

A FEASIBLE LAPAROSCOPIC SURGERY TECHNIQUE FOR COMPLEX ADNEXAL TUMORS

To the Editor:

We were interested to read the report by Chia and Huang on the topic of a feasible laparoscopic surgery technique for complex adnexal tumors [1]. They treated a total of five women diagnosed with complex adnexal tumors, including mature cystic teratoma (MCT) and/or mucinous cystadenoma [1]. In order to establish an appropriate and comfortable operative field during the laparoscopic surgery, the authors used the so-called “controlled intraoperative spillage method” (which is based on our understanding of their technique). The strategies which they used included: (1) identifying an appropriate incision site, which was the most distal part from the tumor base; (2) establishing a small wound for intracystic fluid drainage using unipolar scissors; (3) closing the wound with 10-mm hemoclips; (4) removing the tumor mass using the endobag through the 12-mm trocar site; and (5) finally, irrigating the abdominal cavity with warm saline until clear and clean [1]. This strategy provided many advantages during the operation, including decreasing tumor size, relatively enlarging the operative field, and assisting tumor removal by laparoscopy. We congratulate the authors for successfully dealing with these complicated cases without any reported adverse events.

Laparoscopic surgery has gained global popularity since 1980, and in general, we agree that it is one of the most important procedural advances in the field of surgery [2–8]. The application of laparoscopic surgery for MCT has been well-documented [9–11]. We agree with their efforts to use a new technique to improve the limitation of laparoscopic surgery in managing complicated and complex adnexal tumors. In addition, we agree with their suggestion that the routine use of an enlarged port wound can help us to remove the tumor easily, especially for MCT, and the follow-up procedures, including putting the tumor into the endobag and avoiding or minimizing the risk of any leakage or tear of the endobag during the extraction, are critical. The purpose of all the procedures is to minimize the risk of spillage and spread of the tumor.

However, we have some views that differ from those of Chia and Huang. It would be interesting to know how the authors selected a candidate to receive this kind of surgery. It is not difficult to make a preoperative diagnosis of the ovarian MCT via high resolution

ultrasound, but it may not be easier to get the preoperative diagnosis of the ovarian mucinous tumors. It would be nice to learn how the authors made a preoperative diagnosis of these tumors.

Furthermore, the following comments do not argue against the concept that the laparoscopic surgery is an appropriate method for managing MCT. Rather, it should be said that MCT always constitutes a difficult situation for surgeons, because of the potential risk of intraperitoneal rupture causing spillage of the cyst contents during laparoscopic surgery, with resultant chemical peritonitis [12,13], and most importantly, a serious but rare situation when MCT is sometimes accompanied with malignant transformation [14–16]. That is why we do not agree with the authors’ recommendation of the routine use of a feasible technique being applied in laparoscopic surgery for complex adnexal tumors, especially for MCT. Although their technique seems logical, including the establishment of the wound for “controlled intraoperative spillage”, the closure of the wound would later result in “spillage” of tumor contents into the abdominal cavity, even though they used a lot of normal saline to remove debris after the operation. In addition, the “real” situation after their procedure was not followed up to ensure there were no sequelae. It is a surgical principle that all ovarian cysts be removed intact, if possible. Nevertheless, we cannot underestimate the value of Chia’s technique for managing patients with MCT. In fact, we highly recommend that this wonderful and feasible technique be used as a rescue method when rupture of MCT occurs during laparoscopic surgery, because the technique is easy and not impeded by the learning curve, and, most importantly, it may also save operation time [1].

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Reply:

Dear Dr Wei-Min Liu and Dr Peng-Hui Wang,

Many thanks for your comments on my letter to the editor: “A Feasible Laparoscopic Surgery Technique for Complex Adnexal Tumor”. I totally agree with your opinion that ovarian mature cystic teratoma (MCT) always creates a difficult situation for surgeons, in view of the potential risk of intraperitoneal rupture in causing spillage of the cyst contents during laparoscopic surgery, which might result in chemical peritonitis and, in rare situations, malignant transformation. I always remind myself that these situations might occur after a success laparoscopic surgery for complex adnexal tumor, and hence I always hesitate to perform such surgeries.

For the preoperative diagnosis of ovarian MCTs and ovarian mucinous tumors, I used the combination of computed tomography, ultrasound, and serum tumor markers as the preoperative diagnostic tools. It seemed

to provide a high preoperative diagnostic accuracy in my small number of cases.

For the postoperative follow-up, there were no sequelae or complications noted in this small series of patients. It could be that our cases were simple, without any intra-abdominal lesions, endometriosis, pelvic adhesions or pelvic inflammation disease.

I do agree that the routine use of this technique in laparoscopic surgery for complex adnexal tumors, especially for MCT, is not recommended. It is really amazing that this technique is recommended to be used as a rescue method when rupture of MCT occurs during laparoscopic surgery.

Thanks again for your recommendations, I really appreciate it. I will follow them in my future surgeries.

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