack of publications or oral communications on laser stapedectomies or laser palatoplasties is surprising. Time will tell whether a technique offers little or nothing compared with other more ‘‘conventional’’ ones.

Thirdly, we fully agree that we should offer our patients the best possible treatment ‘‘avoiding media chatter and surgical fashions’’. Regarding laryngeal surgery we are certain that at present there are equally effective alternatives to the robot which are also much faster and more economical. We are as yet unclear as to whether the robot offers any significant benefits for the oropharynx, since comparative literature is scarce and our speciality possesses great experience in non-robotic, minimally invasive, transoral approaches. As we expressed in our article, we believe that robotic surgery has great development potential for the base of the skull and we are working with it in this area in the experimental operating room and in the ‘‘operating theatre next door’’.

References