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Intersphincteric resection - Operative technique

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The standard surgical treatment for rectal adenocarcinoma located up to 5 cm from the anal verge is the abdominoperineal resection (APR). In order to avoid definitive colostomy in these patients, the intersphincteric resection (IR) was first described in the 1980s and now is defined as a procedure that can obtain satisfactory oncological and functional outcomes.

The principle of the technique is based on the dissection of the anatomical plane between the internal sphincter. The surgical procedure is initiated by the abdominal approach, either laparocopicaly or open, performing the high ligation of the inferior mesenteric vessels and mobilization of the splenic flexure. It is then followed by total mesorectal excision until the levator ani muscle and the anorectal junction. The perineal time is initiated with placement of a Gelpi retractor or an autostatic Lone Star retractor in the anal canal to expose the mucous, which is circumferentially opened. Dissection proceeds until the already dissected intraperitoneal portion of the rectum is found. Then, the specimen is removed through the anus and the coloanal anastomosis is performed with interrupted sutures, idealy after the confection of a colonic J pouch. Usually the procedure is finished with a diverting loop ileostomy or colostomy to protect the anastomosis.

The success of the rectal cancer treatment involves the combination of a good oncologic outcome and an acceptable quality of life for the postoperative patient. Modern surgery should not be limited to curative tumor resections, since the functional result and quality of life of these has become part of the primary treatment and has been assessed together with the oncologic outcomes.

Despite all the effort to develop new surgical techniques and preoperative therapies, some patients with rectal cancer are not eligible for IR and, inevitably, APR will be indicated, especially for those with tumors in advanced stages, next to the anal margin and little responsive to neoadjuvant treatments.

Biography

Daniel Cesar is a young surgeon from Brazil. He has completed his medical school program at the Mount Sinai School of Medicine, NY, USA. Back in Brazil he finished his specialization in General Surgery and now he is at the last year of the Surgical Oncology Fellowship at the Brazilian National Cancer Institute. He has a special interest in Neuroendocrine Tumors, Colorrectal Cancer and Abdominal Hernia. He has published papers about this subjects in reputed journals and has been serving as an editorial board member of World Journal of Gastroenterology, World Journal of Gastrointestinal Surgery and World Journal of Clinical Cases Conference.

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