

25.8 Total mesorectal excision for rectal cancer decreases local recurrence

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Patients & Method: 174 patients with adenocarcinoma of rectum within 12 cm from anal verge underwent curative low anterior resection with total mesorectal excision (TME) between October 1993 to February 1998 in Queen Mary Hospital. By the end of February 1998, 71 had 2-4½ years follow up. 87 computer match patients operated between September 1986 to September 1993 using conventional technique (CT) was chosen as control.

Results: The age, sex ratio, length of follow up, Dukes' staging was similar in the 2 group. The average tumour level for TME group was 7.5 cm and CT group 8.8 cm. The average distal margin was 2 cm for TME and 8.8 cm for CT group. Systemic recurrence recurred in 21.1% of TME patients and 23% of CT patients. Local recurrence for TME group was 5.6% and 19.5% for CT group ($p < 0.05$). It was concluded that by employing TME technique, local recurrence may be dramatically reduced.

25.9 Video-assisted thoracoscopic procedures on reoperated chests

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Background: A previous operation is generally considered to be a relative contraindication to minimal access surgery. We reviewed our experience with video-assisted thoracic surgery on reoperated chests.

Methods: From September 1992 to March 1998, 874 patients underwent video-assisted thoracic procedures of whom 27 patients (22 men; age range, 9 to 78) had prior operations on ipsilateral side of the chest: 13 after prior open procedures and 14 after video-assisted thoracic procedure. The second procedures consisted of bullectomy or bulla ligation (8), mediastinal and hilar mass biopsy (8), wedge lung resection (6), talc insufflation (3), and decortication (2).

Results: Adhesions were noted in all patients ranging from minimal to strong fibrous adhesions. However, in only 1 patient was the procedure abandoned because of adhesions. Video-assisted thoracic surgery was completed in all other patients. There was no mortality or intraoperative complications and mean hospital stay was 6 days (range, 2-17).

Conclusions: Video-assisted thoracic surgery on reoperated chests is feasible and does not carry a higher morbidity or mortality compared with first-time operations, even though it may be technically more difficult. Experience and clinical judgment are required to select these patients for reoperation with video-assisted thoracic surgery.