Effect of Morbid Obesity and Tumor Diameter on Feasibility of Posterior Retroperitoneoscopic Adrenalectomy for Cushing's Syndrome: Reply

Pier Francesco Alesina · Martin Walz

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We thank Agarwal and coauthor for their comments about our article [1]. Concerning the question about the number of morbidly obese patients, we found that from 170 patients affected by manifest (mCS) or subclinical Cushing's syndrome (sCS), 51 patients (30%) had a body mass index (BMI) > 30 (range, 31–62). The majority were affected by mCS (32 cases, 63%). In particular, 26 patients (51%) had a BMI > 35. As demonstrated, the posterior retroperitoneoscopic approach is feasible and safe even in these patients as only one conversion to open surgery occurred in this series. Technically essential is an increased CO₂-pressure (up to 30 mmHg) that allows an adequate creation of the retroperitoneal space.

Concerning suspected adrenal malignancies, we do not follow the concept that the laparoscopic transabdominal approach should be preferred over the retroperitoneoscopic access. In contrast, we see a potential advantage of the retroperitoneoscopic route as peritoneal spillage of tumor cells can be avoided. Fourteen tumors (14/170, 8.2%) were at preoperative imaging ≥ 6 (range, 6–10) cm. If predictable, we do not approach adrenocortical cancer minimally invasive. Beside tumor size and imaging features, type of hormone secretion has to be taken into account. Based on these parameters, we were extremely successful; we

removed only one adrenocortical cancer in the series of 170 Cushing patients. As demonstrated earlier, large tumor size itself does not represent a contraindication for retroperitoneoscopic adrenalectomy [2, 3]. Today, we do not see the critical size for malignancy in adrenocortical tumors ≥ 6 cm but in those ≥ 8 cm. From this estimation excluded are bilateral macronodular hyperplasias that are almost always benign.

References

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P. F. Alesina (✉)
Department of Surgery, Kliniken Essen-Mitte, Essen, Germany
e-mail: pieroalesina@libero.it

M. Walz
Klinik für Chirurgie und Zentrum für Minimal Invasive
Chirurgie, Kliniken Essen-Mitte, Essen, Germany