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Research Article

THE MANUAL ANASTOMOSIS RECTAL COLON TODAY

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ABSTRACT

Introduction: In the surgery of tumors under peritoneal the need to remove all the meso rectum for the purpose of obtaining the radicality of cancer, by packaging an anastomosis that falls near the muscular plane of the elevators of the anus, is now a consolidated procedure. Anal anastomosis has considerable technical difficulties, especially when it is performed by hand, especially in obese patients with a narrow and deep pelvis. These unfavorable conditions contribute to predispose the patient to the onset of complications for which it is preferable in principle to perform a mechanical anastomosis. **Materials and methods:** From January 2010 to December 2017, the database of the University of Catania Polyclinic AOU was investigated in 37 cases of tumor-site neoplasm in the sigma-rectum. A 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. **Results:** The tumor was found to be between 4 and 10 cm from the rhyme, such a neoplasm had a max diameter of between 3 to 5 cm, the macroscopic appearance of the neoplasm was 70% vegetative and polypoid or pedunculate and sessile for the remaining 30%. The definitive histological examination confirmed the ultrasound diagnosis with a demonstrated sensitivity of 95%. **Discussion:** In the execution of the resection intervention, two main times are schematically distinguished, the abdominal time in which the rectum mobilized in the abdomen is sectioned freehand on the plane of the anus lifters. Why this is possible It is necessary to point out how the mobilization is made broad and invests the splenic flexure and part of the transverse colon in order to allow an easy lowering of the colon in the pelvis. The flap of the big oment is pushed and placed in the pelvis to fill the void created by the removal of the rectum. The results obtained also demonstrated in our case studies as the observation of the few rules implemented and illustrated, the therapeutic success was assured in relation to the containment of the risk of complications, morbidity and mortality. **Conclusion:** The colon anal anastomosis in compliance with oncological criteria have proved to be current and feasible. In spite of the fact that a widely demolition procedure is performed, it is possible to conserve the sphincter anal apparatus so as to ensure an acceptable quality of life.

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INTRODUCTION

In the surgery of tumors under peritoneal the need to remove all the meso rectum for the purpose of obtaining the radicality of cancer, by packaging an anastomosis that falls near the muscular plane of the elevators of the anus, is now a consolidated procedure.(1,2,3,4,5) Anal anastomosis has considerable technical difficulties, especially when it is performed by hand, especially in obese patients with a narrow and deep pelvis. These unfavorable conditions contribute to predispose the patient to the onset of complications for which it is preferable in principle to perform a mechanical anastomosis.

However, when the manual anastomosis is chosen, the following criteria must be respected: The intestinal heads are both vital and abundant, exceeding the length necessary to connect the two stumps, strip the anastomosis of the fat fringe where the sangnigni vessels run, the suture must be regular with detached stitches and the slow absorption suture thread, the non-devitalizing points, the knots are knotted inside the intestinal lumen .(6,7,8,9,10) With a good flap of the epiploon specially prepared to fill the pelvic cavity, with an enterostat upstream of the anastomosis leaving it a blunt of free and open section. The rectal anastomosis proposed by Parks in 1972 can be performed with an anastomosis terminal term between the

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colon and the anal canal located in the comb line, manually and anal. His indication today has found a new application because in the literature it has been shown that there is no statistical difference in terms of survival and disease-free interval between the intervention of RA and AAP. (11,12,13,14,15) It follows that distal clearance was considered sufficient at 2 cm. The recognition of the importance of regional loco neoplastic diffusion has highlighted the need to completely remove the perirectal lymphatic endopelvic cell tissue. This confirms that this demolition is necessary, and the confirmation that recurrences of the rectal arch are of extra-spatial origin. The spread of the mechanical staplers has further allowed to broaden the indications of conservative surgery and sphincter function, with the realization of a radical intervention. The indications for anal anastomosis are: a 5 cm neoplasm from the anus cutaneous line, the presence of narrow or obese pelvis, the difficulty of packing with the mechanical stapler (incomplete rings) the anastomosis with the failure of the mechanical suture, in injuries of the rheumatic or inflammatory rectum. The incongruity of the diameters of the intestinal garments makes the latero-terminal anastomosis prefer, however, not all authors agree in supporting this indication because if the rectum is dissected right above the elevators its lumen is reduced and adapts well to the descending colon.(16,17,18.19.20) The success of the anastomosis is conditioned by the respect of the rules that establish the maintenance of a good vascularization, an abundant availability of the colon and a precise technical execution. the aim of the present study is to evaluate the performed interventions and the anastomoses in order to find indicators that can prevent possible complications

MATERIALS AND METHODS

From January 2010 to December 2017, the database of the University of Catania Polyclinic AOU 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. 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 7 cases we performed a colon anal anastomosis of which 4 in lateral term and n 3 in terminal terminal. Fig 1

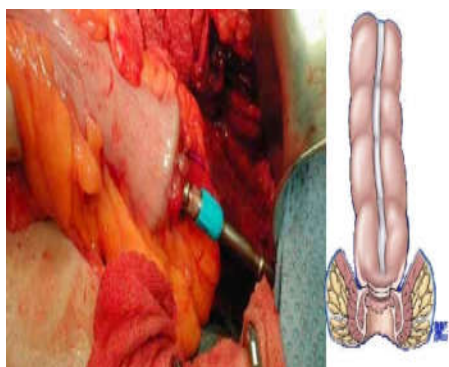


Fig 1 colon anal anastomosis Stapler

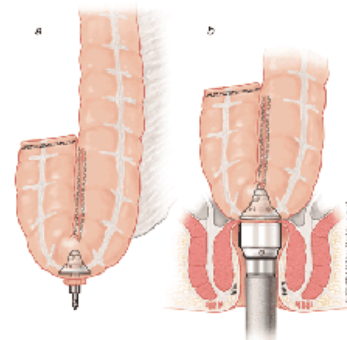


Fig 2 reservoir colon anal

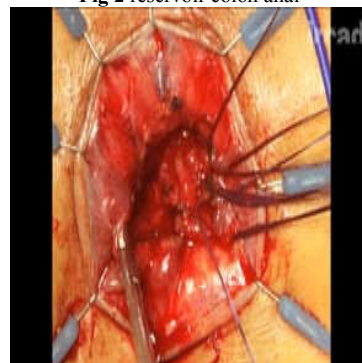


Fig 2 manual colon anal suture

RESULTS

The tumor was located on average between 4 and 10 cm from the anal rhyme, such neoplasm had a max diameter of between 3-5 cm, the macroscopic appearance of the neoplasm was 70% vegetative and polypoid or pedunculate and sessile for the remaining 30%. The definitive histological examination confirmed the ultrasound diagnosis with a demonstrated sensitivity of 95%. The microscopic investigation showed an extension of the neoplasm limited to the superficial layers of the wall in 11% for T1 tumors and 37% for T2 tumors. In these cases in which this extension was present, relapses occurred after local resection and lymphatic and venous invasion and under mucosa were present on the anatomical piece. In all patients treated with local resection, the margins of resection were found to be free of histological examination. Histological grading was classified as low and only in 2 cases of medium grade of malignancy. Patients who underwent local and curative excision were subjected with a limited follow-up every 3 months for the first 24 months thereafter every 6 months for 5 years. The operation consisted of anterior rectum colal resection with complete removal of the middle rectum accompanied by the lymphectomy of the iliac chains. The mean distance between the lower margin of the neoplasm and the distal section line was 3 cm with a range of 2-6 cm. the complications were subdivided into early as dehiscences and late as stenosis, and the first and with a resection under local anesthesia of the exceeding colonic stump were resolved with a temporary stomy.

DISCUSSION

In the execution of the exeresis intervention, two main times are schematically distinguished, the abdominal time in which the rectum mobilized in the abdomen is sectioned freehand on the plane of the anus elevators. Why this is possible It is

necessary to point out how the mobilization is made broad and invests the splenic flexure and part of the transverse colon in order to allow an easy lowering of the colon in the pelvis. The flap of the big omentum is pushed and placed in the pelvis to fill the void created by the removal of the rectum.(21,22,23,24,25) Vascularization must be good in the anastomotic tissues and is entrusted to the inferior mesenteric artery at the origin, and preserving of the colonic arcade. (26,27,28,29,30) It must be carefully evaluated and if it is considered insufficient, the resection must include the entire section of intestine considered to be at risk. In the anastomosis we make sure that the sutures are placed at full thickness in the intestinal wall from both the head and the other so that the suture is invaginating. At the same time the mucosal edges are still to be produced with a regular slow-absorbing all-encompassing suture with a thickness of 3-4 / 0 on a trauma needle uniformly distancing by a few millimeters.(31,32,33,34,35) In cases of incongruity of the intestinal diameters, space is left between the points passed on the side of the larger abutment, usually the rectal abutment is to correct the difference. In order to obtain a lumen of regular diameter, it is necessary that the resection takes place on the transverse plane by uniformly attracting the front and back walls of the organ. (36,37,38,39,40)Therefore taking care to iron the rear wall which has a large curvature exceeding the front. Peri anal time includes in a gentle anal divulging with antiseptic solution, with apposition of 4 points positioned in a cardinal way on the circumference of the anus , successively section the rectum abdominal way up to the apex of the columns of the Morgagni. If the surgical operation is not possible, the resection is performed peri anal after eversion of the rectum provided that we are in the presence of small and initial tumors so that the passage of the completed anastomosis is possible.(41,42,43,44,45) Cardinal points are placed on the top line of the Morgagni columns, which are considered for the anastomosis that is performed at detached points and with slow absorption sutures (ethibond,) having taken care to fully understand the colon wall and the wall of the abutment of the anal canal and knotted inside the lumen. Although we are dealing with only a few patients in our series, mortality was absent. the complication of dehiscence was trivial and easily controlled.(46,47,48,49,50) Stenosis in the case of excess stump required endoscope modeling. the reservoir suture made with stapler (fig 2,2 bis) after it had folded the last section of the U-shaped colon, the reservoir thus obtained was lowered into the pelvis and the end passed through the anal canal and subsequently sutured to points detached on the combed line.(51,52,53,54,) The results obtained also demonstrated in our case studies as the observation of the few rules implemented and illustrated, the therapeutic success was assured in relation to the containment of the risk of complications, morbidity and mortality. (55,56,57,) An anastomosis performed correctly should not be lost, so there is no reason to test or stress the tightness of the same. Indications to not carry out an intestinal anastomosis, are related to the conditions of the patient, the intestine and the abdominal cavity. Therefore it is avoided to pack a colic anastomosis in the presence of an intra-abdominal infection.(58,59,60)

CONCLUSION

The coloanal anastomoses in compliance with oncological criteria have proved to be current and feasible. In spite of a

widely demolition procedure, it is possible to conserve the anal sphincter apparatus so as to ensure an acceptable quality of life. The reservoir functionality was documented with instrumental clinical examinations that allow to quantify the results obtained and to modify the surgical technique. and the amount of colon to be removed, taking care of the recognition and protection of nerve vascular structures. the distance from the tumor that in our experience was on average 3 cm is useful as well as necessary for the packaging of the anastomosis itself.

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