Minimally invasive lateral pelvic lymph node dissection has been shown to be safe and feasible in the treatment of rectal cancer. Internal iliac lymph nodes are the most commonly affected lymph nodes in low rectal cancer, and therefore clearance of this lymph node group is of utmost importance. After clearance of external and obturator lymph nodes, the most caudal part of the lymph nodes beyond the bifurcation of the inferior vesical artery, which is surrounded by the lateral sidewall, the ureterohypogastric fascia and levator ani muscles, should be cleared. Dissection along the many branches of the internal iliac artery can be difficult. We have routinely dissected the vessel with ligation of its branches at its roots and termination at the bladder wall. All branches of the internal iliac artery can be ligated if dissection is performed on a single side. This is easier to perform with a shorter operative time, allowing complete eradication of lymphatic tissue and reduced blood loss. We have not encountered any incidence of bladder ischaemia with this technique.

The accompanying video (Video S1 in the online Supporting Information, Data S1) demonstrates laparoscopic left lateral pelvic lymph node dissection with division of vascular structures in a patient with low rectal cancer after completion of total mesorectal excision.

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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 left pelvic lymph node dissection with ligation of internal iliac artery branches in a patient with locally advanced low rectal cancer.

Data S1. Transcript for pelvic lymph node dissection video.

Perineal hernia repair – a video vignette

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Dear Sir,

Video S1 shows an open perineal hernia mesh repair through a Pfannenstiel incision. A 57-year-old woman with a retro-rectal neuroendocrine tumour (NET-G2) initially underwent a local excision with coccygectomy. Abdominoperineal resection and lymphadenectomy were performed 2 years later for local recurrences. The patient presented thereafter with a large symptomatic perineal hernia. The patient's symptoms included difficulty sitting and local pain. A pelvic MRI showed a large hernia with omentum as content. Preoperative Positron emission tomography/computed tomography using ^{68}Ga -labelled DOTA⁰-Tyr³ octreotide (DOTATOC-PET-CT) showed a local single local recurrence without any other abnormal captation. We performed an excision of the local recurrence and a perineal hernia repair with mesh, through the initial Pfannenstiel incision (Video S1). We placed the mesh above the uterus, which allowed us to use the uterus as a spacer. A composite mesh, 'custom-fitted', was fixed to the promontory and the remaining peritoneum. Finally, an omentoplasty was performed to avoid long-term adhesions of small bowel to the mesh.

Postoperatively, the patient developed a pelvic seroma, which was treated by percutaneous drainage. Pathology confirmed complete excision of the local recurrence.

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This video was presented at the 2nd Swiss Hernia Days, Sept. 20–21 2018, Basel, Switzerland.

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. Perineal hernia repair intervention, with audio comments.