In the last years a wide range of new techniques offers the possibility to have R0 resection in colorectal cancer. We report our experience about Single Port Laparoscopic Surgery (SPL) for not advanced right colon cancer and about pelvectomy with cilindric Abdominal Perineal Resection (APR) for advanced rectal cancer. SPL offers mainly cosmetic advantages but also quicker recovery. No touch technique with adequate surgical margin and lymphectomy were respected. Operative time of SPL was 85-115 minutes, the incision was 5 cm long. There were no complications. Length of hospital stay was 4-6 days.

With advanced pelvic cancer, pelvic exenteration with en-bloc resection is indicated. Then we propose a case of a 55 years old woman with a pelvic recurrence from a metastatic rectal cancer involving the right obturator fossa, the vaginal stump, the right ureter. Modern surgical technique give us the chance to offer the most appropriate oncologic surgical treatment.

Key words: Single Port Laparoscopic Surgery (SPL), cilindric Abdominal Perineal Resection (APR), pelvic exenteration, advanced rectal cancer.

In the last years surgery is developed with a wide range of new techniques offering the possibility to have R0 resection both in advanced and not advanced colorectal cancer. We report our experience about Single Port Laparoscopic Surgery (SPL) for not advanced right colon cancer and about pelvectomy with cilindric APR for advanced rectal cancer. Single port laparoscopic surgery (SPL) is a rapidly spreading surgical innovation offering mainly cosmetic advantages but also a quicker recovery after laparoscopic abdominal surgery. Laparoscopic colorectal surgery is able to achieve some advantages related to reduced surgical trauma and the minimal abdominal wall incision, such as shorter hospital stay, faster return to normal bowel function, reduced postoperative pain, and wound-related complications compared with open resections. Furthermore, it has been demonstrated that the laparoscopic approach is able to reach the same oncological results as open surgery both in terms of recurrence and survival.

New techniques, such as natural orifice transluminal endoscopic surgery (NOTES) and single incision (SILS) or single-port laparoscopic surgery (SPLS) have been attempted to reduce even more of the surgical trauma. NOTES technique has the advantages of a true "no scar" procedure, on the other hand SILS seems to have some advantages compared with NOTES. Using the umbilicus as the only entry port surgeons are able to perform even more complex minimally invasive procedures using the small incision to introduce SILS instruments, to extract specimens and to perform anastomosis.

By SILS technique the intraoperative view is excellent, because standard or high-definition laparoscopic scopes and all common laparoscopic instruments can be used obtaining good exposure, clear dissection plane, and good tractions and contra-tractions reproducing almost completely the technique used during equivalent traditional laparoscopic procedures.

Furthermore, using the single-incision approach, it is always possible to add two or more trocars to complete the dissection and using the incision-single incision to extract the specimen and to complete the anastomosis converting the SILS in a "traditional" laparoscopic procedure.

We performed three right hemicolectomies for colon cancer by means of a single incision laparoscopic device with a multichannel system placed throughout a short umbilical surgical incision.

Oncologic surgical principles of no touch technique with adequate surgical margin and lymphectomy were respected. Pathological specimens were extracted through the umbilical incision and extracorporeal ileocolic anastomosis were performed. Operative time was 85-115 minutes, the length of incision was 5 cm. There were no intraoperative and postoperative complications. Length of
hospital stay was 4-6 days. SPL right hemicolectomy is feasible and safe also in patients with malignant lesions. Adherence to adjacent intra-abdominal organs or structures can be encountered in 15% of patients with colorectal cancer. Infiltration of the surrounding organs may still be considered inoperable by some surgeons. With advanced pelvic cancer, pelvic exenteration with en bloc resection of the involved organs and structures, including portions of the bony pelvis, is indicated. This type of resection achieved survival rates similar to those of patients with non-invasive tumors. However, surgery which violated the tumor margins achieved survival.

We know that for a successful result in colorectal cancer tailoring of treatment and R0 surgical resection were essential and it’s the same in colorectal cancer local recurrences. Although there are no homogeneous data about staging of colorectal cancer (CRC) local recurrences (LR) and no guide lines for treatment. With a multidisciplinary approach and a R0 resection a 5-years survival rate of 35% has been reported.

Patients with incompletely-resected locally-advanced or recurrent colorectal cancer have a poor prognosis, with a mean survival ranging from 8-12 months. Surgical resection remains the primary and the only potentially-curable treatment for colorectal cancer. En bloc resection of locally-advanced, adherent colorectal tumor is the ideal surgical method and is the basis of R0 resection. The intent of the operating surgeon should be to achieve complete tumor removal with adequate margins of the involved structures.

The only way to achieve a surgical cure in patients with locally-advanced primary or recurrent rectal cancer is an extended resection (such as pelvic exenteration), eventually followed by sacral resection.

Then we propose a case of a 55 years old woman with a pelvic recurrence from a metastatic rectal cancer involving the right obturator fossa, the vaginal stump, the right ureter. She also had a tumour at the anal verge, two centimeters below the anastomotic ring. A posterior pelvectomy with ureter resection was planned. Accurate dissection of the pelvis leads to the identification of the preanastomotic colon, the right ureter and the mass arising from the right obturator fossa and invading the vaginal stump. The colon was resected. The distal right ureter was resected and re-implanted into the bladder. The preanastomotic colon was dissected posteriorly and the presacral space was entered. Anterior dissection was not performed. A terminal colostomy was performed in the left iliac fossa. A posterior swab was positioned in the pelvis as well as a tube drain. The patient was then turned prone, in the Lloyd-Davies position. An incision was then made in the natal cleft skin and extend to include the anus and the posterior peri vaginal skin. Using the coccyx as landmark, the entire perineum is dissected and the anastomotic colon delivered out through the defect created. Lateral dissection in the ischioanal fossa is performed and eventually the dissection of the anterior part of the specimen is completed resecting the posterior wall of the vagina en bloc with the “Miles” specimen. Accurate haemostasis is obtained. Pelvic floor reconstruction using Permacol® Biological implant is then performed and the perineal wound closed on a suction drain. Modern surgical technique within new technologies give us the chance to offer the most appropriate, radical and personalized oncologic surgical treatment of colorectal cancer. It’s very important to define oncologic specialized colorectal units where there are the skills, the means, and the right organization to give the most tailored therapy for every case: target has to be R0.

SUMMARY

OD MINIMALNO DO MAKSIMALNO INVAZIVNE HIRURGIJE KOLOREKTALNOG KARCINOMA: MODERNA EVALUACIJA ONKOLOŠKIH SPECIJALIZOVANIH JEDINICA

U poslednjoj godini širok dijapazon novih tehnika nudi mogućnost da se rade R0 resekcije kod kolorektalnog karcinoma. Mi prikazujemo naše iskustvo u "single port" laparoskopskoj hirurgiji (SPL) za karcinom ranog stadijuma desnog kolona i pelvemije sa cilindričnom abdominoperinealnom resekcijom (APR) kod uznapređenih karcinoma rektuma. SPL nudi uglavnom bolje kozmetiske rezultate ali i brži oporavak. "No touch" tehnika sa adekvatnim hirurškim marginama i limafadenektomijska su poštovani. Vreme operacije kod SPL bilo je 85-115 minuta, a incizija je bila oko 5 cm dugasta. Nije bilo komplikacija. Dužina hospitalnog lećenja bila je 4-6 dana. Kod uznapređenog pelvičnog karcinoma, "en block" pelvična egzenteresa je bila indikovana. Prikazujemo slučaj 55 godina stare žene sa recidivom karcinoma rektuma, koje zahvataju opturatornu jamu, rog vase i desni ureter. Moderna hirurška tehnika daje nam šansu da ponudimo najprimereniji onkološki hirurški tretman.

Ključne reči: Single Port laparoskopska hirurgija, cilindrična abdominoperinealna resekcija, egzenteresa, uznapređevali karcinom rektuma

REFERENCES


