Oesophagectomy performed by trainees is as safe as that performed by consultants†

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We read with interest Handagala et al.’s recent paper [1] demonstrating that oesophagectomy was equally as safe when performed by trainees as it was when performed by consultants. We congratulate the authors for their thought provoking paper, especially in the light of several publications which seem to suggest that both surgeon and hospital volume are important prognostic factors in complex cancer operations. We are a high-volume thoracic oncology unit operating an average of 160–170 patients with oesophageal cancer annually and have similar results. We believe, however, that these conclusions need to be interpreted cautiously with the caveats under which this study was conducted.

First, the surgeries were performed in a relatively high-volume centre, with adequate supervision by trained and experienced oesophageal surgeons. These results cannot be extrapolated to a centre which is neither high-volume nor one where supervision of trainees is not equally meticulous. Second, we wonder whether the authors analysed the oncological safety of the procedure when performed by trainees. Though the number of lymph nodes harvested is a surrogate of the surgical technique, the relative occurrence of positive margins, especially the circumferential resection margin, would have been particularly interesting. To take this a step forward, did the authors analyse the overall and disease-free survival in the two groups? Though we do understand that the paper describes the early results of surgery, this would be an important outcome to look at, perhaps in a subsequent paper? Finally, how were the surgeries where the trainee performed one part of the surgery (which is how, we assume, most surgical units would blood their trainees into these complex surgeries) classified? In our unit, a trainee would perform the thoracic part of one surgery, go on to the abdominal part of another surgery and finally to perform the entire surgery on his/her own.

None of the above points detract from what we consider is an extremely informative and stimulating study, but we believe that the conclusions of this paper need to be interpreted in the context in which this unit functions—namely, a high-volume centre with graded exposure to trainees and adequate supervision. We agree with the senior author’s comments that it is indeed a shame that they are the final thoracic oesophageal unit in the country.

REFERENCE


†The corresponding author of the original article [1] was invited to reply but did not respond.