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## Snapshot Study on the Value of Omentoplasty in Abdominoperineal Resection with Primary Perineal Closure for Rectal Cancer

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### TO THE EDITOR:

The reviewing of the results of the ‘snapshot study on the value of omentoplasty in abdominoperineal resection with primary perineal closure for rectal cancer’ (*Ann Surg Oncol.* 2018; 25: 729–736)<sup>1</sup> during a recent national congress, has revived our interest in this study. With great interest we reread the manuscript together with a subsequent letter to the editor,<sup>2</sup> reply<sup>3</sup> and author reflection.<sup>4</sup>

This retrospective snapshot study lumped together 477 patients that underwent abdominoperineal resections in 71 hospitals. Between 172 patients in which an omentoplasty was performed (in 46 hospitals) and 305 patients without an omentoplasty, no significant differences were reported in terms of non-healing of the perineal wound at 30 days, non-healing at the end of the follow-up, pelvic abscess or re-intervention for ileus. Merely a significant difference was noted in perineal hernia development: in 22 omentoplasty patients (13%) and 32 (7%) non-omentoplasty patients.

As mentioned by the authors in their discussion and elaborated by Sandhu et al. in their letter to the editor, the presented snapshot study design is prone to confounding by indication: a greater tendency to perform an omentoplasty as the perineal defect size increased. Such a tendency would explain a higher perineal hernia incidence in the omentoplasty group. But most importantly, the type of omentoplasty and methods to verify its vascularization

were not mentioned. Vascularization can be derived from the right or left gastroepiploic artery. The omentum itself can be elongated by merely a unilateral division of the greater omentum distally from the gastroepiploic vessels with or without leaving the adhesions with the transverse colon intact. Another technique would be to open the lesser sac by dissecting free the adhesions between the omentum and the transverse colon and the lesser sac after which the omentum can be elongated by skeletonization along the greater flexure of the stomach leaving the gastroepiploic vessels intact and dividing them on one side. There are also colleagues that confuse the positioning of an omental slip in the pelvis with an omentoplasty. Furthermore, a transmesocolic and even transmesenteric passage can be made to optimize length and minimize the risk of future bowel obstructions. Finally, the vascularization can be assessed in different ways, including by fluorescence such as indocyanine green.

In their conclusion, the authors note that, in the absence of randomized controlled trials, this large, comparative cohort study provides the best available evidence questioning the routine use of omentoplasty for primary filling of the pelvic space. In a reflection on their own article published 10 months later, they conclude that, on the basis of these results, APR (including extralevator APR that was part of their study) without omentoplasty can be considered the standard of care.<sup>4</sup> We consider it crucial to know the quality of the technique under investigation as suggested for studies investigating surgical techniques.<sup>5</sup> Without such knowledge, the methodological approach is not appropriate, and the comparison as reported by the authors and its resulting induced suggestion, that an omentoplasty is not of added value and results in more perineal hernia, is not justified.

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