LETTER – COLORECTAL CANCER

Reply to “Commentary to Matsuda et al., *Ann Surg Oncol* (2013) 20:856–863,” by Karl Kodeda and Richard J. Heald (doi:10.1245/s10434-013-2951-4)

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TO THE EDITORS:

Dr. Kodeda and Prof. Heald's remarks on our meta-analysis focused a welcome spotlight on a disregarded procedure for surgeons. We could clearly demonstrate the effect on the reduction of anastomotic and local recurrences after anterior resection for rectal cancer.¹ Although to my knowledge almost all surgeons in Japan consider this procedure routine, it surprised us that the execution rate of this procedure is quite heterogeneous worldwide.² Considering that rectal washout is oncologically beneficial, simple, quick, safe, and inexpensive, it seems that there is no rationale for surgeons to hesitate to perform it. Spreading the word about this beneficial procedure and entering into further discussions regarding the best type and volume of solution, as Dr. Kodeda mentioned, are an indispensable means to improve the outcomes of rectal cancer surgery. Our results of subgroup analysis revealed that a favorable oncological effect of washout with normal saline alone might be a good candidate for further investigation.¹

Additionally, we should note that the reported cases of anastomotic recurrence along the staple line after colonic resection using functional end-to-end anastomosis (FEEA) procedure are increasing.^{3–5} These cases imply that implantation of exfoliated cancer cells during FEEA, which does not

include the procedure of cleanup of bowel lumen, is a causative mechanism of anastomotic recurrence. Taken together, our results and previous results emphasize the oncological importance of preventing the implantation of free cancer cells at the anastomotic site not only in rectal cancer surgery, but also in colonic cancer surgery.

Disclosure The author declares no conflict of interest.

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