

enabling precise anatomical dissection are important in complex pelvic surgery. The authors report a robotic posterior pelvic clearance in a 64-year-old female with a body mass index of 41, diagnosed with a low rectal cancer invading the uterus (T4 N2 Mx adenocarcinoma on MRI). She underwent long course chemoradiotherapy followed by a combined laparoscopic and robotic posterior pelvic clearance. Patient consent was taken for filming during the operation and educational video production.

A pT3 N0 resection was histologically confirmed in the *en bloc* multivisceral specimen. The patient remains well, on regular clinical and radiological surveillance and remains disease free 15 months following her posterior pelvic clearance.

This video provides supporting evidence of the ability to achieve oncologically clear margins with the assistance of the robot, while performing the surgery with greater precision and control. The use of robotics in pelvic exenterative surgery as part of a multidisciplinary approach is feasible and should be developed in specialist centres, improving patient choice and access to technical innovations in surgical oncology.

L. J. Vitone*, **M. Smith†** and **C. R. Selvasekar***

Departments of *Surgery, and †Gynaecology, The Christie Hospital, 550 Wilmslow Road, Manchester, M20 4BX, UK
E-mail: louisvitone@doctors.org.uk

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Supporting Information

The video may be found in the online version of this article and also on the Colorectal Disease Journal YouTube and Vimeo channels:

Video S1. Robotic posterior clearance.

Up-to-down rectal resection with total mesorectal excision through single-incision laparoscopy – a video vignette

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Dear Sir,

Conventional laparoscopy of the rectum has shown advantages over laparotomy with equal oncological results [1,2]. Single-incision laparoscopy is worthy of consideration during up-to-down rectal resection [3] because it allows single access at the site of the temporary ileostomy placed at the end of the procedure.

This video shows an up-to-down single-incision laparoscopic total mesorectal excision with rectal resection in a 49-year-old woman presenting with a rectal adenocarcinoma at 12 cm from the anal margin. Preoperative assessment showed it to be a T2N0M0 tumour. The procedure was entirely performed with curved reusable instruments according to DAPRI (Karl Storz - Endoskope, Tuttlingen, Germany), inserted through the same incision in the right flank. The uterus and the pelvic peritoneum covering the vagina were retracted using sutures inserted through the anterior abdominal wall. The rectum was transected by a linear stapler and a circular mechanical colorectal anastomosis was performed. A temporary loop ileostomy was placed at the site of the single-access.

The procedure lasted 297 min and blood loss was insignificant. The final scar was 2.5 cm long, and the patient was discharged at 5 days. Histopathological examination of the resected specimen showed a pT2N0M0 adenocarcinoma with 20 negative nodes.

In conclusion, up-to-down single-incision laparoscopic total mesorectal excision with rectal resection gives the possibility of placing the temporary ileostomy at the single-incision site, offering a scope of resection comparable to conventional laparoscopy.

Conflicts of interest

G. Dapri is consultant for Karl Storz-Endoskope, Tuttlingen, Germany. The other authors have no conflict of interest or financial ties.

G. Dapri, L. Antolino, N. Bachir and G.-B. Cadiere

Department of Gastrointestinal Surgery, European School of Laparoscopic Surgery, Saint-Pierre University Hospital, Brussels, Belgium
E-mail: giovanni@dapri.net

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Supporting Information

The video may be found in the online version of this article and also on the Colorectal Disease Journal YouTube and Vimeo channels:

Video S1. <https://www.youtube.com/watch?v=8FWbMpazzfU>.

Laparoscopic pelvic side-wall resection: video vignette of the surgical anatomy

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Dear Editor,

The incidence of metastasis to the pelvic side-wall lymph nodes has been shown to be around 20% in locally advanced low rectal cancer [1,2] and often leads to local recurrence, even after chemoradiotherapy [3]. Survival after recurrence of local nodal metastases in the lateral compartment is poor, especially in the case of an R+ resection, with a 5-year survival rate of approximately 10% [4].

The pelvic side wall, or pararectal space, is an anatomical space not often dissected by the colorectal surgeon. In the case of locally advanced rectal cancer or involvement of the pelvic side-wall lymph nodes, however, dissection is necessary. The medial aspect of the pelvic side wall is formed by the ureter and the lateral border is formed by the parietal pelvic fascia covering the obturator internus muscle. A linear thickening of the obturator internus fascia anchors the levator ani muscle, which forms the base of the pararectal space, to the pelvic side wall.

Dissection of the pelvic side wall should therefore start by identifying the ureter, the obliterated umbilical artery (which may branch off a nonobliterated superior vesical artery) and the external iliac vessels (Video S1). Within this triangle it is safe to open the covering peritoneum and resect the pelvic side-wall lymph nodes, always taking into account that the anatomy of the structures within can vary considerably.

A. L. A. Bloemendaal*, **P. N. Pathiraja†**,
K. Haldar†, **R. J. Guy*** and **R. Hompes***

*Department of Colorectal Surgery, Churchill Hospital, Oxford University Hospitals NHS Foundation Trust, Oxford, UK and †Department of Gynaecological Oncology, Churchill Hospital, Oxford University Hospitals NHS Foundation Trust, Oxford, UK
E-mail: bobbloemendaal@gmail.com

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Supporting Information

The video may be found in the online version of this article and also on the Colorectal Disease Journal YouTube and Vimeo channels:

Video S1. Laparoscopic resection of the pelvic side-wall.

Laparoscopic component separation as part of a large incisional hernia repair – a video vignette

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Dear Sir,

Incisional hernia is a common long-term complication of abdominal surgery and is reported to occur in 12.8% of all abdominal surgeries and in up to 44% of midline open laparotomies [1]. Large midline incisional hernias potentially require abdominal component separation to achieve closure of the defect, as first described by Ramirez *et al.* in 1990 [2]. Open component separation necessitates a substantial subcutaneous dissection to reach the aponeurosis of the external oblique, which may lead to impairment of skin perfusion and consequent delay in wound healing [3].

In a meta-analysis that included five studies and 162 patients a laparoscopic approach to component separation was shown to significantly reduce surgical morbidity [4]. In that report, 18% of patients undergoing laparoscopic repair developed a wound