# Plenary Session

## ESSO Award Lecture

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### ESSO award lecture: The challenge of quality assurance in surgical oncology

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Quality assurance in surgical oncology is a challenge because to be comprehensive it must satisfy at least three types of criteria: scientific, technical and clinical.

The first one is the easiest to record objectively. It consists in checking the conformity of all surgical data submitted within the frame of a trial with the trial protocol. This insures that selection criteria, treatment sequences and timing were respected, and all requested biological samples furnished for programmed studies.

It states the capacity of a surgical team to participate to co-operative trials, where reliability is essential.

The second aspect concerns the surgical procedure. It must be conform to set standards. Its quality viewed from the patient perspective can be measured by the absence of per- or postoperative complications, a good functional result and little cosmetic damage.

Surgical trials are undertaken to find out which procedure achieves these goals best. Here also, objective criteria can be reported and evaluated. They measure the quality of the overall care given by a surgical team.

The third and most important aspect of quality assurance involves the entire process of planning the treatment of each individual patient with cancer. It should be curative whenever possible, palliative otherwise, always with the optimal quality of live.

The surgeon who does not want to be just a resection technician or an organ replacer must take part in the counselling and decision process regarding all cancer patients before treatment is started. Too often, each oncology discipline is called in turn to intervene when the current treatment fails.

The first step is to decide if surgery is indicated, and then when to perform what type of operation, alone or in combination with other treatments.

This depends on the general status of the patient and the type and stage of the tumour. The choice of a well informed patient when alternative approaches are possible must be taken into account, and sometime also socio-economic factors.

The most important challenge in quality assurance in surgical oncology is the assurance that the surgeon who diagnoses and treats cancer patients is a true oncologist. Surgical oncology must be recognised. It does not matter if it is labelled as a specialty, subspecialty or special competence. What it implies is graduate and post-graduate teaching of basic and clinical oncology to all medical students first and to specialising surgical trainees later, and access to surgical residencies in oncology centres of excellence. Certification by examination and peer-recognition are both practised in Europe in some countries but without legal value.

The recognition of surgical oncology is a political decision that has already been taken explicitly in some countries and medical faculties and implicitly by most oncology communities. We have now to convert a reluctant surgical profession. Our challenge is not to claim any kind of monopoly but to assure the best possible care to our patients. It is not a matter of clanship, it has become a matter of ethics.

## Special Lecture

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### Minimal invasive surgery in oncology

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**Introduction:** The role of minimal invasive surgery in oncology depends upon whether oncological radicality can be achieved as reliably as in open surgery, and, simultaneously, whether a significant reduction of the patients strain can be achieved.

**Current Status:** Currently, this can be assumed in case of early cancer (pT 1 a), being investigated best in gastric cancer. If the probability of lymph node metastases is very low, the combined intra- and extraluminal full wall extirpation can be considered as an accepted method of treatment.

In more advanced but surgically curable cancers, the value of minimal invasive procedures is questionable. Radical lymphadenectomy is difficult to achieve, larger specimen still cannot be removed properly and manipulations favoring tumor cell spread are not completely avoidable. Minimal invasive procedures still require more time and expense, but the benefit to the patient including at least comparable survival rates has still to be demonstrated. If ever, these procedures should be performed in clinical trials, but general use is not (yet) recommendable.

Minor invasive surgery, however, is indicated if surgical radicality is no precondition, i.e. in the diagnostic work-up and in palliative surgery. Diagnostic laparoscopy improves the precision of tumor staging (peritoneal spread, free intraabdominal tumor cells, peripheral lymph nodes). By laparoscopic ultrasonography, a more detailed information upon liver metastases and vascular involvement can be achieved. In case of Barrett's and gastric cancer, the impact on therapy has already been shown, thus making diagnostic laparoscopy indispensable if multimodal therapy is considered. In pancreatic cancer, laparoscopy is suitable only to avoid laparotomy in irresectable cases, but the diagnostic importance may increase as soon as neoadjuvant regimens are available.

In palliative surgery, the advantages of laparospic procedure are unequivocal (gastroenterostomy, intestinal by-pass operations, feeding fistulae), in particular if performed immediately after diagnostic laparoscopy.

**Conclusion:** Laparospic surgery in oncology is currently under evaluation. The impact upon the diagnostic work-up is increasing. The value in palliative procedures is evident. The auspices in case of surgically curable tumors are still unclear (with the exception of early cancer of the mucosa type). Further clinical evaluation is required prior to general use.