

## The incomplete story of complete mesocolic excision

### Authors' reply

We thank Fahima Dossa and colleagues<sup>1</sup> for their interest in our study.<sup>2</sup> By contrast with rectal cancer, local recurrence after colon cancer is not well defined and distinction between, for example, carcinomatosis and recurrence in the site of the original tumour, is difficult. When is a recurrence in lymph nodes a local recurrence? Which recurrence is the first if multiple locations are found? In our Article, we reported only the first recurrence regardless of location to avoid the risk of misclassification. In unpublished data we found similar distributions of local and distant recurrence in the complete mesocolic excision and non-complete mesocolic excision groups, but fewer recurrences occurred after complete mesocolic excision.

The review cited by Dossa and colleagues<sup>3</sup> included the same patients twice in the analysis, which questions the validity of its findings. In many studies, complete mesocolic excision is either not undertaken according to the definition by Hohenberger and colleagues<sup>4</sup> or described at all. Whether or not the superior mesenteric vessels were exposed to ensure the central dissection is often unclear. The central dissection is probably the important difference between complete mesocolic excision and conventional surgery; not the perfection of the mesocolic dissection plane. By omitting the central dissection, the surgeon potentially leaves tumour tissue—eg, tumour satellites, and lymph node metastases—in the patient. This explanation is the most obvious for the increased risk of local and distant recurrence after conventional surgery; however, whether any tumour cells have been left behind cannot be proven if

complete mesocolic excision is not performed.

All four hospitals included in our study are obliged to report to the Danish Colorectal Cancer Database, the National Patient Register, and the National Pathology Database, which secures completeness of data. With the differences in methods of follow-up favouring the control group and data showing the safety of complete mesocolic excision in trained hands,<sup>5</sup> the results are unquestionable in favour of complete mesocolic excision. The strength of evidence is as good as can be because blinded trials are not feasible. Complete mesocolic excision is well defined by specific anatomical structures by contrast with conventional surgery, and surgeons who were to complete mesocolic excision might tend to do more extensive resections in the non-complete mesocolic excision group. The surgeon must decide whether to do good surgery or not, and we must perform the former.

CAB and AUN have been affiliated with Olympus Finland by performing live surgery at courses for educational purposes only. JK declares no competing interests.

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