Surgery Collaborative and Long-term Practical Experience Learning **SCaLPEL**

Case report

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INTRODUCTION

*M, 56 y.o.
*12/2022 initial referral to oncology:
adenoca recti, poypus coli ascendentis (unresectable, high dysplasia)
*History: spinal surgery, covid, PE (fragmin 2x7500 iu)
*MDT: neoadjuvant chemoradiotherapy
(CapOx + short course)
*preoperative colonoscopy
Adenoma vilotubulare (partially resected, mostly low dysplasia), adenoca recti (18-20 cm from ACJ)
*preoperative MR and CT -> regression of the tumor

Now what?

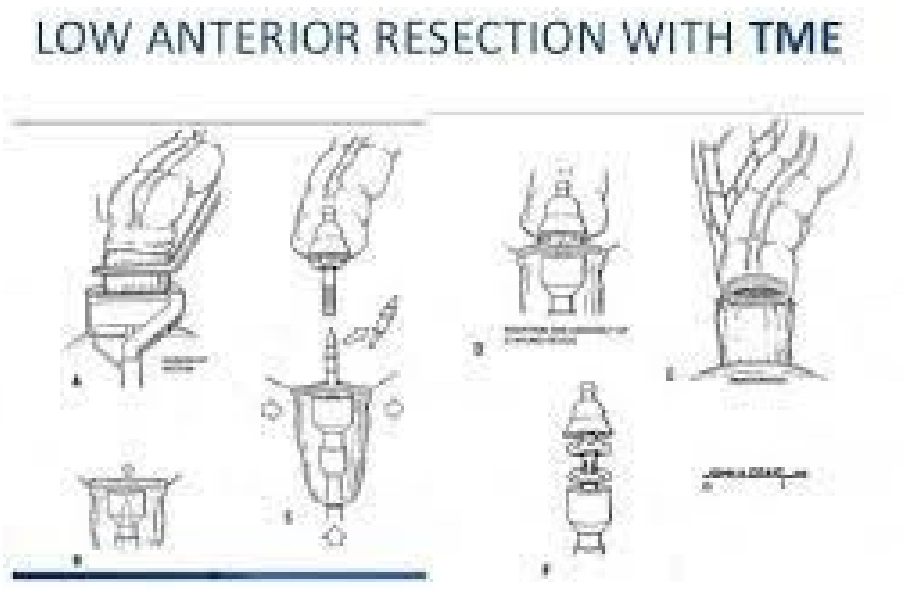
A) Right hemicolectomy + low anterior resection
B Low anterior resection only + watchful waiting
) Total colectomy
C)

SURGERY

Low anterior resection
Colorectal anastomosis with circular stapler No 31
(end-to-end)
Drainage, PHD

PHD:

Adenoca recti T3N1c, G2
Total mesorectal excision



POSTOPERATIVE COURSE

Clinically stable, afebrile (the first three days)

Fever (38°C) and abdominal pain a few hours after drain removal (day 4 postop)

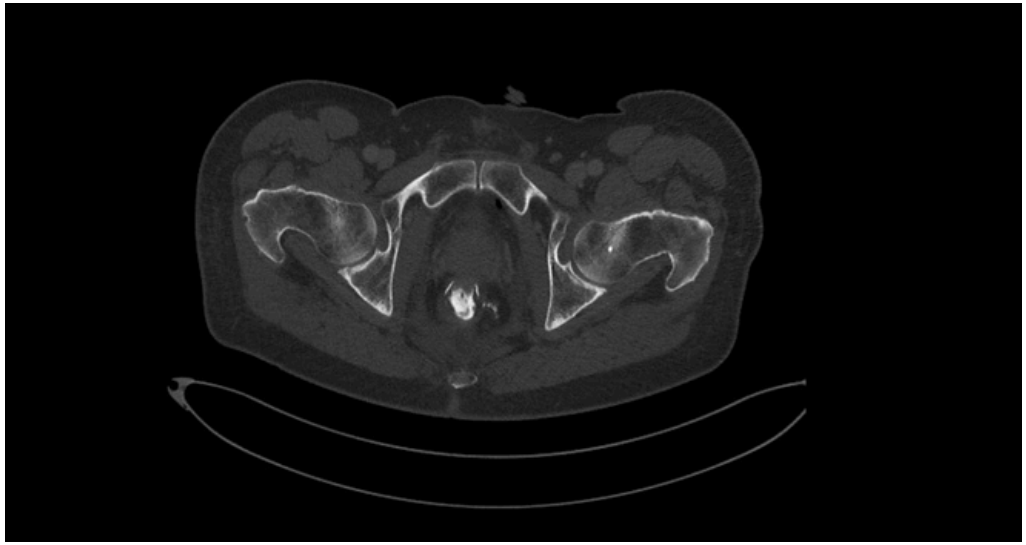
CRP: 1.2 (0) - 27.8 (1) - 31.6 (3) - 92.5 (4)

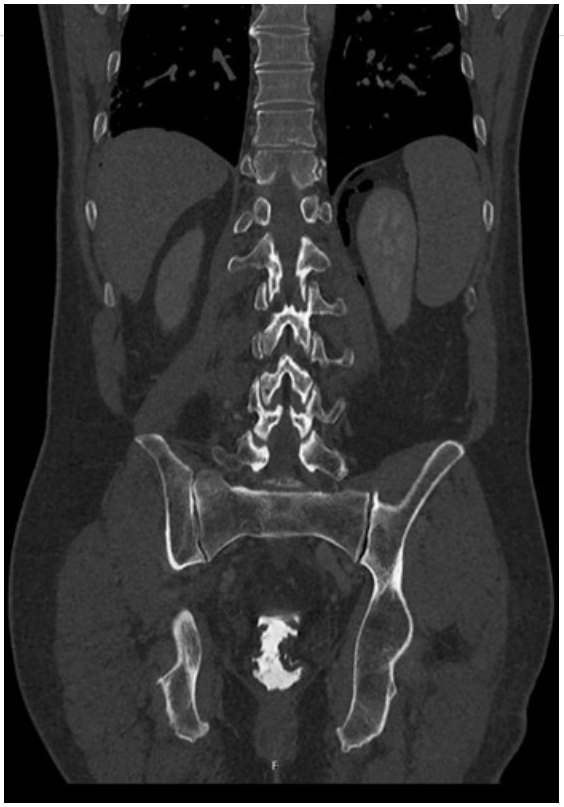
Now what?

A) MSCT
B Watchful waiting
) Colonoscopy
C)

MSCT

* MSCT with per rectum contrast
  * anastomotic leak
  * collection 44x32mm





Now what?

A) Revision
B Conservative therapy
)

Surgery…again

Intraoperatively confirmed anastomosis dehiscence

Resection of the anastomosis

Unipolar colostoma

Drainage

Postoperative course uneventful, discharge home on the 10th postop day (initial surgery)/ 6th postop day

Just the beginning…

*On the 16th postop day consulted in the ER
-abdominal pain, heavy fatigue
-physical: no peritonitis, perineal pain, stoma wf

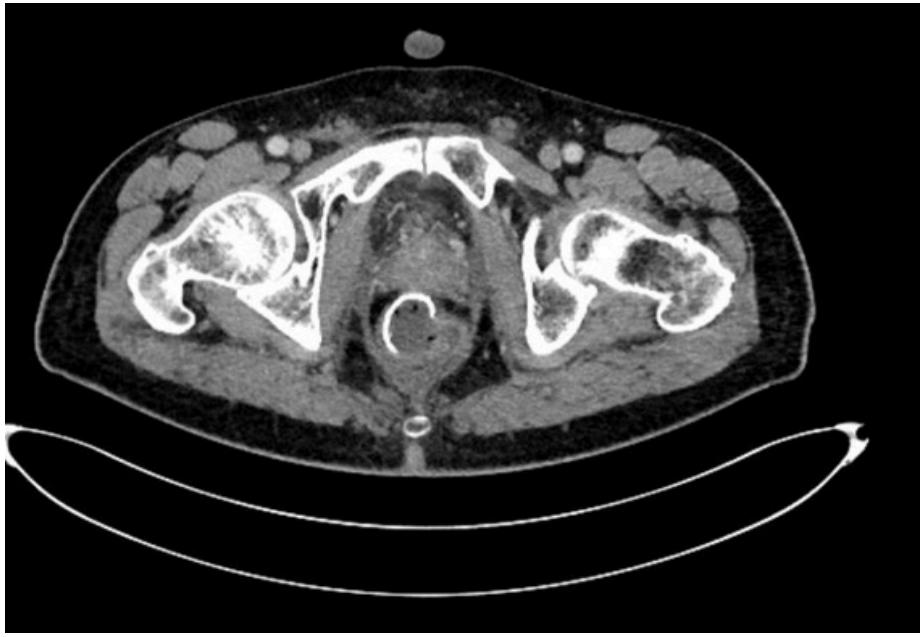
LABS

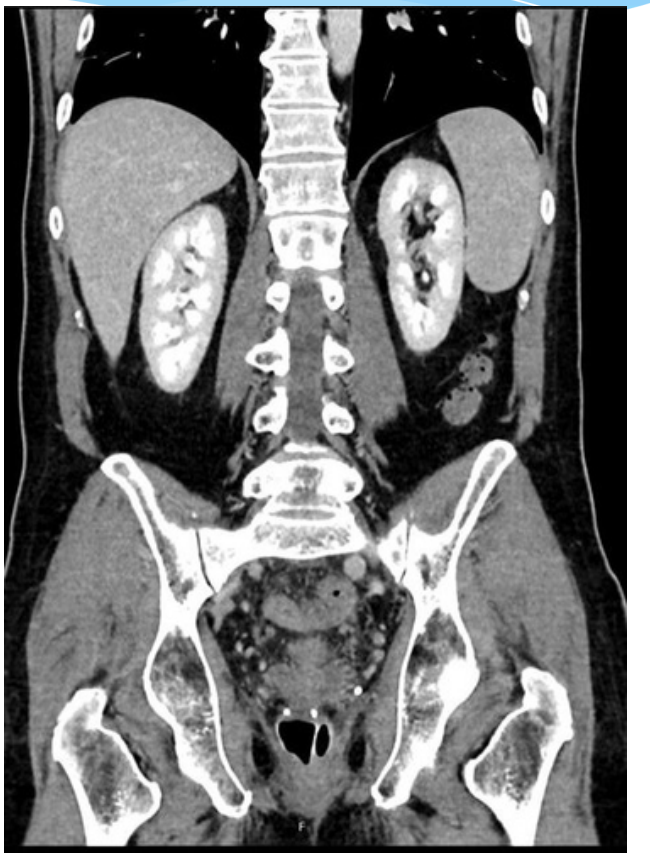
L 14.2, Nth 79.5%, CRP 112.5

->MSCT of the pelvis

MSCT

* Progression of the pelvic collection to 58mm





Now what?

A) Surgery
B Conservative atb therapy
) Intervention radiology (CT guided drainage)
C)

Surgery

Which approach?

* Medial laparotomy?

Surgery

*Transanal drainage of the abscess
Drainage

Postoperative course:
CRP drop 121 -> 71 (2) -> 29 (4)
Discharged home on the 8th postoperative day

Current status

Last check - up one month after last surgery:
Sporadic bloody discharge through anus
Stoma functioning

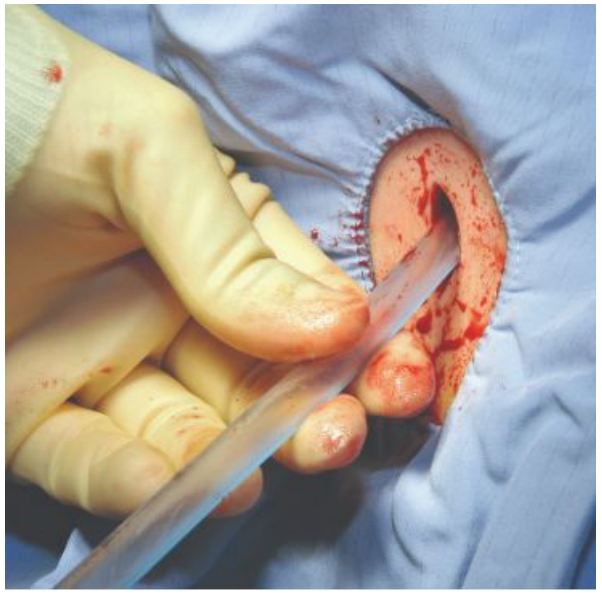
Plan:
Control colonoscopy in 3 months
Further oncological monitoring

Discussion

Drain types used in GI surgery

-Blake drain

- Abdominal drain



Discussion

*Patient had total mesorectal excision

Partial (tumour specific) mesorectal excision?

› Ann Coloproctol. 2023 Mar 31. doi: 10.3393/ac.2022.00689.0098. Online ahead of print.

Partial mesorectal excision can be a primary option for middle rectal cancer: a propensity-score matched retrospective analysis

Ee Jin Kim [1], Chan Wook Kim [1], Jong Lyul Lee [1], Yong Sik Yoon [1], In Ja Park [1], Seok-Byung Lim [1], Chang Sik Yu [1], Jin Cheon Kim [1]

Affiliations + expand

PMID: 36999173 DOI: 10.3393/ac.2022.00689.0098

Free article

Local (5.3% vs. 4.3%, P>0.999) and systemic (8.5% vs. 16.0%, P=0.181) recurrence rates did not differ between the 2 groups, respectively, in patients with middle and upper rectal cancer.

The 5-year disease-free survival (81.4% vs. 74.0%, P=0.537) and overall survival (88.0% vs. 81.1%, P=0.847) rates also did not differ between the PME and TME groups, confined to middle rectal cancer.

Postoperative complication rate was higher in the TME than in the PME group (21.4% vs. 14.5%, P=0.027).

Conclusion: PME can be primarily recommended for patients with middle rectal cancer with lower margin of >5 cm from the anal verge.

Thank You!