



Case Series

Combined laparoscopic and robotic surgery for synchronous colorectal and genitourinary cancer: A case series



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ABSTRACT

INTRODUCTION: Advances in diagnostic techniques and treatment have resulted in an increase in patients with synchronous cancer. Surgical reports of combined laparoscopic and robotic resection for synchronous colorectal and genitourinary cancer are rare.

MATERIALS AND METHODS: Between August 2015 and November 2017, three patients underwent combined laparoscopic and robotic surgery for synchronous colorectal and genitourinary cancer in our hospital.

RESULTS: Case 1 was a 59-year-old man with synchronous rectal and prostate cancer treated by combined laparoscopic anterior resection and robotic-assisted prostatectomy. Case 2 was a 77-year-old man with synchronous cancer of transverse colon and left kidney treated by combined laparoscopic transverse colectomy and robotic-assisted partial nephrectomy. Case 3 was a 74-year-old man with synchronous adenocarcinoma of descending colon and prostate treated by combined laparoscopic left hemicolectomy and robotic-assisted prostatectomy.

DISCUSSION: In simultaneous endoscopic surgery, it is necessary to consider sequence of resection, intraoperative position of patient and port arrangement. Simultaneous surgery allows promptly for postoperative adjuvant chemotherapy.

CONCLUSION: Combined laparoscopic and robotic surgery for synchronous colorectal and genitourinary cancer is suitable for advanced cancer cases requiring multidisciplinary treatment.

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1. Introduction

Recently, advances in diagnostic techniques have resulted in an increase in synchronous cancer patients. However, surgical reports of combined laparoscopic and robotic resection for synchronous colorectal and genitourinary cancer are rare [1,2]. We performed combined laparoscopic and robotic surgery in three such patients. The procedures and clinical experience are described below with review of selected literature.

2. Materials and methods

Between August 2015 and November 2017, three patients underwent combined laparoscopic and robotic surgery for synchronous colorectal and genitourinary cancer in our hospital. This report is retrospective case series. This work has been reported in line with the PROCESS criteria [3].

3. Results

3.1. Case 1

A 59-year-old man was referred for evaluation of positive fecal occult blood test and elevated prostate-specific antigen (PSA). His past medical history were hypertrophic cardiomyopathy and three surgeries for ascending colon diverticulitis. Colonoscopy found rectal adenocarcinoma (Fig. 2a), with evidence of lymph

Abbreviations: PSA, prostate-specific antigen; CT, computed tomography; MRI, magnetic resonance imaging; RARP, robotic-assisted radical prostatectomy; TAE, transarterial embolization.

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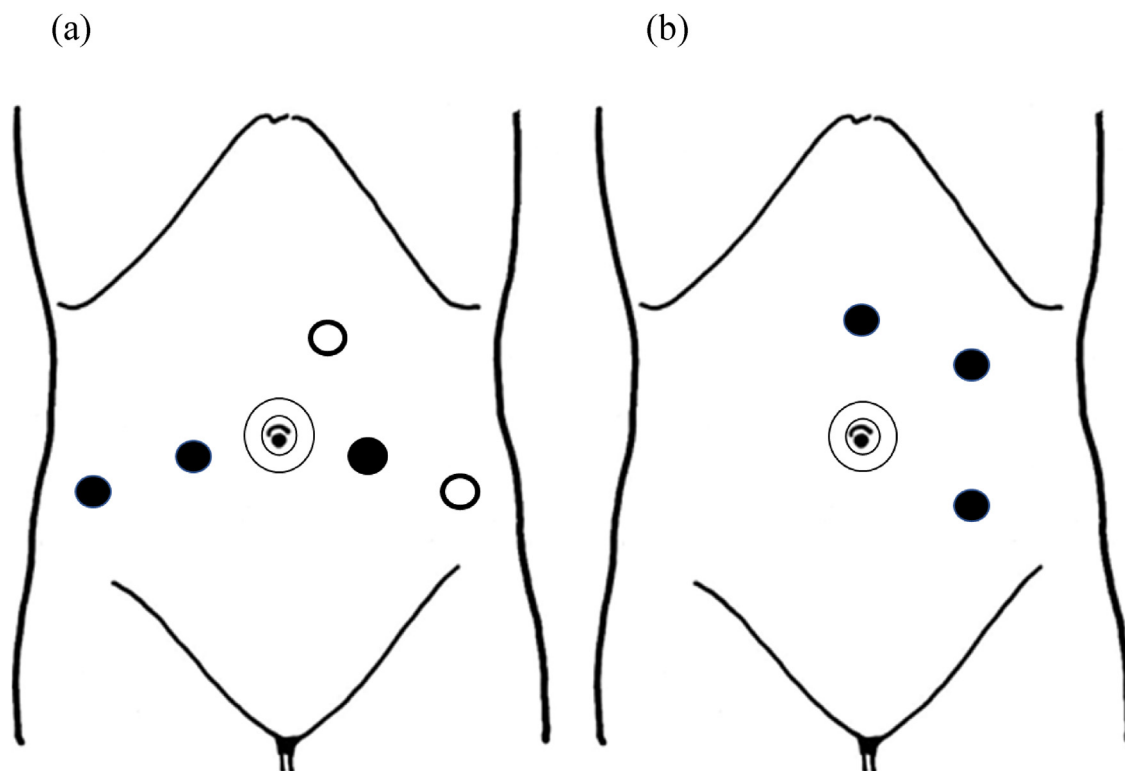


Fig. 1. Port arrangement in each operation (◎: 12 mm trocar, ●: 8 mm trocar, ○: 5 mm trocar) (a) Case 1 (b) and case 3. (b) Case 2.

node metastasis on computed tomography (CT, Fig. 2b). Magnetic resonance imaging (MRI) and biopsy revealed prostatic adenocarcinoma (Fig. 2c). We decided to perform simultaneous endoscopic surgical resection. Under general anesthesia, the urologists performed robotic-assisted radical prostatectomy (RARP) with the patient in the lithotomy position (Fig. 1a). It took a long time to separate intra-abdominal adhesions resulting from previous surgery. After resection of the prostate and urethrovesical anastomosis, the surgeons performed a laparoscopic low anterior resection using the same port site. A diverting stoma of the ileum was constructed because the anastomosis was near the anal wedge. The procedure time was 676 min. The pathological diagnoses were rectal adenocarcinoma, stage T3N2M0 and prostate adenocarcinoma, stage T2cN0M0. The patient was diagnosed with recurrences in para-aortic and mediastinal lymph nodes 6 months after surgery. Chemotherapy is ongoing, with stable disease 32 months after surgery.

3.2. Case 2

A 77-year-old man was referred to the outpatient department because of diarrhea, nausea, and abdominal pain. Abdominal CT revealed obstruction of the left transverse colon (Fig. 3a), cancer of the left kidney (Fig. 3b), and a splenic aneurysm. Colonoscopy confirmed a constricting tumor of the transverse colon (Fig. 3c) pathologically diagnosed as adenocarcinoma. Endoscopic decompression was performed with a self-expanding metal stent, and transarterial embolization of the splenic aneurysm was done to prevent perioperative rupture. Combined laparoscopic transverse colectomy and robotic-assisted partial nephrectomy were performed. Under general anesthesia, the patient was placed in the right, lateral decubitus position with the port placement as shown in Fig. 1b. The surgeons mobilized the colon, the tail of the pancreas, and the spleen. After mobilization, the urologists performed robot-assisted partial nephrectomy. After rotating the table to bring the

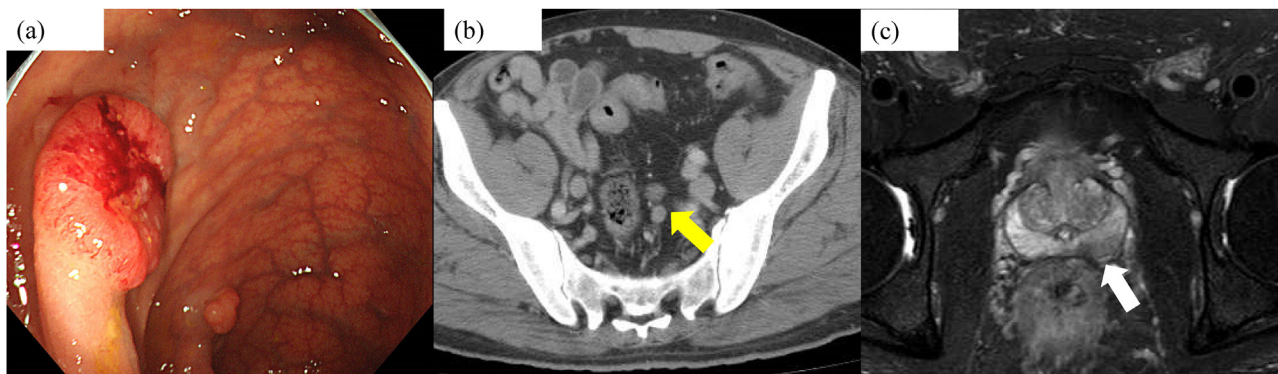


Fig. 2. The examination of imaging before the operation in case 1. (a) Colonoscopy showed rectal cancer. (b) CT suggested lymph node metastasis (yellow arrow). (c) MRI showed prostate cancer on the left lobe (white arrow).

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