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Commentary: Minimally invasive Ivor Lewis esophagectomy: Unless you have tried it, don't knock it!

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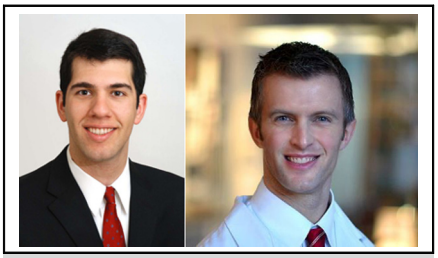

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CENTRAL MESSAGE

This video atlas describes a laparoscopic/thoracoscopic minimally invasive Ivor Lewis esophagectomy technique distilled down into 10 steps and backed with excellent published outcomes.

The evolution of esophageal resection and reconstruction techniques has been "the tale of men repeatedly losing to a stronger adversary yet persisting in an unequal struggle until the nature of the problem became apparent and the war was won."[1] While attempting to reduce the risk of significant morbidity and mortality while maximizing quality of life and long-term survival, the refinement of esophagectomy approaches has also required tenacity on the part of pioneering surgeons to persevere in the face of harsh criticism, such as Dr Alton Oschner's colorful condemnation of Dr Mark Orringer's early transhiatal esophagectomy series presented at the American Association for Thoracic Surgery 58th Annual Meeting, to which Dr Griffith Pearson replied, "Unless you have tried [it], don't knock it! "[2,3] Throughout their evolution over the last 30 years, minimally invasive esophagectomy (MIE) techniques have been similarly disparaged. However, there is now level 1 evidence from 2 multicenter randomized trials demonstrating that MIE is associated with less morbidity and improved quality of life as compared with open approaches, without compromising oncologic quality. As experience with minimally invasive techniques expanded to more and more surgeons and with the accumulating body of evidence in the literature supporting its benefits, MIE emerged as the most common esophagectomy approach in the United States[4] and is the clear direction of the art of esophagectomy.[5]

In this issue of *JTCVS Techniques*, Harrington and Molena[6] clearly and concisely outline their laparoscopic/thoracoscopic minimally invasive Ivor Lewis esophagectomy technique, distilled down into 10 critical steps. Their video atlas and accompanying text will be a valuable resource for both novices and experienced MIE surgeons wishing to refine their own techniques.[5] Importantly, for those interested in using this atlas and other resources to begin their own MIE program, a dedicated systematic team approach, persistence, and constant reassessment of one's outcomes are essential, as the authors' and other surgeons from their institution have demonstrated for standard laparoscopic/thoracoscopic[7] and robot-assisted MIE.[8]

Compared to the details described in this video atlas, some MIE surgeons (ourselves included) may tout slight differences in the specifics of our preferred MIE techniques, including instrumentation; philosphy on tissue handling and extent of nodal dissection; routine use of a pyloroplasty/pyloromyotomy, a feeding jejunostomy tube, or a formal pedicled omental flap; the specific anastomotic technique; or whether to use a standard laparoscopic/thoracoscopic or robot-assisted approach. However, it should be acknowledged that the true testimony of the quality an operation is an honest appraisal of its outcomes. Indeed, excellent outcomes have been previously published by Dr Mungo and colleagues, further evidence of the quality of the operation detailed in this video atlas.[7] We spend too little time away from our own busy clinical practices to learn from our

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colleagues and grow as surgeons. This video atlas provides such an opportunity to efficiently learn from an expert esophageal surgeon.

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