

of laparoscopic surgery.<sup>16</sup> Our analysis, however, shows that although most of our cases - 53% - were T3, the conversion rate remained low - only 5.7%. Conversion rates are expected to scale back over time. The CLASICC trial, for example, had a conversion rate of 34%<sup>17</sup> for rectal cancer, while this was 16%<sup>18</sup> in additional recently published trials from Western population regions. Surgical experience is one of the most crucial elements for quality patient care in laparoscopic procedures. Recent studies show that with increasing laparoscopic hospital volume, conversion decreases below 10% with only a minimal impact of conversion on short-term postoperative outcome. To perform an early conversion may be an appropriate decision, and this kind of conversion should not be considered a failure.<sup>19</sup>

Some oncological parameters like tumor size, number of lymph nodes retrieved, and surgical margin, are important to assess the oncological adequacy of the operation. Of those, lymph node status is probably the strongest pathologic predictor of patient outcome, and it represents a high quality indicator for cancer care. Sufficient node staging (TNM) is absolutely essential to establish definitive diagnosis and prognosis of the patient and is essential for planning further oncologic treatment. Several studies support that number of lymph nodes harvested during an operation (minimum 12 lymph nodes) is one of the strongest predictor for cancer treatment because it is associated with a better survival rate. In our study, the average number of harvested lymph nodes was 13, which is a very important result, showing adequate oncological resection. In terms of tumor size, our data shows that almost all of the operated patients had PT2, PT3 lesions (87.7% together), which is a reflection of the low screening rate within our population. Laparoscopic surgery for advanced colorectal cancer has become widespread, with demonstrated short-term benefits and better long-term oncological outcomes than open surgery.<sup>4,16,21-23</sup> However, for locally advanced pathological T4 (pT4) carcinoma based on the American Joint Committee on Cancer (AJCC) TNM staging system,<sup>24</sup> the safety and feasibility of laparoscopic procedures remain controversial. In pT4 carcinoma, technically demanding surgical procedures, including en bloc resection of adjacent infiltrated organs or structures, are generally required. It is well-known that open multivisceral resection for pT4 colon cancer includes a high postoperative morbidity and a high risk of microscopically positive surgical margins.<sup>25</sup> For these reasons, some authors consider pT4 colon cancer to be a relative contraindication to laparoscopic surgery which could lead to prolon-

352 ·