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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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Transanal transection and single-stapled anastomosis for ileo-anal pouch surgery – a video vignette

Dear Editor,

Transanal transection single-stapled anastomosis (TTSS) has been proposed for low rectal surgery [1,2]. Compared with the double-stapling technique, TTSS provides a precise distal transection and a single-stapled double purse-string anastomosis. In this video (Video S1 in the Supporting Information) we demonstrate the application of TTSS in pouch surgery.

A 48-year-old female patient was scheduled for laparoscopic single-port trans-stomal completion proctectomy and TTSS ileo-anal pouch anastomosis.

The ileostomy site is used for the single-port access. A J pouch is constructed and a laparoscopic close rectal dissection is carried out, down to the levator muscles plane.

For the transanal part, a purse-string is placed at an adequate distance from the dentate line. The rectotomy is made close to the purse-string folding. As the rectotomy is completed, the specimen is extracted transanally. A second purse-string is placed on the rectal cuff. Subsequently, the anvil placed at the tip of the pouch is passed through the anus. The purse-string is tightened around the anvil and a single-stapled double purse-string anastomosis is created.

Compared with the transanal total mesorectal excision pouch technique, in TTSS a complete dissection is achieved from above.

Therefore (a) during the purse-string for rectal closure there is no risk of including the prostate capsule, vagina or pelvic floor fascia/muscles (already dissected free from above), (b) during rectotomy there is minimal risk of entering the wrong planes and injuring surrounding structures and (c) at anastomosis there is no need to detach the rectal cuff.

CONFLICT OF INTEREST

AS, CF, FMC, MS and MC have nothing to disclose.

ETHICS APPROVAL


Ethics approval has been obtained to perform the study.

AUTHOR CONTRIBUTIONS

AS conceived the study and critically revised the manuscript and the media. MC and AS wrote the manuscript and prepared multimedia material for submission. MS, CF and FMC revised the manuscript and the multimedia material.

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SUPPORTING INFORMATION

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A stepwise approach to laparoscopic right hemicolectomy with D2 excision. An illustrated video guide for training colorectal surgeons - a video vignette

Abstract

We present a stepwise approach to performing a laparoscopic right hemicolectomy along with D2 excision. The video illustrates a modular approach for set up and resection, performed on a 60-year-old male patient, with a cancer in the ascending colon. The procedure is divided into its key steps, which include patient position, port placement and anatomical exposure, medial to lateral dissection with vessel control, sub-ileal dissection, lateral mobilization, hepatic flexure mobilization and extraction with extracorporeal anastomosis. The key regional anatomy is highlighted alongside diagrams illustrating standard anatomy and common anatomical variants. We believe this video provides a valuable resource for trainee surgeons to expand their understanding regarding steps of the procedure and associated anatomy.

Step 1: Patient position, port placement and preliminary exposure

We position the patient supine; ports are placed as per the diagram. Following port placement the patient is tilted head down and right shoulder up, omentum is moved into the right upper quadrant above the liver and small bowel is positioned into the left side of the abdomen.

Step 2: Medial to lateral dissection

The principle of Step 2 is a medial to lateral dissection of the ascending colon; two key stages will be separation of the duodenum and vessel control. We begin our dissection under the ileocolic pedicle.

Following an initial incision into the peritoneum we can see we have entered the correct plane. This is a bloodless plane which is easily dissected with a combination of hook diathermy and blunt dissection.

As we progress towards the duodenum we separate retroperitoneal structures and fascia from the mesocolon. Here you can clearly see important retroperitoneal structures such as the inferior vena cava, gonadal vessels and ureter.

Once the duodenum is identified it is separated from the mesocolon using a combination of scissors and blunt dissection. We

INTRODUCTION AND CASE SUMMARY

Here we present a stepwise approach to laparoscopic right hemicolectomy with D2 excision. Our patient is a 60-year-old man with the following history; the tumour can be visualized on the CT scan.