JSCP-KSCP Symposium

2026年11月20日(金) 9:50 ~ 11:10 | 第5会場（1F 会議室102）

JSCP-KSCP Symposium 2　Precision & Extent: The Evolving Standard of Colon Cancer Surgery

Moderator: Gyu-Seog Choi (Kyungpook National University, Korea), Ichiro Takemasa (Osaka International Medical and Science Center, Japan)

[JKS2-1] T1 Colon Cancer Treatment Strategy after EMR or ESD

*Rumi Shin[1] (1. Department of Surgery, Seoul National University Boramae Medical Center / Seoul National University College of Medicine, Korea)

[JKS2-2] Which is the optimal approach for advanced transverse colon cancer, transverse colectomy or extended right hemicolectomy? -JCOG2304-

Tomonori Akagi[1], Takumi Hasegawa[1], Masafumi Inomata[1] (1. Department of Gastroenterological and Pediatric Surgery, Oita University Faculty of Medicine, Japan)

[JKS2-3] Minimally Invasive Surgery for T4 Colon Cancer: Is It Safe?

*Byung Soh Min[1] (1. Yonsei University College of Medicine, Korea)

[JKS2-4] Robot-Assisted Colon Cancer Surgery Using Various Types of Robotic Surgical Systems

*Yasumitsu Hirano[1] (1. Department of Gastroenterological Surgery, Saitama Medical University International Medical Center, Hidaka, Saitama, Japan)

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Endoscopic resection is first-line for lesions that look benign, so pT1 colon cancer is usually diagnosed only after the specimen reaches pathology. The surgeon must then decide on a specimen rather than a tumour: completion colectomy, or surveillance. About 11% of pT1 colorectal cancers harbour nodal metastasis, yet the Japanese criteria flag roughly 80% of patients for additional surgery - sensitivity 100%, specificity 19% - so four in five of those operations treat node-negative disease.

Risk stratification: mutually adjusted, only lymphovascular invasion (OR 3.16), tumour budding (2.83) and poor differentiation (2.14) remain independent predictors; submucosal depth does not (1.73, 95% CI 0.96-3.12). Depth is a gradient, not a switch: 1.3-2.6% when it is the only adverse finding, 11.0% beyond 2,000 micrometres, and surgery for depth alone did not reduce recurrence.

Indications, and their cost: Japanese, Korean and Western rules draw the line in different places, and Korea itself has two guidelines that disagree. Refined criteria based on budding, poorly differentiated clusters and lymphovascular invasion reduced false positives by 41-45% without missing nodal disease, and a Korean nomogram adds a factor no guideline counts - cancer in a residual adenoma (OR 0.58).

Oncologic safety and individualised decisions: where the Japanese criteria say no, nodal metastasis is 1.8%, recurrence 0.4% and five-year disease-free survival 99.6%. Nodal risk is only one side of the equation; age, comorbidity, a low rectum and the ability to commit to surveillance change what the operation costs - which is why this belongs in a multidisciplinary discussion, not a checklist.

I will propose one minimum pT1 pathology dataset for KSCP and JSCP, reported the same way in both countries.

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[JKS2-2] Which is the optimal approach for advanced transverse colon cancer, transverse colectomy or extended right hemicolectomy? -JCOG2304-

Tomonori Akagi[1], Takumi Hasegawa[1], Masafumi Inomata[1] (1. Department of Gastroenterological and Pediatric Surgery, Oita University Faculty of Medicine, Japan)

Based on previous reports, transverse colectomy for Stage II/III transverse colon cancer is expected to have the same long-term outcomes as extended right hemicolectomy and to reduce postoperative loss of bowel function. Although the short-term outcomes of both techniques are controversial, transverse colectomy has been reported to reduce postoperative loss of bowel function by preserving the organs. In general, small bowel-colon anastomosis is considered more advantageous than colo-colon anastomosis in terms of blood flow after reconstruction, and this has been one of the reasons for choosing extended right hemicolectomy. However, recent advances in surgical instruments and the introduction of ICG blood flow evaluation during anastomosis have enabled stable anastomosis even with colo-colon anastomosis. A survey conducted in October 2021 by the Colorectal Cancer Group on the selection of the surgical technique for this population from 47 centers showed that 58% of the patients underwent extended right hemicolectomy and 41% underwent transverse colectomy.

We designed the JCOG2304 trial to evaluate the efficacy of a transverse colectomy compared to an extended right hemicolectomy. The target population for this study is Stage II/III transverse colon cancer patients whose tumor responsible vessel is the middle colonic artery and who require D3 lymph node dissection. The primary endpoint is recurrence-free survival, and secondary endpoints include overall survival, Wexner score, LARS score, and quality of life assessment. A total of 498 patients are planned to be enrolled, with an enrollment period of 5 years, a follow-up period of 3 years after completion of enrollment, a 1-year analysis period, and a total study period of 9 years. The results of the questionnaire survey on transverse colon cancer in the JCOG Colorectal Cancer Group and an overview of new clinical trials will be reported.

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[JKS2-3] Minimally Invasive Surgery for T4 Colon Cancer: Is It Safe?

*Byung Soh Min[1] (1. Yonsei University College of Medicine, Korea)

Background: T4 colon cancer carries a high risk of recurrence, particularly peritoneal metastasis (PM). The oncological safety of minimally invasive surgery (MIS) remains controversial.

Methods and Results: Recurrence rates in T4 colon cancer are 32%, 34%, and 63% for N0, N1, and N2 disease, respectively. Several retrospective studies reported higher PM rates after laparoscopic surgery. A Japanese multicenter study of 2,380 patients with pT4a cancer found higher PM incidence after laparoscopic than open surgery (13.0% vs. 7.7%, P = 0.001). However, pooled randomized trial data showed no significant difference. Preventive hyperthermic intraperitoneal chemotherapy (HIPEC) has yielded conflicting results: COLOPEC showed no significant benefit, whereas HIPECT4 improved locoregional control. Neoadjuvant chemotherapy in the FOXTROT trial improved tumor downstaging and R0 resection rates while reducing recurrence risk.

Conclusion: Laparoscopic colectomy may be appropriate for carefully selected patients with T4 colon cancer, although its impact on PM remains uncertain. Individualized patient selection, meticulous surgical technique, and multidisciplinary strategies are essential. Further prospective studies are needed to clarify oncological safety and establish selection criteria.

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[JKS2-4] Robot-Assisted Colon Cancer Surgery Using Various Types of Robotic Surgical Systems

*Yasumitsu Hirano[1] (1. Department of Gastroenterological Surgery, Saitama Medical University International Medical Center, Hidaka, Saitama, Japan)

Background and Aims: Colon cancer surgery has evolved differently in Japan and Korea, reflecting variations in surgical approaches and training systems. With the widespread adoption of robot-assisted surgery, harmonisation and standardisation of surgical techniques are increasingly important. Our department has implemented a multi-platform strategy using the da Vinci Xi, SP and 5 systems. This study evaluated their practical application in colon cancer surgery and their potential to contribute to harmonisation of surgical practices between Japan and Korea.
Patients and Methods: We retrospectively reviewed patients who underwent robot-assisted surgery for colon cancer at our institution. Technical characteristics, case-selection strategies and short-term outcomes of these systems were evaluated, focusing on procedural standardisation, minimal invasiveness, tissue-handling safety and objective assessment using digital data.
Results: Safe and precise colon cancer surgery was feasible with all three platforms. The Xi, with its versatility and established workflow, was suitable for standardised surgery and training. In selected patients, the SP enabled a single-port approach with safety comparable to the Xi, while reducing abdominal wall trauma through a shorter incision and less postoperative pain. The da Vinci 5 provided force feedback, allowing real-time awareness of tissue traction, while Case Insights enabled objective assessment of surgical performance. These findings suggest that standardisation does not require a single platform; rather, common surgical principles can be maintained while selecting the most appropriate system for each patient and procedure.
Conclusions: A multi-platform strategy using the respective strengths of the Xi, SP and 5 may achieve both minimal invasiveness and surgical safety. Shared principles of case selection, procedural standardisation and data-driven evaluation may contribute to a precise, reproducible and globally applicable standard for robotic colon cancer surgery.

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