

LETTERS TO THE EDITOR

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

Dear Editor,

We appreciate the comments made by our colleague and the opportunity to respond to them. Regarding these comments, we would have some coincidences and also some specific differences:

- 1) We agree on the usefulness of endorectal ultrasound as a method to estimate the preoperative staging of the distal polypoid lesion. Even so, the concept of a 5 cm distal margin – although ideal at one time – seems a bit excessive in current times, both for this and for the advanced tumor, at least in light of somewhat more recent studies^{1,2} which indicate that narrower distal margins – up to 1 cm – would not negatively affect the prognosis. Remembering, also, that a key element of oncological quality is mesorectal integrity together with high vascular ligation, the details of which we do not go into because we consider that the interest of the video was to focus on intraoperative endoscopic assistance.
- 2) In case 3, the pT4 staging was precisely postoperative.

No preoperative element (size on endoscopy and CT) suggested such a degree of parietal invasion, which motivated the attempt to identify it by tattooing and endoscopy. Of course, the intraoperative findings (tumor exteriorization and parietal rigidity) already suggested a greater infiltration, but they were surprising for the acting team.

We hope that our response will contribute to the discussion on this topic.

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2. Manegold P, Taukert J, Neeff H, Fichtner-Feigl S, Thomusch O. The minimum distal resection margin in rectal cancer surgery and its impact on local recurrence - A retrospective cohort analysis. *Int J Surg.* 2019;69:77-83.