

Title	TAMIS management of large peritoneal entry for recurrent rectal polyp: A video vignette
Authors	Flanagan, Michael;Ryan, Jessica M.;Connelly, Tara;Cooke, Fiachra;McCullough, Peter;Neary, Peter
Publication date	2021-11-22
Original Citation	Flanagan, M., Ryan, J. M., Connelly, T., Cooke, F., McCullough, P. and Neary, P. (2021) 'TAMIS management of large peritoneal entry for recurrent rectal polyp: A video vignette', Colorectal Disease. doi: 10.1111/codi.15996
Type of publication	Video
Link to publisher's version	10.1111/codi.15996
Rights	© 2021, Wiley Periodicals LLC. This is the peer reviewed version of the following item: Flanagan, M., Ryan, J. M., Connelly, T., Cooke, F., McCullough, P. and Neary, P. (2021) 'TAMIS management of large peritoneal entry for recurrent rectal polyp: A video vignette', Colorectal Disease, doi: 10.1111/codi.15996, which has been published in final form at https://doi.org/10.1111/ codi.15996. This article may be used for non-commercial purposes in accordance with Wiley Terms and Conditions for Use of Self-Archived Versions.
Download date	2025-05-09 02:57:36
Item downloaded from	https://hdl.handle.net/10468/12289



University College Cork, Ireland Coláiste na hOllscoile Corcaigh MS JESSICA M RYAN (Orcid ID : 0000-0001-6161-9630)

Article type : Video Correspondence

Title TAMIS management of large peritoneal entry for recurrent rectal polyp: A video vignette

## Authors

Mr. Michael Flanagan MRCSI a Ms. Jessica M Ryan HDip MRCSI a Ms. Tara Connelly PhD FRCSI a, b Professor Fiachra Cooke MD FRCSI (Gen-Surg) a, b, c Mr. Peter McCullough MD FRCSI (Gen-Surg) a Professor Peter Neary MD FRCS(Colorectal) a, b

a) Department of Academic surgery, University Hospital Waterford, Dunmore Road, Waterford
b) University College Cork School of Medicine, College Road, Cork
c) Royal College of Surgeons in Ireland, 123 St. Stephen's Green, Dublin 2, Dublin

Corresponding author Mr. Michael Flanagan MB MRCSI

Department of Academic surgery, University Hospital Waterford, Dunmore Road, Waterford

Email: michaelflanagan@rcsi.com

Tel: (051) 848 000

Conflicts of interest The authors MF, JMR, TC, PM, FC, and PN have no conflicts of interest to disclose

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the <u>Version of Record</u>. Please cite this article as <u>doi:</u> 10.1111/CODI.15996

This article is protected by copyright. All rights reserved

## Transcript

We present a case of a 55 year old female with a rectal polyp in the site of previous polypectomy scar performed 1 year previous. The polyp is approximately 4 cm in size with some dotted adenomatous change spreading circumferentially. The patient underwent trans anal minimally invasive surgery or TAMIS using the Gelpoint platform with Airseal to maintain pneumorectum. The tumour is anterior so we prefer to place the patient in the prone jack-knife position with open legs. The lesion is marked circumferentially with diathermy.

We start dissection at the distal aspect of the marking taking care not to enter the peritoneal cavity anteriorly until the tumour is almost completely dissected . A full thickness excision is performed and the mesorectal fascia is clearly visible. In the setting of recurrent disease submucosal dissection was not considered due to fibrosis of the tissue planes.

We have now breached the peritoneal cavity anteriorly. Peritoneal entry does not commonly result in intra-abdominal infection or seeding of malignancy into the peritoneal cavity. Pneumorectum is maintained using airseal. When performing TAMIS for anterior rectal lesions the prone position facilitates an easier closure of the defect, avoids bowel injury and maintains pneumorectum. Indications for TAMIS include endoscopically unresectable polyps . Special indications include more advanced cancers that are unfit for curative resection.

The cap is removed from the Gelpoint port to remove the specimen. The specimen is sent pinned with orientation sutures to the pathology lab. We identify an extensive defect in the rectal wall, the intraperitoneal upper third of the rectum and sigmoid colon, and the appendix. The resulting defect after excision is greater than 50% of the rectal lumen circumference. The defect is closed in a transverse fashion so as not to narrow the lumen of the rectum. We choose to close the defect with a monofilament absorbable v lock barbed suture which does not require knot tying. Finally the integrity of the suture line and adequacy of the closure is checked with intra-abdominal air leak test . Other acceptable management strategies include contrast enema or clinical evaluation. Pneumoperitoneum is achieved using Visiport access to the right of the midline. The rectum is insufflated endoscopically. No bubbles indicate there is no detectable air leak from our suture line. Bilateral tap blocks were performed. Organ preservation techniques such as TAMIS avoid the significant bowel disfunction associated with proctectomy. This patient was discharged on post-operative day 1. Final histology identified tubulovillous adenoma with low grade dysplasia and 5 benign reactive lymph nodes in the adjacent fat.