

showed no distant metastases but local invasion of the greater curvature of the stomach and the tail of the pancreas.

Video S1 shows the intra-operative set-up (standard four trocar placement as for standard laparoscopic splenic flexure resection) and confirmed infiltration of the two organs requiring *en bloc* multi-organ resection in order to achieve R0 resection. The tumour was then removed through a suprapubic incision followed by side to side colo–colic intracorporeal anastomosis.

The postoperative course was uneventful, with a length of stay of 9 days. The pathology results confirmed the diagnosis of colonic adenocarcinoma pT4b (infiltration of the whole colonic wall, the perivisceral fat, the omentum, the pancreatic tail and the gastric wall to the gastric mucosa which demonstrates ulceration), N0 (0/45 nodes), with negative peritoneal cytology.

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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 *en bloc* resection of the splenic flexure, the greater curvature of the stomach, tail of the pancreas and spleen for T4 colonic cancer.

Robotic excision of a difficult retrorectal cyst – a video vignette

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Dear Editor,

Contrary to historical teachings about addressing very distal retrorectal (presacral) cysts via perianal incision, our preferred, current method for treating most of these lesions involves a robotic abdominal approach [1,2]. Benefits of this approach include excellent exposure and no perianal wound creation, which tends to frequently become infected [1].

A 31-year-old female presented with a recurrent, presacral 8 cm cyst located at the level of the mid-lower rectum and without rectal communication. The dissection was completed as depicted in the video vignette (Video S1; video transcript in Data S1). Robotic and assistant ports were placed as depicted in Fig. 1. The cyst was firmly adherent to the medial aspect of the levators and the rectal wall. Flexible sigmoidoscopy was used periodically to distend and collapse the rectum, in order to visualize and transilluminate a safe dissection plane. The cyst had a very thin wall. Although a small hole was inadvertently made, we found the resultant partial decompression aided in resection by allowing for delineation of the obscure aspects of the cyst wall.

The patient's post-operative course was unremarkable. She was discharged home the next day. Pathology revealed a benign, unilocular epidermoid cyst. At fifteen

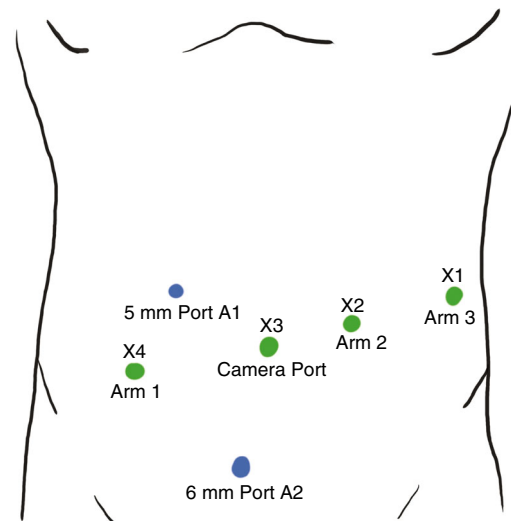


Figure 1 Placement of trocars.

months, the patient has not experienced any recurrence or anorectal complaints.


Removal of the entire cyst tissue is paramount in preventing recurrence. In the deep pelvis, the robotic platform allows for excellent exposure, stability, and precise dissection in comparison to the limited ergonomics of laparoscopy [3–5]. It also allows one to avoid the perineal wound when compared to trans-levator approach [1].

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Conflicts of Interest

There are no conflicts of interest to declare.

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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. Video of the robotic excision of a difficult retrorectal cyst.

Data S1. Script of the video.

Transanal and transabdominal laparoscopic Hartmann's reversal with rectal stump fistula management – a video vignette

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Dear Editor,

Laparoscopic techniques may be preferable to open surgery for reversal of Hartmann's procedure [1]. Recently, transanal laparoscopy has been used for revisional colorectal surgery and also for Hartmann's reversal [2].

A 54-year-old man who had undergone a Hartmann's procedure for a rectal tumour 6 months earlier was admitted for reversal using a combination of laparoscopic and transanal techniques. Preoperative imaging confirmed the presence of a small leak from the stapled rectal stump.

The first part of the operation was closure of the fistula by transanal laparoscopy, using nonabsorbable double figure-of-eight sutures (Fig. 1). A transabdominal and transanal 'rendez-vous' was performed to accommodate the spike of the circular stapler into the low rectum (Fig. 2a,b), thereby enabling a low end-to-end colorectal anastomosis to be performed anterior to the site of the repaired fistula (Fig. 3). Contrast-enhanced indocyanine green (ICG) perfusion was used to check the anastomosis at 5 cm from the dentate line. On completion, a defunctioning ileostomy was fashioned.

A gastrografin enema at 2 months after surgery revealed a suspected posterior anastomotic fistula. A further endoluminal repair using transanal laparoscopy was carried out. Colonoscopy at 4 months showed a sinus track which was not seen on imaging. Subsequently, the ileostomy was closed. At 6 months' follow-up the patient was well.

The presence of rectal stump leakage cannot be considered as a contraindication to reversal of Hartmann's

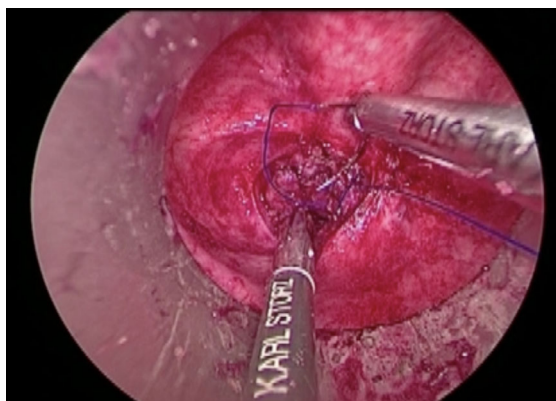


Figure 1 Closure of the rectal stump fistula by transanal laparoscopic suture.