

Supporting Information

The video may be found in the online version of this article and also on the Colorectal Disease Journal YouTube and Vimeo channels:

Video S1. Laparoscopic repair of perineal hernia after abdominoperineal excision of the rectum and anus.

Robotic total mesorectal excision for mid-rectal cancer using the Senhance[®] robotic platform – a video vignette

doi:10.1111/codi.14940

Dear Editor,

For patients undergoing excisional surgery for rectal carcinoma total mesorectal excision (TME) is accepted as the ‘gold standard’ approach. It can be performed laparoscopically or using conventional open techniques. A recent meta-analysis suggests that open TME gives better pathological specimens but minimally invasive techniques may have advantages when considering lymph node harvest, complications and mortality [1]. We have previously shown that the Senhance[®] robotic platform is safe and feasible in all abdominal procedures [2] including colorectal [3,4].

Here, we present a case of robotic TME in a 57-year-old man. The patient was admitted to our clinic complaining of bloating, changes in bowel habits and rectal bleeding. On examination, a semi-circular rectal mass 6 cm from the anal verge was found. Histology was reported as a moderately differentiated adenocarcinoma. No distant metastases were found on chest and abdominal CT. Pelvic MRI suggested a T3N1 cancer. Long course chemoradiotherapy was recommended after multidisciplinary team discussion. The patient received 50.4 Gy of radiotherapy for 5 weeks and 5-fluorouracil-based chemotherapy in weeks 1 and 5. Six weeks after completion of neoadjuvant treatment, the patient underwent a robotic low anterior resection (Video S1) with defunctioning ileostomy. His postoperative course was uneventful and he was discharged on day 6. The final pathology was reported as a ypT2N0 tumour.

Low anterior resection is challenging particularly in obese men with low lying, large tumours that have been irradiated. This video demonstrates that robotic TME using a Senhance[®] robotic system is a safe and feasible option in these patients.

Conflicts of interest

The authors declare that no conflicts of interest exist. The authors alone are responsible for the content and writing of the paper. The authors declare that this video vignette has not been published elsewhere and that it has not been submitted previously for publication elsewhere.

Author contributions


NES, VK, VJ, AS and AD contributed to this work, satisfying the following four criteria of the guidelines of the International Committee of Medical Journal Editors: substantial contributions to the conception or design of the work, or the acquisition, analysis or interpretation of data for the work; drafting the work or revising it critically for important intellectual content; final approval of the version to be published; agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Ethical approval

All procedures involving human participants were performed in accordance with the ethical standards of the institutional and/or national research committee and the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. This article does not contain any studies using animals.

Informed consent

Informed consent was obtained from the patient.

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Lateral internal sphincterotomy for chronic anal fissure under perianal anaesthetic infiltration – a video vignette

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Dear Editor,

There are a large number of treatment options for chronic anal fissure and the choice of the most appropriate treatment may be difficult. Lateral sphincterotomy (LS) was described more than 60 years ago and has been widely adopted by surgeons worldwide [1]. Although this procedure gives good results, with healing of the fissure and thus high patient satisfaction, the risk of incontinence should always be kept in mind [2]. LS should be the next step in treating chronic fissures when the medical treatment is unsuccessful. Here we describe a case of chronic anal fissure treated with open LS.

A 35-year-old woman presented to our clinic complaining of a 1½ year history of persistent pain both during defaecation and for several hours afterwards. There was also blood on the stool. Anal examination confirmed a chronic anal fissure and the patient was scheduled for surgery as a day case. The patient was placed in the prone jack-knife position. Perianal anaesthetic infiltration was performed using a mixture of bupivacaine and lidocaine solutions. A 5–6 mm skin incision was performed above

the intersphincteric groove on the left lateral side. The internal anal sphincter was gently separated from the external anal sphincter laterally and subcutaneous tissue medially up to the level of the dentate line. The internal anal sphincter was divided up to the level of the dentate line with fine scissors. Gentle compression on the operative area for 1–2 min allowed perfect haemostasis to be achieved (Video S1).

A recent systemic review and meta-analysis showed that LS is the most effective treatment for anal fissure, curing all but 6% of patients. Minor incontinence is more likely with LS than medical therapy but the likelihood is very low – only 14 cases per 1000 [3].

In conclusion, we feel that LS is the best treatment for chronic anal fissure refractory to medical treatment.

Conflicts of interest

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Author contributions

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