DEPARTMENT OF SURGERY

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Our Ref: RHK/ak/

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Dr C Longson
Director
Centre for Health Technology Evaluation
National Institute for Health and Clinical Excellence
MidCity Place
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Dear Dr Longson

I enclose a reply to the Aberdeen Health Technology Assessment Groups' report on laparoscopic colorectal cancer surgery, completed on 15 November 2005.

With best wishes,

Yours sincerely

Mr R H Kennedy MS FRCS
Consultant Surgeon

The Association of Coloproctology of Great Britain and Ireland response to the Aberdeen Health Technology Assessment for NICE Technology Appraisal No. 17 on Laparoscopic surgery for colorectal cancer

The Aberdeen Health Technology Assessment Group (AHTAG) have stated that *'survival following laparoscopic resection of colorectal cancer appears to be similar to that following open surgery'*, but that *'laparoscopic surgery is associated with short term recovery benefits'. 'The use of laparoscopic surgery within the NHS will depend upon the judgements about the balance between additional cost and shorter recovery' – 'currently the difference in cost is approximately £250-£300 per patient'*.

This is a balanced assessment of the current literature that has been provided by the AHTAG but it does not accurately reflect the magnitude of improvement in recovery following laparoscopic surgery, partly because there is not yet any qualitative research published on the subject. The Assessment is, of necessity, based on historic data which no longer reflects the improvements in outcome that are now apparent with increasing experience of the technique. The increased experience results in reduced conversion rates, a decrease in operative duration and increased applicability of the technique in elective colorectal cancer surgery - conversion rates of 7% (reference 40, AHT Assessment) have recently been reported, with applicability of the technique to more than 90% of elective colorectal cancer surgery (Association of Coloproctology of Great Britain and Ireland (ACP) submission to NICE). Although this data may be considered efficacy data at present, there is no doubt that it will be reproducible throughout a large proportion of British surgical practice following appropriate training.

The meta analysis of short term outcomes after laparoscopic colorectal cancer resection reported by Abraham (reference 1, ACP submission, not mentioned in the AHT Assessment) documented significant reductions in hospital stay, post operative pain, blood loss and complications in an analysis of 2512 procedures from 12 randomised trials. Conversion of the laparoscopic procedure to open surgery occurred in 14% of patients reported in the meta analysis but when this figure reduces to less than 10%, the benefit from laparoscopic surgery will be greater. Coupled with the reduction in theatre time, not only will the clinical results from laparoscopic surgery improve, but the cost of care will also reduce. This is reflected in the trial reported by King et al (Reference 14, ACP submission; reference 40 AHT Assessment) in which, with conversion rates of 7%, costs of laparoscopic resection were less, although not significantly so, than those of open resection. In addition with increasing utilisation of disposable equipment, manufacturer's costs are expected to decrease.

There has been no data reported from randomised trials on the incidence of re-operation for incisional hernia repair or treatment of adhesion obstruction after this type of surgery. The only large study to date, which has looked at it, is a case-matched comparison reporting a significant reduction in re-operations for incisional hernia repair (reference 8, ACP submission). If one considers the incidence of incisional hernia to be 10% following elective open surgery for colorectal cancer, then reduction in this event will be a considerable cost saving to the NHS.

Training

The AHT Assessment has stated that the pool of surgeons within the UK that can provide preceptorship, or training in this subject is small. The preceptorship programme was set up in 2004 and is delivered by 19 surgeons who have performed more than 100 laparoscopic colorectal

resections. In addition, there is a development group of 25 surgeons who have performed more than 50 laparoscopic colorectal resections, who will become preceptors in the near future. The programme involves a structured approach to training which requires established consultant colorectal surgeons to undertake the following:

1 To observe 10 laparoscopic colorectal resections.
2 To visit a preceptor's centre along with the preceptee's theatre staff in order to observe the changes in theatre practices required in laparoscopic colorectal surgery.
3 Preceptorship in 2-4 cases, allowing the preceptee to operate with a preceptor as an assistant.
4 The provision of educational material in the form of structured video recordings to enable development.
5 Guidance on the selection of patients for laparoscopic colorectal surgery during the preceptee's initial operative experience.
6 The advice that the preceptee should undertake approximately 2 laparoscopic colorectal resections per month in the subsequent 2 years.
7 The requirement that preceptees should discuss outcomes following laparoscopic surgery in their local hospital audit meeting, in line with the General Medical Council's guidelines on introducing new techniques in medical practice.
8 A requirement to submit outcome data to the national audit on colorectal cancer outcomes.

Although this preceptorship programme has only been running for a year 27 consultant surgeons have already used it.

Resource transfer between primary and secondary care

The AHT Assessment has suggested that earlier discharge associated with laparoscopic surgery in enhanced recovery programmes may result in transfer of cost to the community (section 7.3). The randomised trial assessing laparoscopic and open surgery within the context of an enhanced recovery programme (King et al, reference 40, AHTA) demonstrated the opposite: a reduction in community costs following laparoscopic surgery, and also a reduction in indirect costs. A further paper by King et al (Colorectal Disease in press – submitted to AHTAG but not included in their references) comparing results following conventional recovery programmes with those of enhanced recovery, did not show a significant increase in community costs associated with enhanced recovery, but did show a reduction in indirect costs.

In conclusion, we would strongly encourage the appraisal committee to approve the further development of laparoscopic colorectal cancer surgery. It has the potential to transform short term outcomes once surgeons have been appropriately trained in these techniques. It is likely to be either cost neutral or to reduce the costs of surgery and it has the potential to improve oncological outcomes following cancer surgery (reference 10, ACP submission), although further research is necessary to clarify this.

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Mr Mark Gudgeon MS FRCS
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