

Hand-Assisted Laparoscopic Surgery

To the Editor—We read with interest the paper by Dr. Ou¹ on laparoscopic-assisted colon resection. We believe that the principle of a “hand-assisted” approach² and the rationale leading to it³ is applicable to a variety of surgical procedures. We have used it to stage Hodgkin’s disease⁴ and to perform splenectomies,⁵ nephrectomies,⁶ gastric funduplications and adrenalectomies, and colon resections. Although we have performed a significant number of colon resections using this method, we believe this is one procedure that the advantages of a laparoscopic approach with or without hand insertion are yet to be proven convincingly. We have a strong bias that most hand-assisted procedures will yield better results if a suprapubic incision can be used.²

REFERENCES

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The Author Replies

To the Editor—I agree with Dr. Kusminsky and colleagues that many intra-abdominal procedures can be applied with laparoscopic hand-assisted minilaparotomy. However, I believe that the advantage of

using laparoscopic hand-assisted minilaparotomy at the upper abdomen more than conventional open laparotomy is greater compared with the counterparts at the lower abdomen, because there is more pain and associated complications in an upper abdominal incision than in the lower abdomen.

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Cimetidine and Colorectal Cancer

To the Editor—We read with considerable interest the paper of Svendsen *et al.* concerning cimetidine and colorectal cancer¹ because it parallels our own experience with cimetidine as an adjuvant agent in colorectal cancer² and also that of Matsumoto of Japan.³ In patients undergoing resection for cure, Matsumoto found a significant survival advantage of 28 percent in patients receiving cimetidine for colon cancer ($P = 0.025$) and 47 percent for rectal cancer. We found a trend to survival advantage for colorectal cancer of 34 percent ($P = 0.17$), whereas Svendsen and colleagues found a trend to survival advantage of 29 percent in patients with Stage C cancers ($P = 0.11$). The major difference between our own and the other two studies is that our patients received cimetidine only in the perioperative period, whereas in the other two studies the patients began the cimetidine postoperatively and continued it for at least 12 months.

We believe there are at least three ways that cimetidine may improve survival in colorectal cancer. First, perioperative cimetidine reduces the immune-suppressing effects of colonic resection.⁴ Animal work demonstrated that this period of postoperative anergy potentiates tumor growth and may increase the risk of metastatic implantation.⁵ Second, cimetidine potentiates the activity of the immune system by antagonizing the effects of histamine on suppressor T lymphocytes.⁶ It has been shown that colorectal cancers produce high levels of histamine that will act to inhibit the local immune response,⁷ and we have shown that patients receiving cimetidine more frequently display a local immune response to their cancers than controls.² Third, histamine acts as a direct growth factor for some colorectal cancers, antagonized by cimetidine.⁸