Article type : Correspondence

357-2017.R1
Correspondence

THE THREE APPROACHES TO THE COLONIC SPLENIC FLEXURE MOBILIZATION – VIDEO VIGNETTE

Giovanni Dapri, MD PhD FACS[12], Nigel Antonio Bascombe, MD[1], Guy Bernard Cadière, MD PhD[1], John H Marks, MD FACS[3]

Department of Gastrointestinal Surgery, European School of Laparoscopic Surgery, Saint-Pierre University Hospital, Université Libre de Bruxelles, Brussels, Belgium[1]
Laboratory of Anatomy, Faculty of Medicine and Pharmacy, University of Mons, Mons, Belgium[2]

Minimally Invasive Colorectal Surgery, Lankenau Medical Center, Main Line Healthcare, Wynnewood PA, US[2]

Corresponding author mail id:- giovanni@dapri.net

Dear Sir,

The mobilization of the colonic splenic flexure during laparoscopic colorectal surgery can be a challenge, especially in anatomically difficult patients, but allows more than 20 cm of colonic redundancy (1). In this video the infra-mesocolic, the supramesocolic and the lateral-to-medial approaches are demonstrated.

The first part of the video shows the inframesocolic approach, where the opening of the transverse mesocolon, above the pancreatic body and tail, allows access to the lesser sac and the exposition of the spleen. The 2nd part of the video shows the supramesocolic approach, where reaching Gerota's fascia allows the flexure to be taken down. The 3rd part of the video shows the lateral-to-medial approach, where opening the lesser sac allows the flexure to be mobilized.

All three approaches are laparoscopically feasible and safe. The goal remains the same, which is to avoid anastomotic tension, at the cost of a trend towards an increased rate of minor complications, and no major adverse events (2). When the splenic downloading is not enough, ligation of the descending branch of left colic artery enables a tension free anastomosis (3). The operating time for this step, during the entire colorectal procedure, is influenced by the patient's characteristics (previous surgery, high splenic

flexure, short mesentery, etc) and the surgeon's experience.

The choice between the three approaches depends on the patient's characteristics and on the surgeon's habitude.

This video has been presented at the Annual Meeting of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), March 22-25, 2017, Houston TX, USA

Disclosure Statement

G.Dapri is consultant for Karl Storz-Endoskope, Tuttlingen, Germany. The other authors have no disclosure or financial ties to declare.

References

1. Kye BH, Kim HJ, Kim HS, Kim JG, Cho HM. How much colonic redundancy could be obtained by splenic flexure mobilization in laparoscopic anterior or low anterior resection? *Int J Med Sci.* 2014;11(9):857-62
2. Schlussel AT, Wiseman JT, Kelly JF, Davids JS, Maykel JA, Sturrock PR, Sweeney WB, Alavi K. Location is everything: The role of splenic flexure mobilization during colon resection for diverticulitis. *Int J Surg.* 2017;40:124-9
3. Reddy SH, Gupta V, Yadav TD, Singh G, Sahni D. Lengthening of left colon after rectal resection: What all is adequate? A prospective cohort study. *Int J Surg.* 2016;31:27-32

Supporting information: video