



The Pelvis-First Approach for Robotic Proctectomy in Patients with Redundant Abdominal Colon

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ABSTRACT

Background. Robotic surgery is increasingly performed for low rectal cancer.¹ A redundant sigmoid colon makes retraction and pelvic dissection challenging. We present a ‘pelvis-first’ approach to robotic proctectomy where pelvic dissection occurs prior to colonic mobilization.

Methods. A 26-year-old woman was diagnosed with a clinical T3N1 rectal adenocarcinoma at 3 cm from the anal verge. The patient had Lynch syndrome, with a germline mutation in the *PMS2* gene. A near-complete clinical response was observed after neoadjuvant chemoradiation (NCRT), and the patient wished to delay surgery and permanent colostomy. Additional FOLFOX was administered and led to a complete clinical response. After 2.5 months of watchful delay of surgery, the tumor regrew, and the patient then underwent robotic abdominoperineal resection (APR).

Results. Initial exploration revealed a highly redundant sigmoid colon. A pelvis-first approach was undertaken. The colon was left tethered and outside of the pelvis during the pelvic dissection. The levator ani was divided transabdominally. Vascular dissection and left colon mobilization were completed after pelvic dissection.² The specimen was removed transanally, obviating the need for abdominal incision. An end colostomy was created laparoscopically, and the perineum was closed primarily after omental flap. The patient recovered without complications.

Conclusions. The ‘pelvis-first’ approach to proctectomy is advantageous for patients with a highly redundant sigmoid colon. Transabdominal division of the levator ani during APR ensures excellent circumferential margin. Although Lynch syndrome-associated rectal cancer can show excellent response to NCRT,³ patients undergoing watchful delay of surgery require close monitoring and prompt triggering of salvage proctectomy when tumor regrowth is observed.^{4,5}

DISCLOSURES Yun Yang, Songphol Malakorn, Kelly Maldonado, Brian K. Bednarski, Colleen M. Kiernan, Selvi Thirumurthi, George J. Chang, and Y. Nancy You have declared no conflicts of interest.

This video was presented at the American College of Surgeons (ACS) Clinical Congress, Boston, MA, USA, October 2018.

Electronic supplementary material The online version of this article (<https://doi.org/10.1245/s10434-019-07416-6>) contains supplementary material, which is available to authorized users.

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First Received: 19 October 2018;
Published Online: 17 May 2019

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