

AperTO - Archivio Istituzionale Open Access dell'Università di Torino

## Reply to Gachabayov et al: Consensus Statement on TaTME: Other Thoughts

### **This is the author's manuscript**

*Original Citation:*

*Availability:*

This version is available <http://hdl.handle.net/2318/1762738> since 2020-11-17T10:07:24Z

*Published version:*

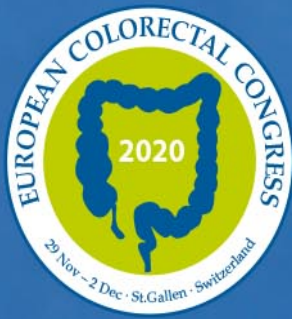
DOI:10.1111/codi.15434

*Terms of use:*

Open Access

Anyone can freely access the full text of works made available as "Open Access". Works made available under a Creative Commons license can be used according to the terms and conditions of said license. Use of all other works requires consent of the right holder (author or publisher) if not exempted from copyright protection by the applicable law.

(Article begins on next page)



29 November – 2 December 2020, St.Gallen, Switzerland

# European Colorectal Congress

JOIN THE VIRTUAL  
EUROPEAN COLORECTAL  
CONGRESS 2020

Sunday, 29 November 2020

## MASTERCLASS

12.50  
Introduction & course objectives  
Michel Adamina, Winterthur, CH

13.00  
Myths and facts about oral antibiotics, bowel preparation, and timing of iv antibiotics to reduce surgical site infection  
Frédéric Ris, Geneva, CH

13.40  
Management of colorectal GIST – all you should know from diagnosis to handling recurrences  
Paris Tekkis, London, UK

14.20  
Handling large rectal adenoma and malignant polyps  
Roel Hompes, Amsterdam, NL

15.00  
What your pathologist can do for you: from standard margins recommendations to molecular pathology, liquid biopsies, and the microbiome  
Phil Quirke, Leeds, UK

15.40  
Prehabilitation, patient blood management, frailty index – welcome addition or resource wasting  
Des Winter, Dublin, IR

16.20  
Selective use of neoadjuvant and adjuvant radiotherapy for rectal cancer  
Chris Cunningham, Oxford, UK

17.00  
Do and don't in taTME surgery – a decade of experience explained  
Willem Bemelman, Amsterdam, NL

17.40  
All techniques to avoid staple line intersections in colorectal surgery  
Antonino Spinelli, Milano, IT

18.20  
Management of pelvic sepsis after colorectal / coloanal anastomosis and oncological outcomes of the GRECCAR 5 trial  
Quentin Denost, Bordeaux, FR

19.00  
Best practices in colostomy construction and repair of parastomal hernia  
Eva Angenete, Göteborg, SE

Sunday, 29 November 2020

## COURSE IN PROCTOLOGY

12.50  
Introduction & course objectives  
Bruno Roche, Geneva, CH

13.00  
Complex anorectal fistula revisited: established wisdom and innovative approaches  
Alexander Herold, Mannheim, DE

13.30  
Diagnosis and repair of childbirth and pelvic floor trauma  
Isabelle Kaelin Gambirasio, Geneva, CH

14.00  
The painful bottom – Proctalgia beyond the classical abscess, fissures, and hemorrhoids  
Bruno Roche, Geneva, CH

14.30  
Sexually transmitted diseases in proctology  
Karel Skala, Geneva, CH

15.00  
Anorectal trauma and foreign bodies  
Richard Cohen, London, UK

15.30  
Pilonidal sinus – strategies and outcomes  
Frédéric Ris, Geneva, CH

16.00  
Fecal incontinence: investigations and conservative treatment  
Beatrice Salvioli, Milano, IT

16.30  
Fecal incontinence: neuromodulation and interventional options  
Joan Robert-Yap, Geneva, CH

17.00  
The pelvic floor revealed: transperineal / transvaginal / transanal repairs explained  
Bruno Roche, Geneva, CH

17.30  
The pelvic floor revealed: investigations and pelvic floor therapy  
Jacqueline de Jong, Bern, CH

18.00  
Obstructed defecation and IBS: investigations, differential diagnosis, and treatment strategies  
Daniel Pohl, Zurich, CH

18.30  
Obstructed defecation: surgical options  
André d'Hoore, Leuven, BE

Monday, 30 November 2020

## SCIENTIFIC PROGRAM

13.50  
Opening and welcome  
Jochen Lange, St. Gallen, CH

14.00  
Is cancer an infectious disease: role of the microbiome  
Philip Quirke, Leeds, UK

14.30  
Ethical considerations in crisis – lessons from Covid-19  
Omar Faiz, London, UK

15.00  
Prophylactic mesh in colorectal surgery  
René H. Fortelny, Wien, AT



15.30  
Lars Pahlman lecture: Extending the limits of liver surgery  
Markus Büchler, Heidelberg, DE

16.00  
Multimodal approaches to colorectal liver metastases  
Mohammed Abu Hilal, Brescia, IT

16.30  
SATELLITE SYMPOSIUM Ethicon  
ETHICON  
Shaping the future of surgery

17.00  
Urogenital dysfunction in patients treated for rectal cancer – what do we know and what can we do?  
Eva Angenete, Göteborg, SE

17.30  
Hemorrhoids – new options and time-tested solutions  
Alexander Herold, Mannheim, DE

18.00  
Anal pain and emergency proctology: what every surgeon should know & do  
Richard Cohen, London, UK

18.30  
All you need to know about anorectal fistula  
Bruno Roche, Genève, CH

19.00  
SATELLITE SYMPOSIUM Medtronic  
Medtronic  
Further Together

19.45  
Strategies and outcomes for obstructive cancers of the colon and rectum  
Willem Bemelman, Amsterdam, NL

Tuesday, 1 December 2020

## SCIENTIFIC PROGRAM

14.00  
Lessons learned along the robotic learning curve: a video guide for colorectal surgeons  
Jim Khan, Portsmouth, UK

14.30  
EAES presidential lecture: Strategies for lifelong learning and implementation of new technologies  
Andrea Pietrabissa, Pavia, IT



15.00  
SATELLITE SYMPOSIUM Intuitive  
INTUITIVE

15.45  
A journey in global surgery – why getting out of the comfort zone  
Raffaele Rosso, Lugano, CH

16.15  
Enhanced recovery pathways reloaded – a practical guide to success  
Roberto Persiani, Roma, IT

16.45  
Cancer at the extremes of age: are there any differences in handling youngsters and seniors  
Des Winter, Dublin, IE

17.15  
SATELLITE SYMPOSIUM BBraun  
B BRAUN  
SHARING EXPERTISE

TOUCHSTONE  
Leading through Innovation

18.00  
Management pearls for early rectal cancer  
Roel Hompes, Amsterdam, NL

18.30  
Ventral rectopexy: indications, tricks of the trade, and long-term results  
Chris Cunningham, Oxford, UK

19.00  
Total neoadjuvant therapy for colon and rectum cancers  
Ronan O'Connell, Dublin, IE

Wednesday, 2 December 2020

## SCIENTIFIC PROGRAM

14.00  
Randomized trial evaluating chemo-therapy followed by pelvic reirradiation vs chemo-therapy alone as preoperative treatment for locally recurrent rectal cancer (GRECCAR 15)  
Quentin Denost, Bordeaux, FR

14.30  
Timeline of surgery following neoadjuvant radiotherapy – balancing morbidity and efficacy  
Torbjörn Holm, Stockholm, SE

15.00  
Place and outcome of total colectomy in the surgical armamentarium  
Neil Mortensen, Oxford, UK

15.30  
Kono S anastomosis and over the valve stricturoplasties: hope for better outcomes  
André D'Hoore, Leuven, BE

16.00  
New drugs, old fears: state of the art management of IBD patients  
Gerhard Rogler, Zurich, CH



16.30  
Do resection of the mesentery in Crohn's & appendectomy in ulcerative colitis alter the course of disease  
Christianne Buskens, Amsterdam, NL

17.00  
SATELLITE SYMPOSIUM Takeda



17.45  
The septic abdomen: getting out of misery and closing the case  
Marja Boermeester, Amsterdam, NL

18.15  
Management strategies for patients with advanced colorectal cancers  
Paris Tekkis, London, UK

18.45  
Anastomotic leak in colorectal surgery: insights, perspectives, and practical strategies  
Antonino Spinelli, Milano, IT

19.15  
Closing words  
Michel Adamina, Winterthur, CH

## Information & Registration

[www.colorectalsurgery.eu](http://www.colorectalsurgery.eu)

The publication of this advertisement does not constitute endorsement by the society, publisher, or Editors, and is unrelated to the content that follows

Article type : Correspondence

**Reply to Gachabayov et al: Consensus Statement on TaTME: Other Thoughts**

On behalf of the TaTME Guidance group representing the ESCP (European Society of Coloproctology), in collaboration with ASCRS (American Society of Colon and Rectum Surgeons), ACPGIB (Association of Coloproctology of Great Britain and Ireland), ECCO (European Crohn's and Colitis Organisation), EAES (European Association of Endoscopic Surgeons), ESSO (European Society of Surgical Oncology), CSCRS (Canadian Society of Colorectal Surgery), CNSCRS (Chinese Society of Colorectal Surgery), CSLES (Chinese Society of Laparo-Endoscopic Surgery), CSSANZ (Colorectal Surgical Society of Australia and New Zealand), JSES (Japanese Society of Endoscopic Surgery), SACP (Argentinian Society of Coloproctology), SAGES (Society of American Gastrointestinal and Endoscopic Surgeons), SBCP (Brazilian Society of Coloproctology) and the Swiss-MIS (Swiss association for Minimally Invasive Surgery)

Participants (in alphabetical order by surname):

Michel Adamina, Felix Aigner, Sergio Araujo, Alberto Arezzo, Shady Ashamalla, Teresa deBecheAdams, Stephen Bell, Willem Bemelman, Carl Brown, Walter Brunner, Nicolas Buchs, Antonio Caycedo, Sami Chadi, Park Sung Chan, David Clark, Quentin Denost, André D'Hoore, Nicola Fearnhead, Nader Francis, Eelco de Graaf, Suguru Hasegawa, Julian Hayes, Alexander Heriot, Roel Hompes, Bert Houben, Masaaki Ito, Mark Katory, Jos Kleijnen, Werner Kneist, Joep Knol, Tsuyoshi Konishi, John Marks, Beatriz Martin-Perez, Justin Maykel, Elisabeth McLemore, Danilo Miskovic, Isacco Montroni Gabriela Möslein, Jae Hwan Oh, Rodrigo Oliva Perez, Marta Penna, Frederic Ris, Gustavo Rossi, Eric Rullier, Gerald Seitinger, Antonino Spinelli, Andrew Stevenson, Patricia Sylla, Ichiro Takemasa, Pieter Tanis, Jared Torkington, Jurriaan Tuynman, Elena Vikis, Janindra Warusavitarne, Mark Whiteford, Hongwei Yao, Seong Hyeon Yun, Zhongtao Zhang, Minhua Zheng

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/CODI.15434](https://doi.org/10.1111/CODI.15434)

This article is protected by copyright. All rights reserved

**Correspondence:**

Roel Hompes, MD, PhD

Department of Surgery, Amsterdam University Medical Centres - location AMC

University of Amsterdam

Meibergdreef 9, 1105 AZ Amsterdam, The Netherlands

Email: r.hompes@amc.uva.nl

Tel: +31 20 – 5662660

Dear Editor,

We thank Gachabayov *et al* for their thoughts and appreciation of our recently published International Expert Consensus Guidance on TaTME [1], and the opportunity to clarify any misunderstandings regarding its purpose and methodology. Firstly, the panellists consisted of 56 internationally known and respected surgeons, experienced in managing rectal cancer not only by TaTME but also by the abdominal approaches. They have performed over 50 TaTME cases each, taught on cadaveric courses, and published literature on the technique. They were also identified and recommended by their national colorectal surgical societies. Given that the aim of the consensus was to formulate guidance specifically on the safe implementation and application of TaTME, rather than the management of rectal cancer as a whole, it is very reasonable for the panel to be composed of practicing surgeons experienced in TaTME. The number of panellists allowed us to bring together the worldwide experience of the technique, with representatives from each of the 14 international societies who also recognised and endorsed the importance of this project. Five rounds of Delphi were required to reach agreement on the statements over three years, suggesting that conformity bias was unlikely as each surgeon clearly expressed their opinion leading to many hours of discussion. The authors quote that 16% of the panellists have a conflict of interest. As stated on the consensus article and on the contrary to another misleading consideration, none of the participants have any direct conflict of interest with regards to the paper. To be open and transparent however we listed commitments with industry by individual

participants. It is not unusual, and in the current era of advancing technical innovation, for specialist senior surgeons to consult and provide direction for these companies.

Secondly, the methodology used consisted of an adapted Delphi method and focus group discussion approach, guided by an expert in guidelines methodology. Consensus was considered achieved when agreement level of >80% was reached. The authors reference a perspective on the Delphi process by Waggoner et al [2] in which the opinion of the three authors was to only include a panel size of 6 – 11 members, based on a few studies and “the lack of current research” [2]. This is in contrast to an extensive set of experiments conducted at the RAND corporation which clearly showed a positive correlation between increasing number of participants with accuracy and reliability of the responses [3]. The size of the panel in most Delphi studies is incredibly variable [2], and often reflects the research question and underlying purpose of conducting the Delphi process which may well lead to varying numbers of participants.

The guidance group acknowledged that at the present time there is no level 1 evidence on TaTME. However, published evidence is accumulating rapidly and, hence we proposed the new concept of “dynamic guidance”, whereby the guidance could be updated as more evidence becomes available. Randomised controlled trials such as COLOR III [4] and ETAP-GRECCAR11 [5] have started patient recruitment but results will not be available for some time. Given the dynamic character of the statements, we also strongly advocated all societies to publish these guidance statements online for review and critical appraisal of their respective membership. Peer review by the wider colorectal community will allow further adaptation and improvement of the current statements.

We agree that “Clinical expertise in the era of evidence-based medicine and patient choice should be integrated with evidence, patients’ preferences, and clinical circumstances” [6].

However, in the context of surgical innovation this is not so straight forward as a technique (and the surgeon’s skill in performing it) may still be evolving and its true benefits and risks not fully known yet.

TaTME is currently in the early part of the assessment phase of the IDEAL framework for surgical innovation [7]. Despite following the IDEAL recommendations and steps closely, especially during the early development of the technique [8], the explorative phase saw a huge surge in TaTME adoption worldwide. This was largely unregulated and unstructured with variable access

to adequate training and provision of experienced proctors. Unsurprisingly, problems soon arose with concerns regarding urethral injuries [8], CO2 embolus [10] and more recently local recurrence [11,12]. It is exactly during these times of widespread discussion and concern about a technique that a consensus is needed. Although the panellists in this consensus may be viewed as being “in favour of TaTME” simply because they perform the technique, the guidance produced actually calls for caution and sets more preconditions and direction for surgeons considering adopting TaTME. By having personally faced the challenges that TaTME can bring, the panellists acknowledge that certain standards and pre-requisites are necessary in order to safely implement the technique. Pre-requisites, such as a minimum annual volume of TME cases, obtaining appropriate training and acquiring advanced surgical skills, are not achievable in every colorectal unit; thus limiting the adoption of TaTME. Furthermore, by setting these standards through the consensus process, self-licensing is more likely to be prevented.

Finally, we feel that the statement “the concept of expert centers is outdated” is incorrect. Expert centres for novel and challenging techniques are vitally important for their safe introduction. Parallels have already been seen with minimally invasive oesophagectomy [13] and endovascular aortic aneurysm repair [14]. The definition of ‘expert centre’ in our consensus contained three components: 1) Centre specifications; 2) Surgeon expertise; 3) Centre performance/outcomes. The latter two categories actually achieved agreement levels of 97.9% and 91.7%, respectively. Only ‘centre specifications’ obtained 62.5% agreement despite lengthy discussions and a further Delphi round. The discussion points regarding this component highlighted the diversity in surgical practice and resource availability around the globe. However, the panellists agreed that complex high-risk cases should not be performed in low volume units sporadically by inexperienced surgeons. Regular exercise of an activity or skill is the way to become proficient in it, hence the importance of securing a high case volume in a well-resourced department.

In conclusion, TaTME captured the colorectal community’s attention, due to perceived advantages, and enthusiasm has led to widespread uncontrolled adoption. This occurred despite the lack of high-level evidence of its equivalence to conventional TME approaches. The International Expert Consensus Guidance aims to promote a more cautious and considered roadmap for the introduction of this new technique into clinical practice. With strong

collaboration, sharing of experiences, high-quality research and regular review of available evidence, surgical innovation can continue to evolve and allow us to provide better patient care.

## References

1. TaTME Guidance Group representing the ESCP (European Society of Coloproctology), in collaboration with the ASCRS (American Society of Colon and Rectal Surgeons), ACPGIB (Association of Coloproctology of Great Britain and Ireland), ECCO (European Crohn's and Colitis Organisation), EAES (European Association of Endoscopic Surgeons), ESSO (European Society of Surgical Oncology), CSCRS (Canadian Society of Colorectal Surgery), CNSCRS (Chinese Society of Colorectal Surgery), CSLES (Chinese Society of Laparo-Endoscopic Surgery), CSSANZ (Colorectal Surgical Society of Australia and New Zealand), JSES (Japanese Society of Endoscopic Surgery), SACP (Argentinian Society of Coloproctology), SAGES (Society of American Gastrointestinal and Endoscopic Surgeons), SBCCP (Brazilian Society of Coloproctology), Swiss-MIS (Swiss Association for Minimally Invasive Surgery). International expert consensus guidance on indications, implementation and quality measures for transanal total mesorectal excision. *Colorectal Dis.* 2020;22(7):749-755.
2. Waggoner J, Carline JD, Durning SJ. Is There a Consensus on Consensus Methodology? Descriptions and Recommendations for Future Consensus Research. *Acad Med.* 2016;91(5):663-8.
3. Dalkey NC. The Delphi method: an experimental study of group opinion, the RAND corporation. RM-5888-PR, 1969.
4. Deijen CL, Velthuis S, Tsai A, et al. COLOR III: A Multicentre Randomised Clinical Trial Comparing Transanal TME Versus Laparoscopic TME for Mid and Low Rectal Cancer. *Surg Endosc* 2016;30(8):3210-3215.

- Accepted Article
5. Lelong B, de Chaisemartin C, Meillat H, et al.; French Research Group of Rectal Cancer Surgery (GRECCAR). A Multicentre Randomised Controlled Trial to Evaluate the Efficacy, Morbidity and Functional Outcome of Endoscopic Transanal Proctectomy Versus Laparoscopic Proctectomy for Low-Lying Rectal Cancer (ETAP-GRECCAR 11 TRIAL): Rationale and Design. *BMC Cancer*. 2017;11;17(1):253.
  6. Haynes RB, Devereaux PJ, Guyatt GH. Clinical expertise in the era of evidence-based medicine and patient choice. *Vox Sang*. 2002;83 Suppl 1:383-6.
  7. McCulloch P, Altman DG, Campbell WB et al. Balliol Collaboration. No surgical innovation without evaluation: the IDEAL recommendations. *Lancet* 2009;374:1105–1112.
  8. Roodbeen SX, lo Conte A, Hirst A, et al. Evolution of transanal total mesorectal excision according to the IDEAL framework. *BMJ Surg Interv Health Technologies* 2019;1:e000004. doi:10.1136/bmjsit-2019-000004
  9. Sylla P, Knol JJ, D'Andrea AP, Perez RO, Atallah SB, Penna M, Hompes R, Wolthuis A, Rouanet P, Fingerhut A; International taTME Urethral Injury Collaborative. Urethral injury and other urological injuries during transanal total mesorectal excision: An International Collaborative Study. *Ann Surg*. 2019 Sep 17. doi: 10.1097/SLA.0000000000003597. Online ahead of print.
  10. Dickson EA, Penna M, Cunningham C, et al. On behalf of the International TaTME registry collaborative. Carbon Dioxide Embolism Associated with Total Mesorectal Excision Surgery: A Report from the International Registries. *Dis Colon Rectum* 2019; 62(7):794-801.
  11. Wasmuth HH, Faerden AE, Myklebust TA, et al., Norwegian TaTME Collaborative Group, on behalf of the Norwegian Colorectal Cancer Group. Transanal Total Mesorectal Excision for Rectal Cancer Has Been Suspended in Norway. *Br J Surg* 2020; 107(1):121-130.
  12. van Oostendorp SE, Belgers HJ, Bootsma BT, et al. Locoregional recurrences after transanal total mesorectal excision of rectal cancer during implementation. *Br J Surg* 2020 Apr 4;107(9):1211-1220
  13. Markar SR, Ni M, Gisbertz SS, van der Werf L, Straatman J, van der Peet D, Cuesta MA, Hanna GB, van Berge Henegouwen MI; Dutch Upper GI Cancer Audit and TIME Study Group. Implementation of Minimally Invasive Esophagectomy From a Randomized



Controlled Trial Setting to National Practice. *J Clin Oncol*. 2020 Jul 1;38(19):2130-2139.

doi: 10.1200/JCO.19.02483. Epub 2020 May 18. PMID: 32421440.

14. Karthikesalingam A, Holt PJ, Vidal-Diez A, Bahia SS, Patterson BO, Hinchliffe RJ, Thompson MM. The impact of endovascular aneurysm repair on mortality for elective abdominal aortic aneurysm repair in England and the United States. *J Vasc Surg*. 2016 Aug;64(2):321-327.e2. doi: 10.1016/j.jvs.2016.01.057. Epub 2016 Apr 1.