Transanal Mobilization of the Distal Rectum in Coloanal Anastomosis

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Dear Sir,

We have read an interesting article in performing coloanal anastomosis written by Givel et al. [1]. They combined low anterior resection with transanal dissection of the distal rectum. The rectum is first cut by a stapler at the level of the pelvic floor. A circumferential mucosectomy is then started from the dentate line. The internal anal sphincter (3-4 cm) with rectal muscle wall (1-2 cm) should be preserved.

We have been performing anoabdominal rectal resection and colonic J pouch anal anastomoses since 1985. One hundred and seven colonic J pouch anal anastomoses and 15 straight coloanal anastomoses were performed using this procedure [2, 3]. We start mucosectomy at the dentate line and dissect the distal rectum circumferentially just above the internal anal sphincter, or add partial (or total) resection of the internal anal sphincter in order to have a free margin in the case of rectal carcinoma [3]. We push back the rectum towards the abdominal cavity with a pack of gauze after closure of the distal stump. At laparotomy, the rectum is easily resected from the abdominal side because the transanal mobilization usually reaches the peritoneal reflection.

The resection line of Givel et al. [1] of the rectum is quite similar to ours. Their procedure would minimize contamination and/or implantation during operation. However, we speculated that the indication for their procedure is limited when performing resection for lower rectal cancer. If the tumor is located above the pelvic floor, double-stapling coloanal anastomosis is enough to preserve anal function. If the tumor (over T2 stage) is located in the anal canal, their method is difficult if one wants to have a clear margin.

Basically, we think their two-step resection of the distal rectum has some arguments when facing patients with lower rectal carcinoma. However, their procedure would be favorable for benign disease. We agree with their concept of preserving the anal sphincters under direct vision. It is important to manage the anal canal structure carefully in order to have a better postoperative anal function.

References

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