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Research Article

THE SURGICAL STRATEGY IN THE RECTAL RESECTION

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ABSTRACT

Indroduction: The principle of deciding to preserve the anal sphincter apparatus is due to studies on the meso-rectum in which the need for removal of the rectum due to the suboperitoneal localizations has emerged (!, 2,3,4) thus making the first choice in the treatment of rectal tumors of the supropronitoneal rectum, having the latter an equal biological behavior and leaving only the tumors located in the intraperitoneal rectum that the resection does not include the whole organ. (5,6,7,8). **Materials and methods** From January 2010 to December 2017 consulted the database of the AOU Polyclinic University of Catania were observed in 37 cases of neoplasia in the seat in the sigma-rectum, the patients selected for this analysis had a mean age of 72 years (range 74-70**). Results** Interventions with preservation of the sphincters (fig 2) represent 95% of our cases (112 cases) in which both postoperative exitus (20%) occurred. that the local recurrence developed in 14% of the cases associated with 6% (3 paz,) the presence of MTS at a distance. the neolasies of the rectum had a max diameter of between 3-5 cm. **Discussion:** The modalities of execution of the surgical intervention include the position on the operating bed which is of fundamental importance for the surgeon to have the possibility of maximum accessibility on the operative field with the possibility of varying every type of maneuver in an optimal condition. In the preoperative: the careful evaluation of the extension of the neoplasm beyond the wall of the bowel, the grading 3, the perforation in the tumor area (46.47.48.49). In advanced disease it is necessary to identify patients with limited and resectable disease (50,51,52,53) O With symptomatic disease that with the use of chemotherapy a reduction of the tumor mass is obtained. Or with symptomatic Disease in good general conditions that use sequential therapy with high toxicity in which the therapeutic and fundamental choice. Finally, the multidimensional evaluation in the patient over 70. In which the surgical option can be proposed in a multidisciplinary way (54,55,56) .**Conclusion:** The rectum colic resection and a surgical intervention that implies a choice of the selection criteria to the intervention, the surgical technique of demolition and reconstruction of complex intestinal continuity and of experience and an oncological radicality, which places the surgeon on a burdensome commitment that the disease proposes is of an environmental and technical social order. . In a society that requires icons of health frenzy (always living, with any illness, and always getting healing), but that does not recognize the merits and the abnegation of these new found heroes, "those who perform an extraordinary and generous act of courage, which involves or may involve the conscious self-sacrifice, in order to protect the good of the health of others.

INTRODUCTION

The principle of deciding to preserve the anal sphincter apparatus is due to studies on the middle-rectum in which the need for removal of the rectum due to the under peritoneal localizations has emerged (!, 2,3,4), making today the first choice in the treatment of above peritoneal rectal tumors, having the latter an equal biological behavior and leaving only the tumors located in the intra peritoneal rectum that resection does not include the whole organ. (5,6,7,8) Indications that include the choice of AAP are either tumors that invade the sphincters or are so low that they leave the segment unusable and ontologically insecure, in obese patients, with bulky tumors adherent with pelvis particularly tight, and in incontinent

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sphincters, (9.10.11.12) In palliative interventions. on the contrary, the indication in ultra-low resection is possible to implement it successfully when the removal of the tissue lymphatic viscera includes all the anatomical territories located above the elevators of the anus. the anal canal may be affected by tumors that originate from the upper third of the anal canal, or in continuity in the caudal cranium direction up to invade the anal canal. the venous mts occurs through the drainage of the upper rectal veins although there are communications with the middle and lower rectal veins. To achieve an ultra-low resection requires good experience and considerable technical ability, with the specific use of abdominal auto-static spreader ribs (rochard of lloyds davies, the gil vernet the robust phobic type metzenbaun nelson, mixet and other to which is associated an ultrasound probe for the intra operative exploration of the liver, in addition to the use of additional lamps and the use of staplers, or of biotechnology (BAR). (13,14,15,16) Increasingly often due to early diagnosis we see the patient in good general tonic condition, with an abundance of fat that does not allow to easily recognize the allocation and sliding plans causing this careful research for a correct dissection. (17,18,19,20) The aim of this study is to evaluate and the surgical strategy in ultra-low resection in order to verify and avoid the occurrence of the possible complications so as to obtain an improvement in the execution of an ultra-low colonic straight resection

MATERIALS AND METHODS

From January 2010 to December 2017, the database of the AOU of the University of Catania was examined in 37 cases of tumor-site neoplasm in the sigma-rectum. The patients selected for this analysis had a mean age of 72 years (range 74- 70). on the clinical examination there was blood in the stool accompanied or not by diarrhea and constipation, asthenia, malaise, rapid weight loss and anemia. All patients performed the occult blood test in the stool. Digital exploration of the rectum. Colonoscopy, (fig 4) echo endoscopy (fig 3) virtual endoscopy, CT and MRI, and PET. With these diagnostic imaging tests, the TNM of Stage I patients (T1 / N0 / M0) was obtained in 25 cases undergoing local resection with postoperative external radiotherapy, in case of failure (more extensive infiltration) we proceeded to the abdomino-perineal resection sec. Miles In Stage II (T2-T3 / N0 / M0) n 12 cases. The histological examination of this group of patients confirmed a 3.4 cm neoplasm, movable to the underlying planes, easily reachable with the transanal access, within two cm from the anal margin, with polypoid and vegetative appearance but not ulcerated, with the absence of infiltration on the definitive piece of the lymph nodes muscolaris, and with a grading of low aggressiveness (G1 G2). In the presence of relapses that occurred in 14% of cases treated (5 patients) and in 6% (3 cases) there were distant MTS. The surgical technique of the intervention in these patients included an ultra-low resection of the rectum or sigma with direct anal anastomosis or with reservoir or Sec Knight Griffen.

RESULTS

The interventions with conservation of the sphincters (fig 2) represent 95% of our cases (112 cases) in which both the postoperative exitus occurred (20%). that the local recurrence developed in 14% of the cases associated with 6% (3 paz,) the presence of MTS at a distance. the tumors of the rectum had a max diameter of between 3-5 cm, the macroscopic appearance of the tumors was 70% vegetative and polypoid or pedicle and sessile for the remaining 30% the lymph node extension was present and the relapses even after local resection. the lymphatic and venous invasion of the submucosa was present on the anatomical piece.

DISCUSSION

The modalities of execution of the surgical intervention include that the position on the operating bed is of fundamental importance because the surgeon has the possibility of maximum accessibility on the operative field with the possibility of varying every type of maneuver in an optimal condition. The preparation of the pelvic rectum takes into account the removal of the left angle and the measurements are evaluated in the field for a possible change in the indications. Colic resection is performed having ample availability of the intestinal segment to be bitten to the skin. Placing it with a wider curvature to better adapt its relations with the great epiploon so as to fill the void of the pelvic excavation. The possibility of minimal hepatic resection requires that the thorax can not be located on a lower level of the pelvis. Therefore it is the need to have an accessible pelvis that is necessary to elevate the distal lumbar column with the sacrum thus creating a lithotomy sec Trendeleburg modified according to the sec. lloyd Davies allows simultaneous intervention in the perineal side in order to pack either a MIles or an anal-anastomosis or introduce a mechanical circular stapler in the sphincter region. The gluteus regions protrude from the operating table the distal part of the operating table. and the operator and his collaborators study and find the position of the patient in a preferable way, and the first operator is distributed in our experience to the left of the patient, the instrumentalist a little more distanced and back, in order to have the ability to move widely. In front of the operator, the assistant takes his place, on the left of the assistant, and the assistant between the legs of the patient for the perineal time. You also have another instrumentalist with a separate servant table. Once the disinfection involving the abdomen and the pelvis and the perineal field has been arranged, the longitudinal incision is made with a median laparatomy and the muscular aponeurotic debridement which will benefit from the application of static auto retractors (Roshard). The navel is passed to the left where it is not connected with the round ligament. In the new resection the previous scar is excised paying particular attention to evaluate the presence of postoperative abdominal hernia to avoid possible loops attached to the abdominal hernia sac. the liver is shallow and then proceeds below where the bladder meets the incision of the urachus, taking care not to damage the organ. To explore the liver carefully, a direct hepatic ultrasound is associated to discover possible mts and associated diseases. The rectal neoplasm if it is not very voluminous, is not appreciable but the manual exploration serves to test the mobility of the lesion and of the intestinal tract. The decision whether to implement an AAP or an ultra-low resection is placed at the completion of the rectum-middle rectum preparation. (21,22,23,24,25) The intestinal loops loyal or are collected in a sac by extracting them outside the abdomen taking care then not to do neither traction do not twist on the mesentery. Or if the conditions are favorable, the ileal loops are pushed into the upper abdomen protected and

collected by a cloth soaked in warm physiological solution. The first act of the dissection intended as anatomical preparation is the liberation of the sigma from the parietal, distal and pelvic peritoneum, then from the uterus and appendages, the latter structures and organs that can connect it with any tenacious adhesions more or less extensive and of acquired origin. (Monk). Once the lysis of the adhesions is completed, the sigma is stretched to evaluate its real extension, then the middle sigma is exposed for safe access to the left ureter. The right ureter is less vulnerable because it is more external and not involved in lymphectomy. Recognized the left ureter and mobilizing it for a good stretch prepares the descending colon by mobilizing it from the left parietal colonic shower, and detaching it from the postero-lateral wall. The help then grabs the descending colon with both hands to help recognize the Toldt line that marks the embryological attachment of the left colon to the back wall of the abdomen. The dissection is bloodless, and the left colic angle is mobilized. Not all authors agree with this procedure. To avoid spinal lesions proceed with the dissection in close contact with the colon and recede the weak connections of the corner proceeding from the right, then detaching the great epiploon. With the apron available, part of it can be adapted to fill the pelvic cavity emptied from the rectum. And therefore we proceed to the packaging of the epiploic flap . You can proceed to aorto-caval lymphectomy, whose limit and the renal vein, here you are witnessing any anatomical anomalies already documented by imaging for images represented by inferior vena cava to the left, double vena cava, left renal vein, aortic retro, ring venous for aortic, right rectal ureter, which from time to time if found must take into account the altered occasional anatomical relationships. continue then dissect the inferior mesenteric artery and vein. The origin of the artery varies and / or leans tenaciously to the aorta or is 3-4 cm lower than the bifurcation, in which often a sclerotic fibrous blanket can hide it. This last one is isolated linked to 2-3 cm from its emergence respecting the fibro nervous and lymphatic structures that surround the origin.

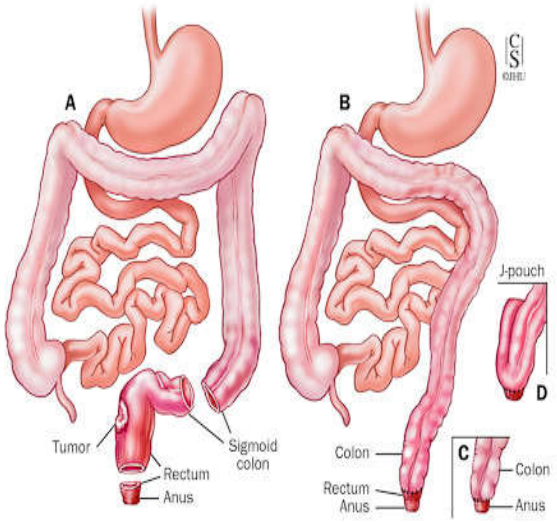

Fig 1 Scheme resection

Vascular sections follow a mobilization of the colon. Once this phase has been completed. The pelvic time is taken up again. The incision on the pelvic peritoneum is affected by the bladder rectal attachment, highlighting both the seminal vesicles and the Denonvilliers fascia which has the appearance of a pearly membrane. On the front face the Douglas 2-cm opens at the front of the rectum (fig 1,2)

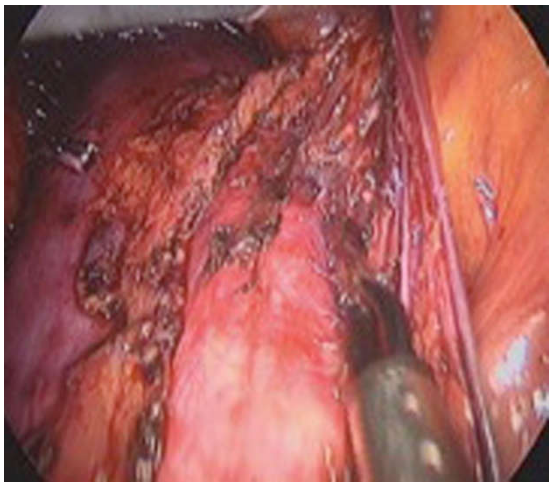

Fig 2 Resection Rectum

And the dissection is continued downwards. The lines of the pelvic dissection are prepared, the colon is sectioned with a GIA or with a PLC at the chosen level and the congruity is calculated until it is clear that the terminal end largely exceeds the edge of the pubic symphysis. The distal proximal abutment, sectioned and closed aseptically by the stapler, is easily operated for the following times. Alternatively, a tobacco bag connected to the disposable device may be applied to the proximal abutment or, if it is closed, open on the tapeworm and perform a mechanical anastomosis lateral termination, or with a reservoir. The method of cleaving the rectum smoothly preserves the integrity of the venous vessels and develops first on the posterior side until reaching the plane of the anus elevators and then proceeding on the anterior plane, up to the section of the wing ligaments, with the rectum. Completely free and widely movable in the small basin. The perineal operator introduces the finger to touch the neoplasm determining the distance from the anus cutaneous line. If you then proceed to an anastomosis at 2 cm above the elevators, it is not necessary to clear the wall of the rectum from the fat because it is naturally naked. (26.27.28.29.30) If instead you decide for a colo-anal anastomosis neoplasm from the rectum and is resected under vision as close to the elevators as possible. The evaluation is entrusted to the operator also in the type of anastomosis to be performed. when there is fabric (2.3 cm) above the elevators it is possible to perform a mechanical anastomosis performed by abdominal route. Faced with particular difficulties, a knight-Griffen can be performed with a double application of staplers without leaving any protective stoma. Once the anastomosis has been completed, the intestinal cylinders produced by the cutting edge are checked and intact. They are not advisable in the manual sphincter trans siliconate drainage to collect the serum-hematic or lymphatic fluid that comes from the area of the abdominal, back and left abdomen. Drainage pipe is not applied to the anastomotic because in the dehiscence where there are harvests the drainage effectiveness of the tube is poor (36,37,38,39,40) Before closing the abdomen attention is paid to the possible integrity of the spleen going then looking for gauze or tools. The small intestine is rearranged according to the mesenteric insertion lines and is closed by incision layers. The operation is concluded by examining the anatomical piece.

To do this surgery well it is essential to know how to manage complications "and know how to deal with them in the post-operative period: anastomotic fibrosis, the trapping of sphincter fibers within the anastomosis, the local (rare) ischemia, the poor position of the tobacco bag, the dehiscence of the suture line with air in the retro peritoneum or peritoneum, the accidental injury (41, 42, 43,44,45) In the preoperative: the careful evaluation of the extension of the tumor beyond the wall of the bowel, the grading 3, the perforation in the tumor area (46.47.48.49). In advanced disease it is necessary to identify patients with limited and resectable disease (50,51,52,53,54) O With symptomatic disease that with the use of chemotherapy a reduction of the tumor mass is obtained. Or with symptomatic Disease in good general conditions that use sequential therapy with high toxicity in which the therapeutic and fundamental choice. Finally, the multidimensional evaluation in the patient over 70. In which the surgical option can be proposed in a multidisciplinary way. (55,56.57,58)

CONCLUSIONS

The rectal colic resection and a surgical intervention that implies a choice of the selection criteria for surgery, the surgical technique of demolition and reconstruction of the complex intestinal continuity and of experience and an oncological radicality, which places the surgeon to an onerous commitment that the disease proposes both environmental and technical social. An incorrect indication of a technical error and a non-attentive or constant postoperative surveillance compromise the therapeutic success and life of the patient. relapses are always present even if with a reduced incidence thanks to the new chemo and radiotherapy protocols. The increase in the age of the European population has been associated with the need to prolong the functional and organic expressions so that a surgery that allows you to fully experience all the expressions of an active life and without mutilations even in the presence of serious diseases such as neoplasia rectal colon poses the challenge that is generously collected by the surgeons. In a society that requires icons of health frenzy (always living, with any illness, and always getting healing), but that does not recognize the merits and the abnegation of these new found heroes, "those who perform an extraordinary and generous act of courage, which involves or may involve the conscious self-sacrifice, in order to protect the good of the health of other.

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