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International Journal of Surgery

journal homepage: www.elsevier.com/locate/ijso

Editor's Perspective

Editor's Perspective: September 2020



In my previous Editor's Perspectives, I talked about Surgery 3.0 being marked by the development in minimally invasive surgery which can broadly be divided into interventional, endoscopic and robotic surgery. I also talked about interventional surgery and started to talk about how the invention of fibre-optic endoscope has revolutionized endoscopic surgery.

One of the major advances in fibre-optic endoscopic surgery is in treatment of early cancer. While it is widely accepted to treat non-invasive and differentiated colorectal carcinoma arising from a polyp by polypectomy, I am going to talk a bit more on endoscopic submucosal dissection (ESD) in treating early stomach, colorectal and oesophageal cancers only involving the mucosa of these organs. The technique of ESD evolved from endoscopic mucosal resection (EMR). EMR initially used a diathermy snare to remove an early mucosal cancer either en bloc or piecemeal. As either piecemeal resection, or even en bloc resection with an inadequate margin resulted in bad prognosis, three methods to improve EMR were developed [1]: injection of saline submucosally to lift up the lesion, snare-resection of the lesion and retrieval of specimen with forceps [2]; endoscopic suction of a lesion to raise its mucosa followed by diathermy snaring; and [3] using a dual operative channel endoscope, through one channel to grasp and to lift the mucosal cancer, and through the other channel to snare and remove the lesion. With further development of these 3 methods of EMR, ESD evolved. The procedure of ESD involves the following 6 steps [1]: using a diathermy to create markings around the mucosal tumour to be cut away [2], injecting saline underneath the mucosal lesion to raise it [3], using an endoscopic insulated knife to cut along the markings, (4) dissecting with the insulated knife to resect the whole lesion from the submucosal tissues, (5) remove the tumour. Send the resected specimen to see whether there is any tumour-involved resection margin, and (6) haemostasis on the raw submucosal area. In carrying out ESD, the most important technical point is to dissect along a correct submucosal plane.

I shall talk about further developments of rigid endoscopes in future issues of the Editor's perspectives.

In this August 2020 issue of International Journal of Surgery, there are three very interesting articles on the COVID-19 pandemic. The first one is a review article on "Health policy and leadership models during the COVID-19 pandemic". The second is a review article on "A

comparative overview of COVID-19, MERS and SARS". The third is a perspective from Sichuan Province, China on "Management of urology during COVID-19 pandemic". These are very interesting articles to go through.

On review articles, there is a systematic review of 1075 patients on "One anastomosis/mini gastric bypass (OAGB-MGB) as revisional bariatric surgery after failed primary adjustable gastric band (LAGB) and sleeve gastrectomy (SG)". This study concluded OAGB-MGB to be safe and effective for these patients. A meta-analysis with trial sequential analysis on "Pretreatment albumin-to-alkaline phosphatase ratio as a prognostic indicator in solid cancers" found the ratio to be a useful prognostic indicator. Finally, there is a perspective on "Trauma of major surgery" which concluded that this is "a global problem that is not going away".

On articles with case-series, there is a prospective cohort study on "Comparison of the learning curves for robotic left and right hemihepatectomy", a retrospective study on "A simple four-factor preoperative recipient scoring model for prediction of 90-day mortality after adult liver transplantation", a retrospective study in "determining factors in relation to lymphovascular characteristics and anastomotic configuration in supermicrosurgical lymphaticovenous anastomosis", a multicenter retrospective study on "comparing different kidney stone scoring systems for predicting percutaneous nephrolithotomy outcomes", a retrospective study on "robotic pancreaticoduodenectomy in elderly and younger patients", a retrospective study on the "relationship between robotic-assisted radical prostatectomy and retropubic radical prostatectomy in the learning curve of a single surgeon as a novice in radical prostatectomy", and a retrospective study on "the Masquelet technique combined with the muscle flap for use in emergency management of acute Gustilo type III trauma of the lower limb with segmental bone loss".

As usual, there are a lot of commentaries in this issue of International Journal of Surgery, including 17 Invited Commentaries on articles accepted for publication in our Journal, and 4 Commentaries/Letters to Editor initiated by readers of our Journal.

During this difficult time of the COVID-19 pandemic, I hope everyone stays healthy!

<https://doi.org/10.1016/j.ijso.2020.08.019>

Available online 21 August 2020

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