Few Comments on “Laparoscopic Splenectomy: Perioperative Management, Surgical Technique, and Results”

Yunqiang Cai · Xubao Liu

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Dear Sirs,

We read with great interest the online first article in *Journal of Gastrointestinal Surgery* by Fisichella et al.¹ entitled “Laparoscopic Splenectomy: Perioperative Management, Surgical Technique, and Results.” The authors presented the description of their preoperative evaluation, surgical technique, and postoperative management and results of laparoscopic splenectomy (LS) in their study. However, we discuss several concerns about their study.

The authors stated that portal hypertension, ascites, and traumatic injuries to the spleen were the absolute contraindications to LS. Portal hypertension was indeed considered as a contraindication to LS in the clinical practice guidelines of the European Association for Endoscopic Surgery in 2008. However, due to development of the operative instruments and accumulating of operating experience, many studies reported that it was safe and feasible to perform LS in patients with portal hypertension.^{2,3} Laparoscopic splenectomy for splenic injury was also reported in several reports.^{4,5} The indications for the LS should be better defined.

The authors reported that they successfully performed LS for three patients with platelet count less than 10,000/ μ L, without platelet transfusion. We have performed approximately 80 cases of LS for immune thrombocytopenia (ITP) patients with platelet count less than 10,000/ μ L. Only three patients in our series required conversion to open surgery. In our practice, the hemostasis of the cut edge could be achieved by using ultrasonic dissector or LigaSure vessel sealing system. However, more evidence is required to validate the safety and feasibility of performing LS for ITP patients with platelet count less than 10,000/ μ L.

A hand port allows surgeons to recover the tactile sensation. The hands of surgeons can work as a retractor, which facilitate the mobilization of spleen. Furthermore, it enables surgeons to get a quick access to hemorrhage and facilitates the retrieval of spleen from the abdomen. Compared with laparoscopic splenectomy, hand-assistant laparoscopic splenectomy is associated with a shorter operating time, lower conversion, and less blood loss. It may be superior to laparoscopic splenectomy in setting of massive splenomegaly or those with adhesions from previous surgeries.

In conclusion, we appreciate that Fisichella et al. shared their scrumptious experience in laparoscopic splenectomy. However, the indications for LS should be better defined. We also recommend that hand-assistant LS is superior to laparoscopic splenectomy in setting of complicated spleens, especially to the less experienced surgeons.

Conflict of Interest Authors have no conflict of interest to disclose.

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Y. Cai · X. Liu (✉)

Department of Hepatopancreatobiliary Surgery, West China Hospital, Sichuan University, No 37, Guo Xue Xiang, Chengdu, Sichuan 610041, China
e-mail: shoubulele@gmail.com