Equipoise of Outcome is Sufficient to Justify the Laparoscopic Approach for Colorectal Cancers

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We read with interest the study on lymphadenectomy by laparoscopic resection in rectal cancer.¹ Over the past 10 years, laparoscopic surgery has been increasingly applied to resection of cancers. Level 1 evidence is now available providing strong support for similar oncological outcomes (both short-term surrogate end-points as well as long-term end-points like disease-free and overall survival) between laparoscopic surgery and open surgery for colon cancers.^{2–5} The colorectal surgical community needs to be congratulated for producing this robust evidence, which now needs to be emulated for other GI sites also being approached by the laparoscopic technique (gastric, pancreatic, small intestine, etc.).

The present study reports a 51% adequate harvest of lymph nodes ($n \geq 12$, according to AJCC TNM staging requirements), which raises some concerns.¹ The authors have mentioned that their two groups were equally matched in terms of pre-operative radio-chemotherapy, but they need to report this proportion, in case that can explain the relatively low proportion of adequacy in number of nodes excised.

We have recently published our experience on long-term outcomes of patients undergoing curative laparoscopic surgery for mid and low rectal cancer, and we feel the excellent long-term survival (both overall and disease-free)

was directly related to the adequacy of surgical resection (both total mesorectal excision and lymph nodal resection).⁶

Placing the above in context and recognizing the true current impact of laparoscopic surgery, i.e., superior patient satisfaction and short-term outcomes, equipoise of long-term outcomes is a sufficient argument *in favor* of the laparoscopic approach.

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