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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. This video demonstrates technical aspects of laparoscopic low anterior resection for rectal bleeding in Klippel-Trénaunay syndrome.

Laparoscopic posterior supralevator exenteration for locally advanced rectal cancer with incisional hernia repair – a video vignette

doi:10.1111/codi.14889

Dear Editor,
Minimally invasive surgery is an accepted modality of treatment for rectal cancer. The indications for minimally invasive surgery have gradually been extended to locally advanced rectal cancer. Laparoscopy beyond total mesorectal excision is not well established; however, selected high volume centres do practise it with good results [1]. We have previously published our techniques of robotic posterior pelvic exenteration and pelvic node dissection in locally advanced rectal cancer [2,3]. Anterior and anterolaterally advanced disease in female patients requires posterior exenteration for clear margins. This video demonstrates easily reproducible steps for the laparoscopic approach. Achieving good anterolateral margins and at the same time preserving autonomic nerves and sphincter complex is of prime importance. In experienced hands, it can be achieved laparoscopically.

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. Laparoscopic posterior exenteration for rectal cancer with incisional hernia repair.
Data S1. Script of the video.

Treatment of rectovaginal postanastomotic fistula with a transanal endoscopic operation – a video vignette

doi:10.1111/codi.14894

Dear Editor,
The reported incidence of postsurgical rectovaginal fistula is very low, with no overall systematic approach to treatment.

We report the case of a rectovaginal fistula after resection of the rectum with total mesorectal excision. The 55-year-old patient had undergone neoadjuvant chemoradiotherapy prior to surgery [1–6].

Three months postoperatively the patient developed a rectovaginal fistula at the level of the anastomosis some 10 cm from the anocutaneous margin. Initially, the Ovesco Over-The-Scope Clip system was used for managing the fistula, but the fistula returned after a month. We then decided to use a transanal endoscopic operation (TEO) system to perform a direct sutured repair of the fistula.

With the patient in the prone position, the fistula, measuring some 5 mm, was identified. The first part of

the procedure consisted of freshening the margin of the fistula (Video S1). Following this, a continuous sutured closure was performed with a resorbable self-locking monofilament suture. Finally, a second layer was used to reinforce the repair using another monofilament, slowly resorbable, suture. After 6 months there has been no recurrence of the fistula.

Postoperative rectovaginal fistulas may be a complication of surgery for rectal cancer and, if they do occur, may be further complicated if preoperative radiotherapy has been employed. An individualized approach may be necessary to achieve successful closure. The TEO system can be a valuable aid but must be used by experienced surgeons.

Conflict of interests

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. Treatment of rectovaginal postanastomotic fistula with a transanal endoscopic operation.

Achievement of haemostasis following a double-stapled (Knight–Griffen) anastomosis using the transanal endoscopic operating system – a video vignette

doi:10.1111/codi.14896

Dear Editor,

Postoperative colorectal anastomotic bleeding is not uncommon following colonic surgery. Endoscopic procedures are usually safe, efficient and successful. The use of endoscopic clips or direct injection of sclerosing agents guarantees accurate haemostasis. Endoscopic electrocoagulation may also be used to deal with anastomotic haemorrhage [1–5].

We present a case of a patient undergoing a sigmoid colectomy for diverticulosis. On the first postoperative day, bleeding occurred from the double-stapled (Knight–Griffen) anastomosis. Initial management was with endoscopic clips but further bleeding occurred after 12 h.

At this stage, we decided to use the transanal endoscopic operating (TEO) system. With the patient in the supine position, the bleeding point was identified and a continuous suture used to under-run the area in question, using a resorbable self-locking monofilament suture. This was successful with no recurrent bleeding.

The TEO system can be an additional valuable aid but must be used by experienced surgeons.

Conflicts of interest

There are no conflicts of interest to declare.

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