EDITORIALS

COVID-19 and the ANZ Journal of Surgery

As more and more people are profoundly affected by coronavirus disease 2019 (COVID-19) restrictions, I wish to share an important update from our publisher, Wiley, on decisions they have made to manage their publishing operations during the pandemic.

Like many of us, Wiley and their vendor partners in most regions are now working from home. This, in combination with some country-wide lockdowns, is leading to disruption across the publishing industry, particularly affecting its workflow.

At present, the most acute challenge is in the distribution of print content. In many countries, the distribution of print materials has been suspended making it impossible to ensure copies reach intended destinations. Fewer passenger flights and the need to prioritize medical supplies has also reduced the availability of air freight.

Given these obstacles and concerns, as well as desire to reduce pressure on supply chain vendors to send their employees to work and increase their risk of exposure to the virus, Wiley has made the decision to suspend all printing and distribution of journal issues including the ANZ Journal of Surgery until further notice.

Fellows, trainees, International Medical Graduates (IMGs) and other College stakeholders have existing access to the online publication, which will definitely continue, via Wiley Online Library. The College Library will continue distributing an electronic table of contents to those who request such. The College will also be working closely with the team at Wiley to help members who rely on print copies to access the journal digitally. Wiley will share more information on options for alternative access as soon as possible.

The journal welcomes manuscripts submitted addressing the impact of COVID-19 on all aspects of surgery. Wiley has processes in place to ensure rapid online publication of those articles following peer review and acceptance.

With the pandemic-associated downturn in elective surgical activity, there is likely to be an increased opportunity for fellows, trainees and IMGs to prepare and submit manuscripts to the journal for publication. In addition, the current forced transition to exclusive online publication of the journal for a potentially unknown duration presents an opportunity for the College to consider moving to online publication on a permanent basis – a recent trend which has been observed with many publications worldwide.

In the meantime, please do not hesitate to reach out with any immediate questions and I will work with the team at Wiley to provide more information and to assist you with access to journal content. COVID-19 is creating a very fast-moving situation worldwide. However, both the College and Wiley are committed to ensuring the least disruption as possible to the assessment and dissemination of surgical research in these challenging times.

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Transanal total mesorectal excision: the new kid on the block or a false dawn?

Introduction of new surgical techniques remains a significant challenge. The evolution of surgery is essential to improve patient outcomes, with the utilization of new technology and approaches, aiming to counter existing difficulties and deficiencies in current management. It is essential that new techniques are evaluated methodically with the aim of maintaining patient safety and avoiding peaks of new complications such as bile duct injuries with the introduction of laparoscopic cholecystectomy whilst minimizing false positives such as the apparent increase in port site metastases in laparoscopic colorectal resections, which delayed the more generalized introduction of this approach.

Rectal cancer continues to be a difficult problem to solve. It should be remembered that one of the core principles of rectal cancer resection, that of total mesorectal excision with sharp dissection, gained notoriety through a personal ‘crusade’ by an individual surgeon, Bill Heald, from a small district general hospital. It was never tested in a randomized controlled trial (RCT), but excellent results from small cohort studies, aligned with demonstrable pathological explanation, resulted in a number of countries adopting the technique through educational courses, and subsequent demonstration of a significant national reduction in local recurrence.1

Increased sophistication in evaluation has resulted in laparoscopic resection of rectal cancer being assessed through RCTs. Whilst a European and Korean trial demonstrated oncological equivalence of laparoscopic resection,2,3 a USA and an Australasian trial did not demonstrate non-inferiority of the laparoscopic

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