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Commentary: Extended pleurectomy decortication: Step 1, standardized techniques; step 2, standardized documentation

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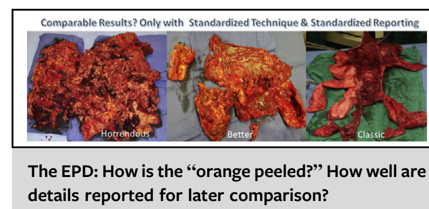

The EPD: How is the "orange peeled?" How well are details reported for later comparison?

CENTRAL MESSAGE

"If you think of standardization as the best that you know today, but which is to be improved tomorrow; you get somewhere."
Henry Ford

Progress in the surgical management of pleural mesothelioma has been difficult enough without having to argue about not only which operation to do, but also how to do it. Thanks to Rice and colleagues,[1] we at least were able to describe the alternative to extrapleural pneumonectomy when concerns were raised about how frequently it should be performed and its safety, as well as its long-term results. Frankly, extended pleurectomy decortication (EPD) deserves better than to be performed like the slogan for Cracker Jack: a surprise in every package. Each surprise is different, and if you want to make any sense about the efficacy, safety, and long-term results of the operation, there needs to be standardization of the technique. Efforts for surgical standardization have already started in the MARS 2 trial, and we await the results.[2] That's why the article by Ripley and Palivela in this issue of *JTCVS Techniques*. The authors have taken all the pearls not only from their own substantial experience but also from the literature to provide both EPD veterans and rising mesothelioma surgeons with a mental checklist to be crossed off during the procedure.[3] This is a must read for every mesothelioma surgical expert across the globe, whether he or she performs 5 procedures per year or 50 per year.

The manuscript beautifully parallels the video, with attention to details like the proper suture to use, as well as lymph node dissections. The technique of the visceral decortication is demonstrated and complements well other static pictorial descriptions of "how to do it." But what is unique about this contribution are the tables, which feature instrumentation that should be available in the performance of EPD, including those for chest wall coagulation control and diaphragm reconstruction tools. Moreover, the intraoperative povidone-iodine technique, which has become a popular adjunct, is a nice addition to the article.

But now for the editorializing. How do you ensure standardization like this? Sometimes standardization is not so difficult for less grueling procedures, such as the original lymph node dissection teaching videos for ACOSOG Z0030.[4] EPD is a little more involved than that. This is where the synoptic operative report certainly helps, and there is an ongoing initiative to be able to develop such a synoptic operative report for mesothelioma surgery. The synoptic report is already in use at some US institutions, and synoptic reporting of the mesothelioma pathology specimen has been supported since June 2017.[5] Only through prospective use of a synoptic operative report will we be able to see whether the quantifiable variables from the report correlate with consistent recurrence-free and overall survivals. Such standardized techniques and documentation are particularly relevant with the reporting of nonsurgical advances in mesothelioma immunotherapy, including dual checkpoint inhibition trials.[6] To have future interpretable data from window of opportunity trials adding surgery to immunotherapy, we need to be able to demonstrate that one surgeon's EPD is indeed another surgeon's EPD.

The "classic" panel in the Central Picture is courtesy of Joseph Friedberg, MD.

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