

LETTERS TO THE EDITOR

Commentary on: “Usefulness of intraoperative endoscopy in laparoscopic rectal resection” by Chinelli et al. *Rev Argent Coloproct* 2024.

Dear Editor,

We agree with the authors of the video on the usefulness of intraoperative endoscopy in laparoscopic rectal resection and would like to make some comments.

Identification of the distal margin of neoplastic lesions of the rectum when laparoscopic resections are performed can be done by prior tattooing with India ink or by rigid or flexible intraoperative rectoscopy. The insufflation required for rectal lesions is less and does not usually hinder the subsequent development of surgery, so endoscopy is the ideal method to locate rectal adenomas that are difficult to palpate due to their soft consistency or small carcinomas that do not compromise the serosa. However, tattooing is also a useful method, and to reduce the risk of intestinal and/or peritoneal dissemination of India ink, a two-step technique was described in the early 2000s, in which saline is first injected to elevate the submucosa and then the dye is injected.^{1,2}

The authors used endoscopy in 3 patients with rectal tumors. In Case 1, two synchronous neoplasms were detected on colonoscopy, an invasive adenocarcinoma 10 cm from the anal verge and a sessile polyp (villous adenoma with high-grade dysplasia) not amenable to endoscopic resection 7 cm from the anal verge. The authors opted for a low anterior resection, including both lesions, with a distal margin of 1 cm. Final histopathology reported a pT4 N2 high rectal adenocarcinoma and a villous adenoma with high-grade dysplasia (pTis). In this case, where prior surgical resection of the most distal lesion was ruled out in order to perform the histopathological study of the entire piece, it would have been useful to perform an endorectal ultrasound to determine preoperatively whether it was an adenoma or a T1 or more advanced carcinoma, in which case the distal margin should have been 5 cm with resection of the corresponding mesorectum (partial excision of the mesorectum)^{3,4} and not just 1 cm based on the result of the preoperative biopsy, which is often inaccurate, regardless of whether the definitive histopathology reported a benign lesion. On the other

hand, invasive T4N2 carcinoma already required a margin of 5 cm, which in this case seemed to have been smaller.

Case 2 is a villous adenoma with low-grade dysplasia occupying $\frac{3}{4}$ of the circumference 10 cm from the anal verge. In this case, preoperative staging was performed: T2N0M0. The lesion was not palpable, so its distal margin was located by intraoperative endoscopy. The final staging (pT1N0) explains why the lesion was not palpable, as it might have been if it were a tumor invading the muscularis propria of the rectum.

Regarding case 3, prior marking with India ink was not useful because it was very widespread. However, it is likely that the lesion was easily identifiable as it corresponded to a pT4 tumor, which implies involvement of the serosa of the rectosigmoid colon, so it could have been excised with a sufficient distal margin without requiring intraoperative endoscopy. However, the latter is always advisable, even after resection to control the anastomosis.

Finally, it is considered good practice for the surgeon to personally perform a preferably rigid endoscopy in the preoperative period to know in advance with more precision the location of the distal margin.

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