Old tools for same old problems. Coloanal anastomosis in two stages: Pull-through

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INTRODUCTION

The treatment of low rectal cancer located less than 1 cm from the anorectal ring (type 2 of the Rullier classification),[1] represents a challenge for surgeons. Ultra-low resection and coloanal anastomosis in one stage, with protective ileostomy, is considered the standard treatment. However, the incidence of anastomotic leak and the morbidity associated with ileostomy are not negligible, with pelvic complications that can affect oncological and functional results.[2]

The pull-through procedure is presented as an attractive alternative.[3] This involves ultra-low resection of the rectum, with total mesorectal excision and nerve preservation, associating a perineal stage where instead of finishing the surgery with a manual coloanal anastomosis and ileostomy, the colon is exteriorized through the anal canal. In a second stage, the coloanal anastomosis is created, thus avoiding the need for an ileostomy.

In tumors with an extremely low location, a partial intersphincteric resection can be performed.

DESCRIPTION

The video shows the case of a 64-year-old female patient diagnosed with low rectal cancer. Magnetic resonance imaging (MRI) of the pelvis shows a lesion 5 mm from the puborectalis muscle and the intersphincteric space free of tumor involvement. Staging was T3N1M0.

Neoadjuvant treatment was performed with long-course radiotherapy plus concurrent chemotherapy with capecitabine. Reassessment at 10 weeks revealed an incomplete clinical response, given by ulceration on digital rectal examination confirmed by rectoscopy. MRI of the pelvis showed a tumor remnant and suspicious mesorectal adenopathy. For this reason, it was proposed to perform an ultra-low resection of the rectum by laparoscopic approach, with partial intersphincteric resection and colonic exteriorization with the pull-through technique. The video shows the ultra-low resection approaching the intersphincteric space via laparoscopy, a maneuver that facilitates the perineal time later. One week after surgery, the second stage of the procedure was performed, which consisted of the perineal resection of the exteriorized colon and the creation of a manual coloanal anastomosis.

The patient evolved favorably, without complications, and was discharged 48 hours after the second procedure.

The pathology of the piece reported a poorly differentiated adenocarcinoma, ypT3N1Mx.

In the three months after surgery, the patient presented an acceptable sphincter tone with good voluntary contraction in agreement with other authors who show similar functional results when compared with the primary anastomosis plus ileostomy.

CONCLUSION

In the case presented, delayed coloanal anastomosis prevented anastomotic leakage and the need for a protective ileostomy, with acceptable short-term functional results.

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VIDEO: https://youtu.be/37QkNb09j-k

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