The surgical technique of isoperistaltic *vs* antiperistaltic ileocolic anastomosis is an interesting point of discussion. We prefer antiperistaltic anastomosis, as the focus should be to maintain the rotation of the mesentery with the goal to prevent torsion [2]. Furthermore, a randomized controlled trial, comparing isoperistaltic to antiperistaltic anastomosis was prematurely terminated due to higher anastomotic leak noted in the isoperistaltic study arm [3].

Meticulous surgical technique in ensuring antiperistaltic anastomosis and maintaining an open mesenteric defect in ileocolic resection plays an important role in outcomes. The authors' practice is to perform antiperistaltic anastomoses leaving the mesenteric defect open. Endoscopy is a useful tool for colorectal surgeons to better understand anatomical issues. Endoscopic evaluation has not been described in the literature, and may be a viable option in clinically stable patients with postoperative obstruction at the site of ileocolic anastomosis.

Y. El-Gohary, S. K. Abbas, S. B. Yelika, W. Smithy and R. Bergamaschi
Division of Colon and Rectal Surgery, Stony Brook School of Medicine, Stony Brook, New York, USA
E-mail: rcmbergamaschi@gmail.com

Received 12 September 2016; accepted 9 November 2016; Accepted Article online 9 January 2017

References

1 Cabot JC, Lee SA, Yoo J *et al.* Long-term consequences of not closing the mesenteric defect after laparoscopic right colectomy. *Dis Colon Rectum* 2010; **53:** 289–92.
2 Oveson BC, Bergamaschi R. Twisting in the wind: intracorporeal ileocolic anastomosis. *Tech Coloproctol* 2016; **20:** 511–2.
3 Matsuda A, Miyashita M, Matsumoto S *et al.* Isoperistaltic versus antiperistaltic stapled side-to-side anastomosis for colon cancer surgery: a randomized controlled trial. *J Surg Res* 2015; **196:** 107–12.

Suprapubic single-incision laparoscopic splenic flexure resection with handsewn intracorporeal anastomosis – a video vignette

doi:10.1111/codi.13601

Dear Sir,

In the last decade single-incision laparoscopy took interest and colorectal surgery can be performed through the suprapubic access, reducing the risk of incisional hernia, the postopertaive pain and increasing the cosmetic outcomes [1,2].

The authors report a 30-year-old woman who presented with episodes of diverticulitis due to segmental diverticulosis of the splenic flexure. The patient was scheduled for a suprapubic single-incision laparoscopic splenic flexure resection.

A right suprapubic incision was made and three reusable abdominal trocars were inserted. Curved reusable instruments according to DAPRI (Karl Storz - Endoskope, Tuttlingen, Germany) were utilized, apart from a 10-mm, 30° regular length scope. Mobilization of the left and transverse mesocolon was performed. After the splenic flexure was completely freed from the attachments, the transverse and left colon were divided by an articulating linear stapler, introduced under the control of a 5-mm, 30° long scope. An intracorporeal end-to-end transverse–sigmoid anastomosis was performed using two-layered continuous sutures (Fig. 1). The mesocolic defect was closed. The specimen was removed through the single access and the final scar measured 4 cm.

Laparoscopic time was 165 min and time to perform anastomosis was 60 min. Intra-operative blood loss was

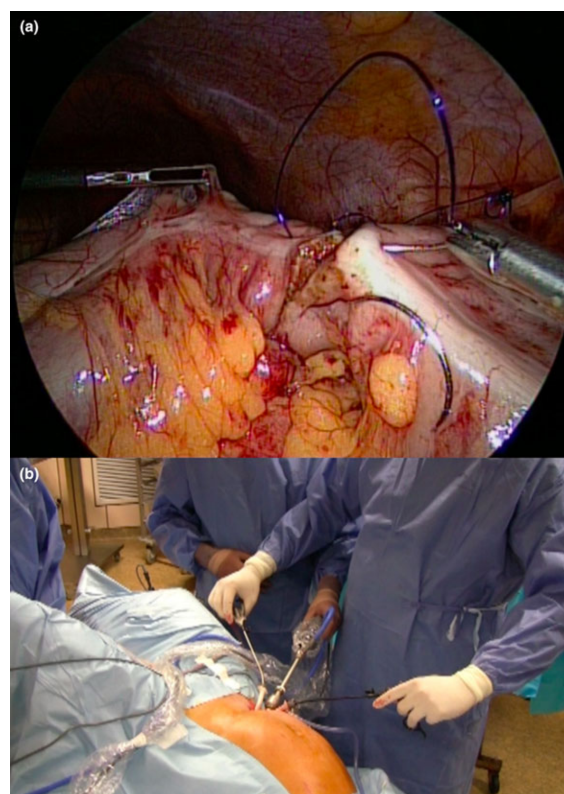

Figure 1 Handsewn intracorporeal transverse–sigmoid anastomosis (a), under external ergonomics (b).

10 ml. The patient was discharged on the fourth postoperative day, and at follow-up visit the symptoms had resolved.

Single-incision laparoscopic splenic flexure resection can be safely performed using suprapubic access, which enhances the cosmetic outcome in addition to having the advantages of minimally invasive surgery. Laparoscopic intracorporeal anastomosis is essential and can be performed by a handsewn method.

Disclosure statement

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

G. Dapri*†, L. Cardinali*, A. Cadenas Fabres* and G.-B. Cadière*

*Department of Gastrointestinal Surgery, European School of Laparoscopic Surgery, Saint-Pierre University Hospital, Université Libre de Bruxelles, Brussels, Belgium and †Laboratory of Anatomy, Faculty of Medicine and Pharmacy, University of Mons, Mons, Belgium
E-mail: giovanni@dapri.net

Received 14 September 2016; accepted 20 September 2016; Accepted Article online 9 January 2017

References

1 Dapri G. Suprapubic single-incision laparoscopic left hemicolectomy: an alternative non-visible scar. *Ann Surg Oncol* 2014; **21:** 841–2.
2 Dapri G, Carandina S, Mathonet P, Himpens J, Cadière GB. Suprapubic single-incision laparoscopic right hemicolectomy with intracorporeal anastomosis. *Surg Innov* 2013; **20:** 484–92.

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=no1I0E33ncA.

Transanal endolaparoscopic circumferential mucosectomy for symptomatic benign rectal stenosis – a video vignette

doi:10.1111/codi.13602

Dear Sir,
Transanal operative endolaparoscopy has become popular since the introduction of total endoscopic microsurgery more than 30 years ago [1]. Recently, an evolution of laparoscopy called transanal minimally invasive surgery has been described [2].

In this video, a 38-year-old man presenting with a circumferential rectal stricture due to a rectal ulcer underwent a transanal endolaparoscopy procedure. The patient had had three unsuccessful endoscopic dilatations previously. Preoperative work-up showed a complete circumferential benign stenosis at 2.5 cm from the anal margin. The procedure was performed with a new reusable trasnanal platform according to DAPRI (Karl Storz - Endoskope, Tuttlingen, Germany), mainly using a monocurved coagulating hook and a monocurved grasping forceps (Fig. 1a,b). After a 360° mucosectomy had been completed, the mucosal edges were approximated and closed by interrupted absorbable sutures.

The procedure duration was 163 min, with minimal intra-operative blood loss. There were no perioperative complications. The patient was discharged on postoperative day 2. The pathological report confirmed the benign nature of the lesion.

Transanal endolaparoscopy can be effective in managing benign rectal lesions where other treatment modalities have failed.

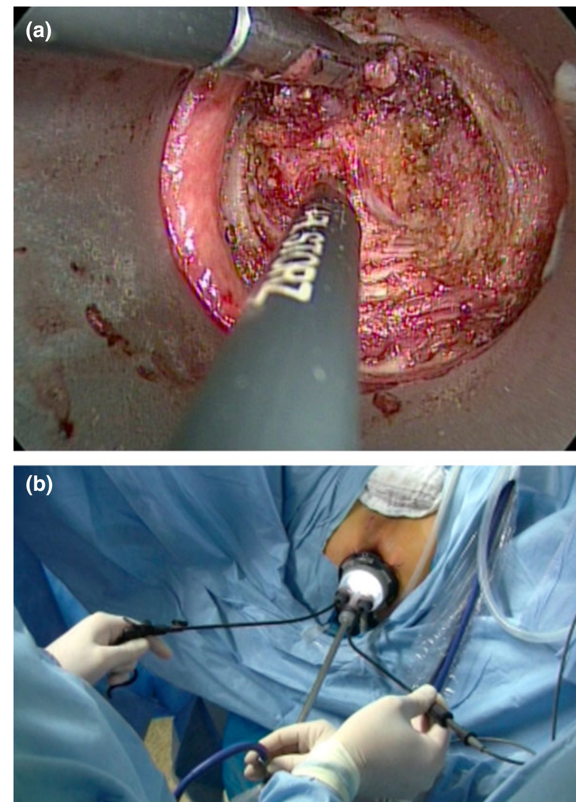

Figure 1 Endoluminal mucosectomy (a) and external transanal platform (b).