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Editorial

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Dear Colleagues and Readers,

The landscape of general and specialized surgery continues to balance the necessity of high-acuity emergency interventions with the refinement of elective procedures. These editorial reviews of eight recent studies from diverse surgical fields in this issue highlight how clinical decision-making relies on regional data and precise multi-variable risk analysis.

Strategic Risk Stratification and Surgical Outcomes in Gastrointestinal Malignancies

Gastrointestinal malignancies frequently present a delicate clinical balance between screening efficiency and acute emergency management. On the screening front, Inlao evaluated the diagnostic performance of the Asia-Pacific Colorectal Screening (APCS) risk score and the quantitative Fecal Immunochemical Test (FIT) among 662 patients.[1] While standalone applications of FIT or an APCS score ≥ 4 yielded modest discriminative value (AUROC < 0.60), combining the two modalities improved diagnostic specificity to 79.0%.[1] Crucially, integrating comorbidities like diabetes mellitus and simple laboratory metrics like hematocrit levels yielded a highly robust predictive model (AUROC = 0.86), offering an efficient tool for risk-based colonoscopy referral.[1]

When early detection fails, patients often present with advanced complications such as obstruction or perforation. Orapan conducted a retrospective cohort study comparing emergency and elective resections among 191 patients with colon cancer at Suratthani Hospital.[2] The emergency cohort demonstrated significantly higher comorbidity profiles, a greater necessity for colostomy, and an elevated in-hospital mortality rate (OR 6.8).[2] Long-term surveillance over five years identified bowel perforation and obstruction as independent predictors of worse survival, though adjuvant chemotherapy remained a highly potent protective factor, demonstrating that presentation type carries an intrinsic prognostic burden independent of staging alone.[2]

Even more challenging is the management of ultra-rare gastrointestinal tumors. Tran et al. documented an exceptional case of a 69-year-old female presenting with an acute abdomen secondary to an ileal perforation, combined with a concurrent level III cervical lymph node metastasis from small bowel adenocarcinoma (SBA).[3] This highly aggressive systemic phenotype underscores the diagnostic difficulty posed by deep-seated jejunoileal tumors and highlights the critical role of urgent laparoscopy and immunohistochemistry panels (CK7/EMA positivity with CK20 negativity) in confirming intestinal tumor origin when primary radiologic findings are ambiguous.[3]

Critical Timing and Systemic Burden in Hepatobiliary and Vascular Emergencies.

Optimizing surgical timing remains a foundational debate in acute inflammatory conditions. The disruption of elective healthcare services during the SARS-CoV-2 pandemic provided a unique natural experiment regarding delayed interventions. Alcalá et al. investigated the impact of delayed care by comparing elective laparoscopic cholecystectomies performed before the pandemic (2019) to those delayed until 2021.[4] Delayed surgeries were directly associated with a significant shift in disease severity, resulting in a distinct surge in moderate acute cholecystitis according to the Tokyo Guidelines.[4]

Expanding on this hepatobiliary dilemma, Wiboonkhwan presented a narrative review evaluating early versus delayed laparoscopic cholecystectomy for acute cholecystitis.[5] While early intervention within 72 hours under optimal institutional settings maximizes cost-efficiency and minimizes total hospital stays, real-world data reveal a peak bile duct injury (BDI) rate of up to 2.8% when surgeries are performed during the subacute fibroblastic phase (days 4–7).[5] Consequently, in settings with limited resources or variable surgical volumes, delaying cholecystectomy following conservative management or advanced drainage techniques—such as percutaneous transhepatic gallbladder drainage (PTGBD) or endoscopic ultrasound-guided lumen-apposing metal stents (EUS-LAMS)—serves as a crucial, patient-centered alternative procedure that prioritizes safe cholecystectomy standards.[5]

A parallel imperative for timely clinical intervention and aggressive comorbidity management is evident in peripheral vascular emergencies. Hanaroonsomboon et al. analyzed outcomes in 152 adult patients who underwent open surgical revascularization for Rutherford Class II acute lower-limb ischemia (ALI).[6] The study observed a substantial 17.1% major amputation rate, identifying hypertension, chronic kidney disease, congestive heart failure, sepsis, and a symptom duration exceeding 24 hours as independent risk factors for limb loss.[6] Conversely, the performance of a fasciotomy emerged as an essential, highly protective modifiable aspect of care to mitigate reperfusion-related compartment syndrome.[6]

Specialized Interventions: From Neonatal Reconstruction to Tissue Engineering

In specialized surgical fields, structural and tissue-level reconstructions require similar refinement in operational priorities and biological enhancement. In pediatric surgery, Lertnuwat retrospectively evaluated the effect of time to surgery on enteral feeding outcomes in 23 neonates with uncomplicated gastroschisis.[7] Although sample size constraints limited statistical significance across cohorts, clear clinical trends demonstrated that earlier surgical reduction and abdominal wall closure (whether via primary fascial closure or staged silo placement) correlated with an increased probability of earlier enteral feeding initiation and a reduced total duration of parenteral nutrition.[7] This clinical benefit strongly supports the role of early prenatal diagnosis and immediate in utero maternal transfer to optimize preoperative stabilization and minimize dangerous postnatal transit delays.[7]

Finally, at the intersection of surgical technique and regenerative medicine, Sakarinpanichakul et al. conducted a prospective, randomized, controlled intra-patient trial to investigate whether topical application of injectable platelet-rich fibrin (I-PRF) accelerates healing of split-thickness skin graft (STSG) donor sites.[8] Evaluating 30 patients using an intra-patient model to control for systemic baseline variables, the study revealed no statistically significant differences in macroscopic epithelialization rates or microscopic epidermal thickness between the I-PRF treated zones and the paraffin gauze controls.[8] Due to the immense micro-environmental biological noise and the potential for local cytokine diffusion across adjacent fields, the routine topical application of I-PRF at graft donor sites is currently not recommended, thereby streamlining operative time and avoiding unnecessary procedural costs without compromising patient recovery.[8]

In summary, these eight investigations on this issue emphasize that modern surgical excellence cannot be dictated by rigid temporal cut-offs. Whether managing neoplastic progression, assessing acute inflammatory boundaries, or introducing autologous tissue adjuncts, surgical success is determined by objective risk stratification, clinical flexibility, and an unwavering commitment to safe, individualized patient-centered protocols.

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