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31ème Congrès annuel

DE L'ASSOCIATION FRANCOPHONE DES INFIRMIER(E)S DE SALLE D'OPERATION

Vendredi 24 mars 2017

MICX (Mons International Congress eXperience)

Renseignements & Inscription : www.afiso.be

asbl AFISO, 95/A rue d'Heure-le-Romain, 4680 Oupeye, Belgique

Programme congrès AFISO 2017

www.afiso.be

11h00 - 12h00 : Session générale 5 - Auditoire 400

S 5.1. Vingt-cinq ans d'évolution en chirurgie colorectale : pas de progrès sans inter-métier centré sur le patient

Prof. Alex Kartheuser, MD, MSc, PhD, Colorectal Surgery, University Hospital St-Luc - 10, Avenue Hippocrate - B-1200 Brussels, Belgium.

25 ans d'évolution en chirurgie colorectale : pas de progrès sans inter-métier centré sur le patient

Alex KARTHEUSER, MD, MsC, PhD

UCL Université catholique de Louvain

Cliniques universitaires SAINT-LUC UCL BRUXELLES

CHIRURGIE DU CANCER COLORECTAL

A. Introduction

COLORECTAL CANCER INCIDENCE

World:

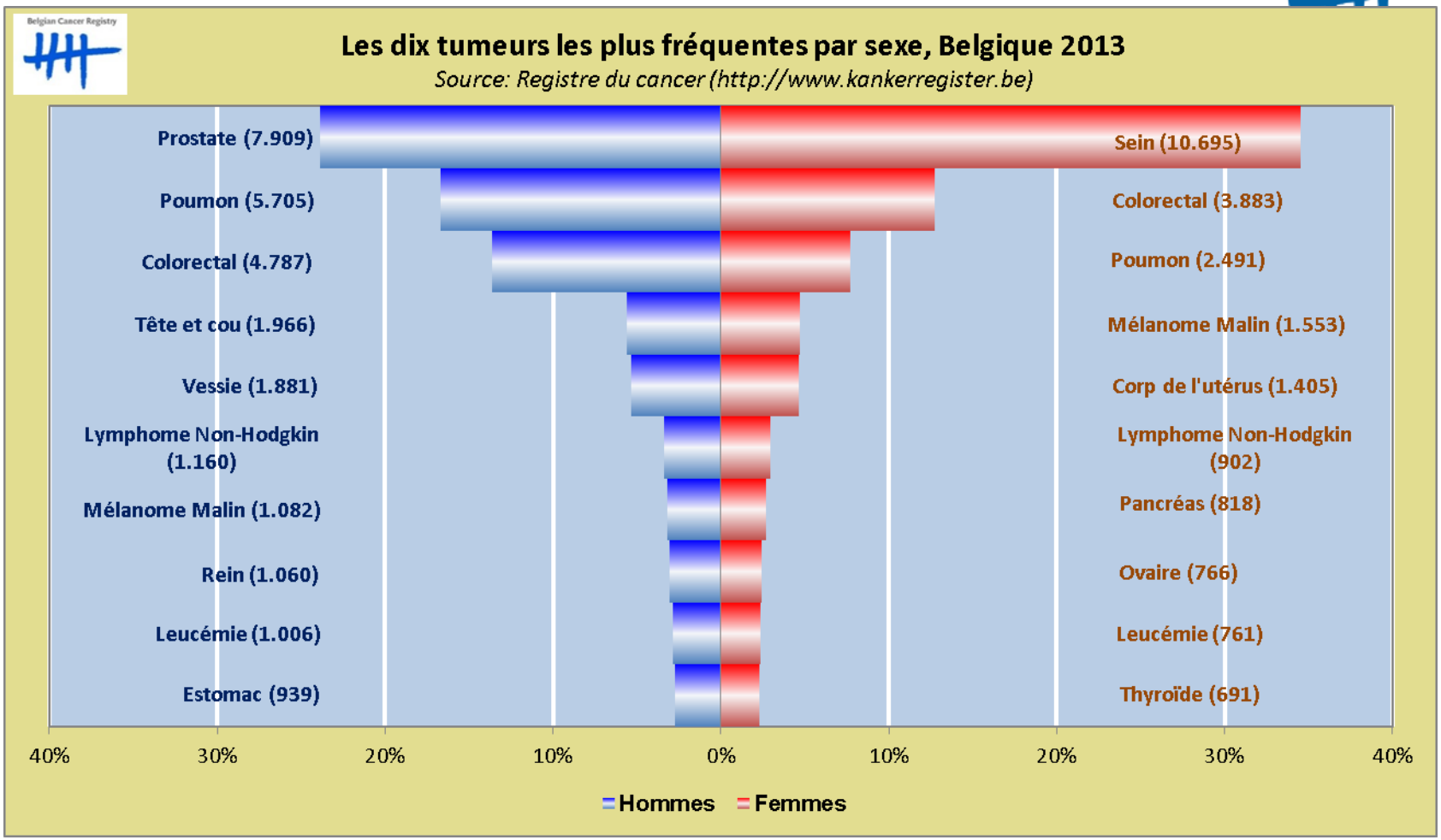
12 millions cancers / year
900.000 colorectal cancers / year : **7,5%**

Europe :

3.200.000 cancers / year
413.000 colorectal cancers / year : **13%**

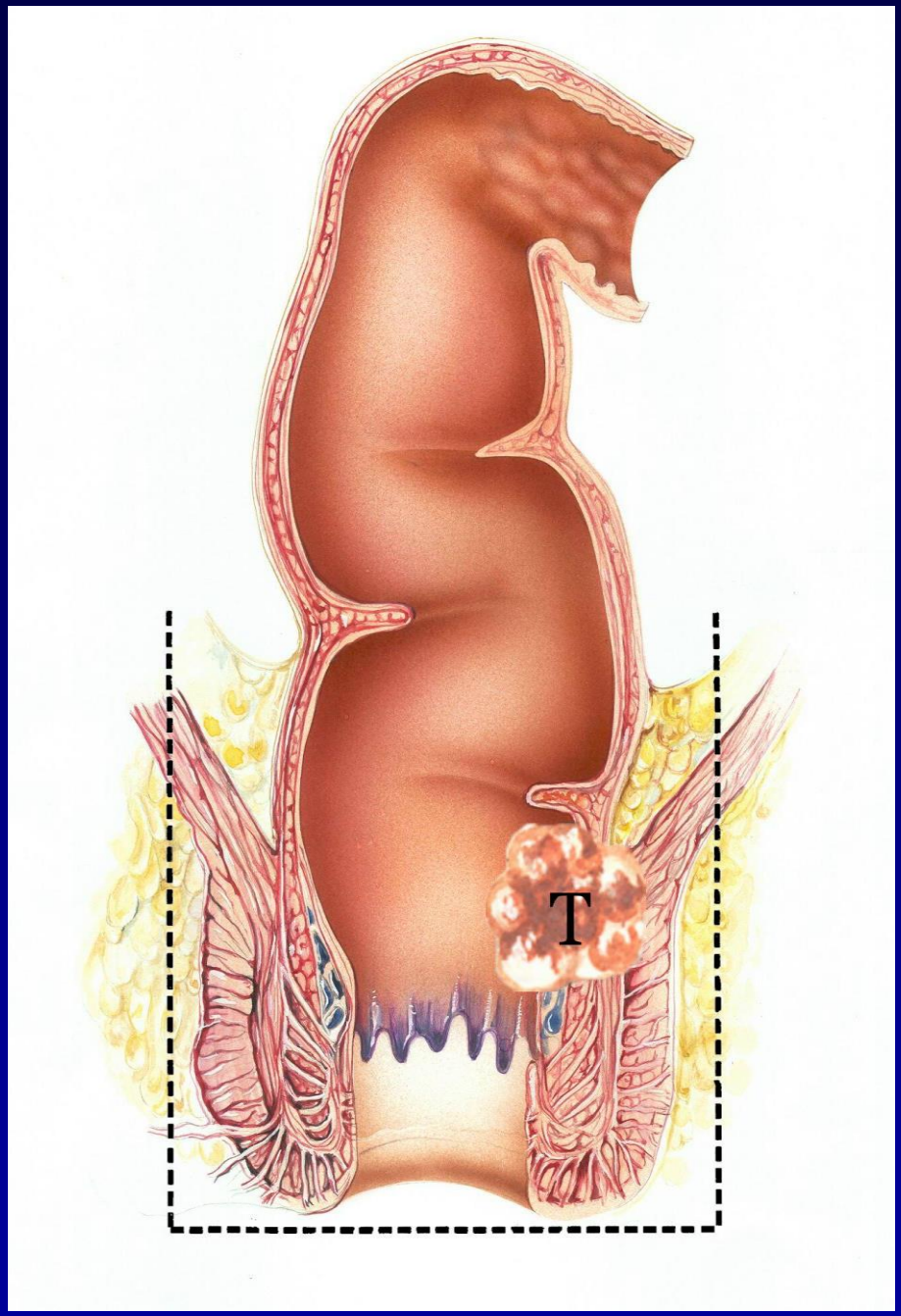
Belgium :

57.000 cancers / an
8000 colorectal cancers / year : **14%**


Les dix tumeurs les plus fréquentes par sexe, Belgique 2013
Source: Registre du cancer (http://www.kankerregister.be)
Prostate (7.909)
Poumon (5.705)
Colorectal (4.787)
Tête et cou (1.966)
Vessie (1.881)
Lymphome Non-Hodgkin (1.160)
Mélanome Malin (1.082)
Rein (1.060)
Leucémie (1.006)
Estomac (939)
Sein (10.695)
Colorectal (3.883)
Poumon (2.491)
Mélanome Malin (1.553)
Corp de l'utérus (1.405)
Lymphome Non-Hodgkin (902)
Pancréas (818)
Ovaire (766)
Leucémie (761)
Thyroïde (691)
40%
30%
20%
10%
0%
10%
20%
30%
40%
Hommes
Femmes

CHIRURGIE DU CANCER COLORECTAL

B. AMPUTATION ABDOMINOPERINEALE DU RECTUM AAP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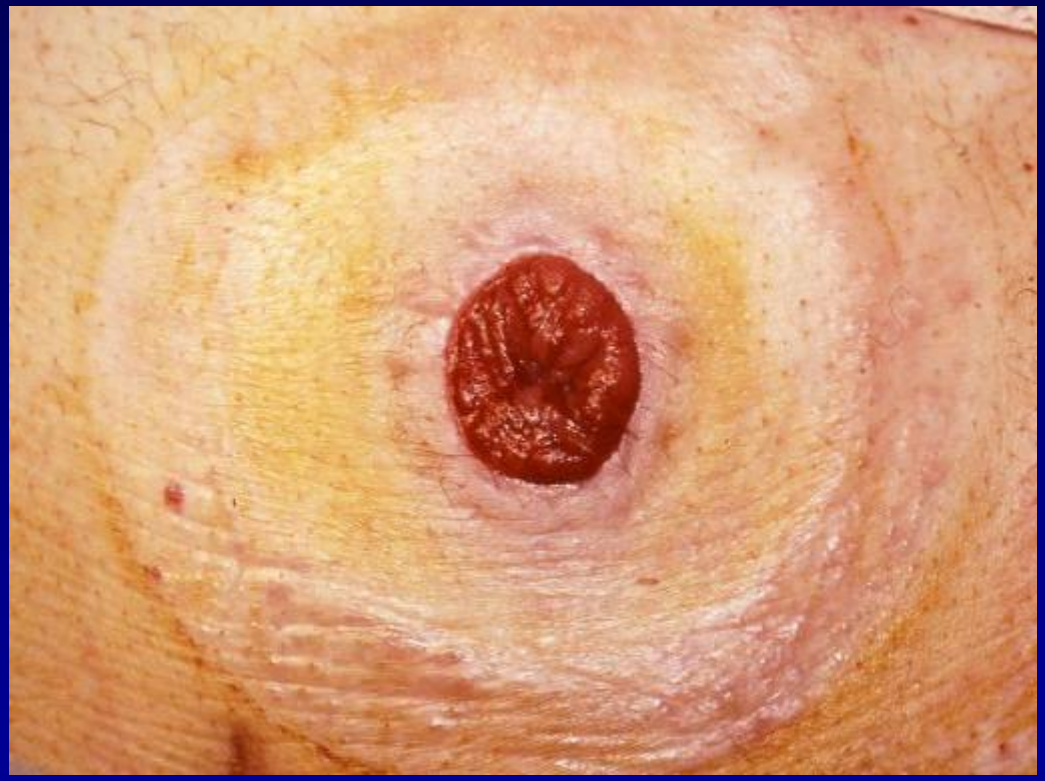
COLOSTOMIE TERMINALE



CHIRURGIE COLORECTALE
Vers un plus grand respect de l'intégrité corporelle

- **1900 – 1980 :**

Chirurgie Colorectale

=

Chirurgie « mutilante »

CHIRURGIE COLORECTALE
Vers un plus grand respect de l'intégrité corporelle

- **1990 – 2016 :**

  Evolution inéluctable vers un plus grand respect de l'intégrité corporelle

CHIRURGIE COLORECTALE
Vers un plus grand respect de l'intégrité corporelle

- **1990 – 2016 :**

  Et parralèlement, une volution inéluctable vers une chirurgie plus « carcinologique ».

CHIRURGIE DU CANCER COLORECTAL

C. STOMATHERAPIE

HISTOIRE DE LA STOMATHERAPIE

Dès 1990, la toute première étape

=

amélioration prise en charge et qualité de vie des patients stomisés.

HISTOIRE DE LA STOMATHERAPIE

L’arrivée des Stomathérapeutes dans la gestion des stomies aura été un grand moment qui sépare la vie des patients en un « avant » et un « après » Stomathérapeutes.

CHIRURGIE DU CANCER COLORECTAL

D. FAST-TRACK

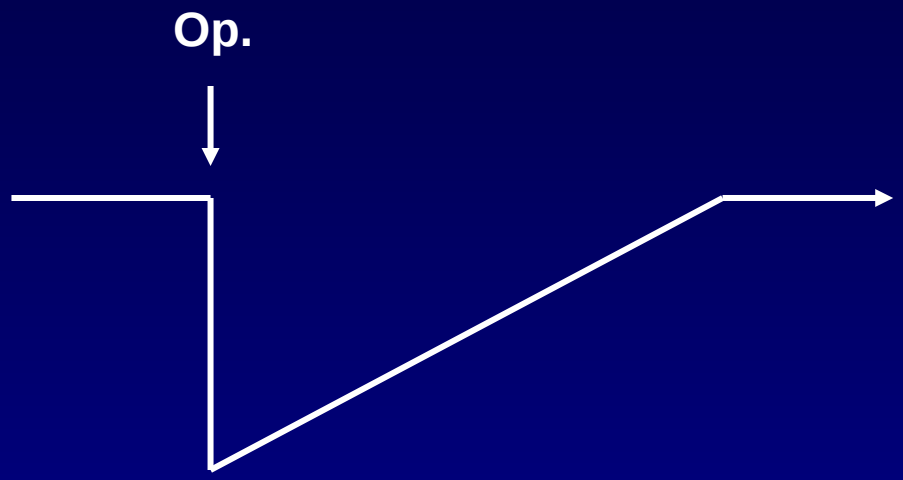
Fast-Track

Philosophie

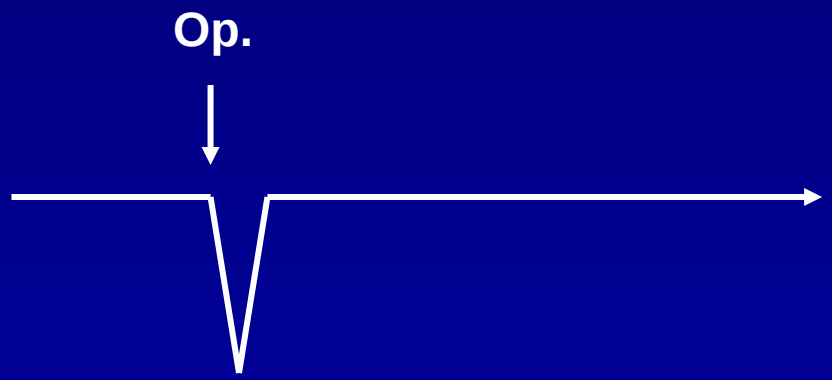
Réduire l’impact du stress chirurgical en optimalisant les soins en périodes pré-, per-, et postopératoires

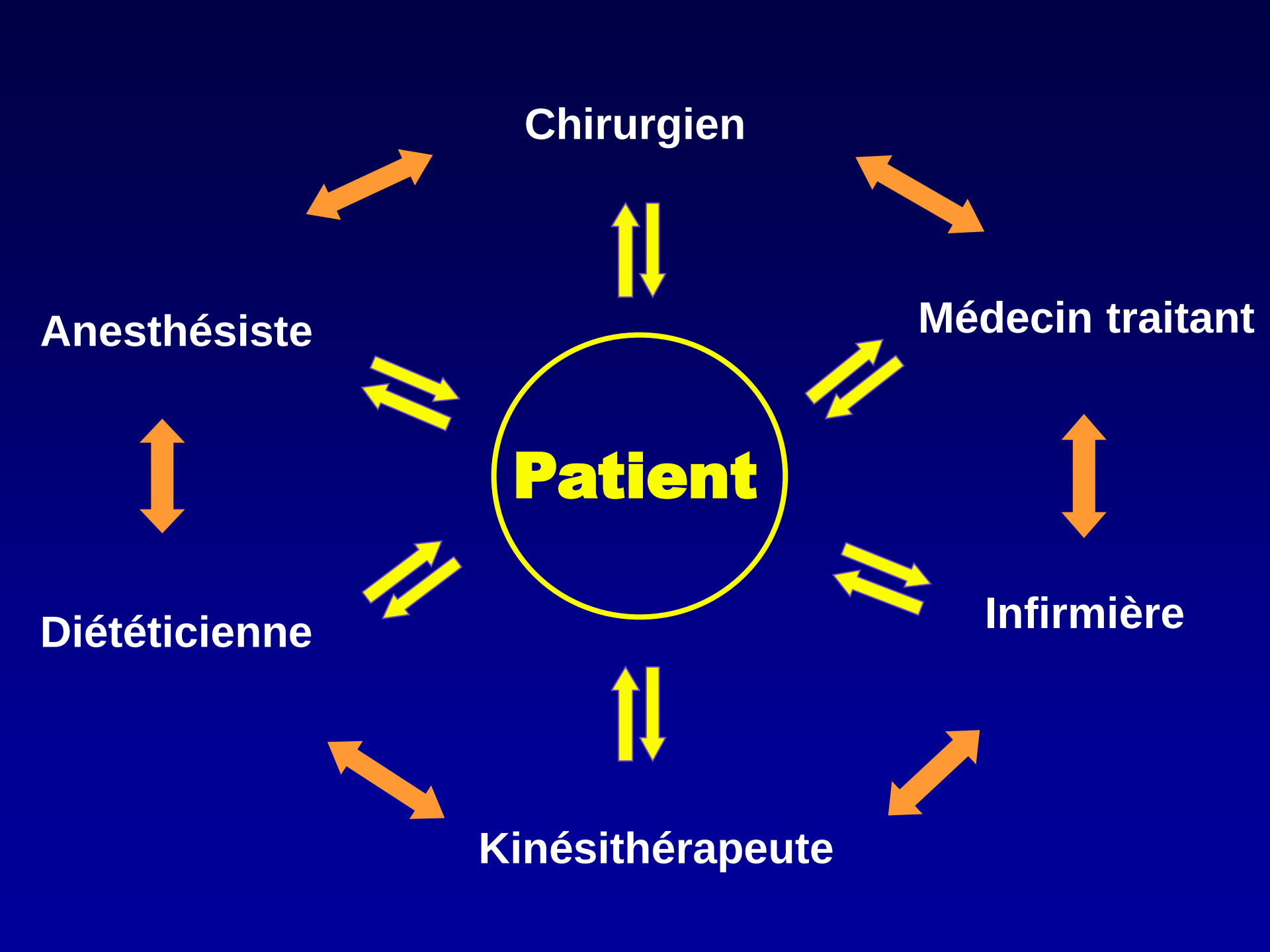
FAST-TRACK

- Chirurgie conventionnelle



- Fast-Track




Chirurgien
Médecin traitant
Anesthésiste
Patient
Diététicienne
Infirmière
Kinésithérapeute

PHILOSOPHIE ET IMPLEMENTATION DU FAST-TRACK

FAST TRACK EN CHIRURGIE COLORECTALE OU LA RÉHABILITATION RAPIDE DES PATIENTS

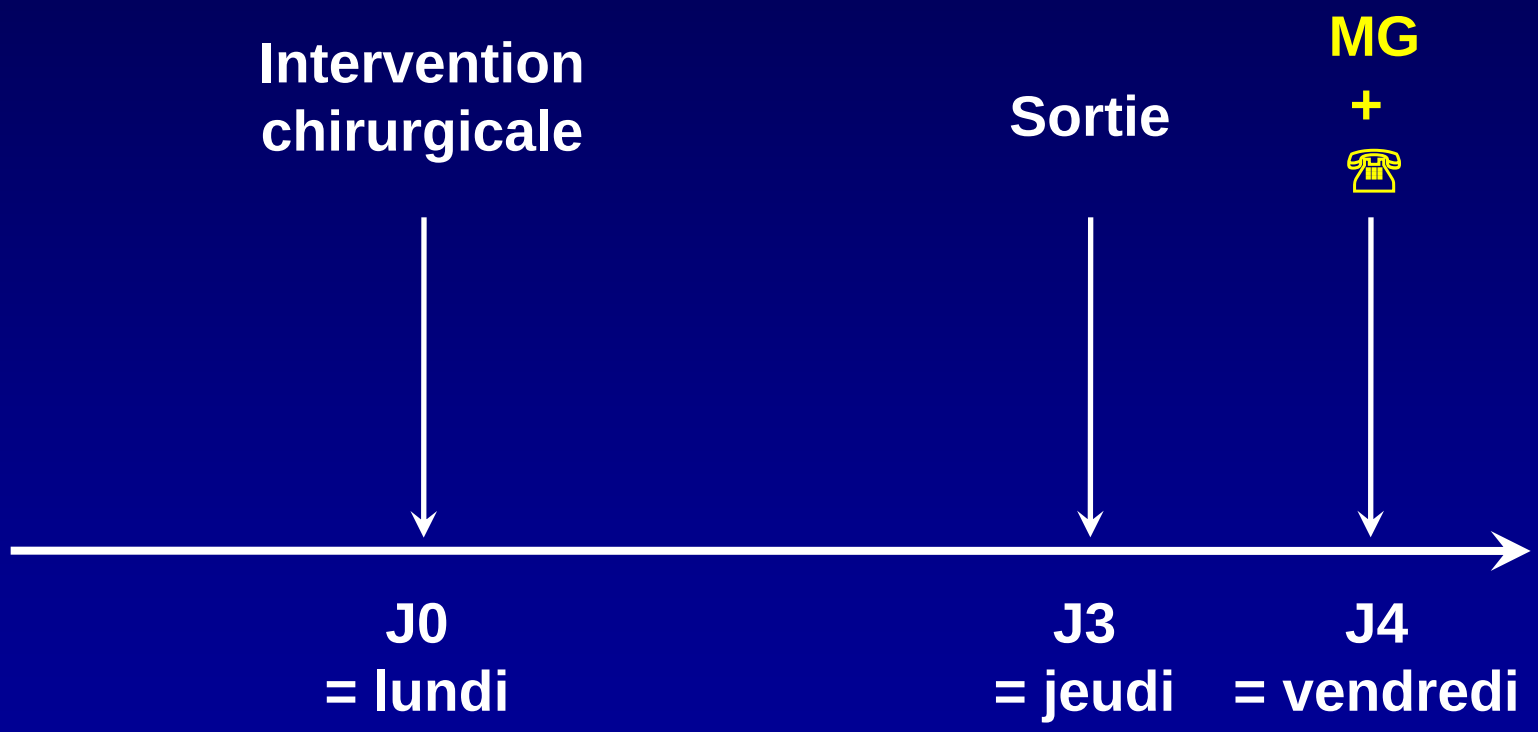
Y. KREMER [1],
CH. REMUE [2], R. DETRY [2],
M. DE KOCK [1], A. KARTHEUSER [2]
ET LE GROUPE D'ANIMATION
DU PROJET FAST-TRACK [3]

Mots-clefs : ERAS (Enhanced Recocery After Surgery), Fast Track, chirurgie colorectale, programme de réhabilitation rapide

Y. Kremer et al., Louvain Médical, 2005


Retour domicile
Médecin traitant
Nutrition orale
péri-opératoire
Audit
Info
patient
Pas de préparation colique
Ablation cathéters
précoce
Pas de jeûne
Stimulation de la
motilité digestive
FAST-TRACK
Pas de prémédication
Prévention TVP
Pas de sonde gastrique
Péridurale thoracique
Analgésiques oraux non opiacés
/AINS
Agents anesthésiques de courte durée
Mobilisation
Procédure
non invasive
Incision courte
Pas de drains
Eviter la surcharge hydro-sodée
Eviter l'hypothermie

IMPLEMENTATION DU FAST-TRACK



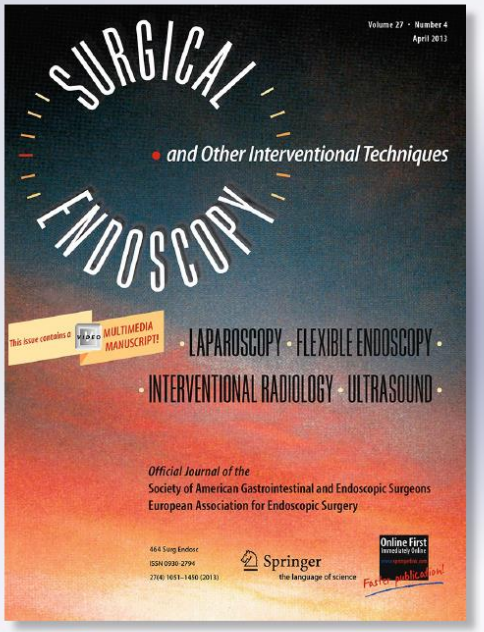
Insights into fast-track colon surgery: a plea for a tailored program

L. Pellegrino, F. Lois, C. Remue, P. Forget, B. Crispin, D. Leonard, J. Jamart & A. Kartheuser

Surgical Endoscopy
And Other Interventional Techniques
Official Journal of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) and European Association for Endoscopic Surgery (EAES)

ISSN 0930-2794
Volume 27
Number 4

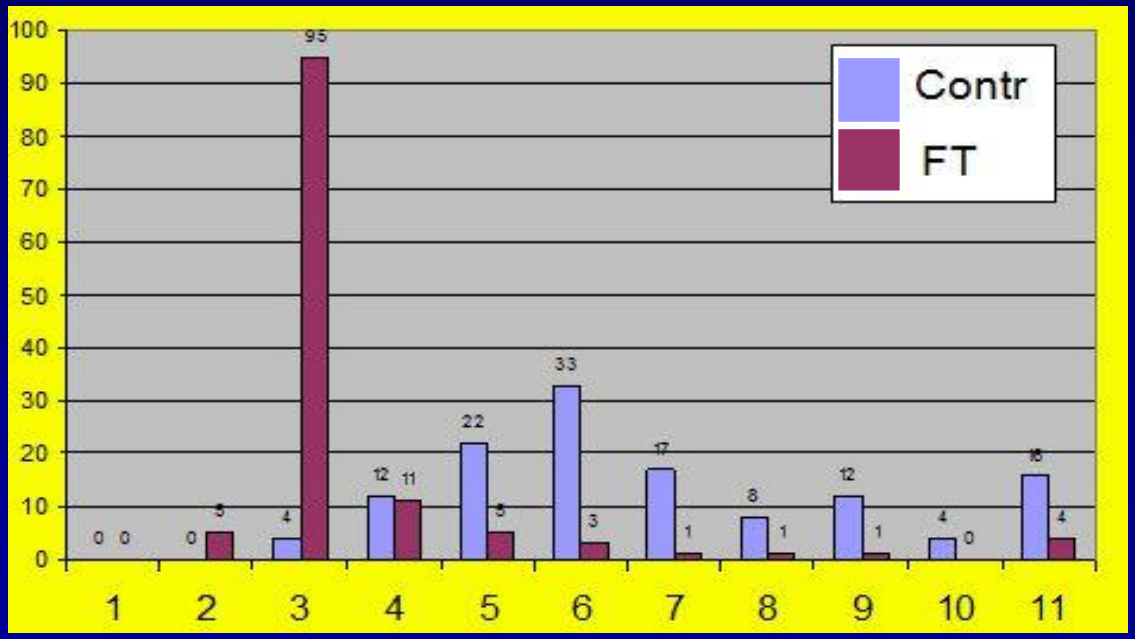
Surg Endosc (2013) 27:1178-1185
DOI 10.1007/s00464-012-2572-1



Springer

FAST-TRACK EN CHIRURGIE COLORECTALE : ETUDE COMPARATIVE

RESULTATS – DUREE HOSPITALISATION



FT	**3 j [2-16]**
Contrôle	**6 j [3-29]**

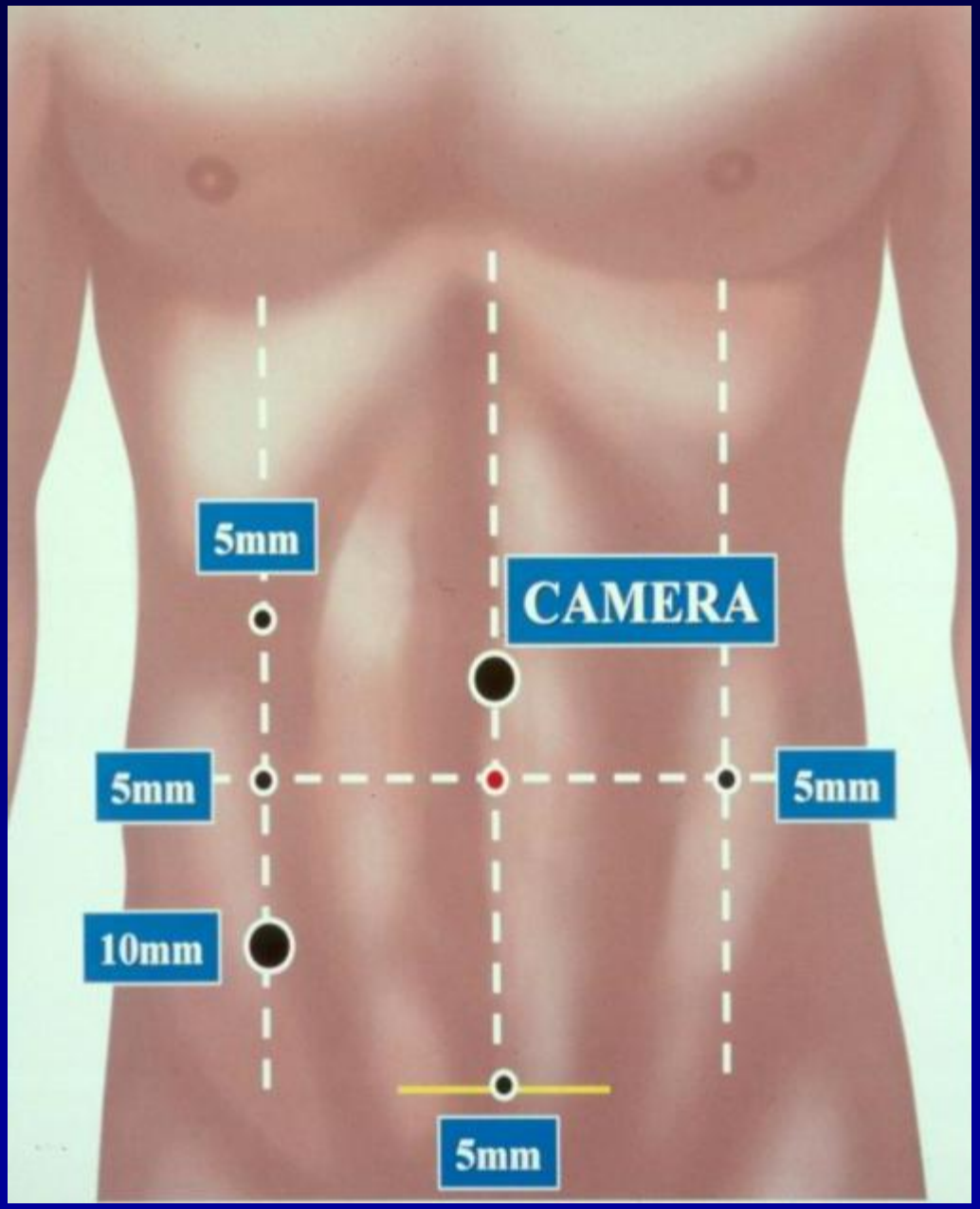
p<0.001

Fast-Track : Perspectives d'avenir

La « Pré-habilitation » avant Chirurgie Colorectale

CHIRURGIE DU CANCER COLORECTAL

E. Laparoscopie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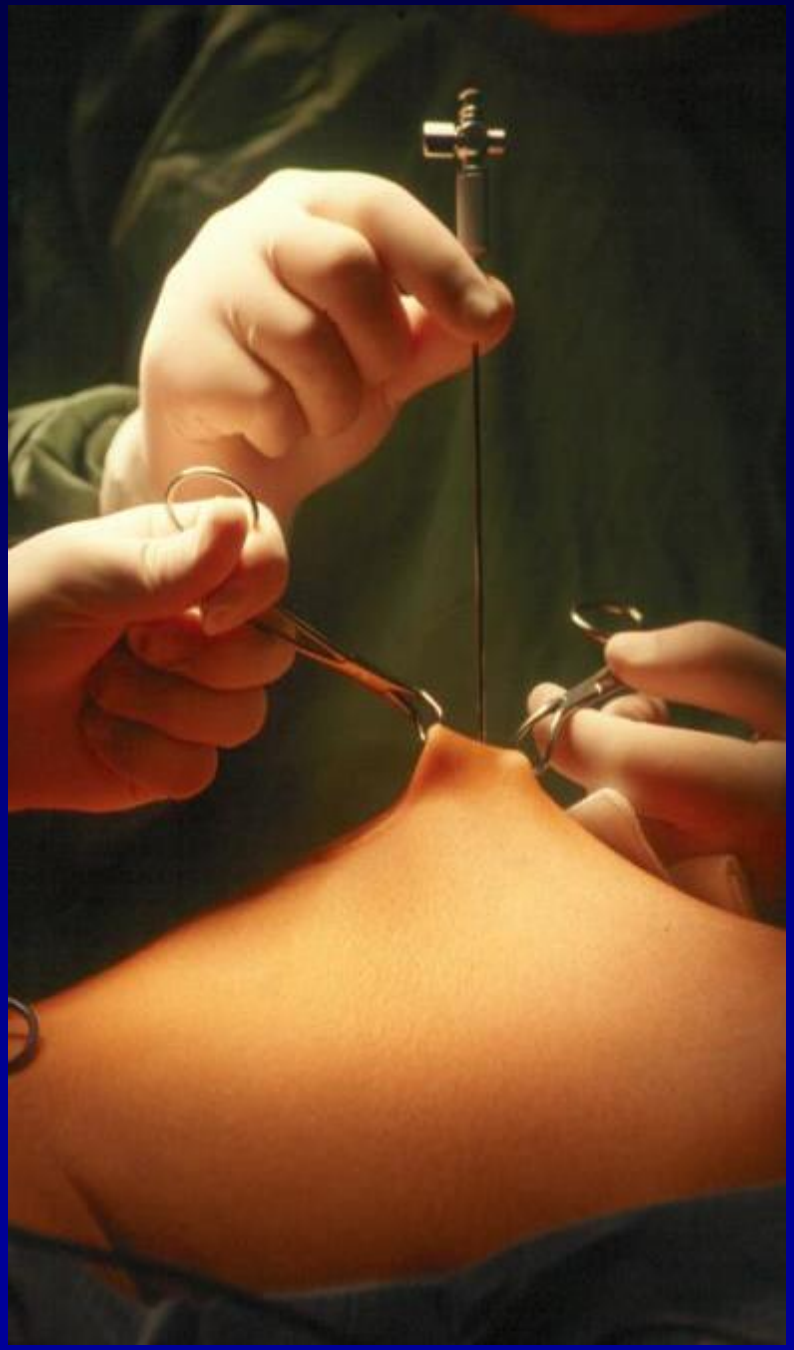
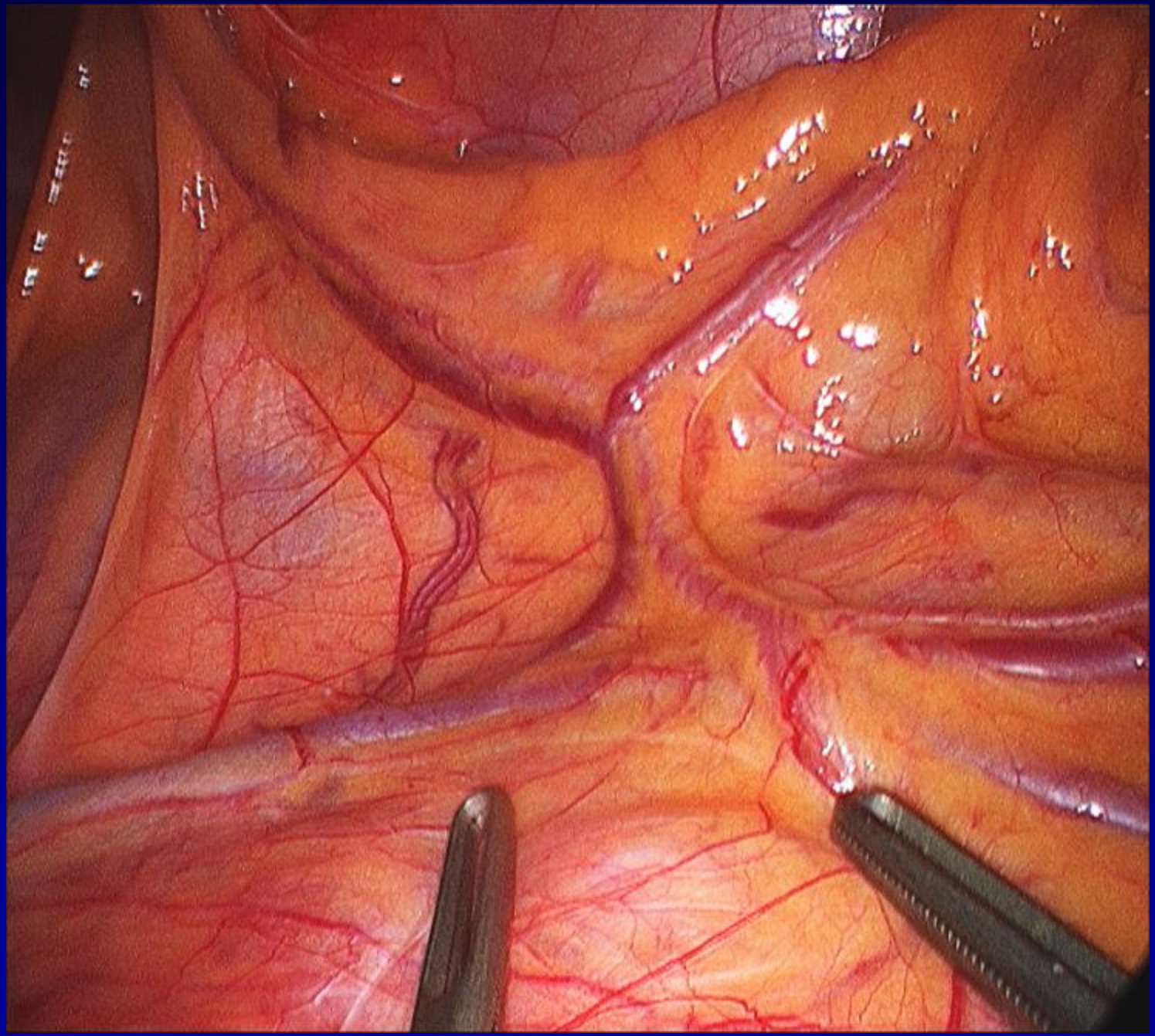
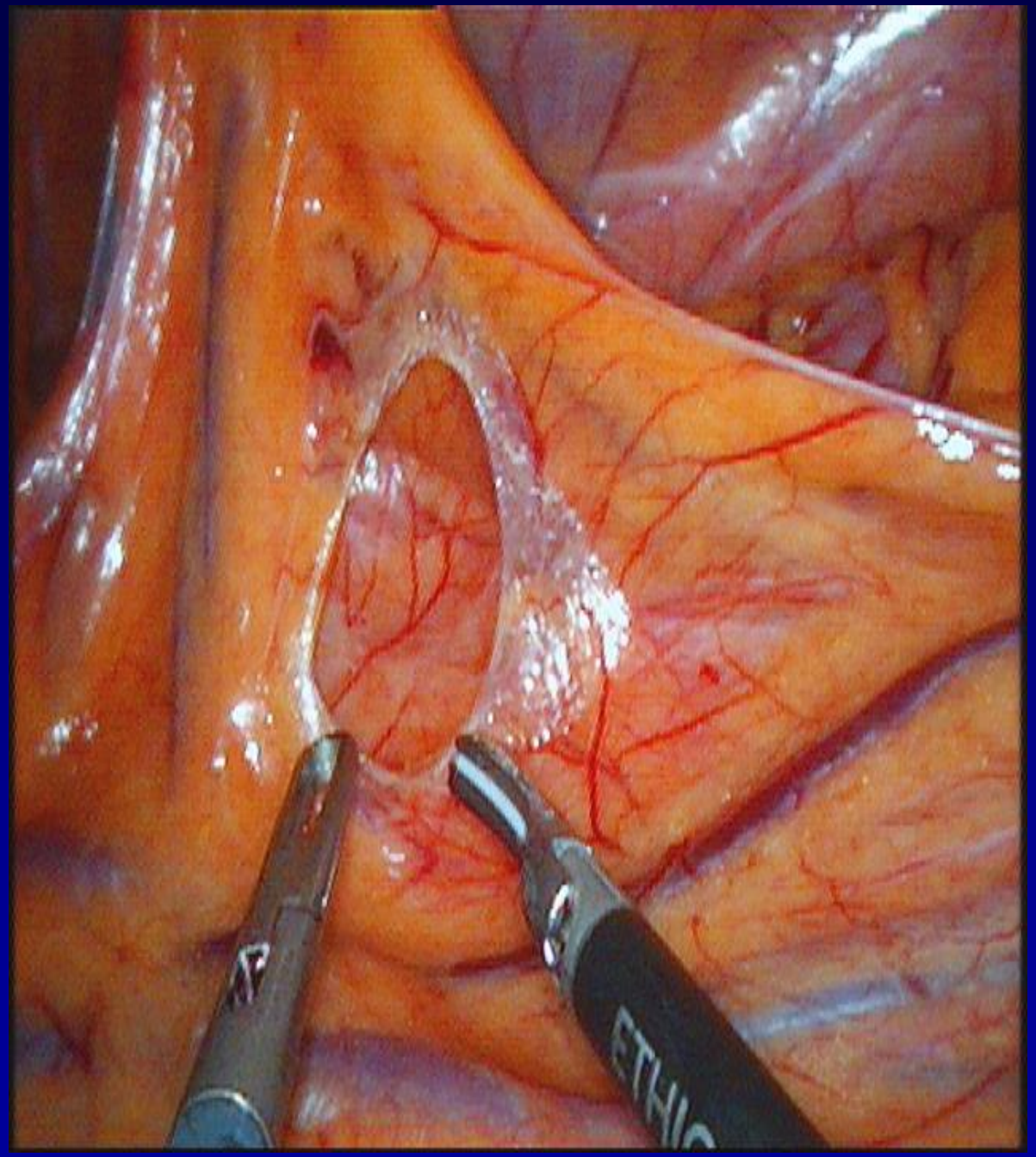
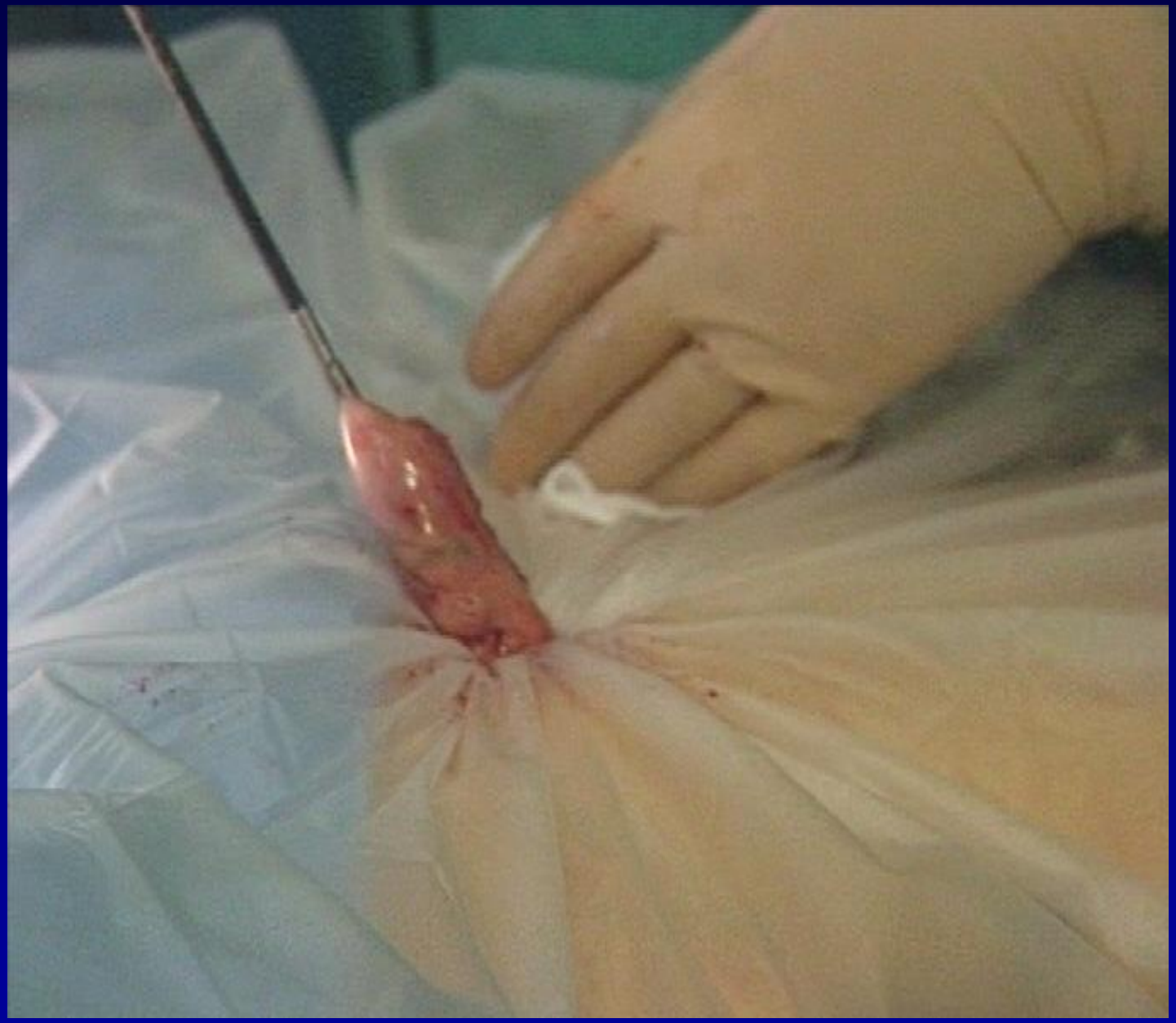
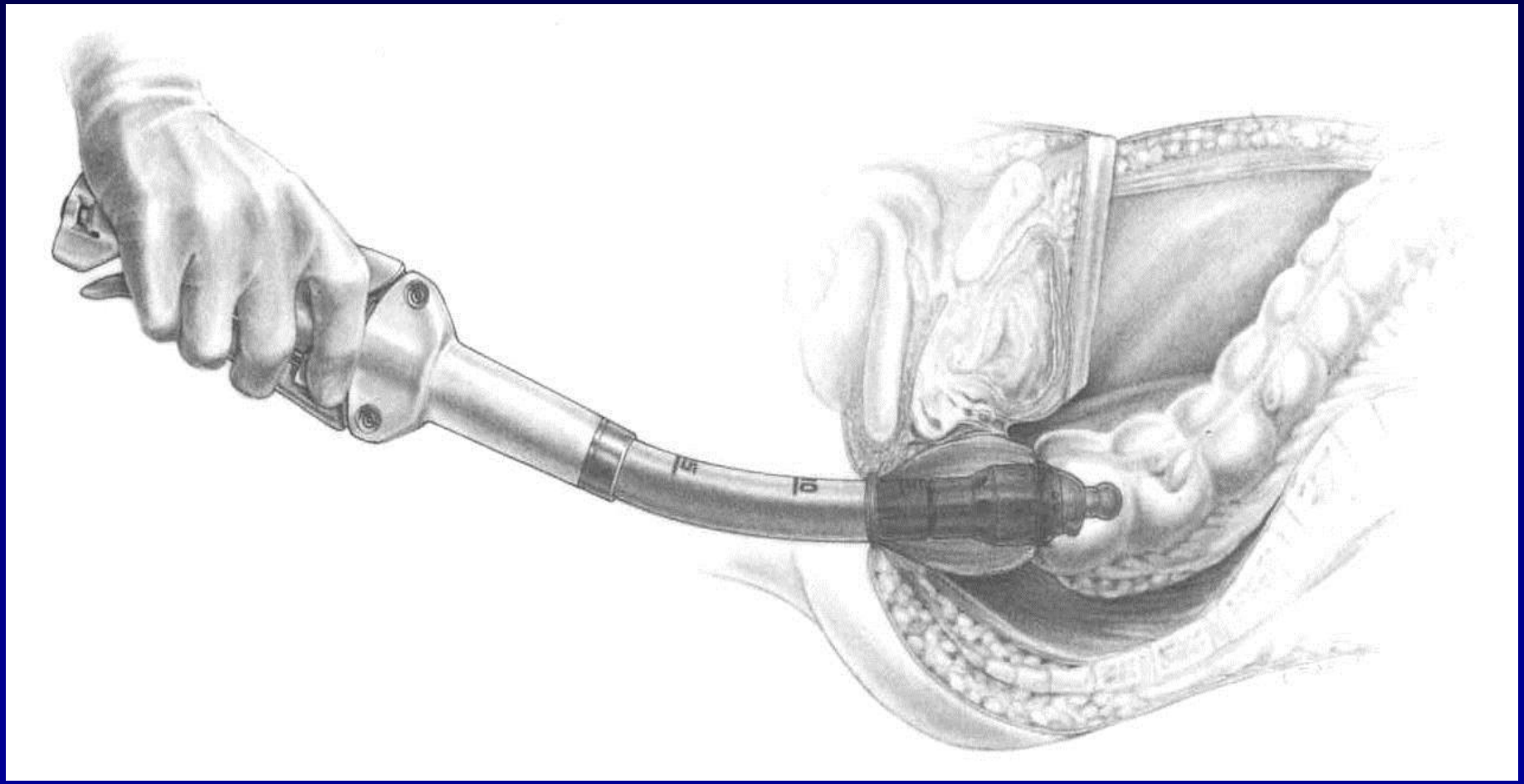
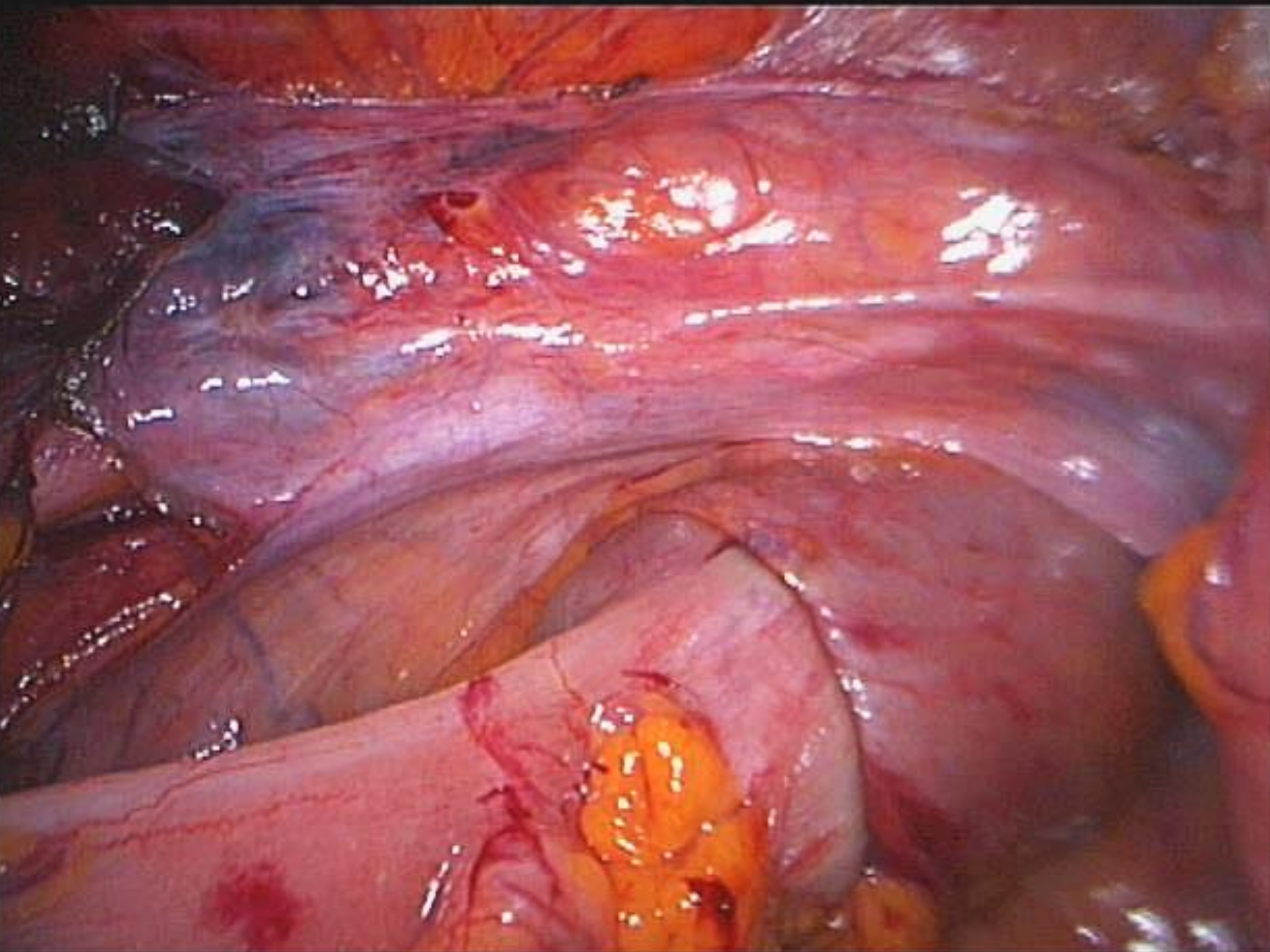


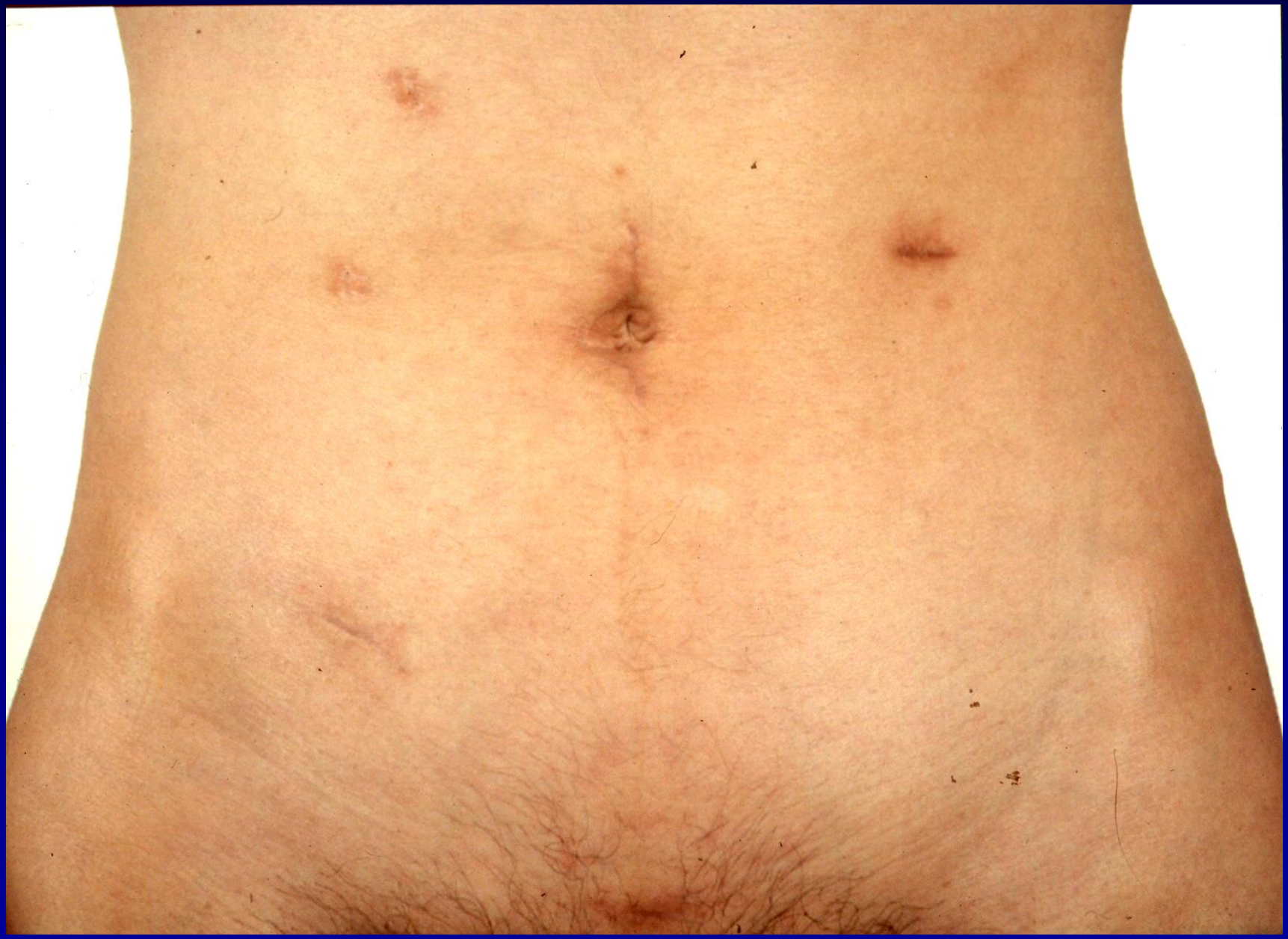


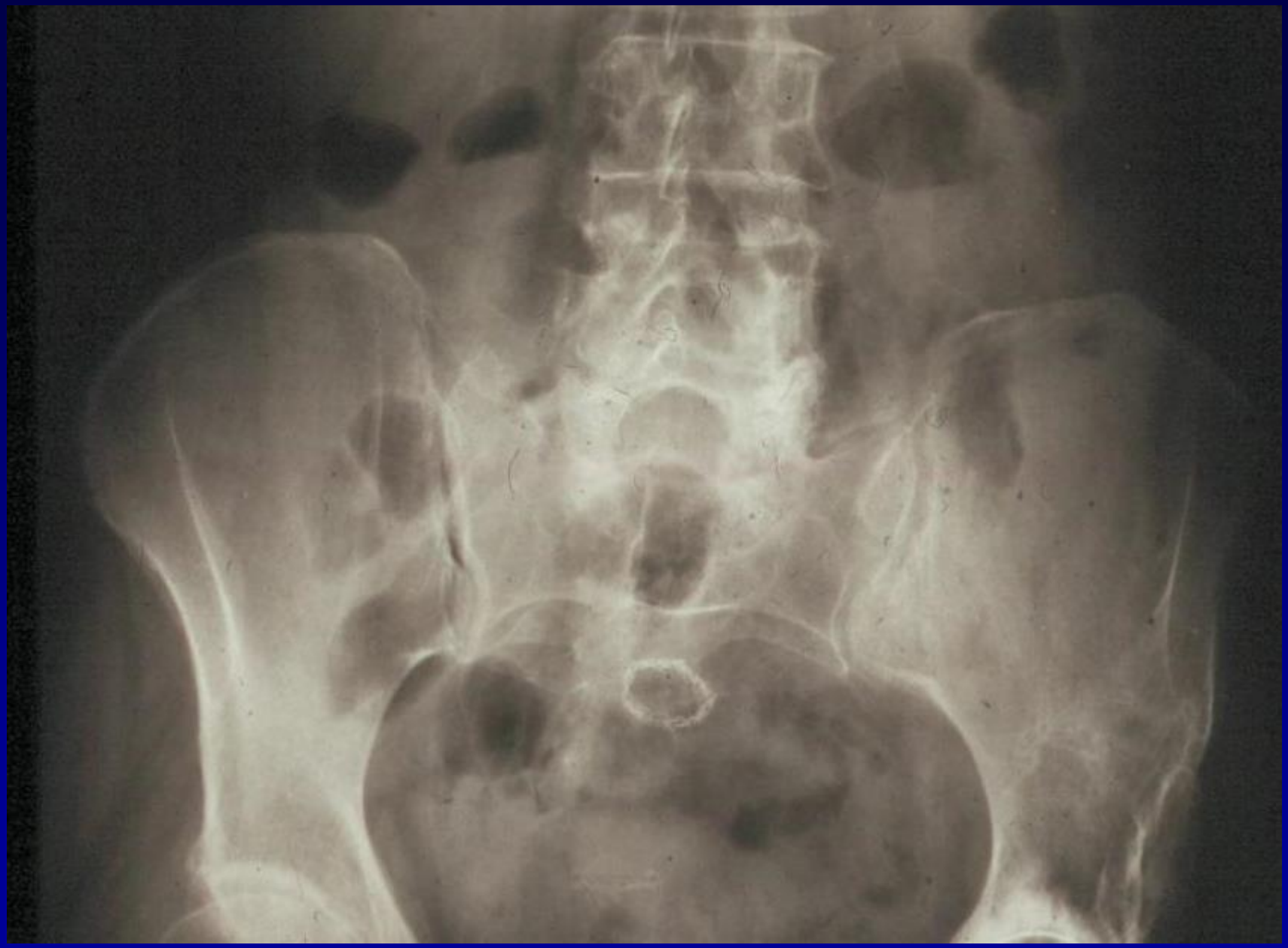


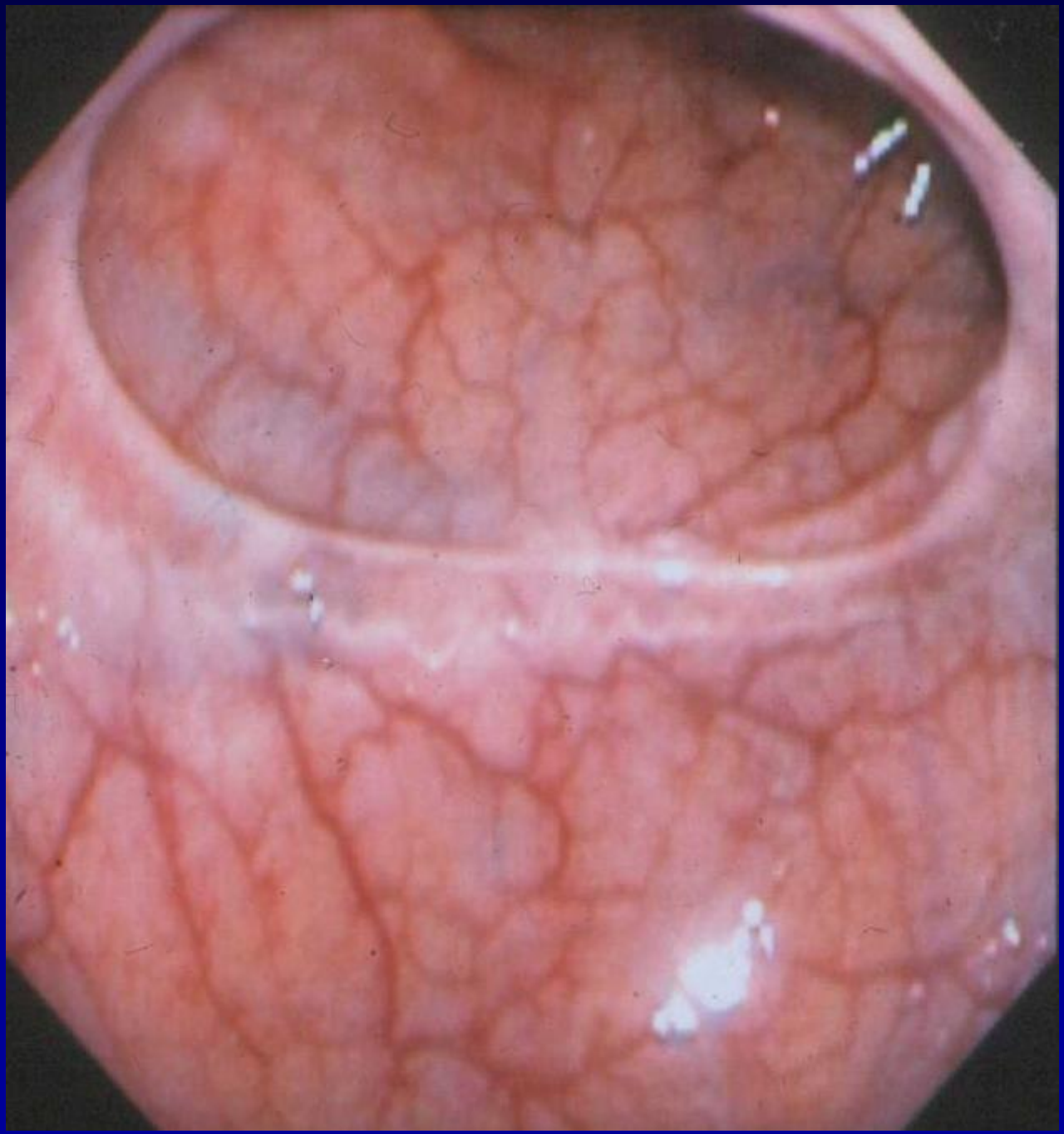












CHIRURGIE DU CANCER COLORECTAL

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

A Randomized Trial of Laparoscopic versus Open Surgery for Rectal Cancer

H. Jaap Bonjer, M.D., Ph.D., Charlotte L. Deijen, M.D., Gabor A. Abis, M.D., Miguel A. Cuesta, M.D., Ph.D., Martijn H.G.M. van der Pas, M.D., Elly S.M. de Lange-de Klerk, M.D., Ph.D., Antonio M. Lacy, M.D., Ph.D., Willem A. Bemelman, M.D., Ph.D., John Andersson, M.D., Eva Angenete, M.D., Ph.D., Jacob Rosenberg, M.D., Ph.D., Alois Fuerst, M.D., Ph.D., and Eva Haglind, M.D., Ph.D., for the COLOR II Study Group*

ABSTRACT

Bonjer H.J. et al, N Engl J Med 2015, 372;14

CANCER COLORECTAL : PROGRES RECENTS

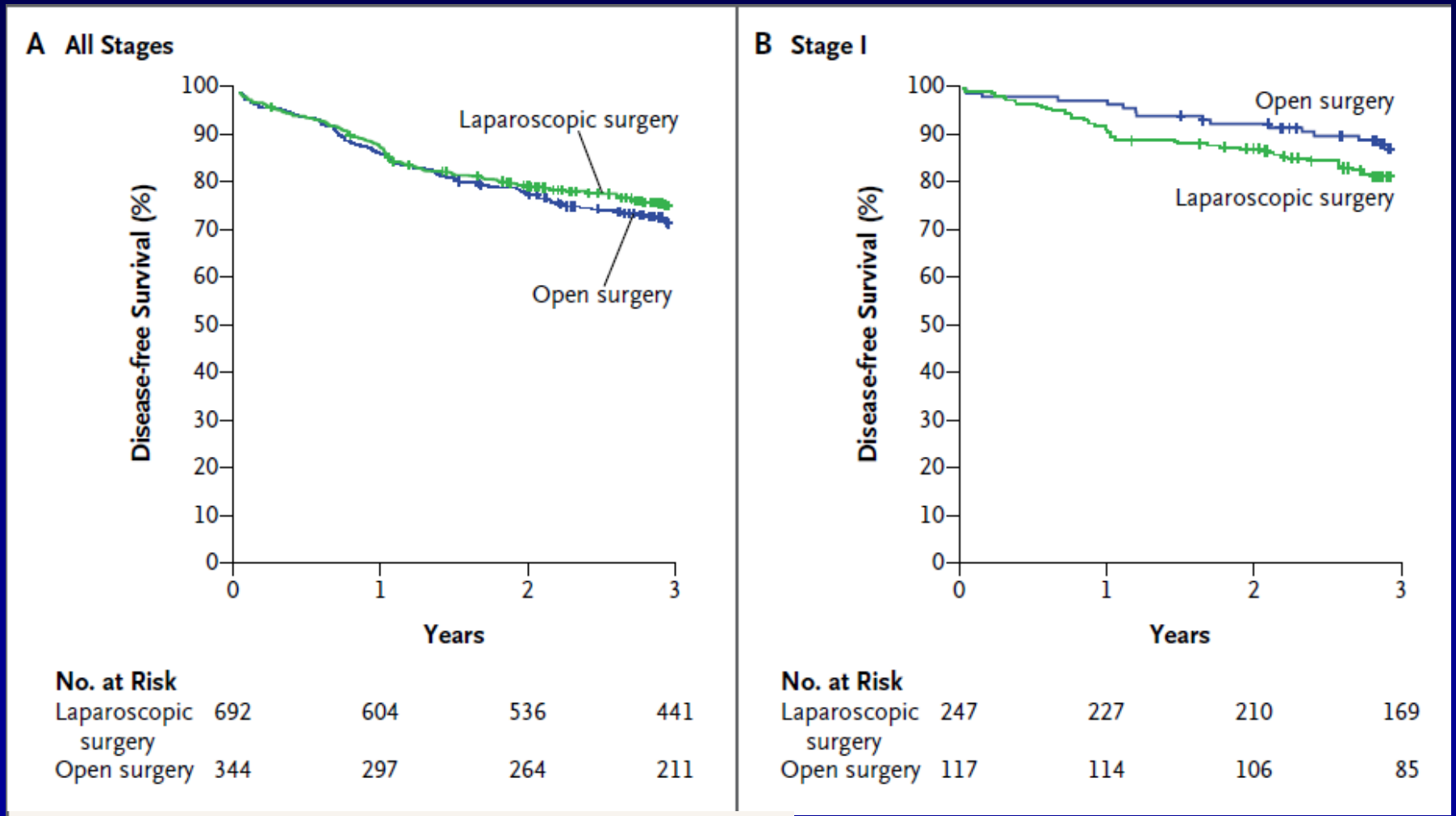


Figure 2. Disease-free Survival, According to Disease Stage.

H.J. Bonjer et al., New Engl J Med, 2015

CHIRURGIE DU CANCER COLORECTAL

F. SINGLE INCISION LAPAROSCOPIC SURGERY SILS

Volume 5 • Numéro 4 • Trimestriel Novembre

Côlon & Rectum

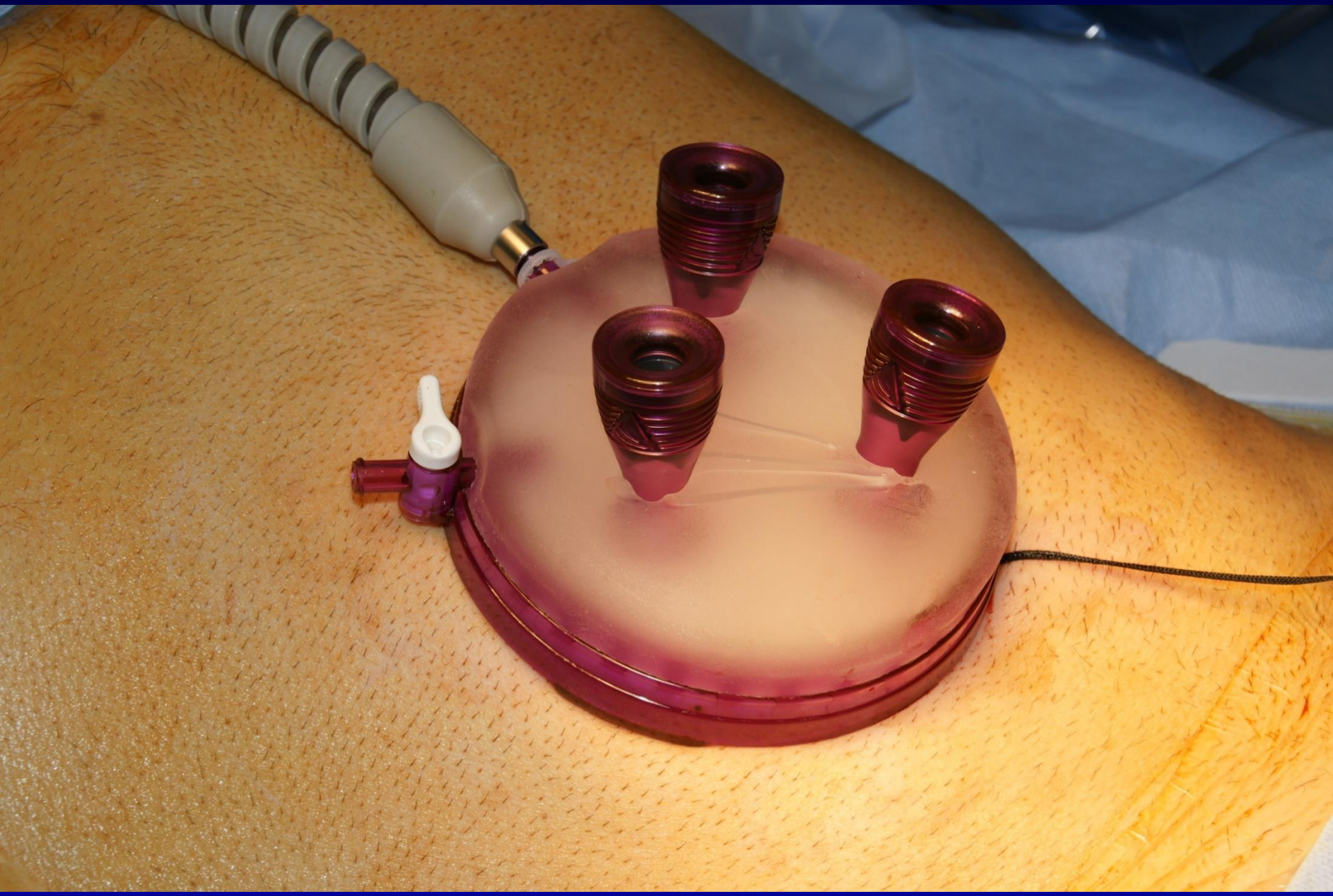
Proctologie ■ Chirurgie ■ Endoscopie

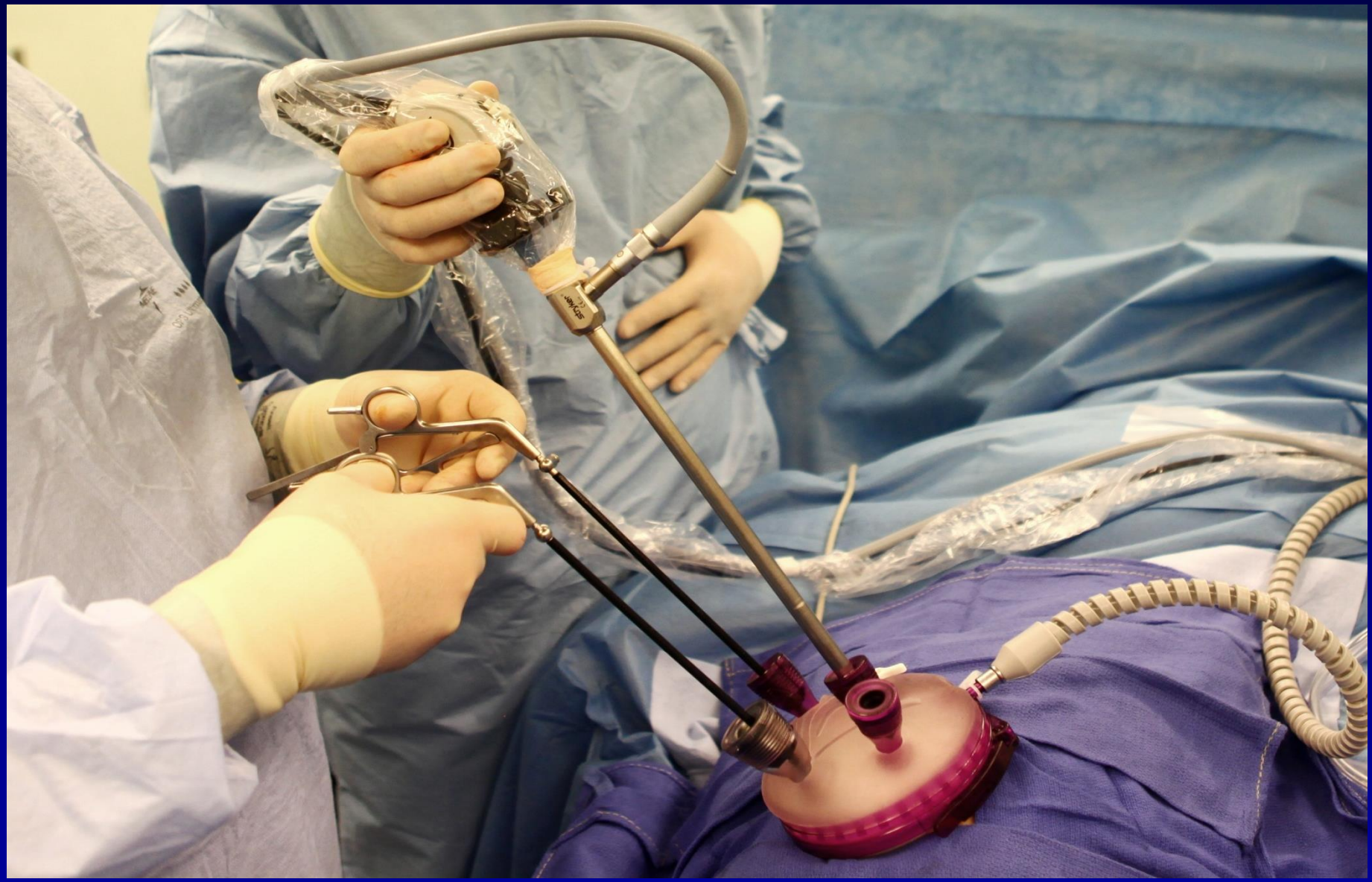
Colon Rectum (2011) 5:223-224
DOI 10.1007/s11725-011-0332-3

ÉDITORIAL / *EDITORIAL*

De la laparotomie à la laparoscopie à un seul trocart ou 25 ans de chirurgie colorectale

L. Maggiori · Y. Panis





CHIRURGIE DU CANCER COLORECTAL

Systematic review

doi:10.1111/j.1463-1318.2012.03105.x

Single-incision laparoscopy for colorectal resection: a systematic review and meta-analysis of more than a thousand procedures

L. Maggiori, S. Gaujoux, E. Tribillon, F. Bretagnol and Y. Panis

Department of Colorectal Surgery, Beaujon Hospital, Assistance Publique Hôpitaux de Paris (AP-HP), University Denis Diderot (Paris VII), Clichy, France

Received 26 January 2012; accepted 13 April 2012; Accepted article online 25 May 2012

Maggiori L. et al, Colorectal Disease, 2012

CHIRURGIE DU CANCER COLORECTAL

SILS: Futur?

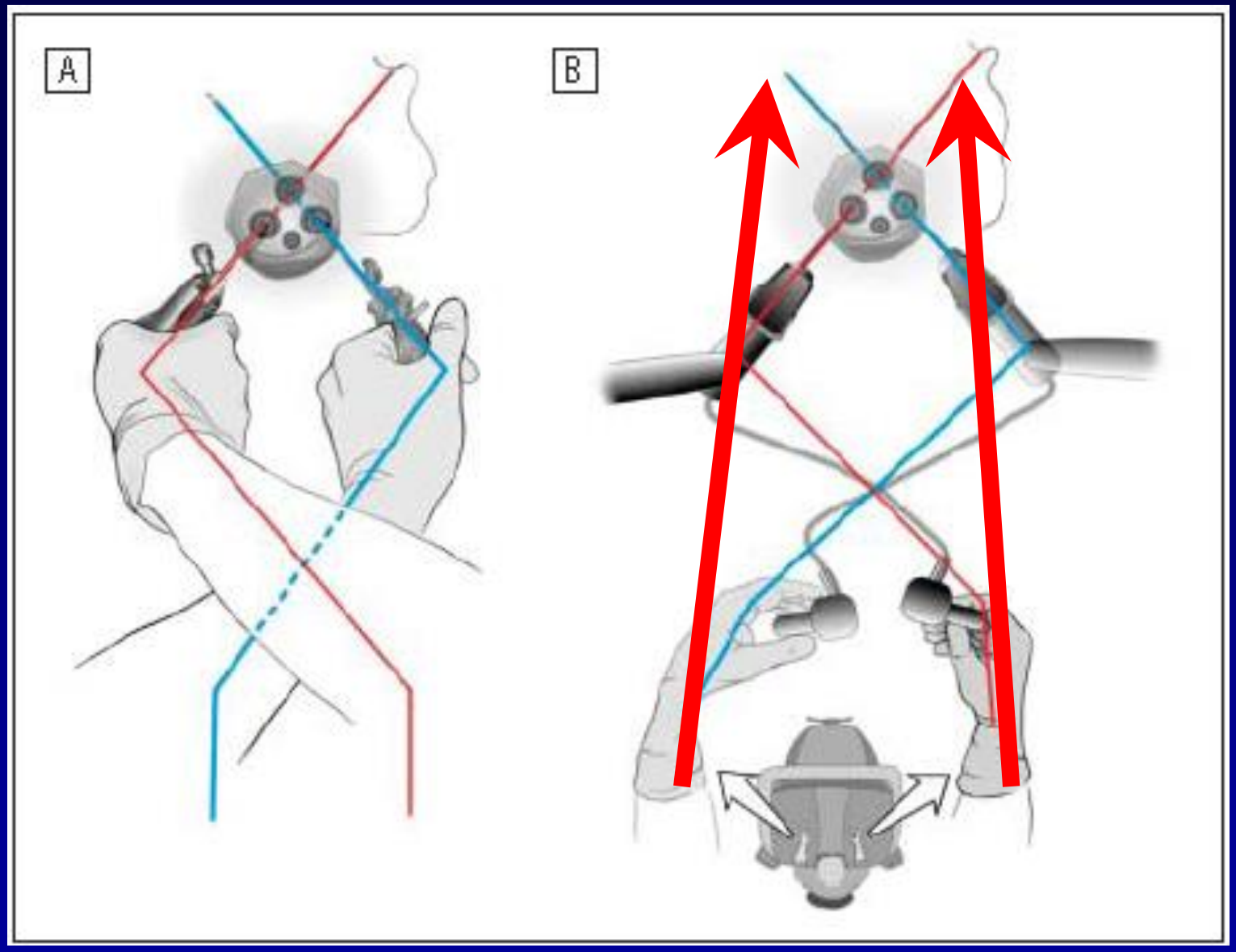
Single-access laparoscopic colorectal surgery

Robotic SILS

Single-Incision Robotic Colectomy (SIRC) case series: initial experience at a single center

Yen-Yi Juo · Samir Agarwal · Samuel Luka · Sean Satey · Vincent Obias

Juo Y.Y. et al, Surg Endosc, 2014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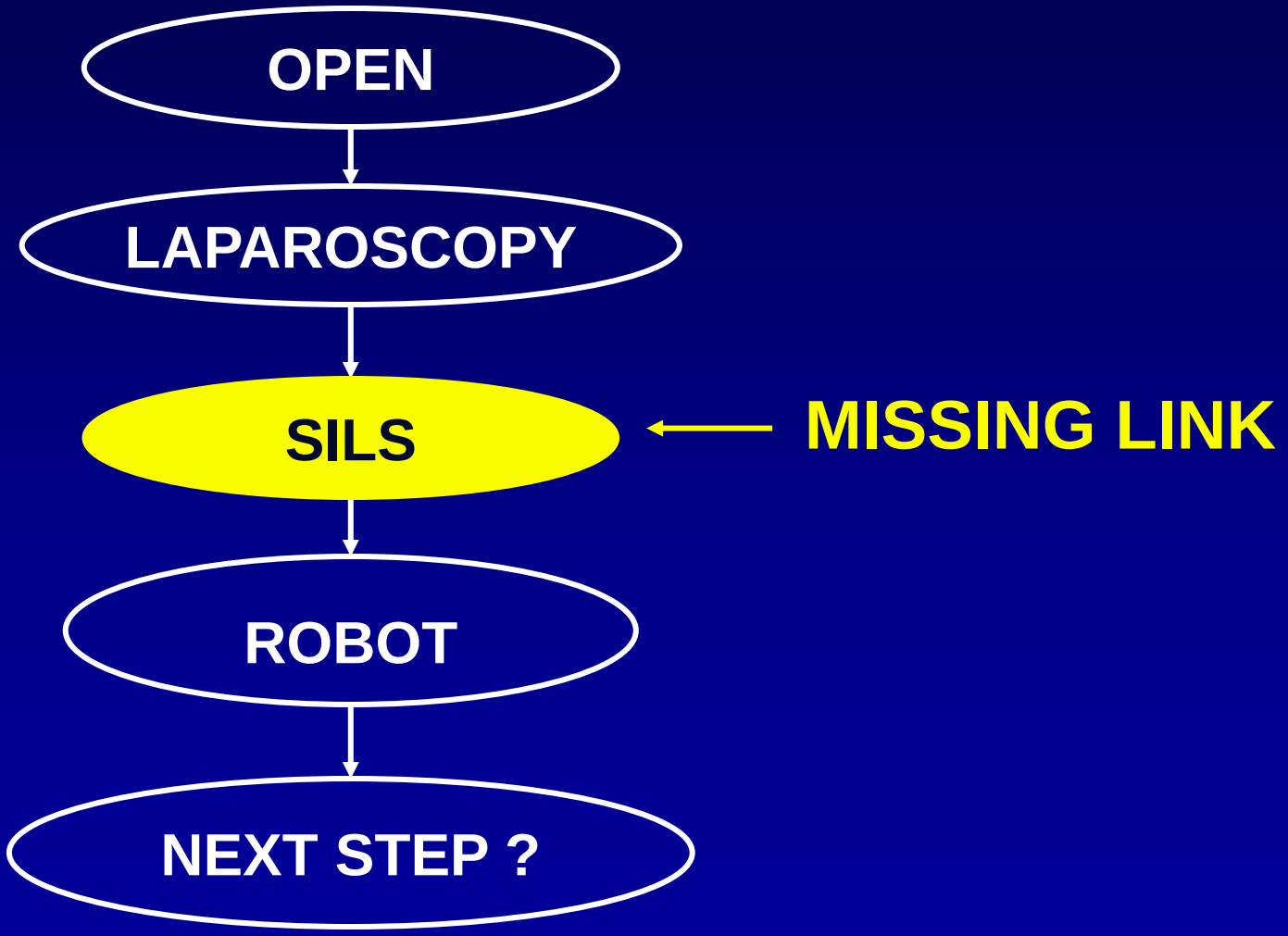
B

Single-access laparoscopic colorectal surgery



CANCER COLORECTAL : PROGRES RECENTS

G. Trans-Anal Minimally Invasive Surgery: TAMIS

TAMIS = SILS par voie périnéale

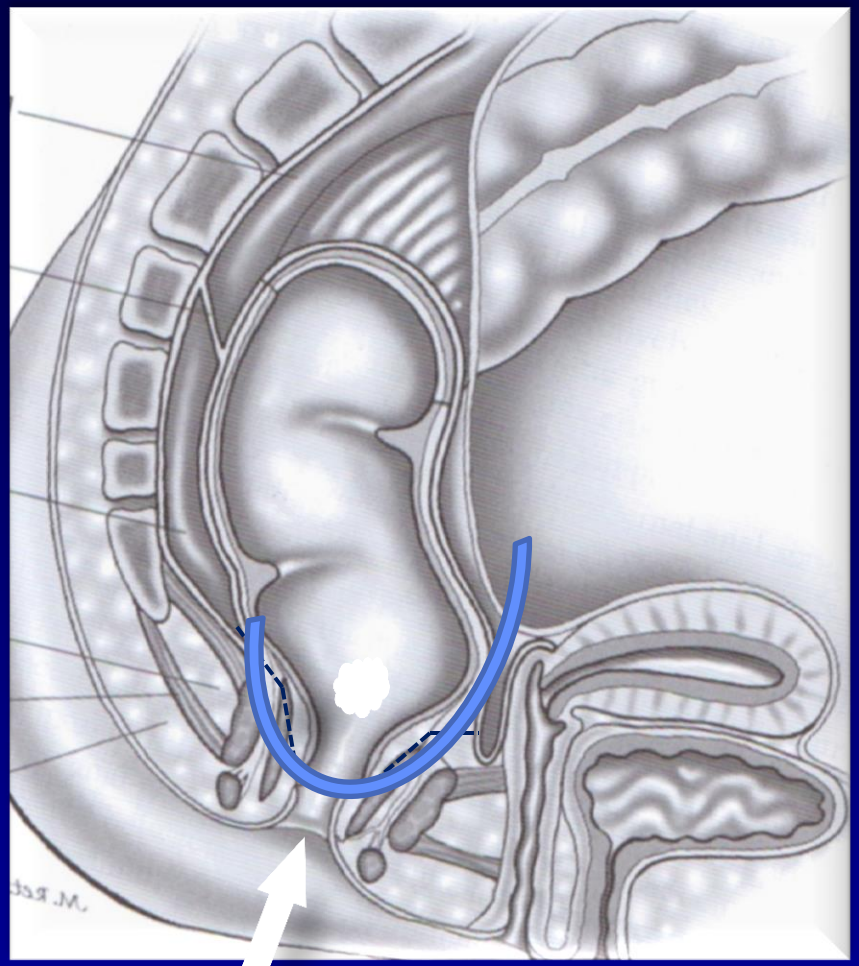
CANCER COLORECTAL : PROGRES RECENTS

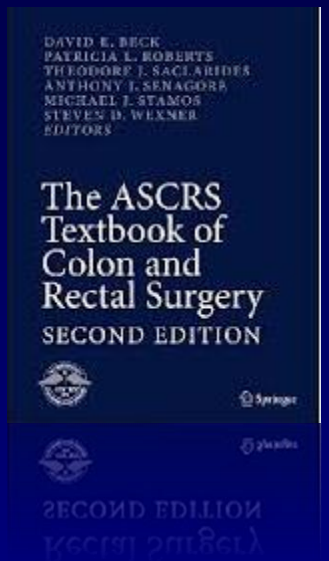
Perineal Transanal Approach

A New Standard for Laparoscopic Sphincter-Saving Resection in Low Rectal Cancer, a Randomized Trial

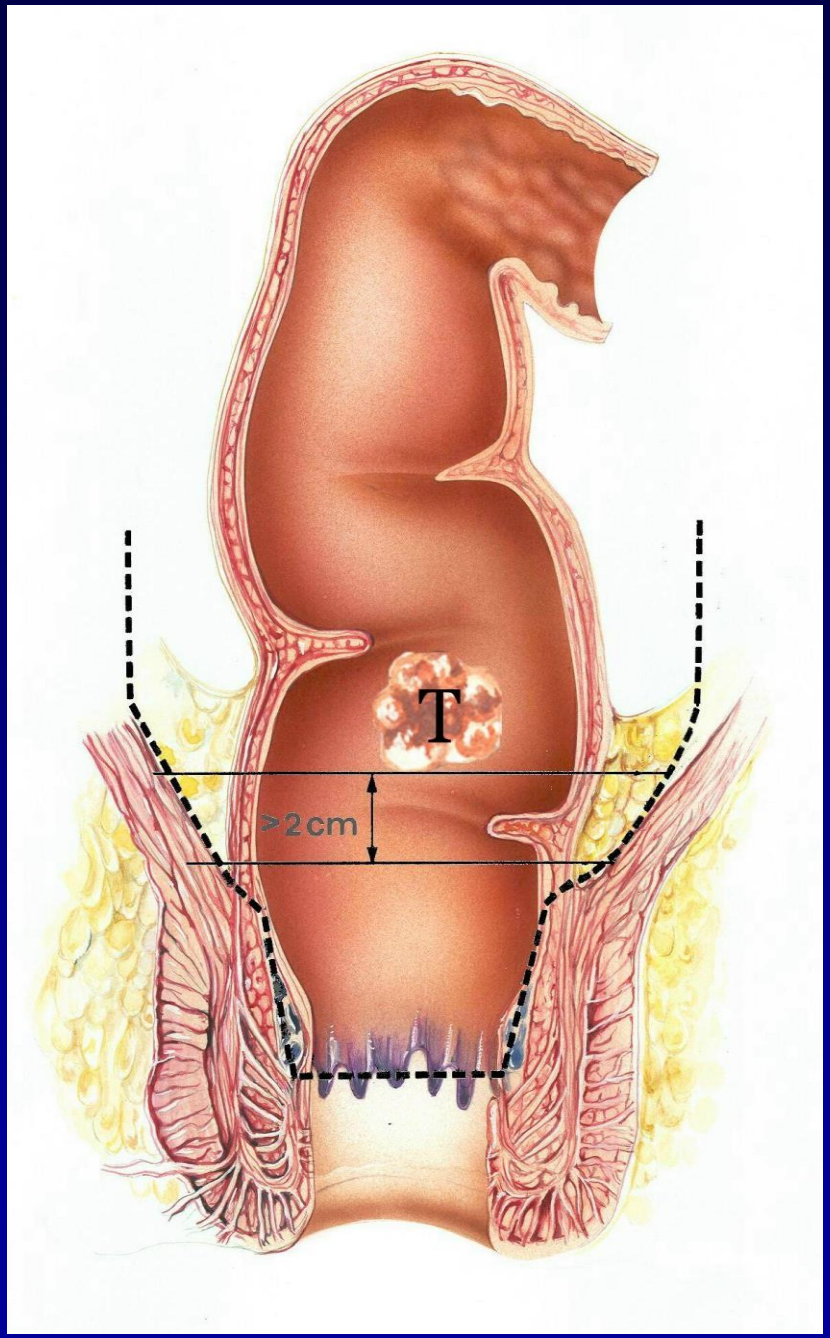
Quentin Denost, MD,‡ Jean-Philippe Adam, MD,*‡ Anne Rullier, MD, PhD,†‡ Etienne Buscail, MD,*‡ Christophe Laurent, MD, PhD,*‡ and Eric Rullier, MD*‡*

Q. Denost et al., Annals of Surgery, 2014





Approche transanale …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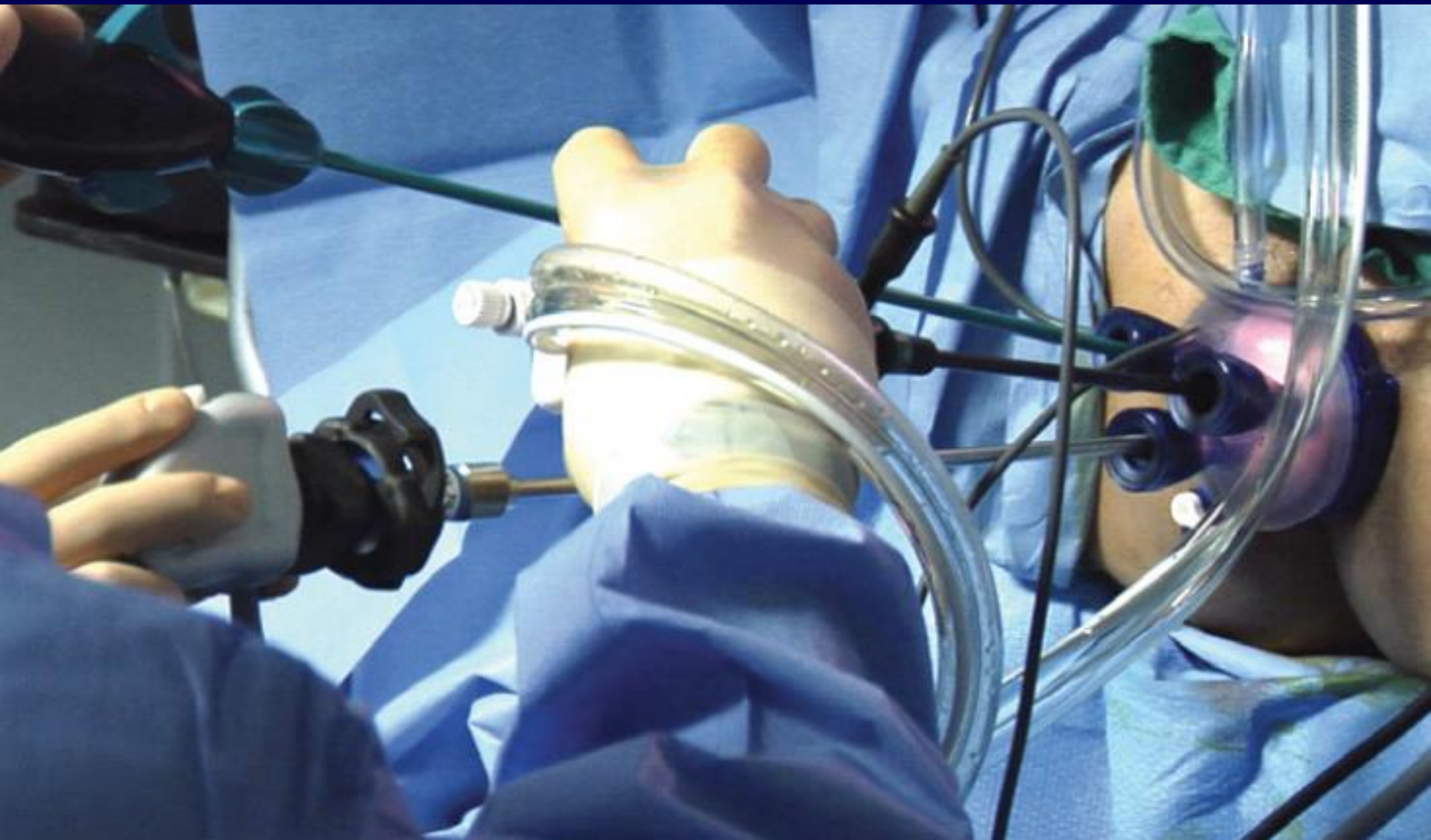

CANCER COLORECTAL : PROGRES RECENTS

Surg Endosc
DOI 10.1007/s00464-015-4615-x

COLOR III: a multicentre randomised clinical trial comparing transanal TME versus laparoscopic TME for mid and low rectal cancer

Charlotte L. Deijen[1] · Simone Velthuis[2] · Alice Tsai[3] · Stella Mavroveli[3] · Elly S. M. de Lange-de Klerk[1] · Colin Sietses[2] · Jurriaan B. Tuynman[1] · Antonio M. Lacy[4] · George B. Hanna[3] · H. Jaap Bonjer[1]

Received: 3 April 2015 / Accepted: 15 September 2015

CHIRURGIE DU CANCER COLORECTAL

TAMIS: Futur?

- Combiner Robot + TAMIS
- Voie périnéale pure

CHIRURGIE DU CANCER COLORECTAL

H. ROBOT


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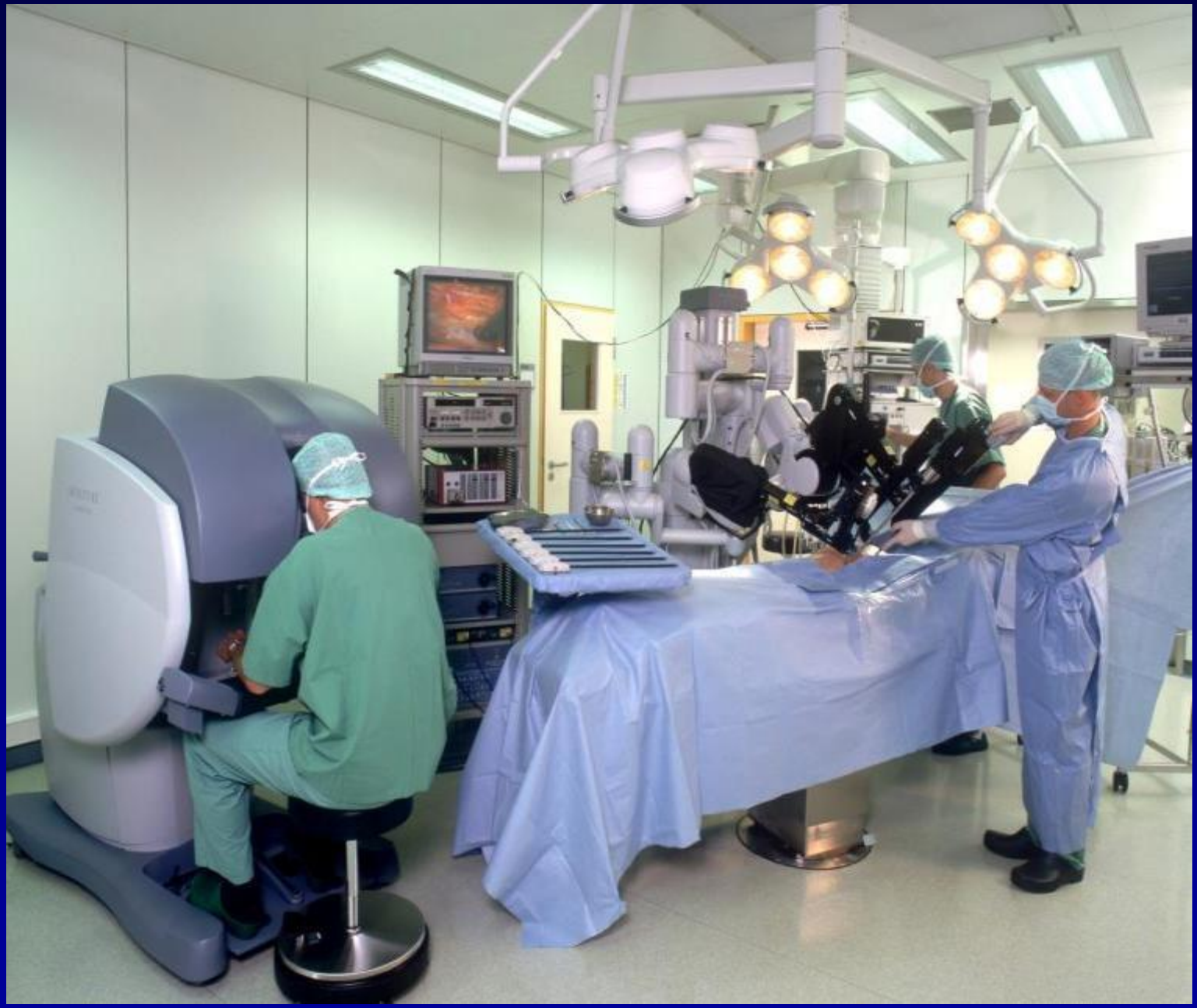
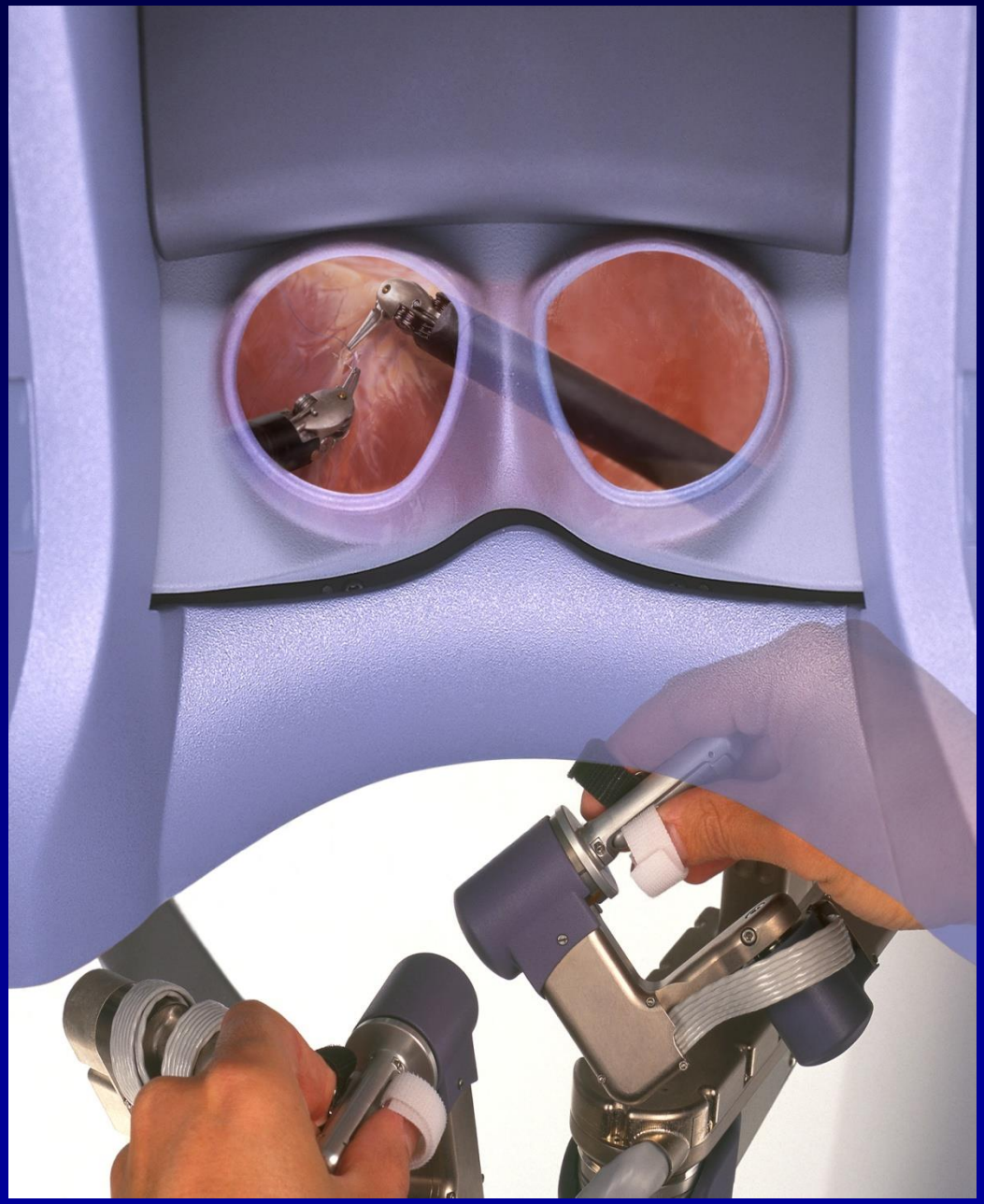
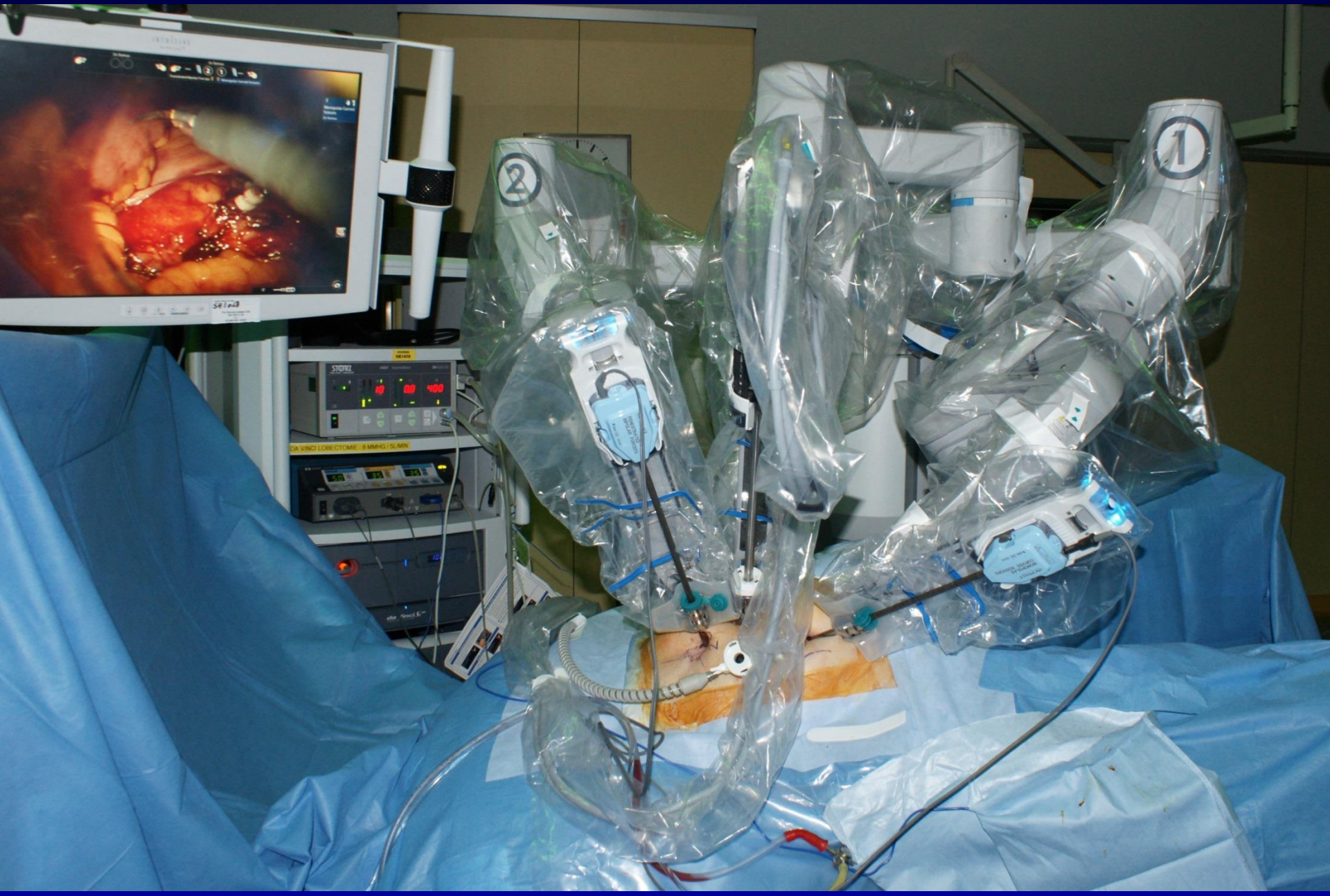
1
3


da Vinci S






2
1
DA VINCI LOBECTOMIE : 8 MMHG / 5L/MIN

PHILOSOPHIE IMPLEMENTATION DU ROBOT

Avantages du Robot

1. Stabilité de l'image
2. Vision 3D
3. Magnification 10x
4. « Intuitive motion » = Mouvements du poignet
5. Suppression tremblements physiologiques
6. Correction croisement instruments SILS
7. Position ergonomique du chirurgien
8. Entrainement par simulateur
9. Double console

⇒ « Démocratisation » du geste chirurgical
(L. BRESLER, Nancy)

PHILOSOPHIE IMPLEMENTATION DU ROBOT

Avantages pour le patient

- Chirurgie pelvienne – cancer du rectum

- Avantages attendus :

  - Qualité exérèse oncologique
  - ↓ Récidives locales
  - Préservation nerfs pelviens
    - Orthosympathiques
    - Parasympathiques

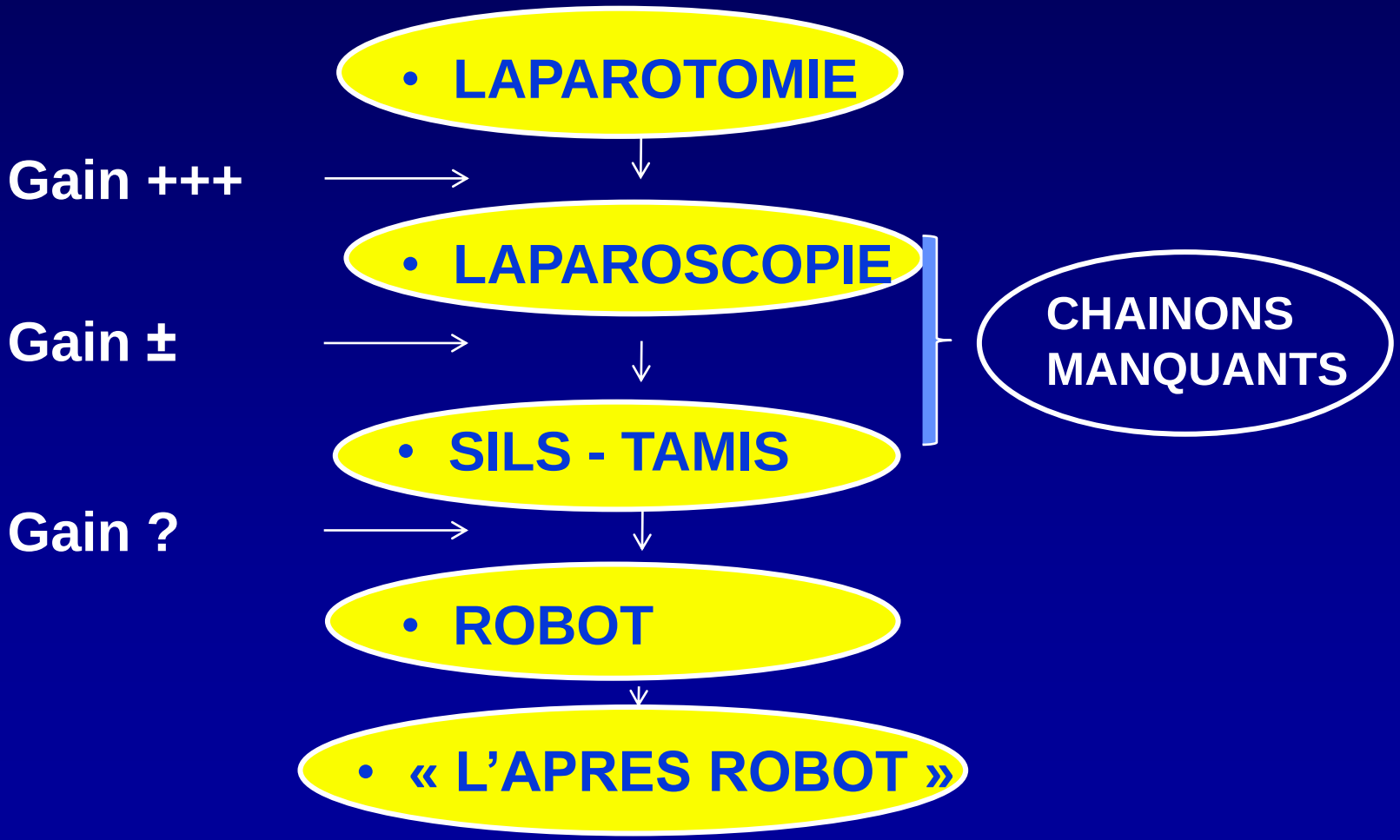
PHILOSOPHIE IMPLEMENTATION DU ROBOT

Avantages pour le patient

- Revue littérature : Peu – Pas d'avantages?
- Etude ROLARR: ↓ taux conversion
- Mais « BIAIS » = « Learning Curve » actuelle de tous les chirurgiens !

PHILOSOPHIE IMPLEMENTATION DU ROBOT

Avantages du Robot



PHILOSOPHIE IMPLEMENTATION DU ROBOT

Pourquoi implémenter le robot en 2016?

→ 2 raisons de stratégie, de perspectives d'avenir:

1- Introduction du SILS
→ Croisement des instruments corrigé par Robot !

2- Introduction du TAMIS
→ Voie trans-anale pure !

= 2 étapes d'une stratégie globale d'avenir !

PHILOSOPHIE IMPLEMENTATION DU ROBOT

Robot – Stratégie : TAMIS ?

Int J Colorectal Dis (2017) 32:249–254
DOI 10.1007/s00384-016-2686-3

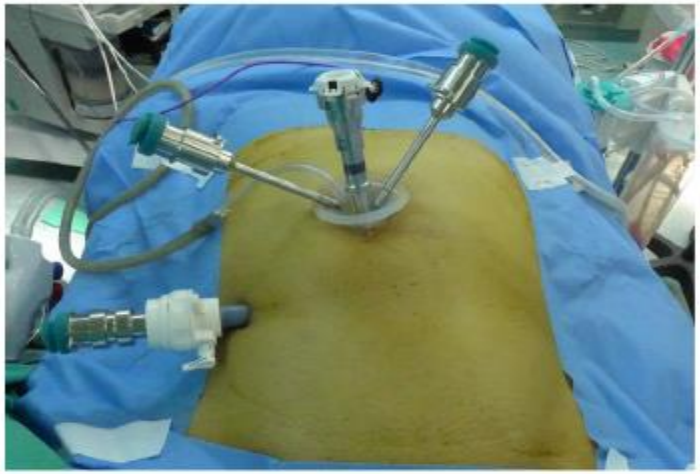
ORIGINAL ARTICLE

Combined robotic transanal total mesorectal excision (R-taTME) and single-site plus one-port (R-SSPO) technique for ultra-low rectal surgery—initial experience with a new operation approach

Li-Jen Kuo [1,2,3] · James Chi-Yong Ngu [4] · Yiu-Shun Tong [5] · Chia-Che Chen [5]

PHILOSOPHIE IMPLEMENTATION DU ROBOT

Robot – Stratégie : SILS ?



Kuo L.J. et al., Int J Colorectal Dis, 2017

PHILOSOPHIE IMPLEMENTATION DU ROBOT

Robot – Stratégie : TAMIS ?

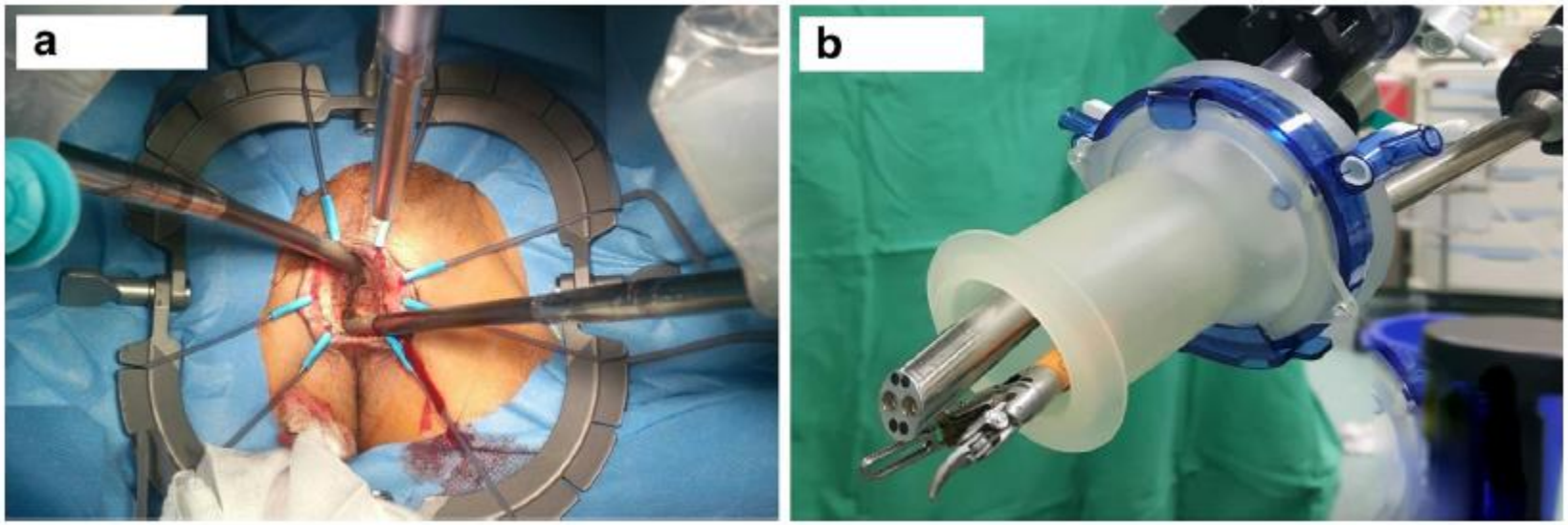


Fig. 2 a The Lone Star Retractor (Lone Star Medical Products Inc., Houston, TX, USA) was used to efface the anus. b The GelPOINT Path Transanal Access Platform (Applied Medical Inc., Rancho Santa Margarita, CA) was positioned.

Kuo L.J. et al., Int J Colorectal Dis, 2017

PHILOSOPHIE IMPLEMENTATION DU ROBOT

Robot – Stratégie : TAMIS ?

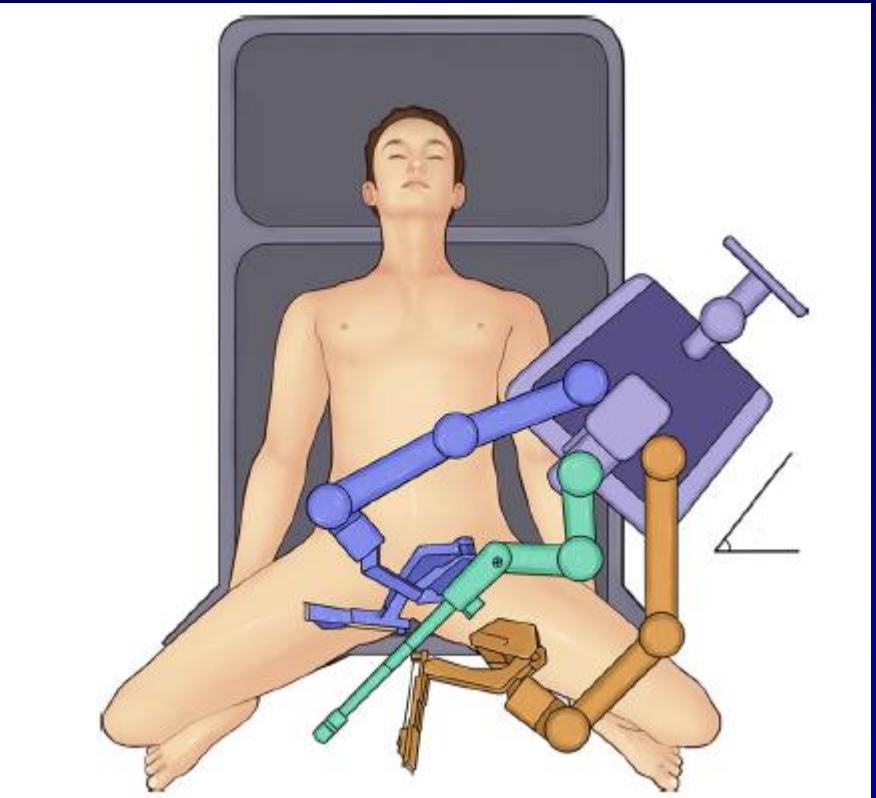


Fig. 1 The robotic cart was docked at 45° from the left cephalolateral aspect of the operating table.

Kuo L.J. et al., Int J Colorectal Dis, 2017

PHILOSOPHIE IMPLEMENTATION DU ROBOT

Robot – Stratégie : TAMIS ?

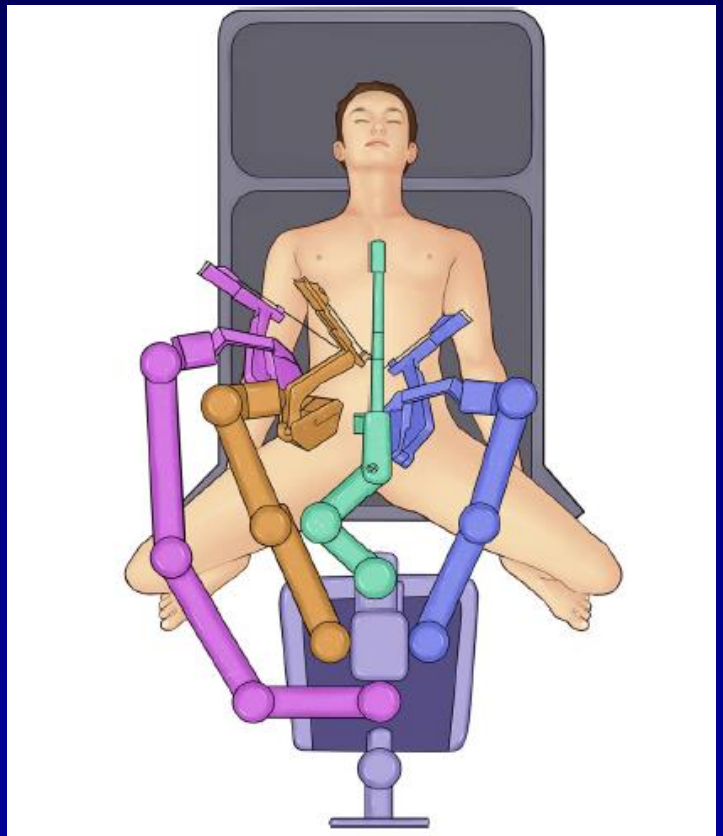


Fig. 3 The robotic cart was docked to the surgical table in between the legs of the patient.

Kuo L.J. et al., Int J Colorectal Dis, 2017

PHILOSOPHIE IMPLEMENTATION DU ROBOT

Rôle des Centres Académiques

A- Recherche clinique

- **Etudes de faisabilité: morbidité, mortalité, etc.**
- **Préciser indications**
- **Etude avantages patients:**
  - **Fonctionnel**
  - **Oncologique**

B- Enseignement

- **Etre prêt pour une formation à grande échelle**

CANCER DU RECTUM

CHIRURGIE ROBOTIQUE

→ QUEL AVENIR ?

Robotic surgery: will it be evidence-based or just "toys for boys"?

Guy J Maddern

Surgeons and government must work together to evaluate new surgical technologies

Maddem GJ, 5 March 2007

CHIRURGIE DU CANCER COLORECTAL

Robot

- **Perspectives d'avenir:**
  - **Réalité augmentée**
  - **« Pelvi-navigation » virtuelle**

CANCER COLORECTAL : PROGRES RECENTS

I. TOTAL MESORECTAL EXCISION TME de HEALD

Exérèse totale du mésorectum selon la technique de Heald

CANCER COLORECTAL : PROGRES RECENTS

TRAITEMENT CHIRURGICAL

1. Risque de récidive locale
2. Lésion des nerfs pelviens
3. Conservation appareil sphinctérien

CANCER COLORECTAL : PROGRES RECENTS

EXÉRÈSE TOTALE DU MÉSORECTUM TECHNIQUE DE HEALD

- **Exérèse totale du mésorectum :**
  → Résection plus oncologique

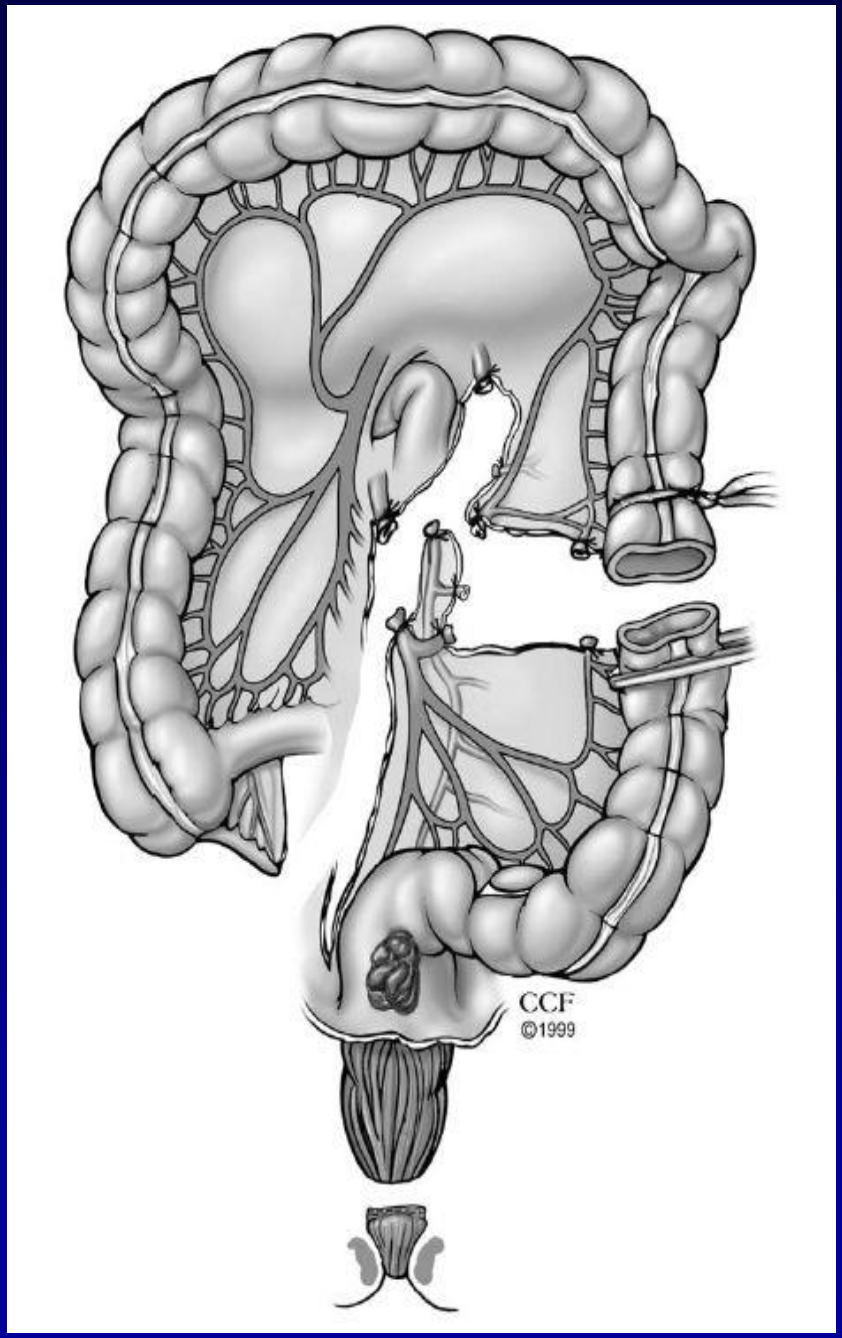
- **Preservation des plexus autonomes :**
  → Plus grand respect de l'intégrité corporelle

CANCER COLORECTAL : PROGRES RECENTS

EXÉRÈSE TOTALE DU MÉSORECTUM TECHNIQUE DE HEALD

« Le plan sacré »

« The Holy Plane »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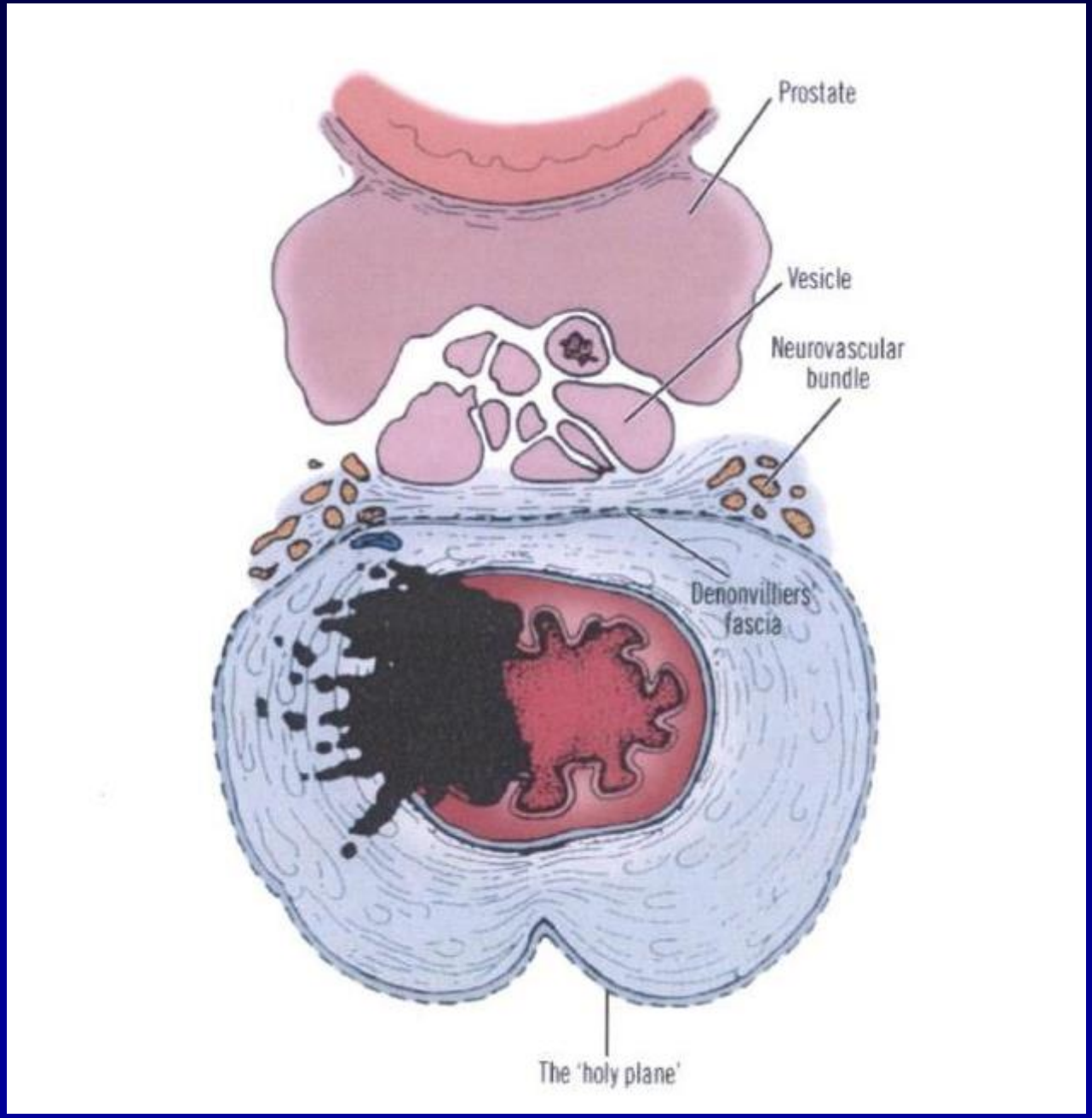
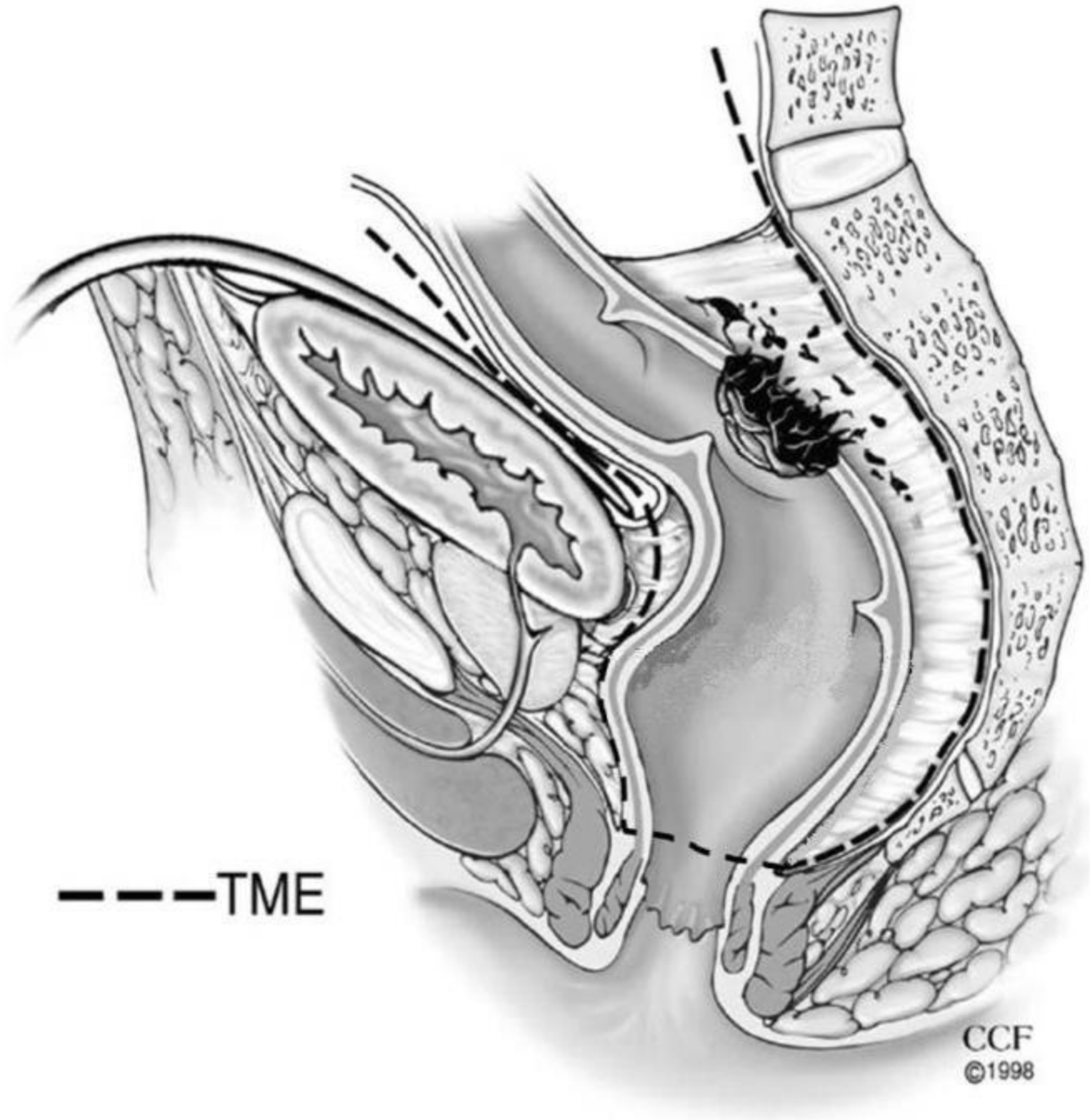
©1999


Prostate
Vesicle
Neurovascular bundle
Denonvilliers' fascia
The 'holy plane'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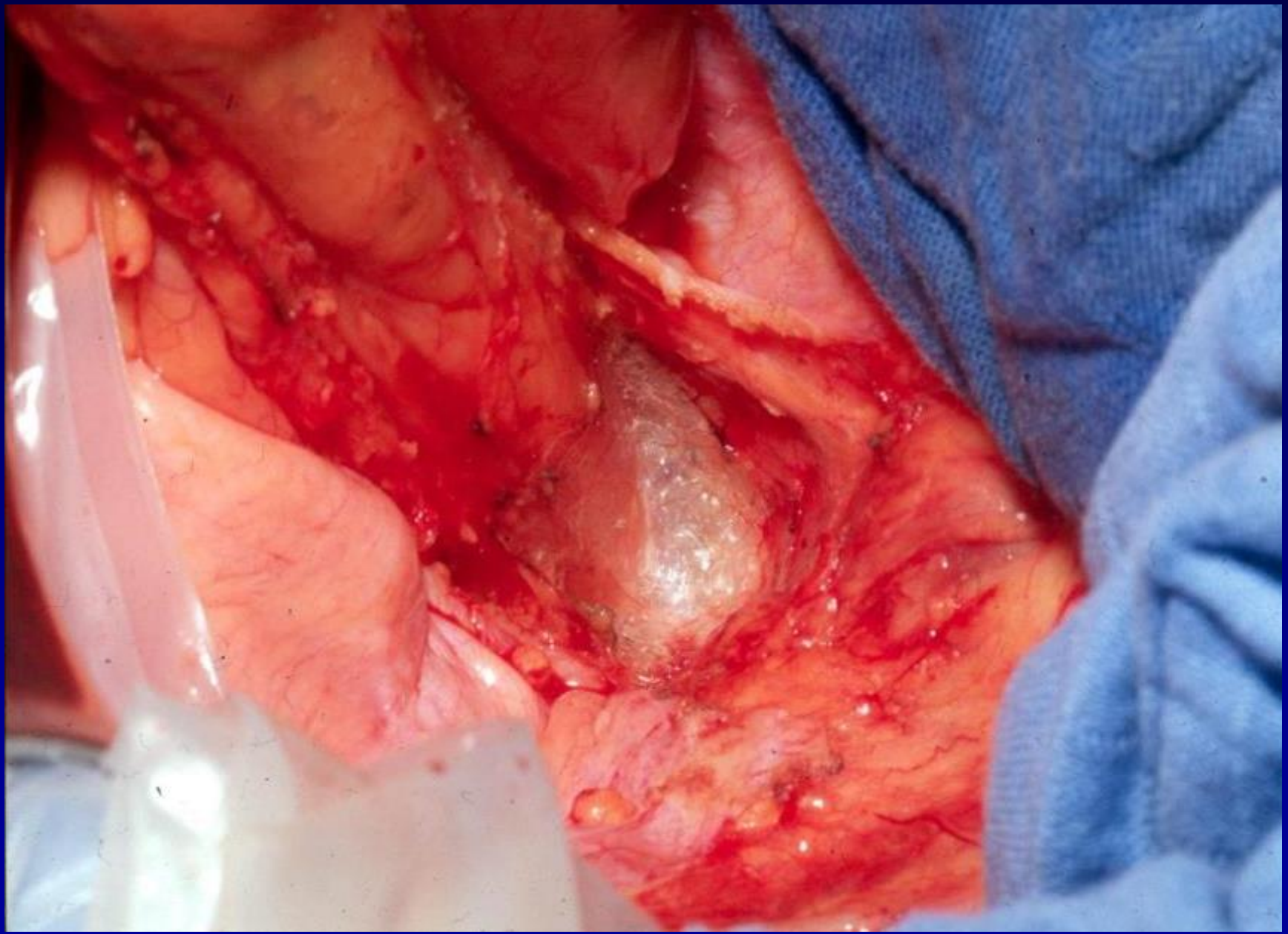
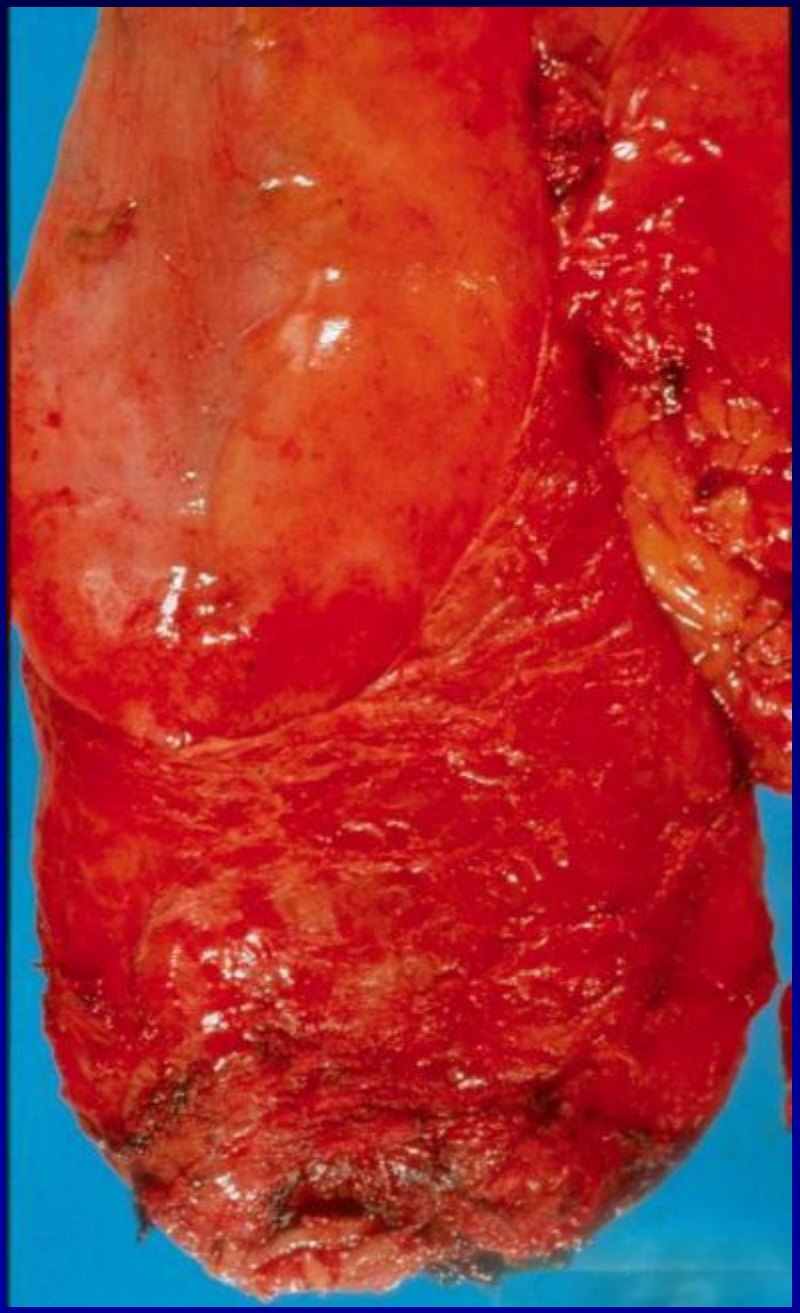
©1998



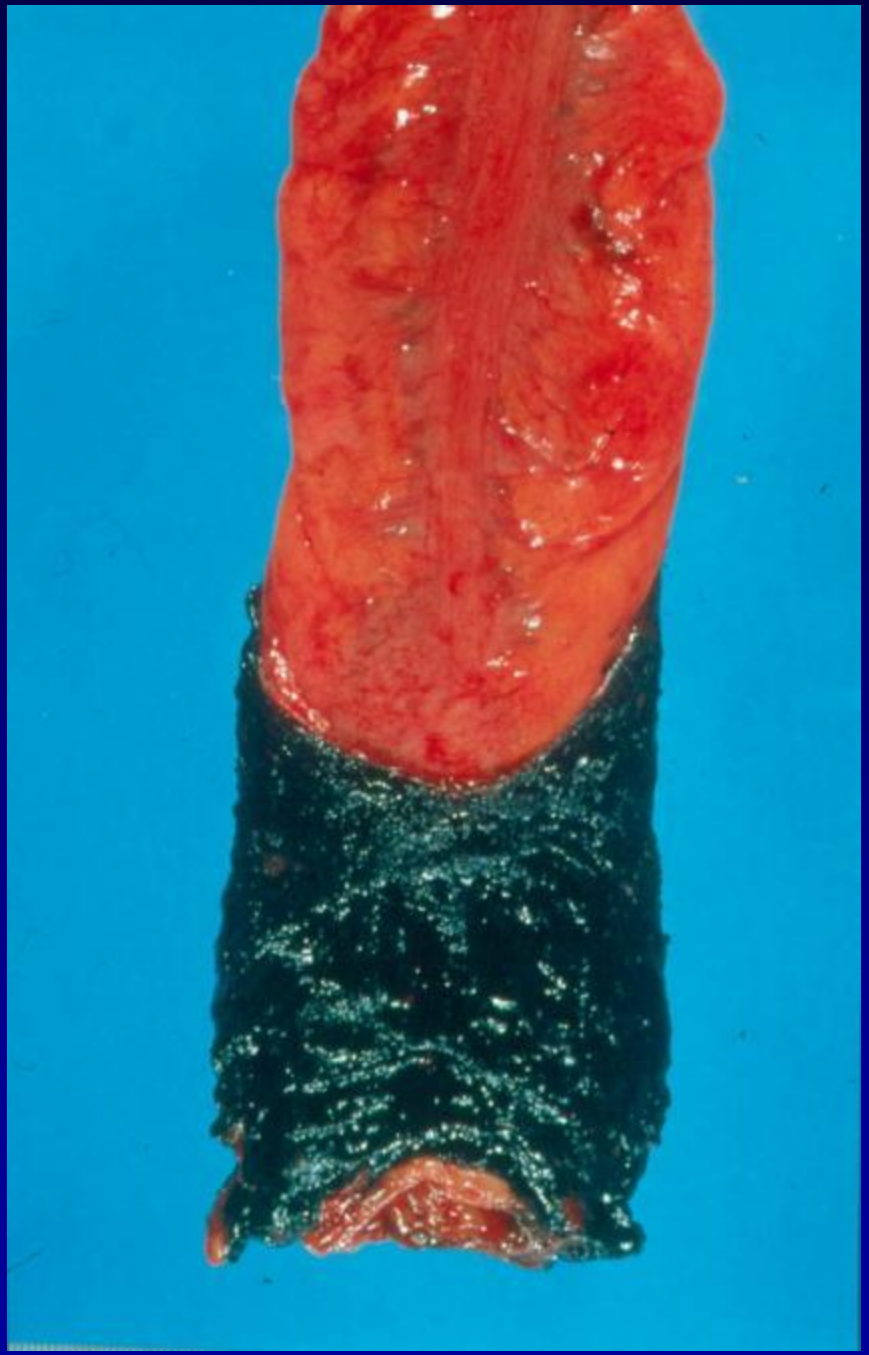


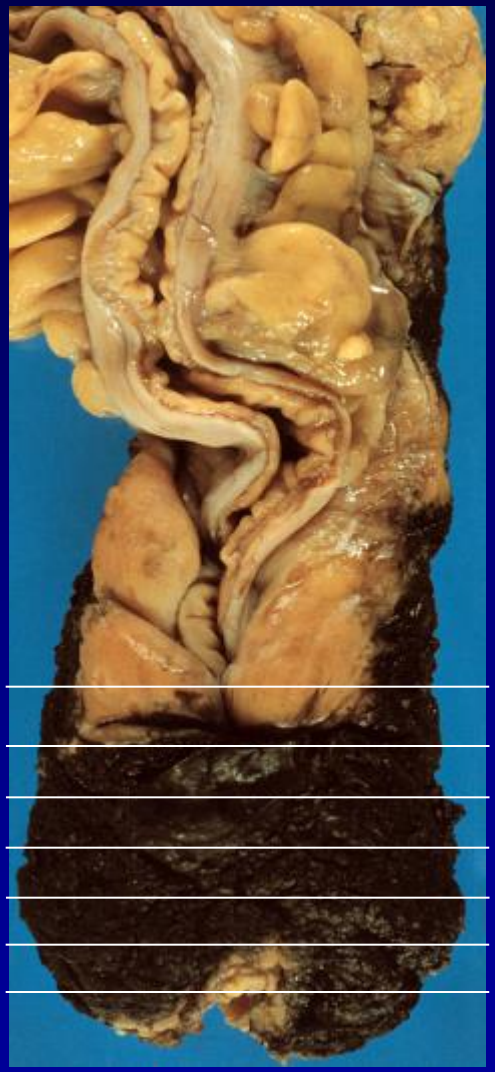
CANCER DU RECTUM

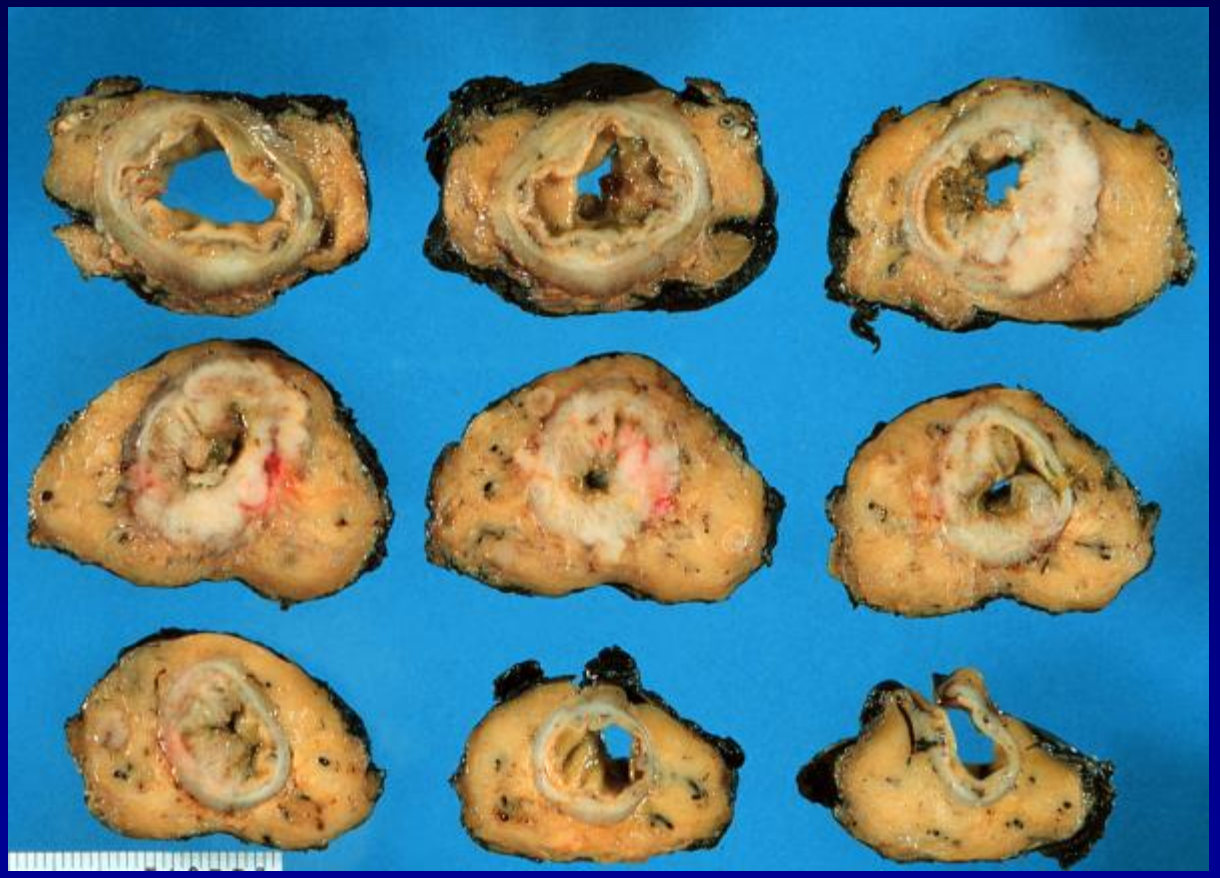
EXÉRÈSE TOTALE DU MÉSORECTUM TECHNIQUE DE HEALD

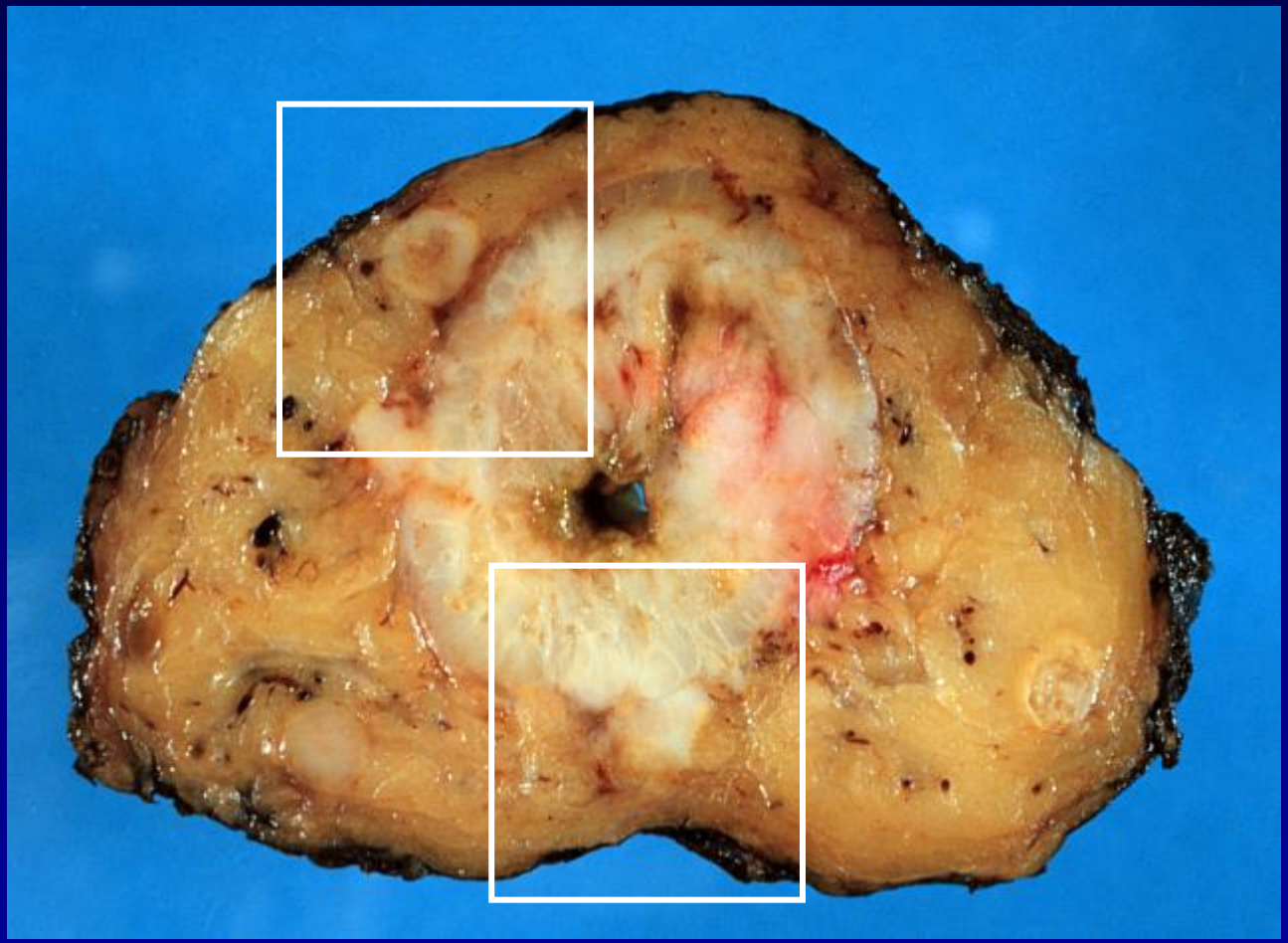
Examen anatomo-pathologique :

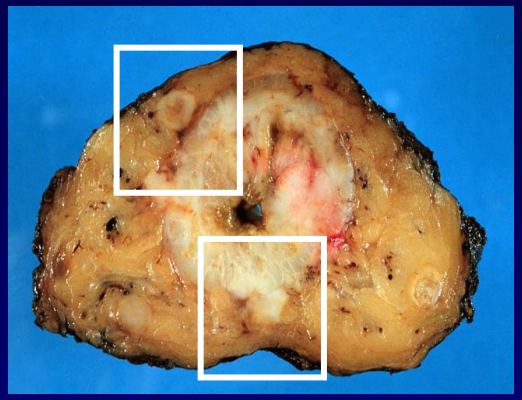
- technique de Quircke
- encre de Chine
- marge sécurité latérale ≥ 2 mm

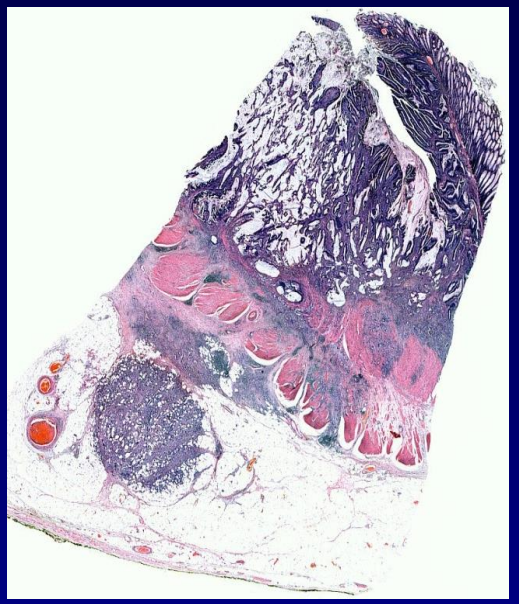


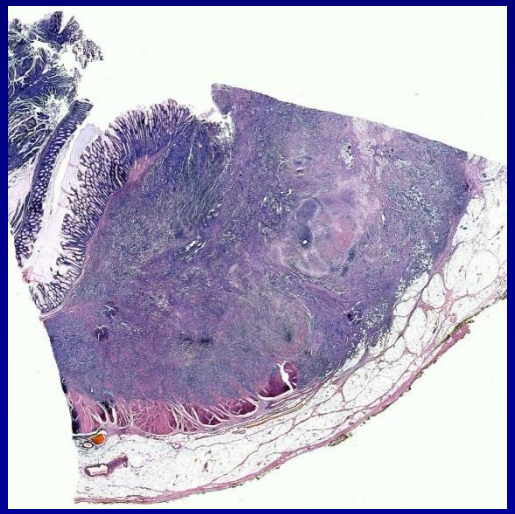












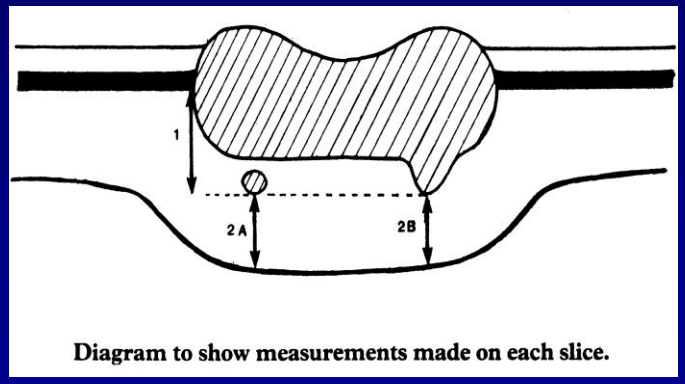


Diagram to show measurements made on each slice.

Quirke et al. Lancet 1986
Int J Colon Dis 1988

EXÉRÈSE TOTALE DU MÉSORECTUM TECHNIQUE DE HEALD

Examen anatomo-pathologique :

Ancien concept de marges de sécurité proximale et distale.

Nouveau concept de marge de sécurité latérale, circonférentielle.

EXÉRÈSE TOTALE DU MÉSORECTUM TECHNIQUE DE HEALD

Résultats : ↓ **récidives locales**

- **avant Heald : 15-40 % à 5 ans**

- **après Heald : 4-10 % à 5 ans**

CHIRURGIE DU CANCER COLORECTAL

Préservation des nerfs pelviens

CHIRURGIE DU CANCER COLORECTAL

Gastroenterology Report, 4(3), 2016, 173–185

doi: 10.1093/gastro/gow023
Advance Access Publication Date: 31 July 2016
Review

REVIEW

Pelvic autonomic nerve preservation in radical rectal cancer surgery: changes in the past 3 decades

Min-Hoe Chew[1,*], Yu-Ting Yeh[1], Evan Lim[2] and Francis Seow-Choen[3]

[1]Department of Colorectal Surgery, Singapore General Hospital, Singapore, [2]Singhealth Academy, Singapore General Hospital, Singapore and [3]Seow-Choen Colorectal Centre, Singapore

*Corresponding author. Department of Colorectal Surgery, Singapore General Hospital, 20 College Road, Academia, Singapore 169856. Tel: +65-6321-4677, Email: chew.min.hoe@singhealth.com.sg

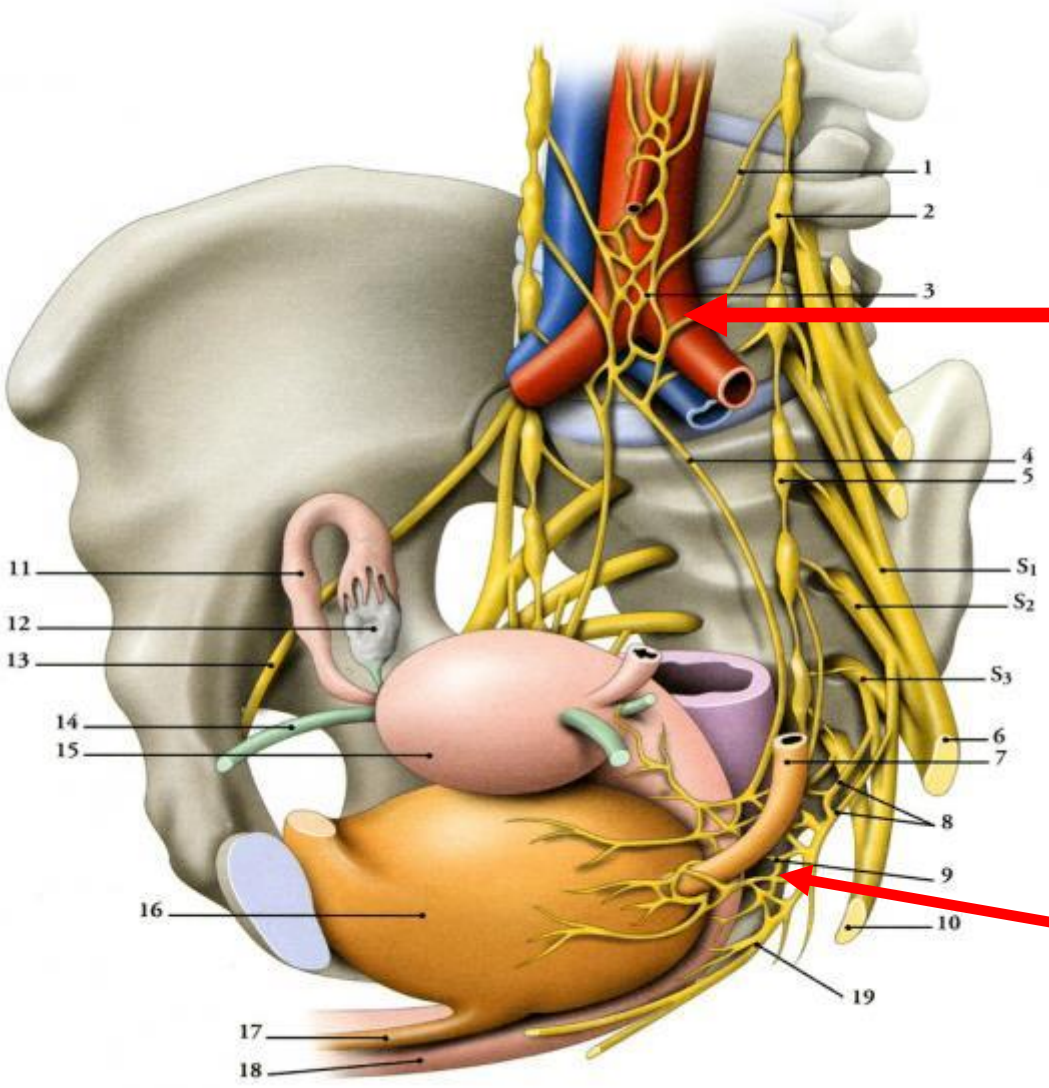


Fig. 10.6 Constitution des plexus hypogastriques chez la femme
(vue antéro-latérale droite)

Superior hypogastric plexus

Inferior hypogastric plexus

Sympathetic et Parasympathetic innervation to the pelvic organs in females

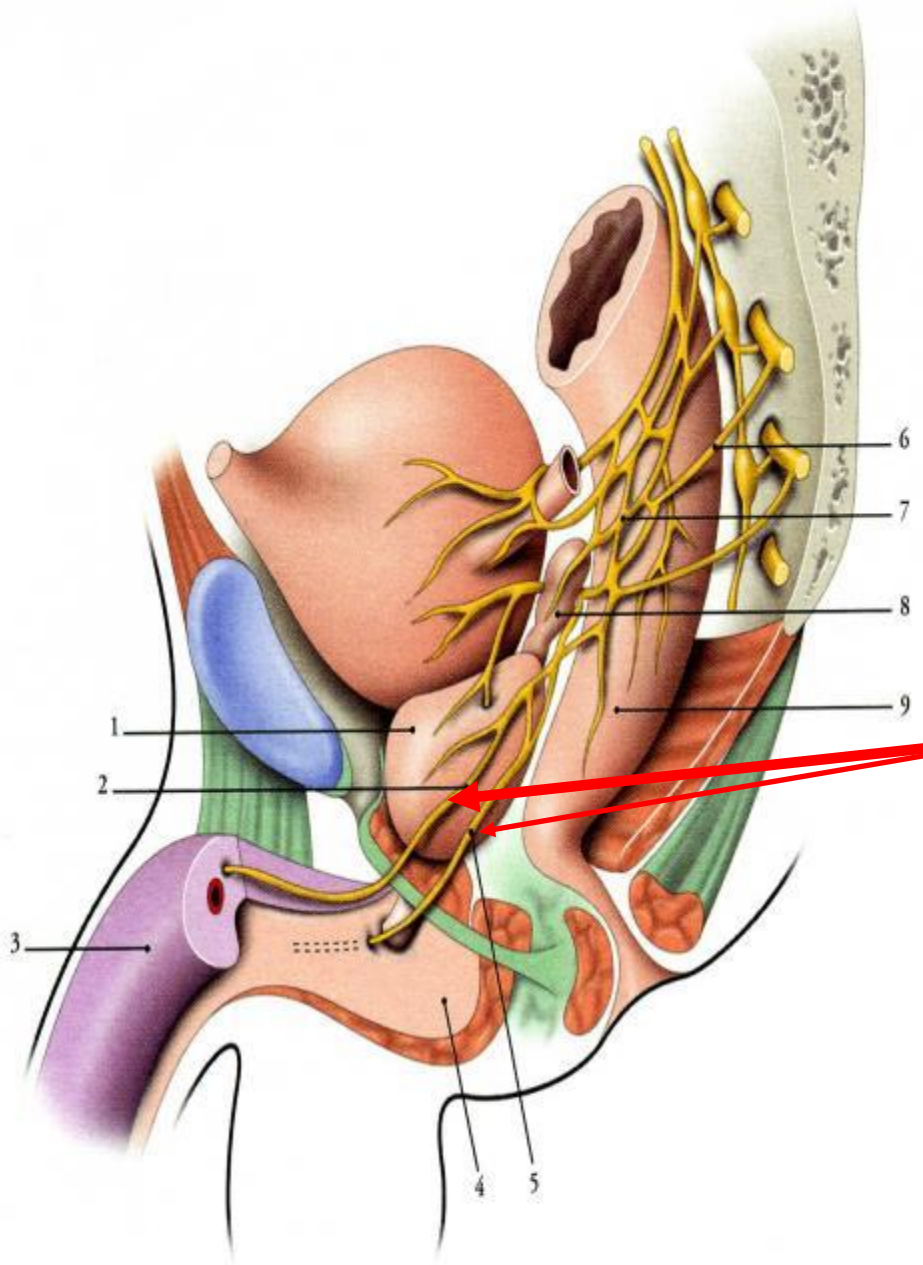
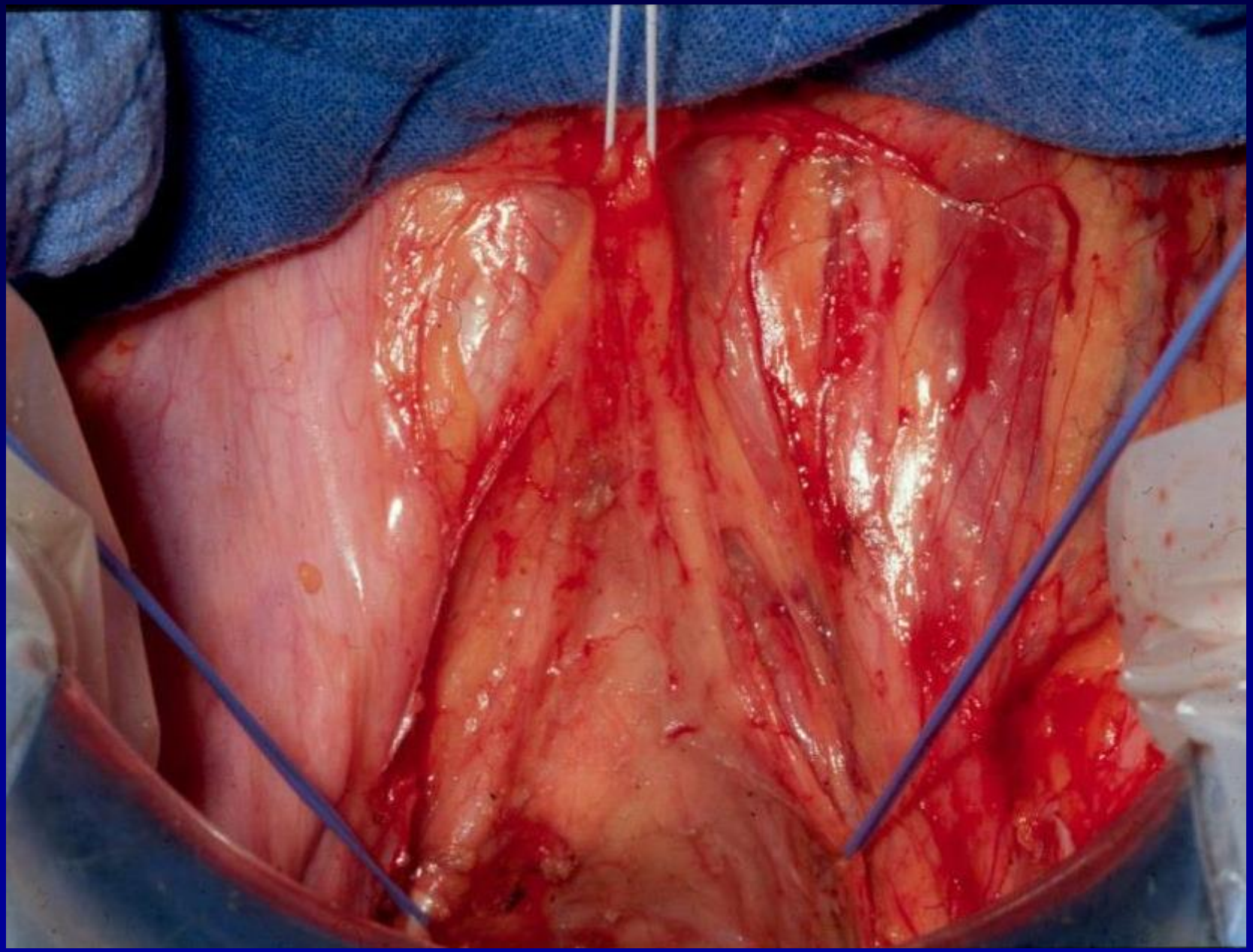
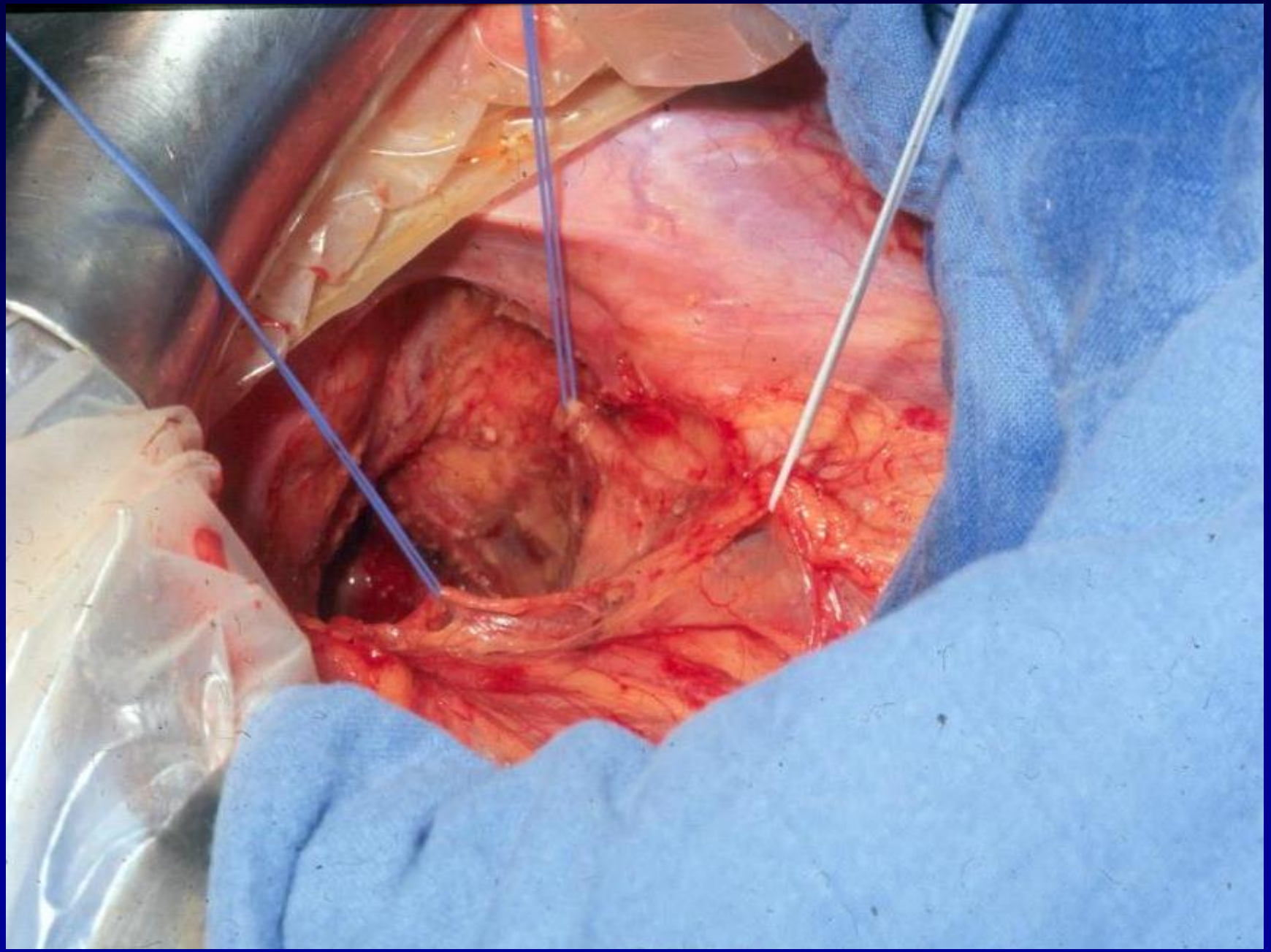


FIG. 10.8. Plexus hypogastrique inférieur chez l'homme

The Inferior hypogastric plexus in males





CANCER DU RECTUM

PRESERVATION DES NERFS PELVIENS

Nerfs autonomes	Fonction urinaire	Fonction sexuelle
Orthosympathique	Sensation	Ejaculation
Parasympathique	Contraction	Erection

CHIRURGIE DU CANCER COLORECTAL

Préservation des nerfs pelviens

Complications	Avant TME	Après TME
Urinaires (%)	22,4 – 79,1	2,1 – 24,4
Sexuelles (%) - Ejaculation - Erection	85% - 100 % 69% - 100 %	12 – 44,2 1,5 – 49,5

CHIRURGIE DU CANCER COLORECTAL

Préservation des nerfs pelviens

Facteurs de risque:

- Volume tumoral
- Adiposité pelvienne
- Pelvis étroit (♂)
- Technique chirurgicale

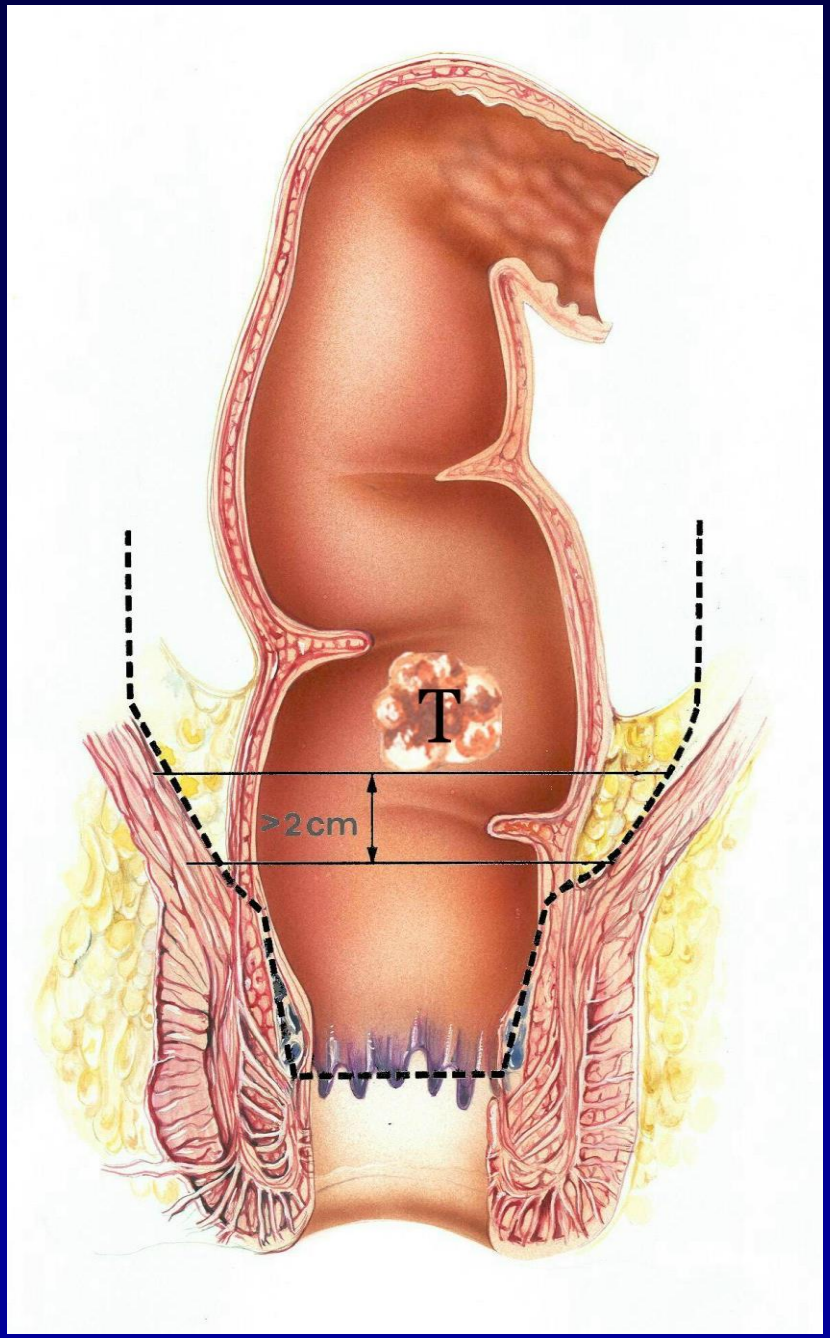
CANCER COLORECTAL : PROGRES RECENTS

J. Anastomose Colo-Anale - ACA et Réservoir

CANCER COLORECTAL : PROGRES RECENTS

ANASTOMOSE COLO-ANALE

- **Technique :**
  - **exérèse totale rectum + mésorectum**
  - **mucosectomie endo-anale**
  - **réservoir colique en « J »**
  - **anastomose colo-anale vraie**
  - **iléostomie de protection**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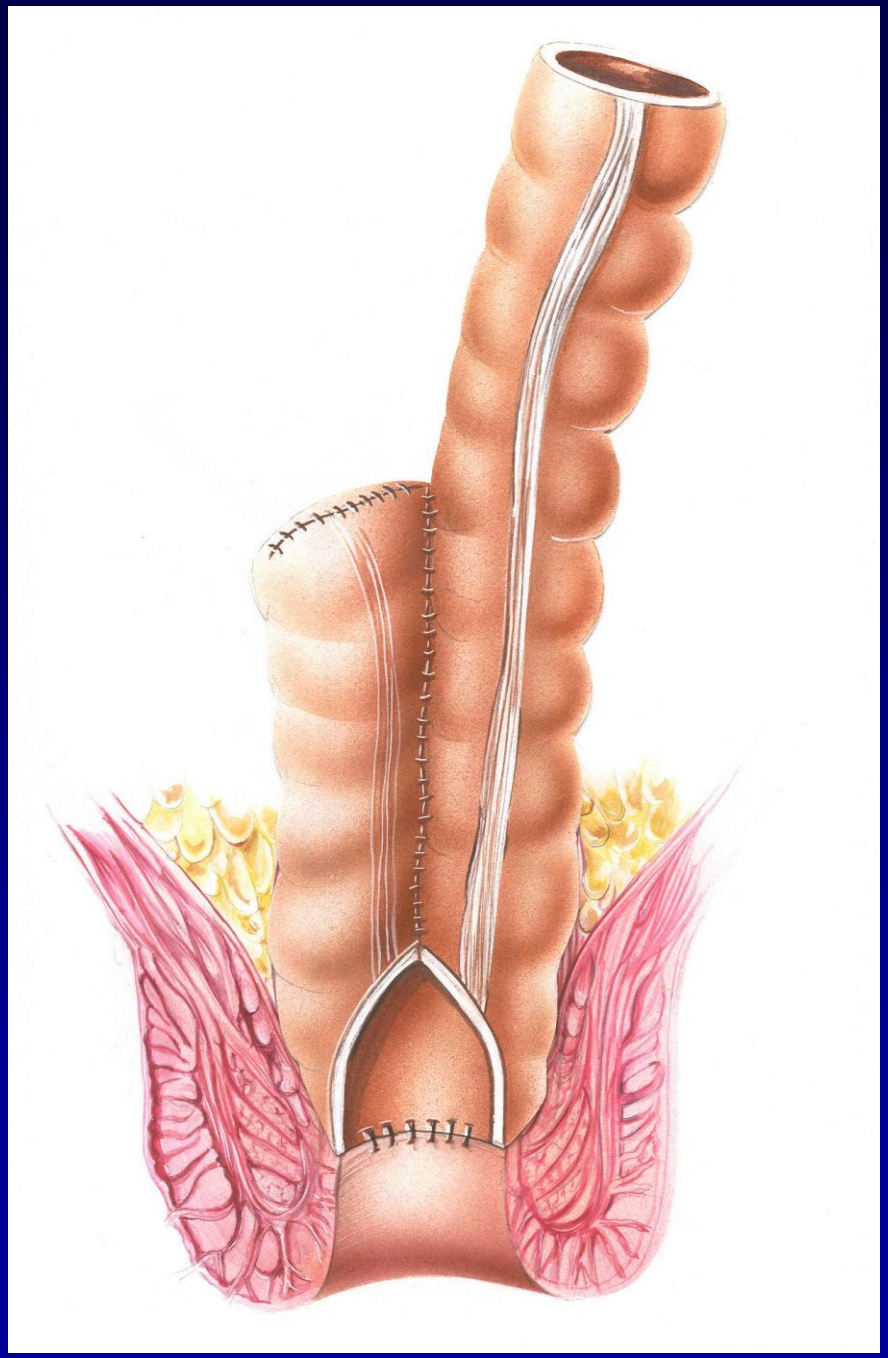

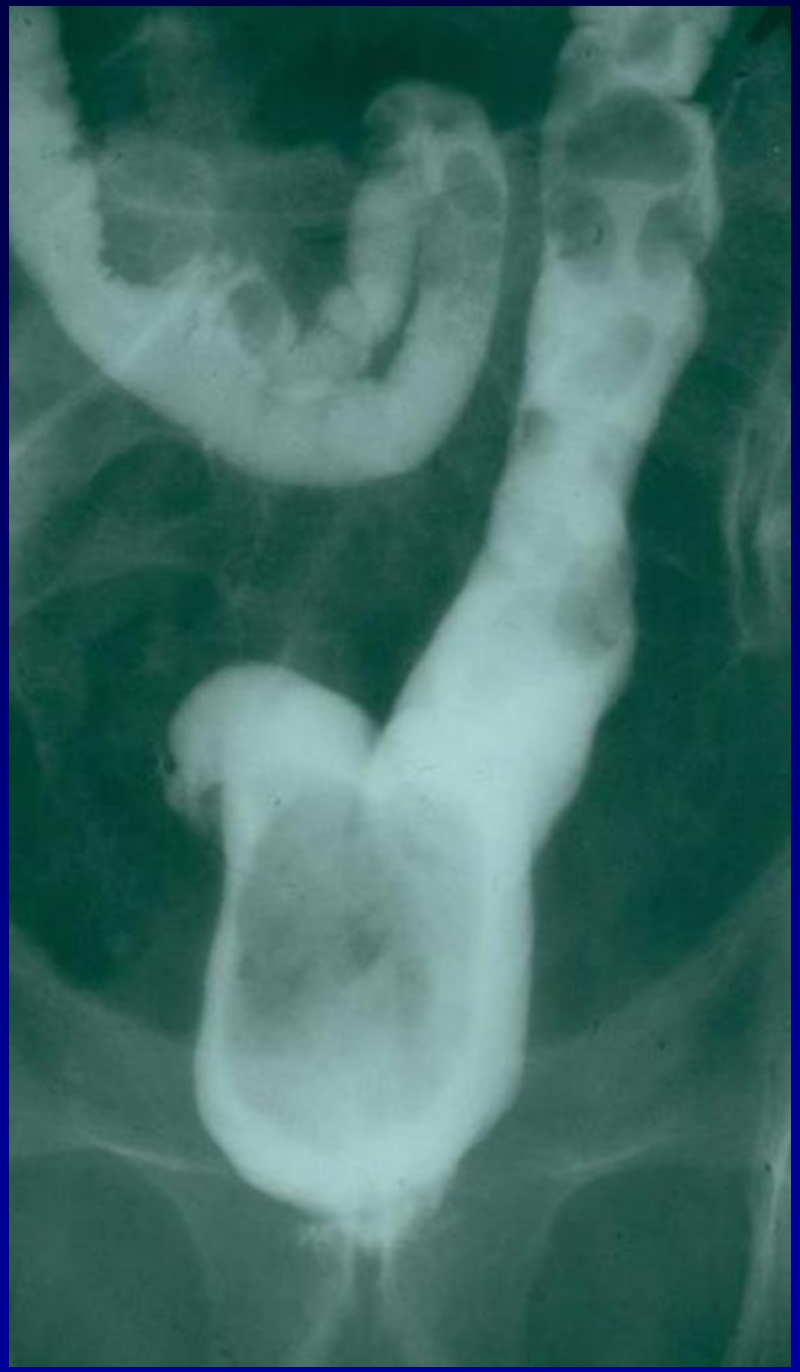

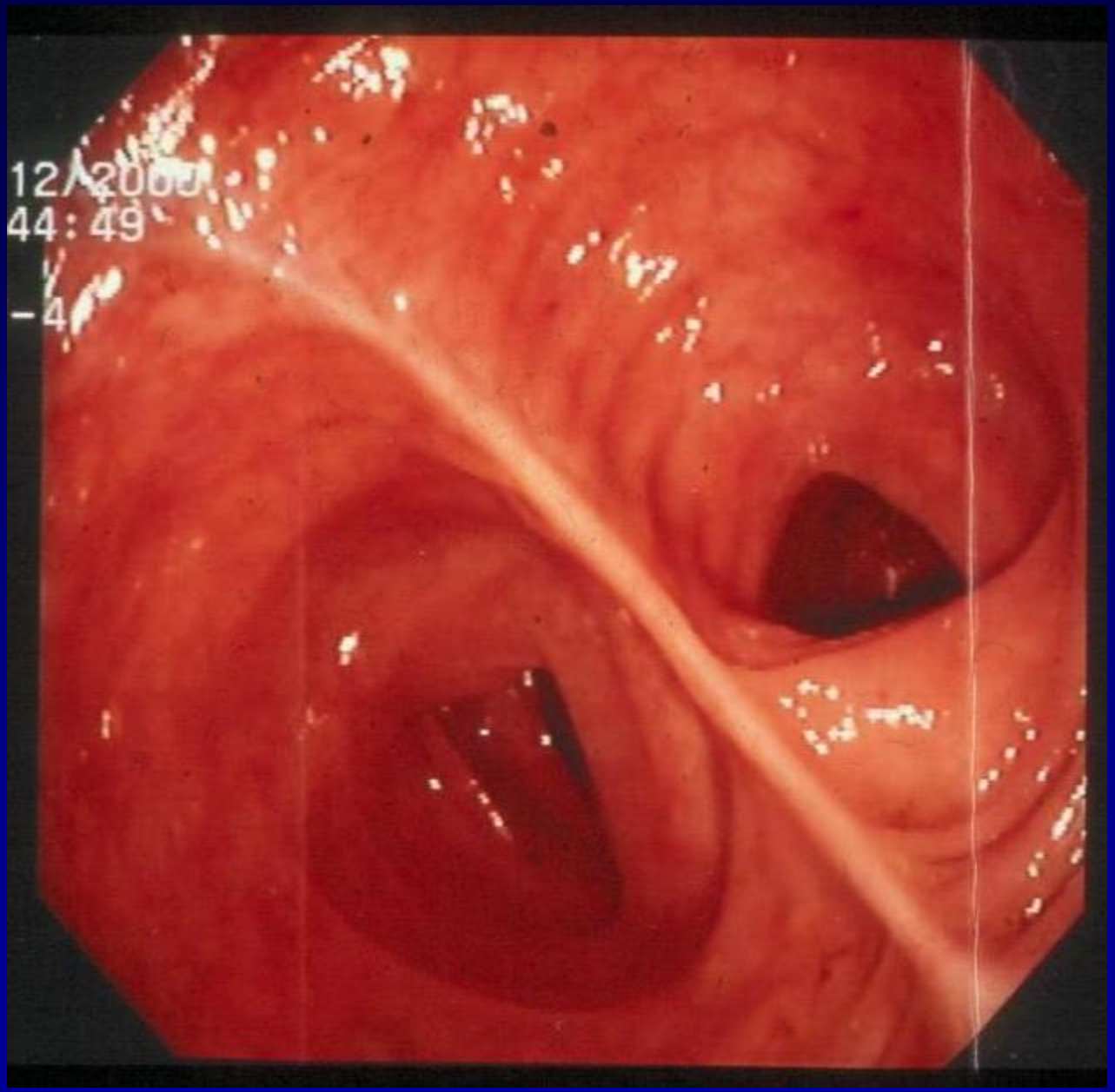
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CANCER COLORECTAL : PROGRES RECENTS

Meta-analysis of colonic reservoirs *versus* straight coloanal anastomosis after anterior resection

A. G. Heriot[1,3], P. P. Tekkis[1–3], V. Constantinides[1], P. Paraskevas[1], R. J. Nicholls[2], A. Darzi[1] and V. W. Fazio[3]

[1]Department of Surgical Oncology and Technology, Imperial College London, St Mary's Hospital, London, and [2]Department of Colorectal Surgery, St Mark's Hospital, Harrow, UK, and [3]Department of Colorectal Surgery, Cleveland Clinic Foundation, Cleveland, Ohio, USA

Correspondence to: Mr P. P. Tekkis, Department of Surgical Oncology and Technology, 10th floor, QEQM Building, St Mary's Hospital, Praed Street, London W2 1NY, UK (e-mail: p.tekkis@imperial.ac.uk)

A.G. Heriot et al., British Journal of Surgery, 2006

CHIRURGIE DU CANCER COLORECTAL

COLO-ANAL ANASTOMOSIS
CAA

Systematic review

Meta-analysis of reconstruction techniques after low anterior resection for rectal cancer

F. J. Hüttner[1,2], S. Tenckhoff[2], K. Jensen[3], L. Uhlmann[3], Y. Kulu[1], M. W. Büchler[1], M. K. Diener[1,2] and A. Ulrich[1]

[1]Department of General, Visceral and Transplantation Surgery, [2]Study Centre of the German Surgical Society, and [3]Institute of Medical Biometry and Informatics, University of Heidelberg, Heidelberg, Germany

Correspondence to: Professor A. Ulrich, Department of General, Visceral and Transplantation Surgery, University of Heidelberg, Im Neuenheimer Feld 110, 69120 Heidelberg, Germany (e-mail: alexis.ulrich@med.uni-heidelberg.de)

Hüttner F.J., BJS, 2015

CHIRURGIE DU CANCER COLORECTAL

COLO-ANAL ANASTOMOSIS
CAA

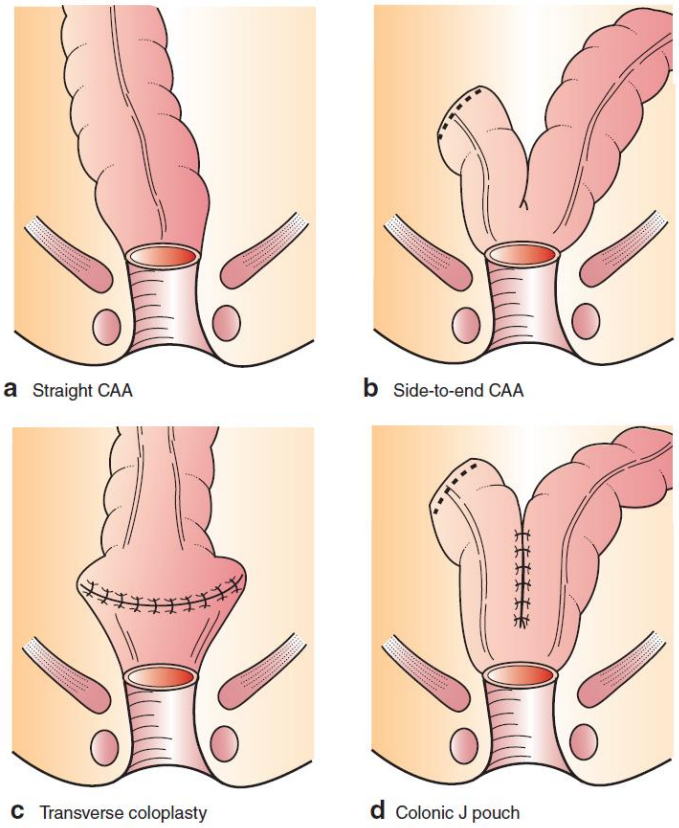


Fig. 1 Illustration of reconstructive techniques: a straight coloanal anastomosis (CAA), b side-to-end CAA, c transverse coloplasty and d colonic J pouch

Hüttner F.J., BJS, 2015

CHIRURGIE DU CANCER COLORECTAL

COLO-ANAL ANASTOMOSIS
CAA

→ **Meta-analysis:**

- **Studies = 21**
- **Patients = 1636**

« Colonic J pouch and side-to-end CAA or transverse coloplasty lead to better functional outcome than straight CAA for the first year after surgery »

Hüttner F.J., BJS, 2015

CHIRURGIE DU CANCER COLORECTAL

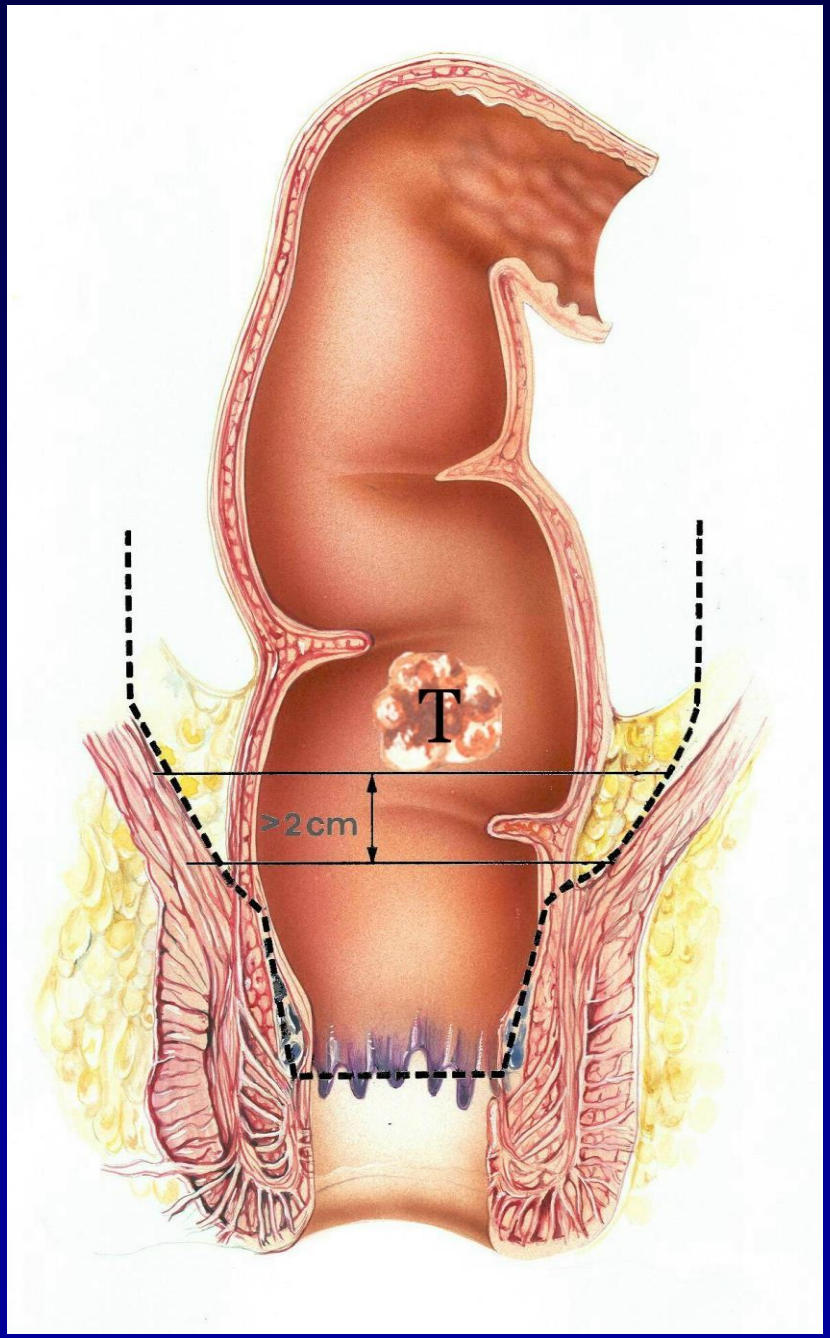
K. Conservation sphinctérienne : DIS et DIT

MID RECTAL CANCER

SPHINCTER SAVING SURGERY

Inferior tumor border ≤ 2 cm superior border sphincter

- **limit : 1 cm above superior border sphincter**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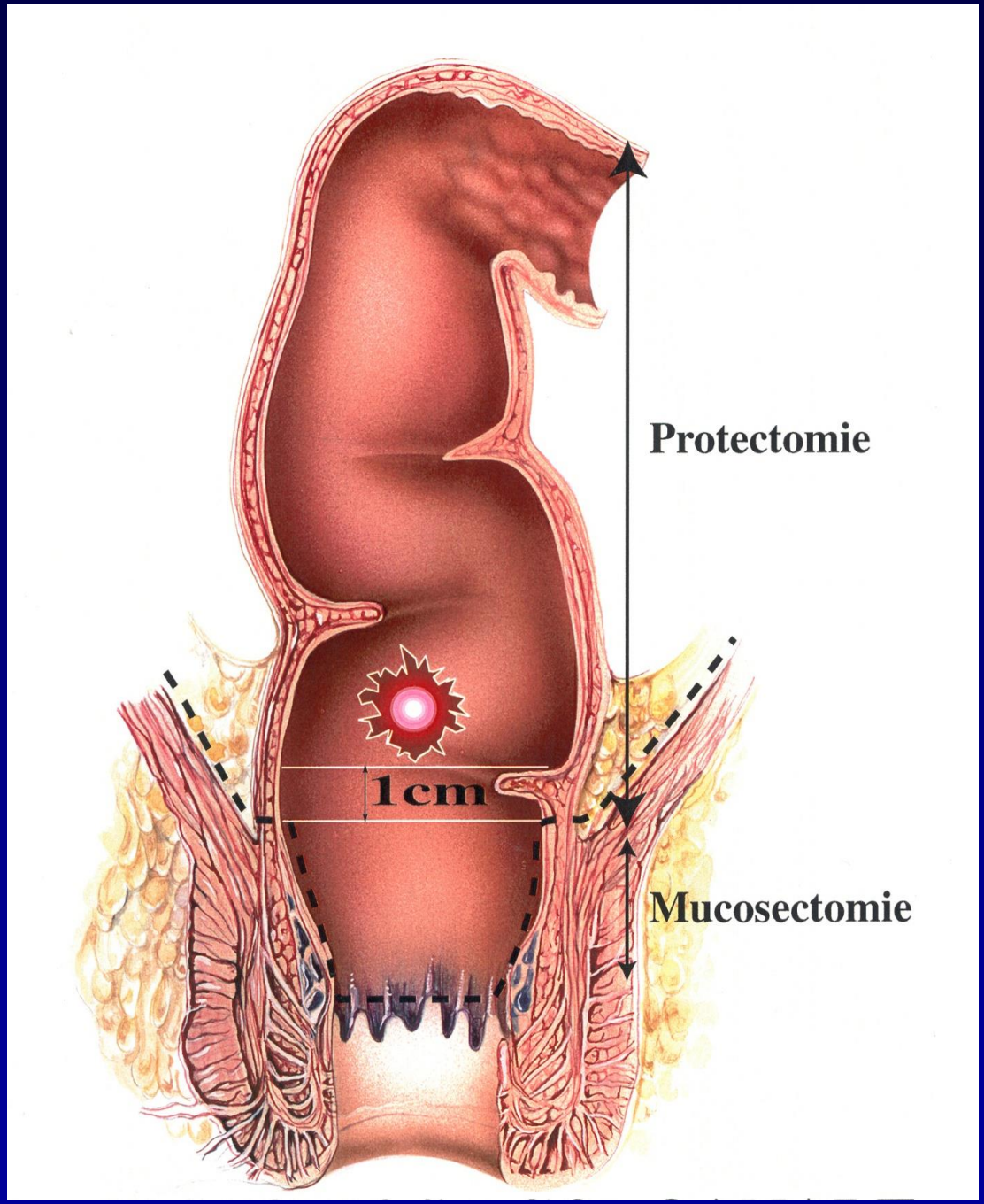
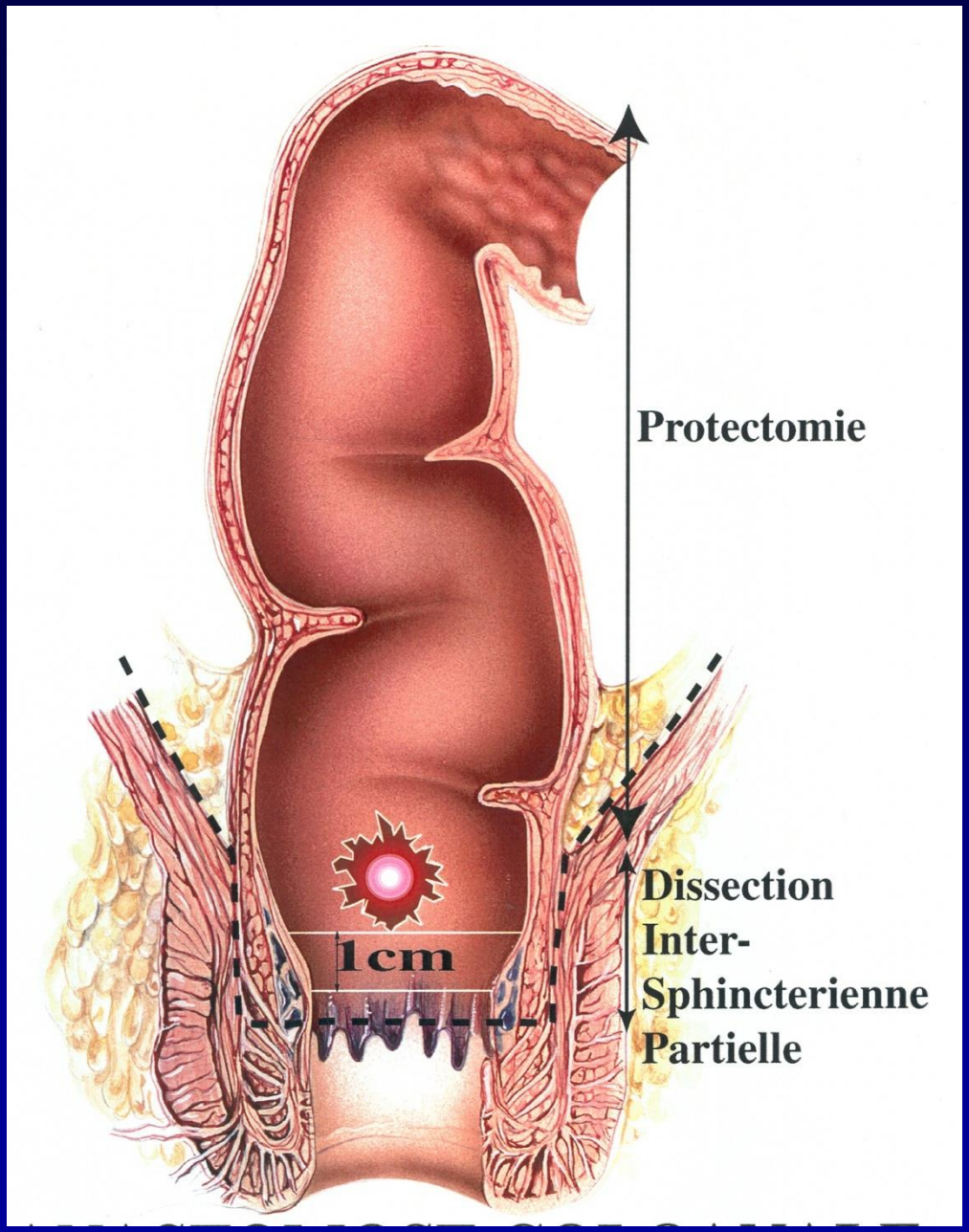

Protectomie
1cm
Mucosectomie

CANCER OF THE LOWER RECTUM

New sphincter preservation limits :

→ T1, T2, T3 ≥ 1 cm pectineal line

⇒ partial intersphincteric dissection


Protectomie
Dissection
Inter-
Sphincterienne
Partielle
1cm

CANCER OF THE LOWER RECTUM

New sphincter preservation limits :

$\rightarrow$ T1, T2, T3 $\geq$ 1 cm anal verge

$\Rightarrow$ total intersphincteric dissection

CHIRURGIE DU CANCER COLORECTAL

INTERSPHINCTERIC RESECTION
ISR

Systematic review

Systematic review of outcomes after intersphincteric resection for low rectal cancer

S. T. Martin, H. M. Heneghan and D. C. Winter

Department of Colorectal Surgery, St Vincent's University Hospital, Elm Park, Dublin 4, Ireland
Correspondence to: Mr S. T. Martin (e-mail: drseanmartin@gmail.com)

Martin S.T. et al, BJS, 2012

CHIRURGIE DU CANCER COLORECTAL

L. EXERESE LOCALE: BUESS

CANCER DU RECTUM

EXERESE LOCALE : VOIE TRANS-ANALE

- **Microchirurgie trans-anale endoscopique : M.T.E.**

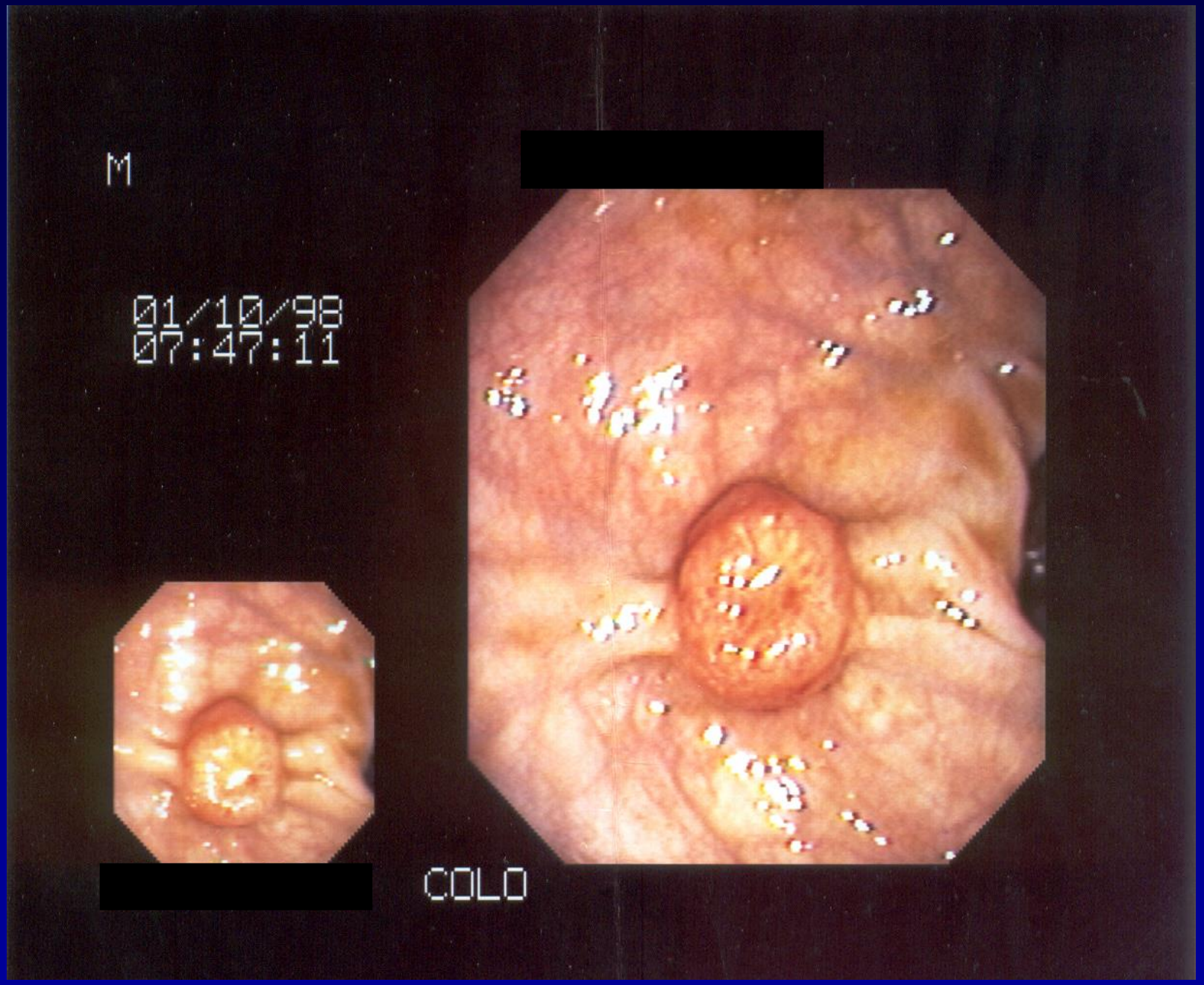
= Technique de BUESS

CANCER DU RECTUM

EXERESE LOCALE : VOIE TRANS-ANALE

Critères :

- **Tumeur < 3 cm ø**
- **uT1, N0**
- **marge saine ≥ 1 cm**
- **Moy à bien différencié**
- **≤ 1/3 circonférence rectale**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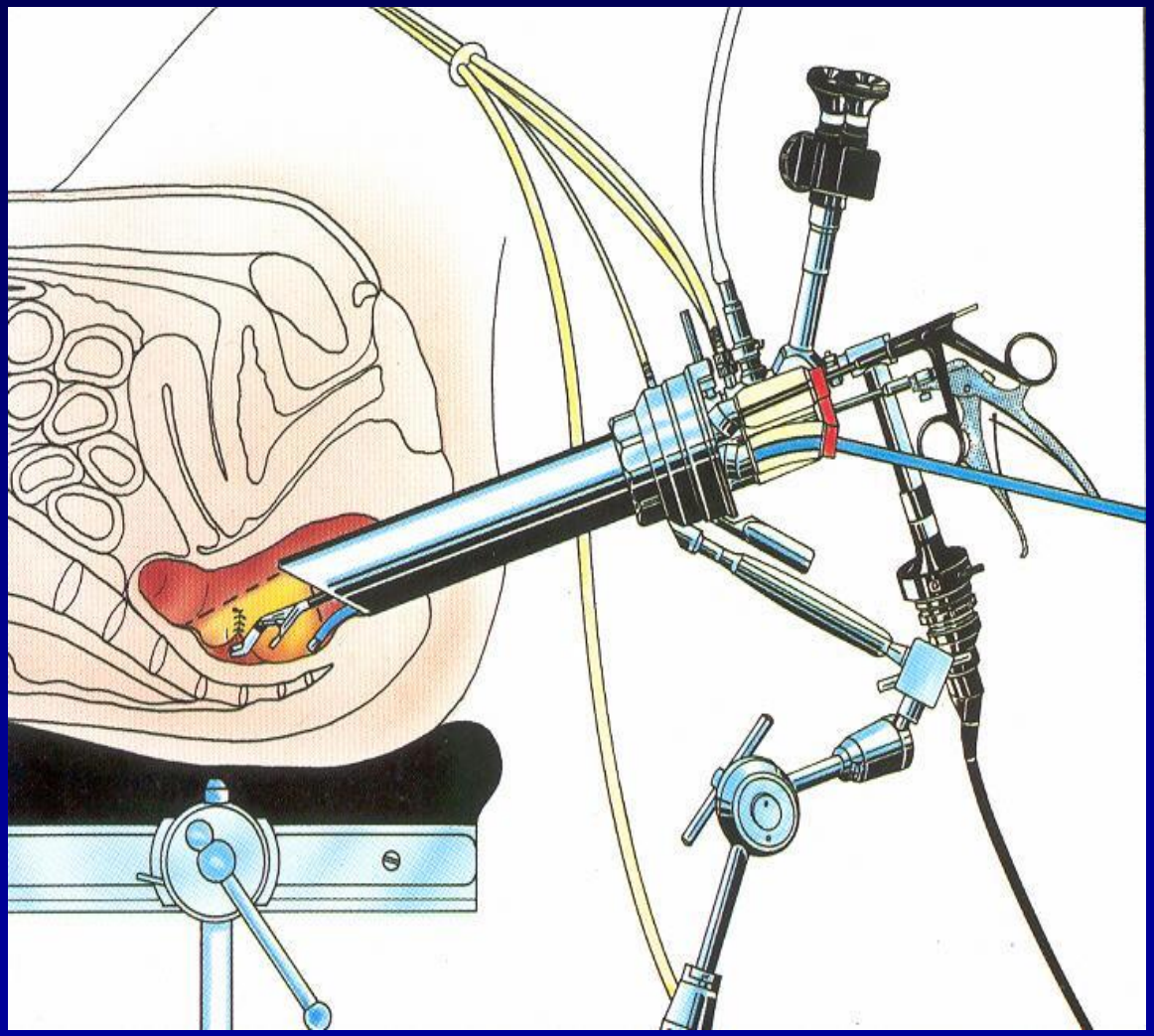
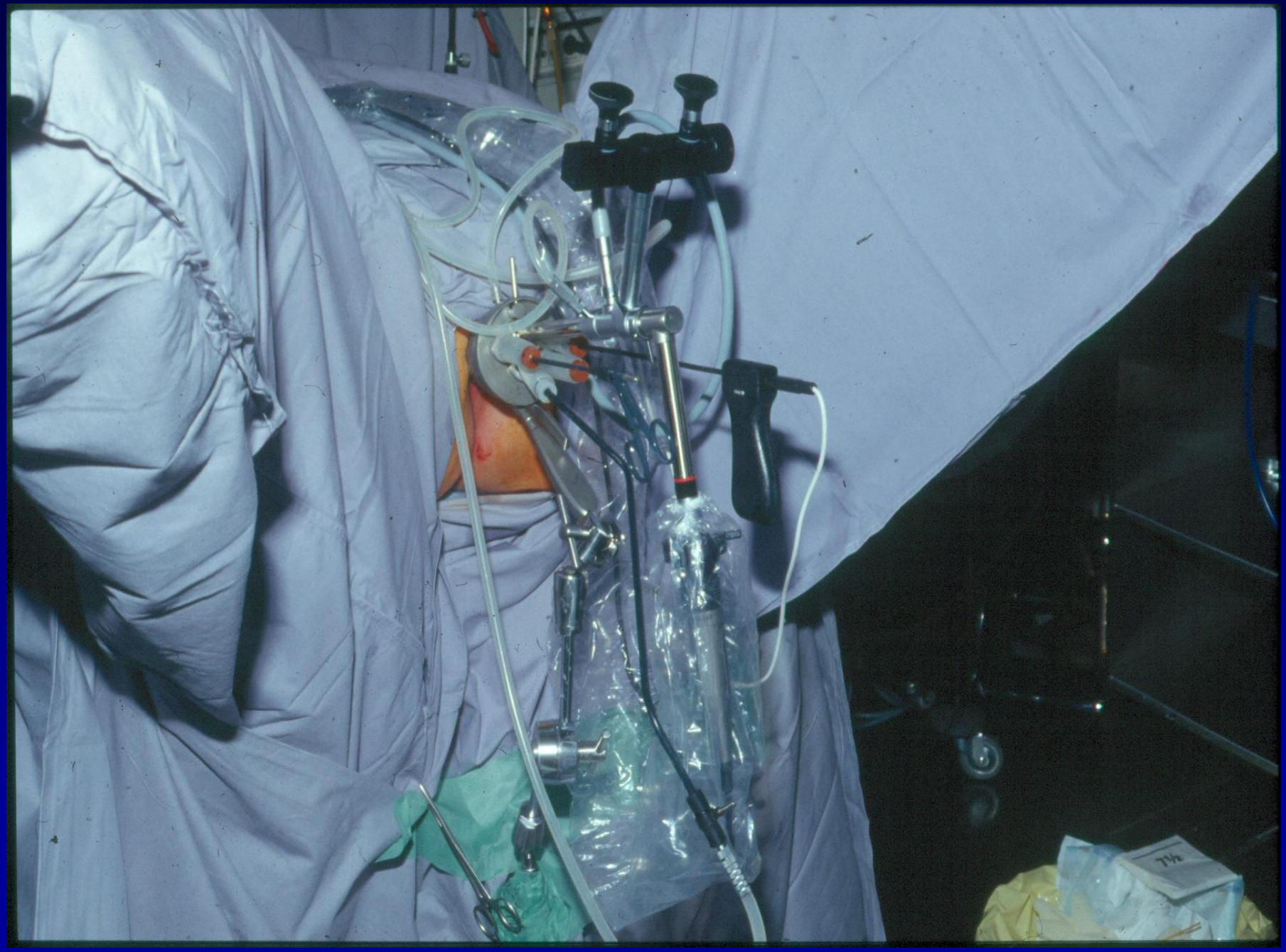
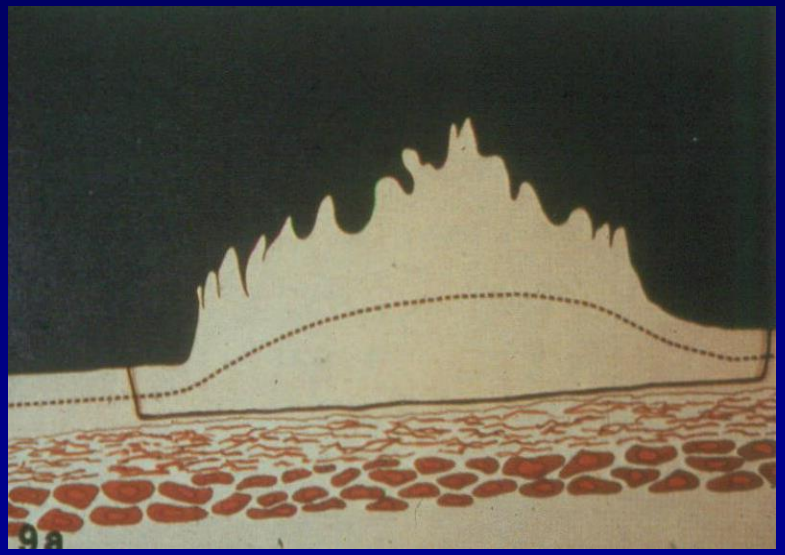
TRANS-ANAL ENDOSCOPIC MICROSURGERY
BUESS TECHNIQUE

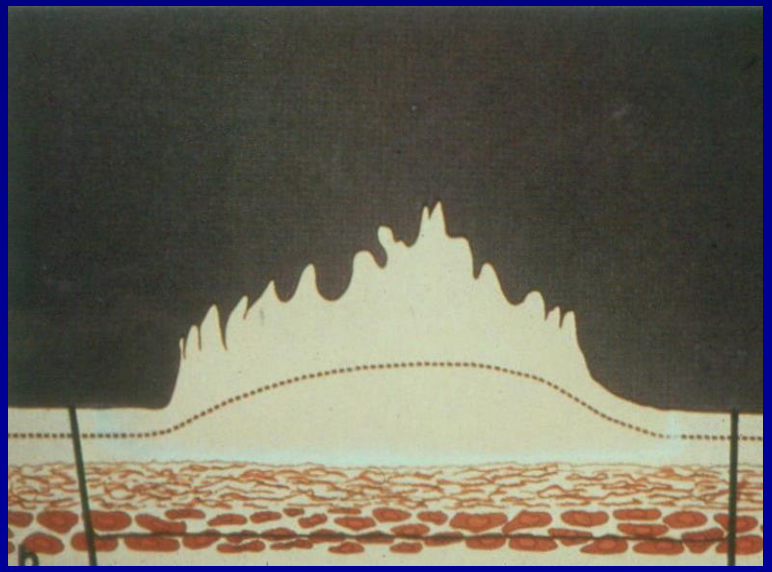


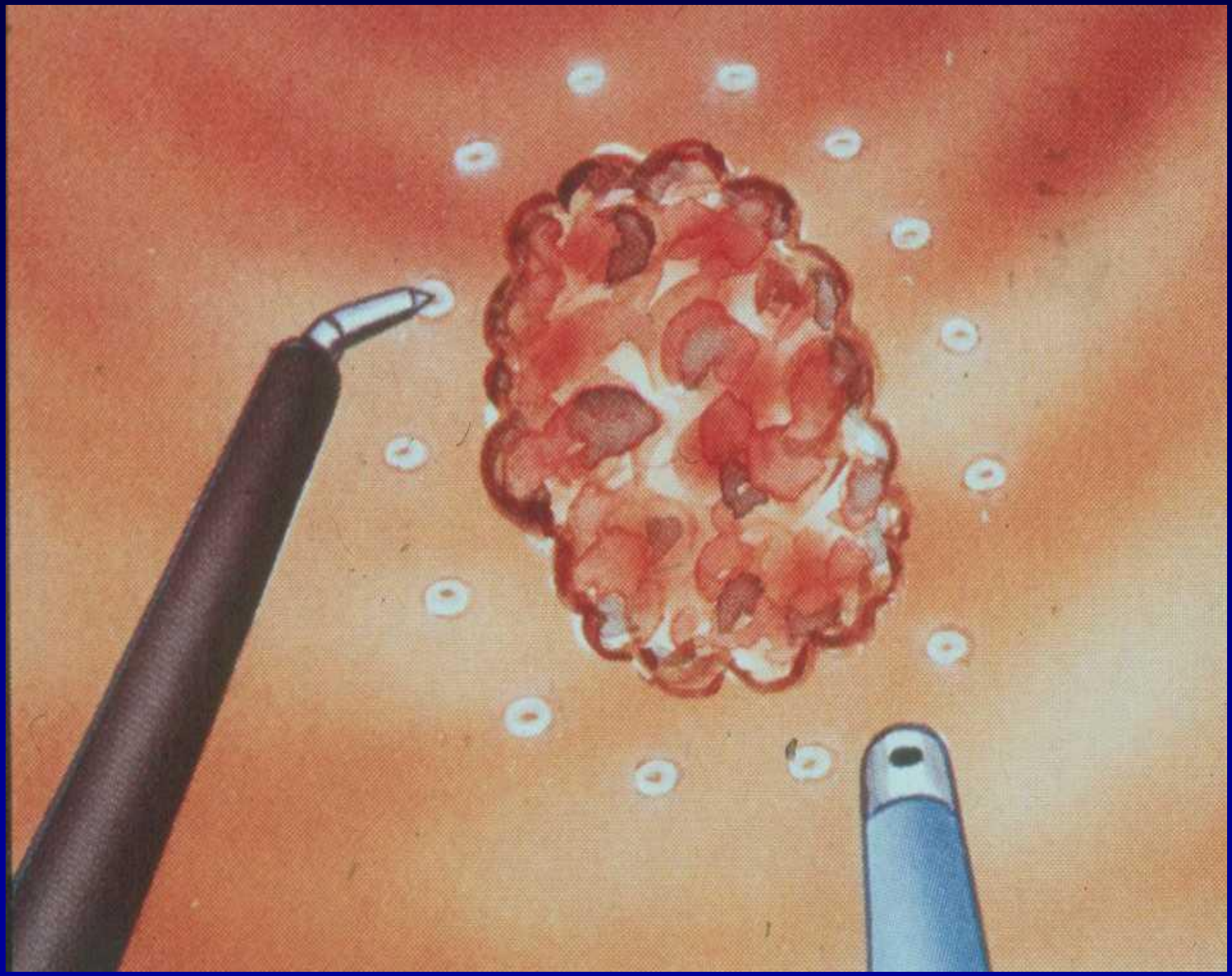


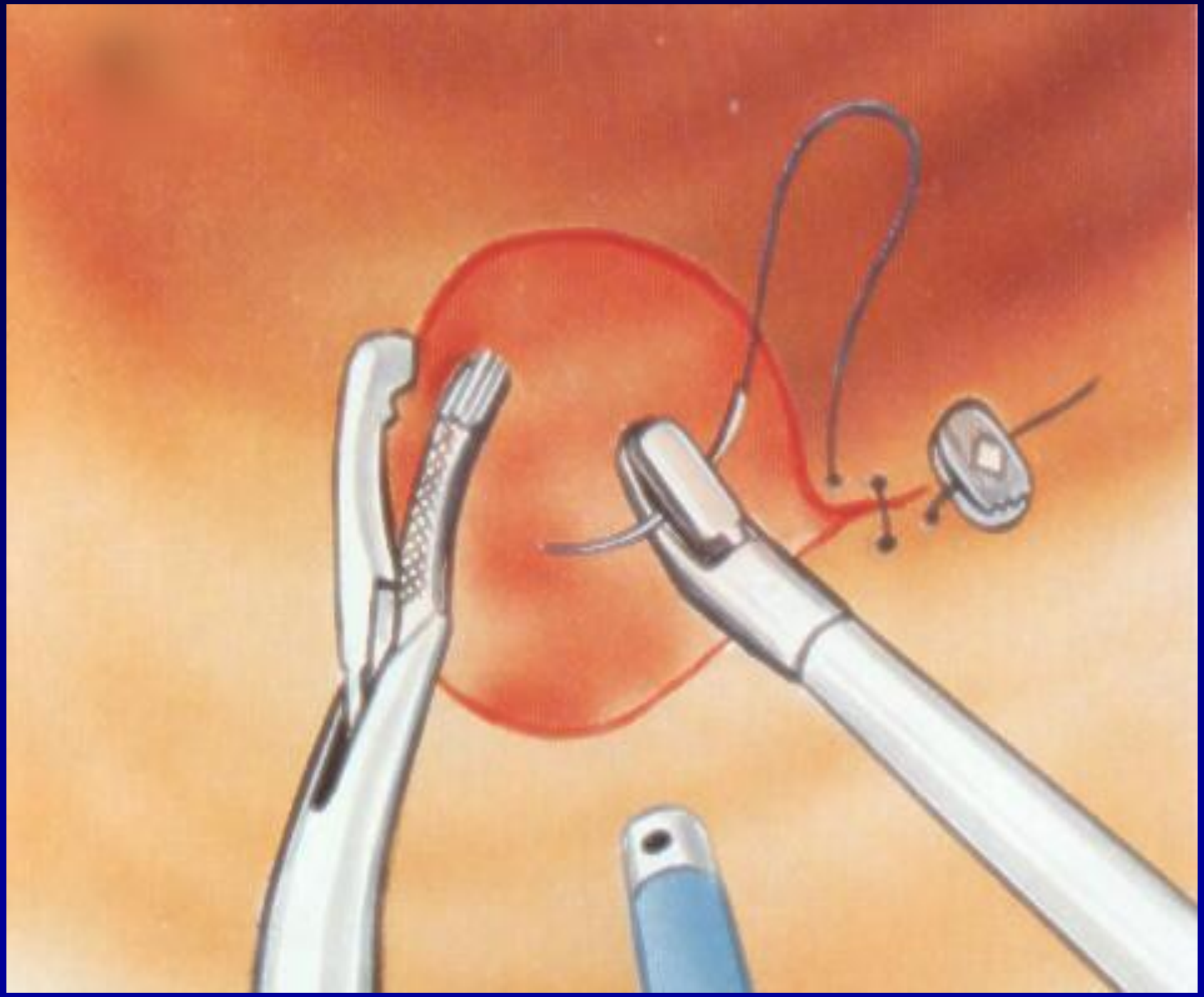
TRANS-ANAL ENDOSCOPIC MICROSURGERY
BUESS TECHNIQUE

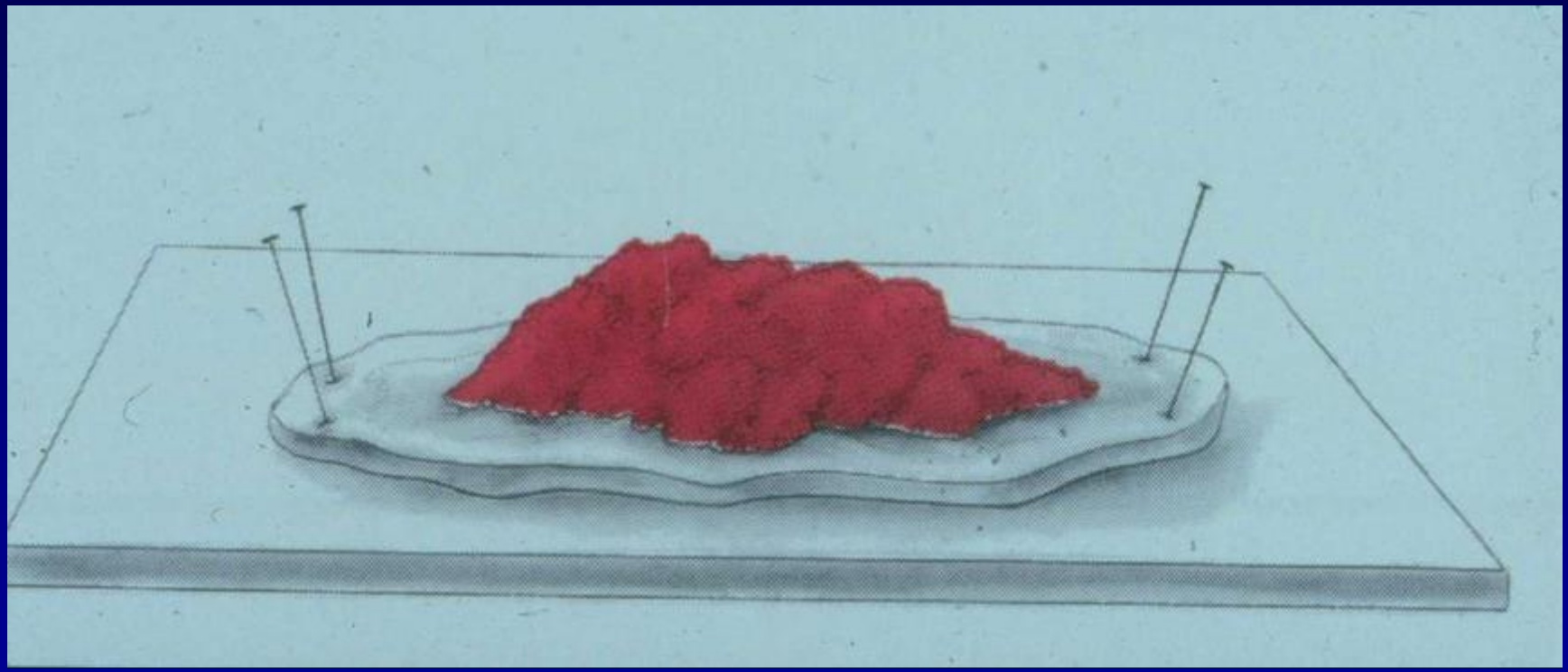
SURGICAL TECHNIQUE

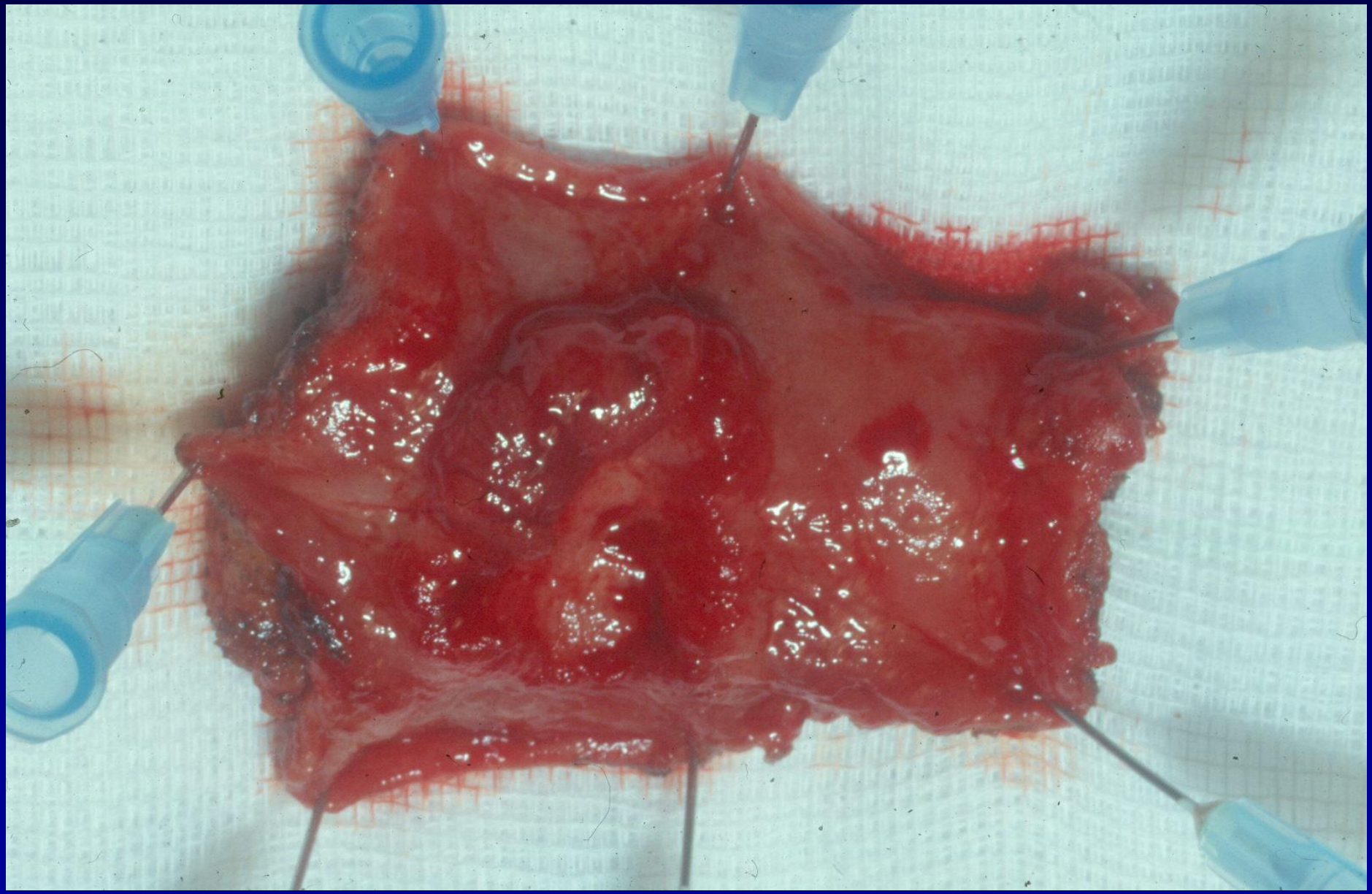


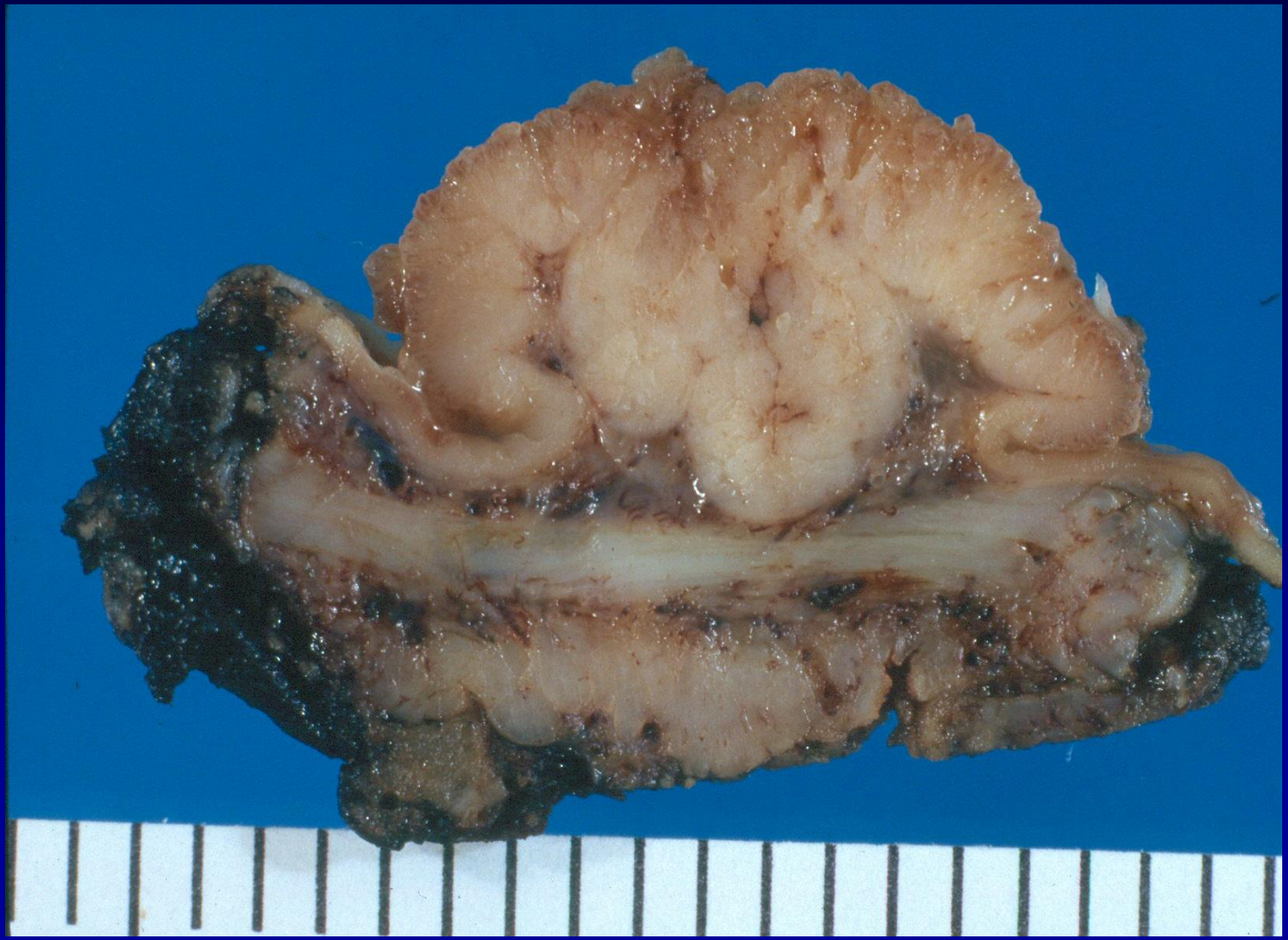


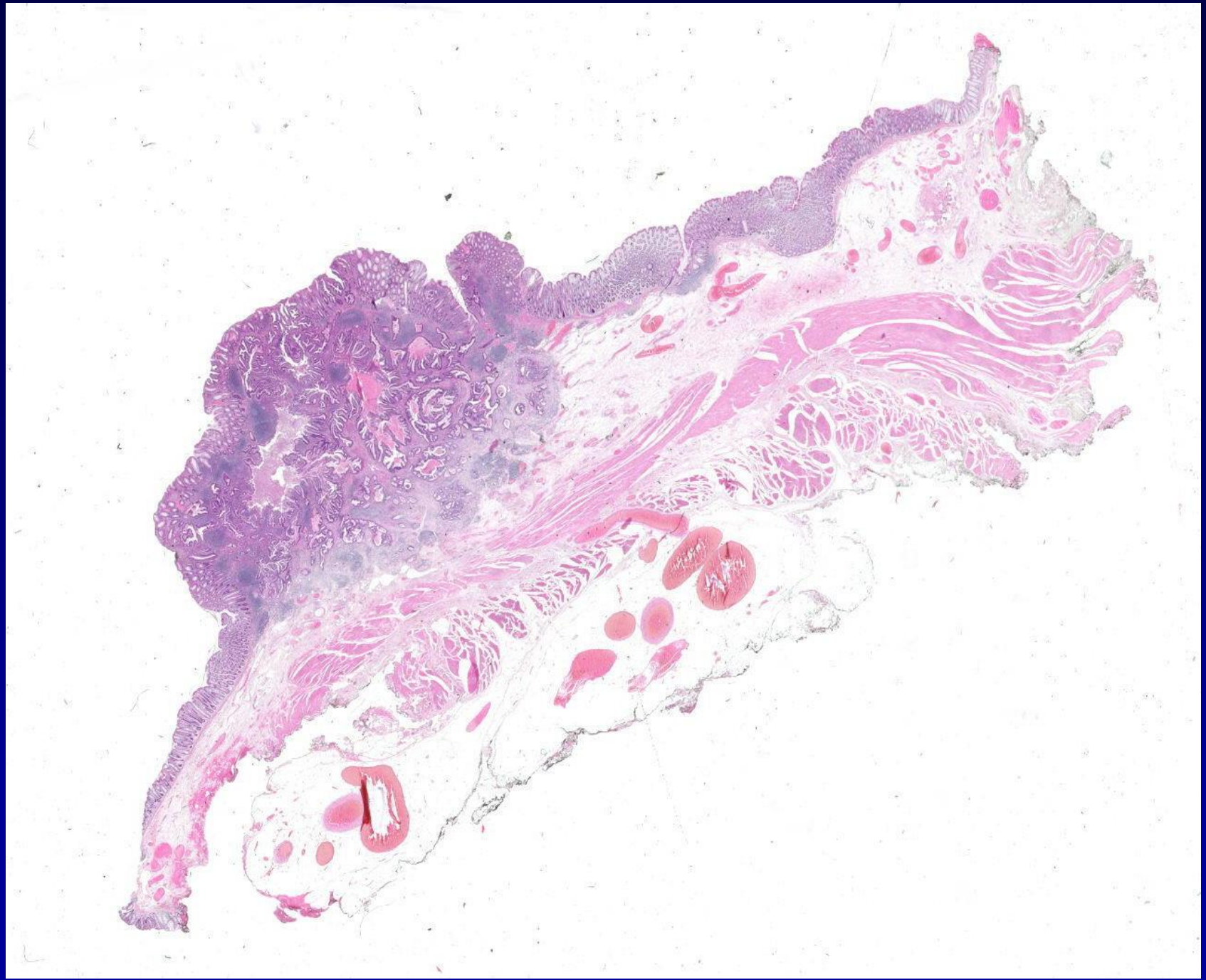


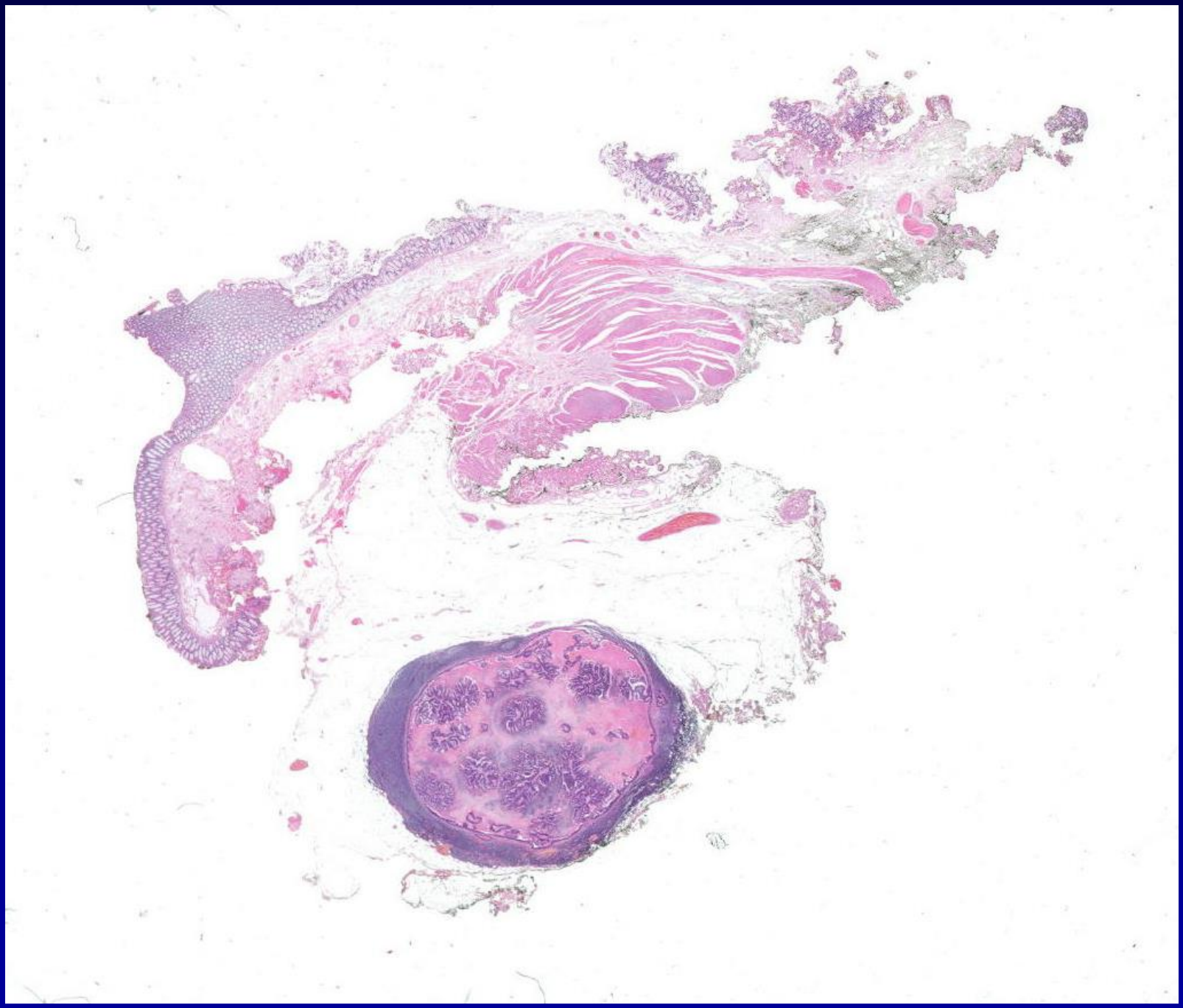












CANCER COLORECTAL : PROGRES RECENTS

Systematic review and meta-analysis of published trials comparing the effectiveness of transanal endoscopic microsurgery and radical resection in the management of early rectal cancer

M. S. Sajid, S. Farag, P. Leung, P. Sains, W. F. A. Miles and M. K. Baig

Department of General and Laparoscopic Colorectal Surgery, Western Sussex Hospitals NHS Trust, Worthing Hospital, Worthing, UK

Received 30 March 2013; accepted 16 July 2013; Accepted Article online 30 October 2013

M.S. Sajid et al., Colorectal Disease, 2013

CHIRURGIE DU CANCER COLORECTAL

M. Conservation rectale après RCT

CHIRURGIE DU CANCER COLORECTAL

Original article

Chemoradiation therapy for rectal cancer in the distal rectum followed by organ-sparing transanal endoscopic microsurgery (CARTS study)

M. Verseveld[1,2], E. J. R. de Graaf[1], C. Verhoef[2], E. van Meerten[3], C. J. A. Punt[5], I. H. J. T. de Hingh[6], I. D. Nagtegaal[7], J. J. M. E. Nuyttens[4], C. A. M. Marijnen[9] and J. H. W. de Wilt[8], on behalf of the CARTS Study Group*

[1]Department of Surgery, IJsselland Hospital, Capelle aan den IJssel, [2]Division of Surgical Oncology, Department of Surgery, [3]Department of Medical Oncology and [4]Department of Radiotherapy, Erasmus MC Cancer Institute, Rotterdam, [5]Department of Medical Oncology, Amsterdam Medical Centre, Amsterdam, [6]Department of Surgery, Catharina Hospital, Eindhoven, Departments of [7]Pathology and [8]Surgery, Radboud University Medical Centre, Nijmegen, and [9]Department of Clinical Oncology, Leiden University Medical Centre, Leiden, The Netherlands

Correspondence to: Dr J. H. W. de Wilt, Department of Surgery, Radboud University Nijmegen Medical Centre, Postbus 9101, 6500 HB Nijmegen, The Netherlands (e-mail: hans.dewilt@radboudumc.nl)

Verseveld M. et al, BJS 2015; 102: 853-860

CHIRURGIE DU CANCER COLORECTAL

Conclusion:

TEM after chemoradiotherapy enabled organ preservation in one-half of the patients with rectal cancer.

Verseveld M. et al, BJS 2015; 102: 853-860

CHIRURGIE COLORECTALE
Vers un plus grand respect de l'intégrité corporelle

N. Endoscopic Trans-Anal Resection: ETAR

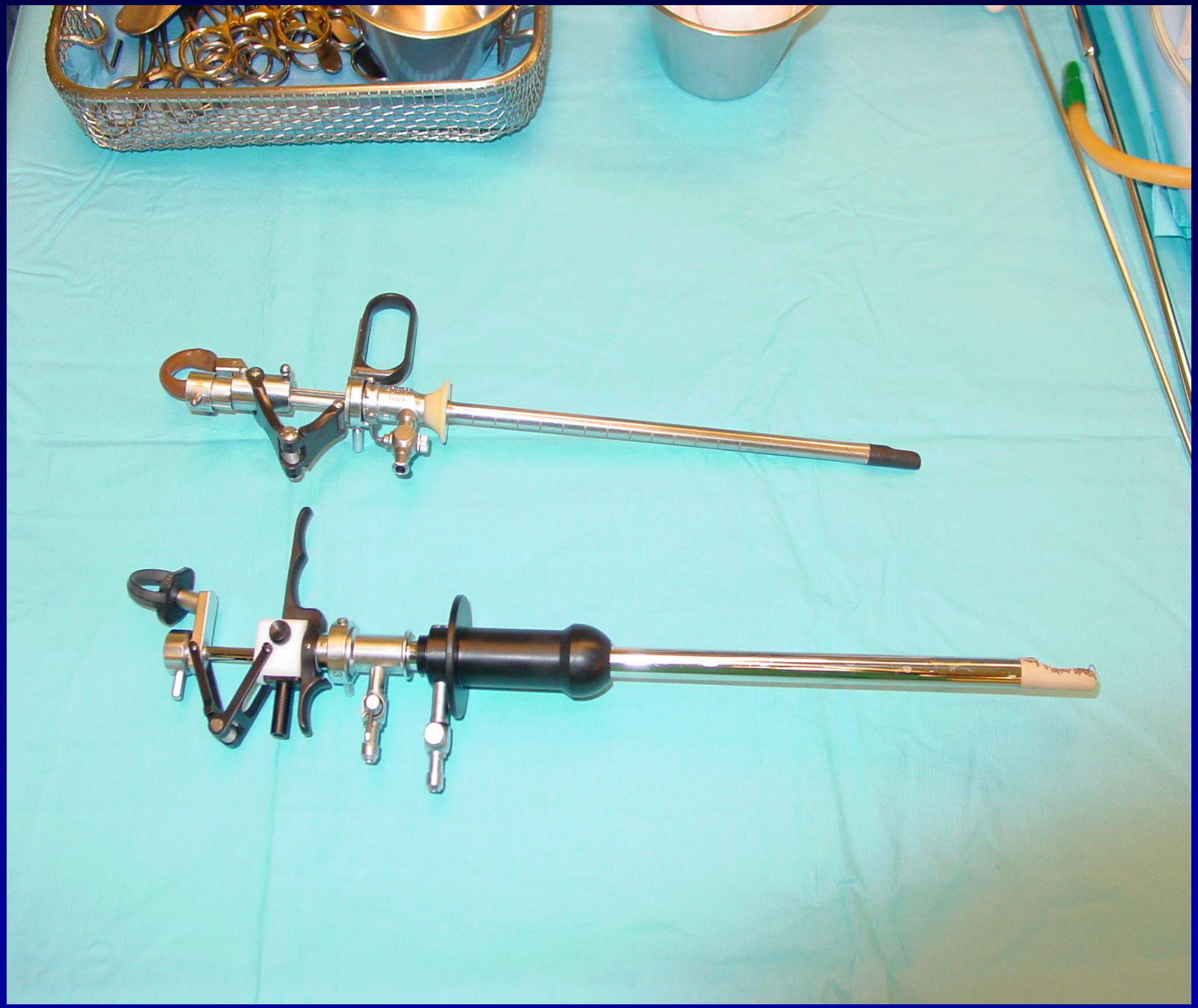
« Résection endoscopique transanale»

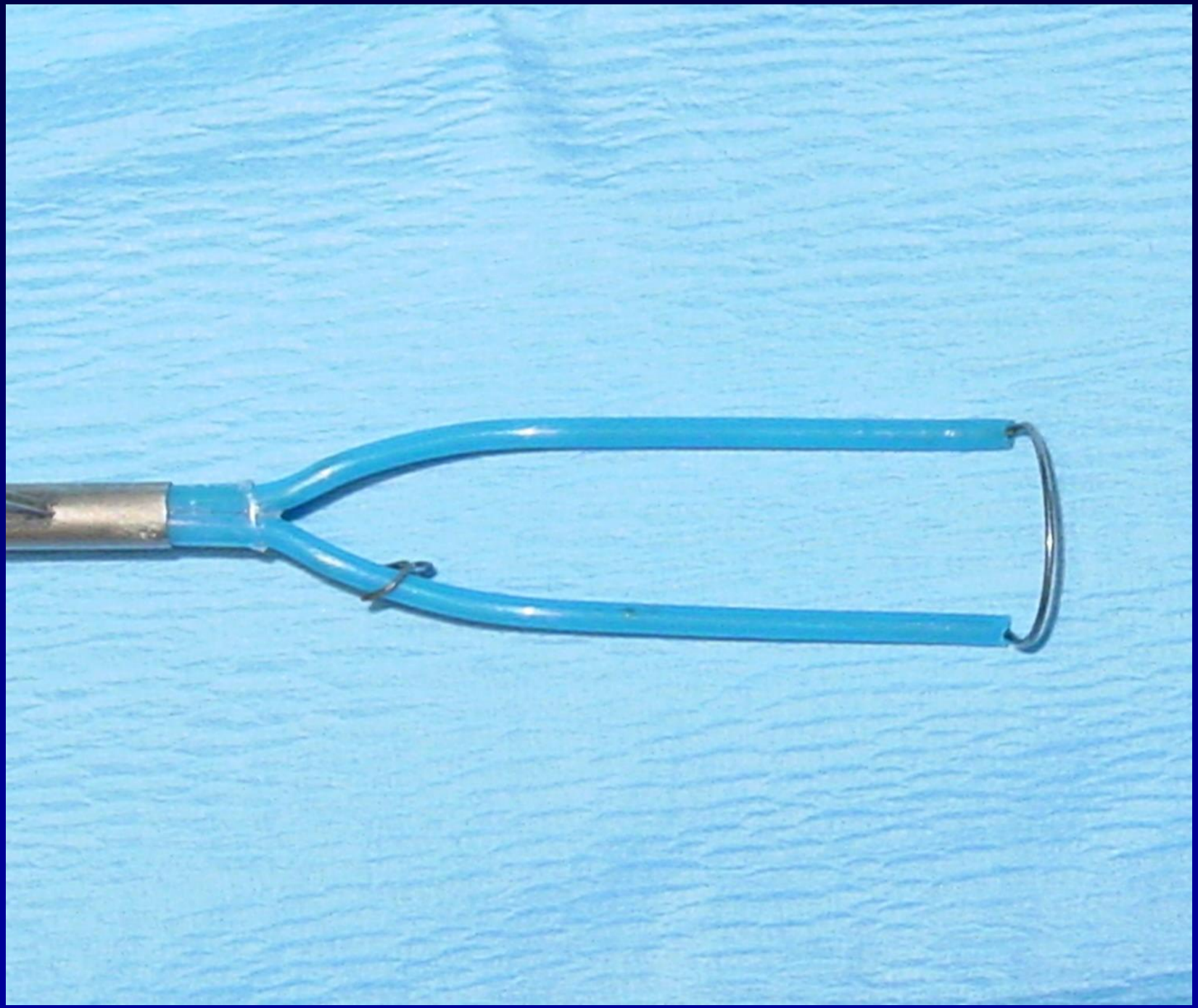
CANCER DU RECTUM

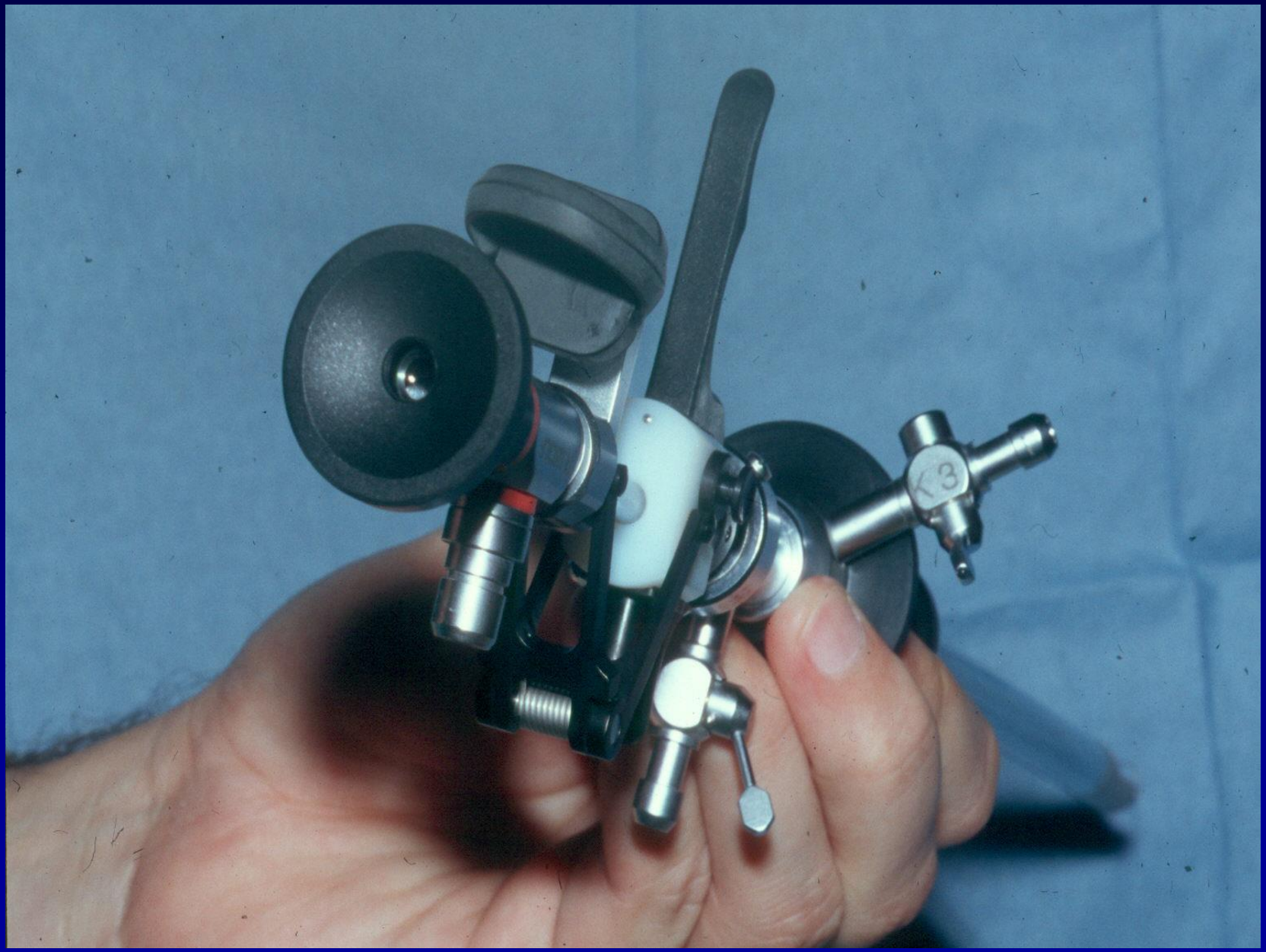
ETAR

=

CHIRURGIE PALLIATIVE



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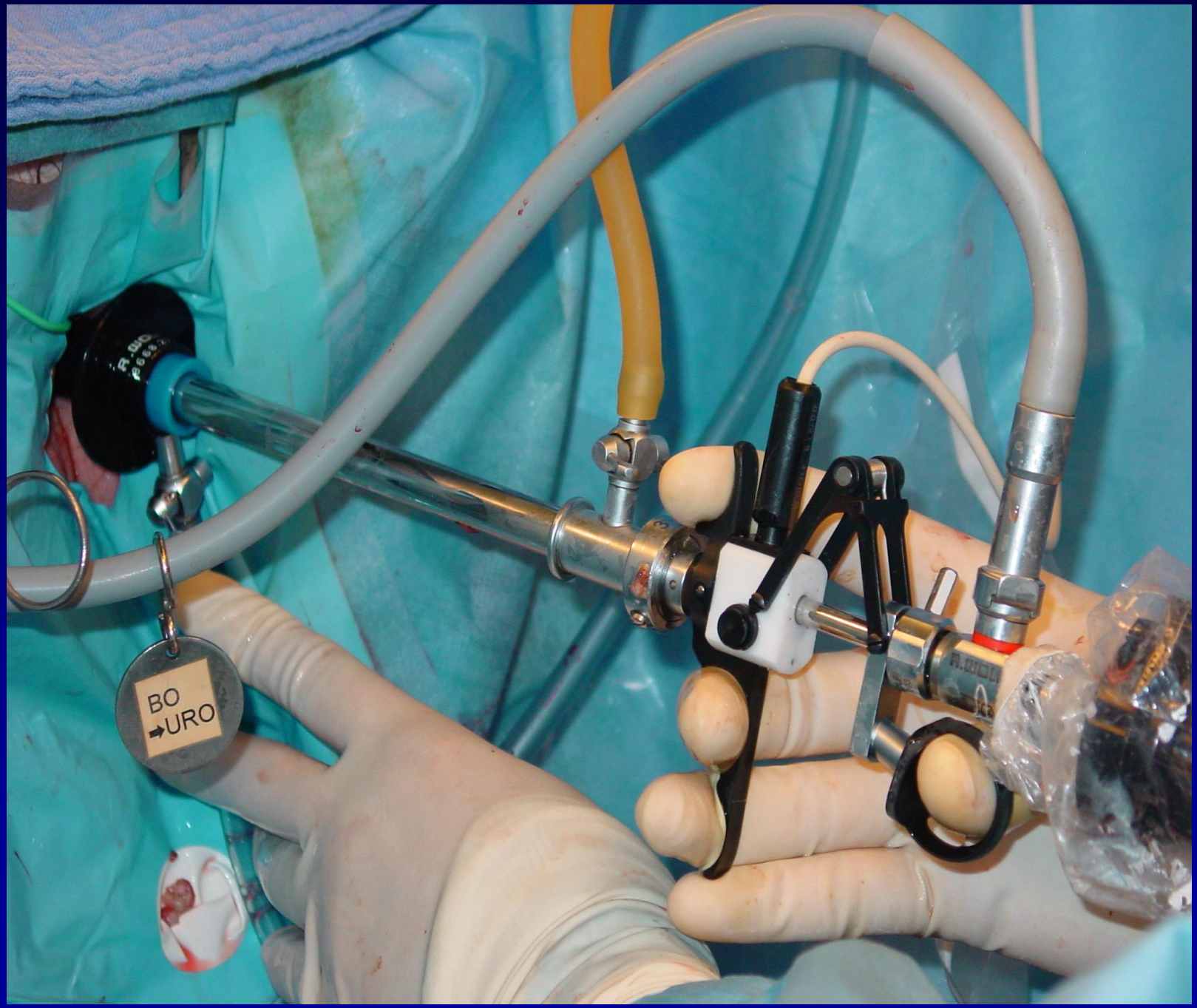
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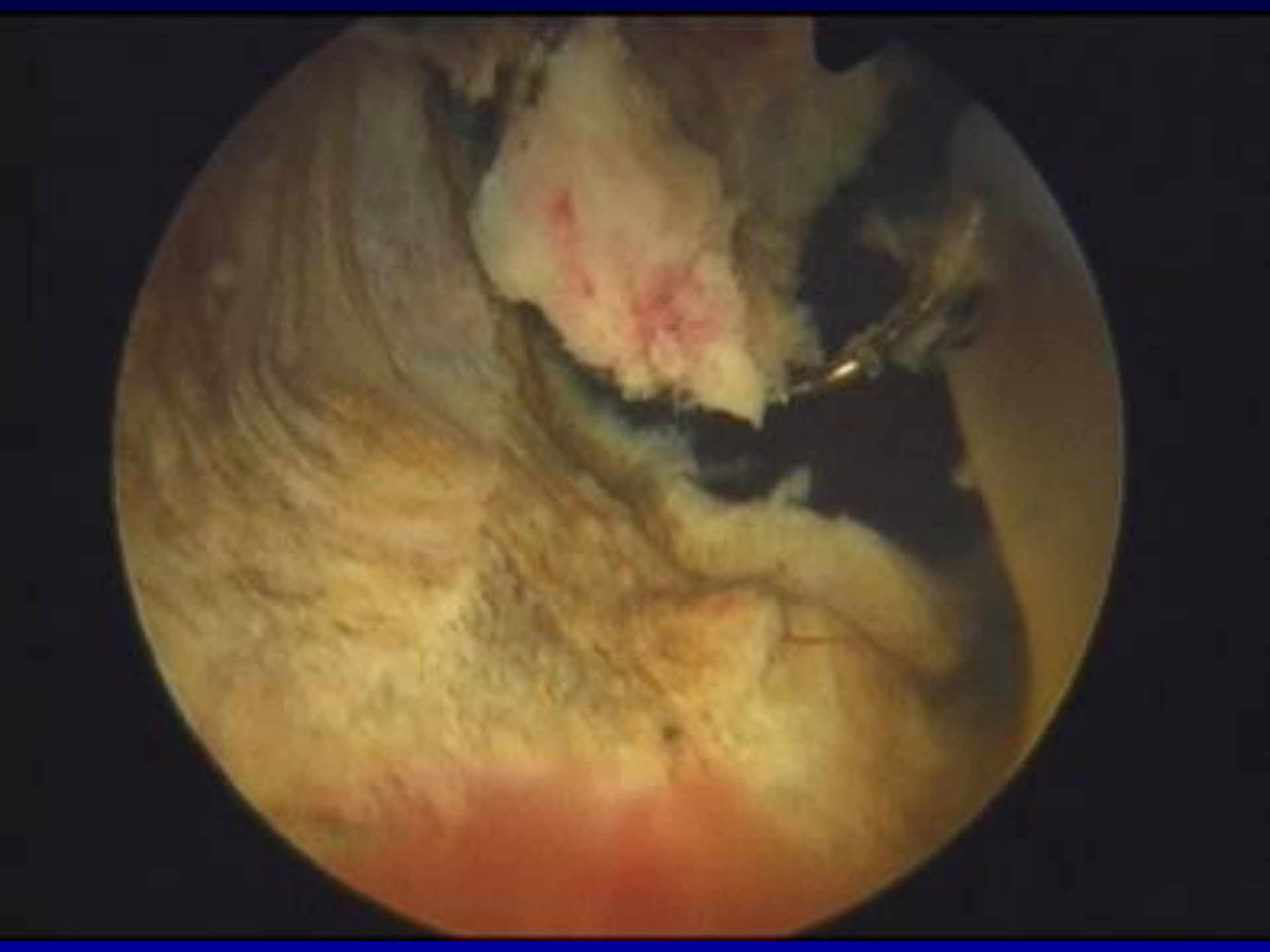
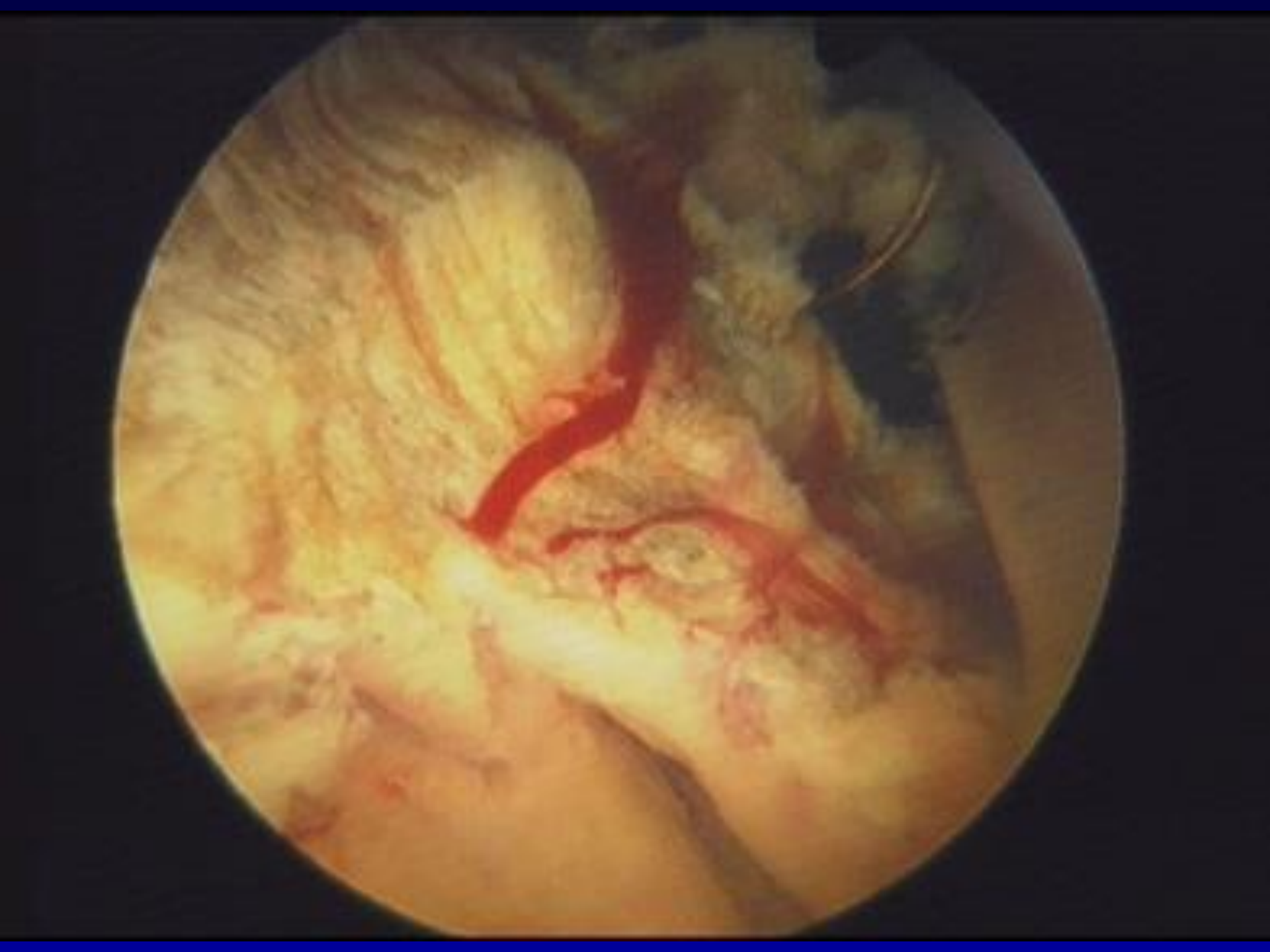
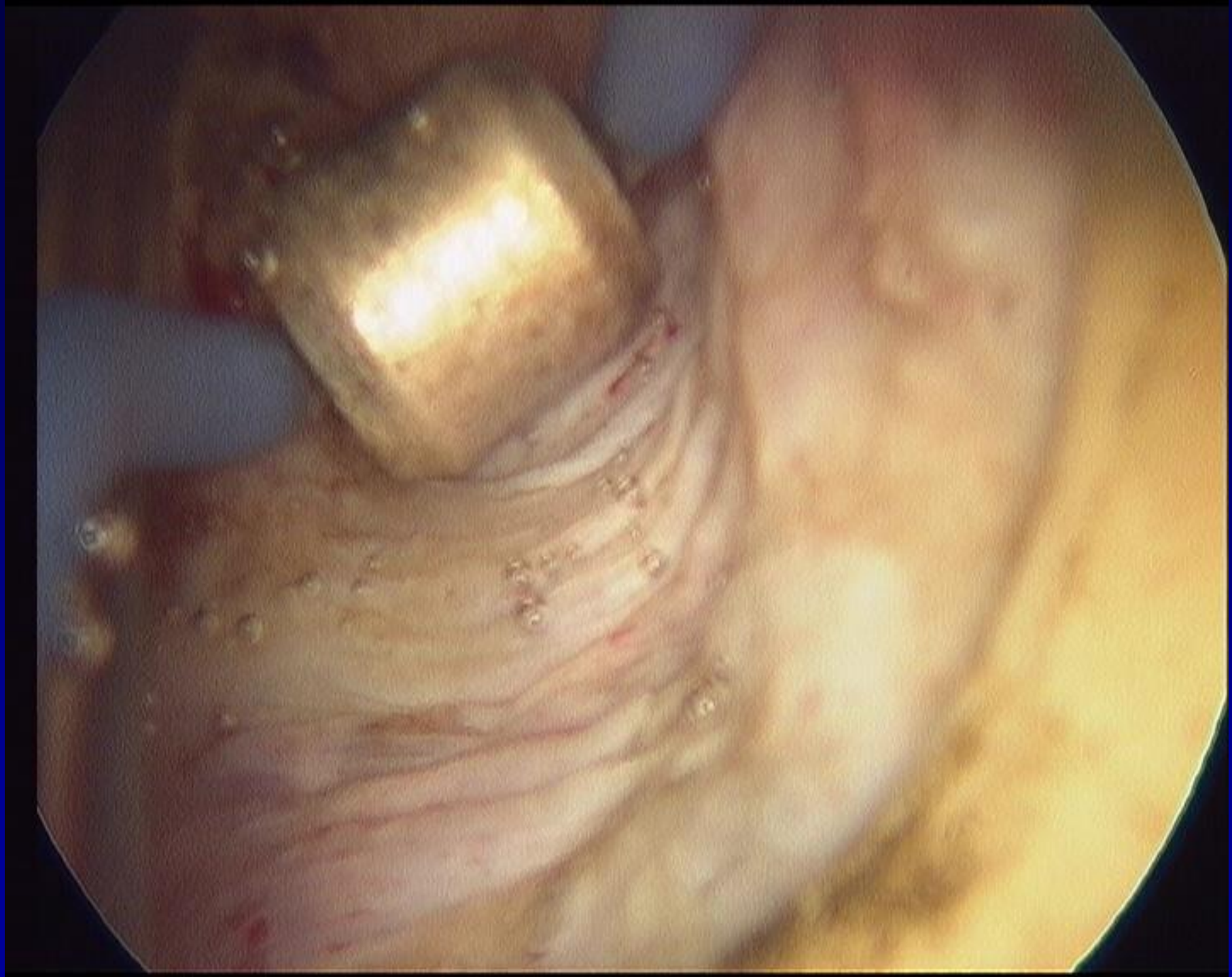
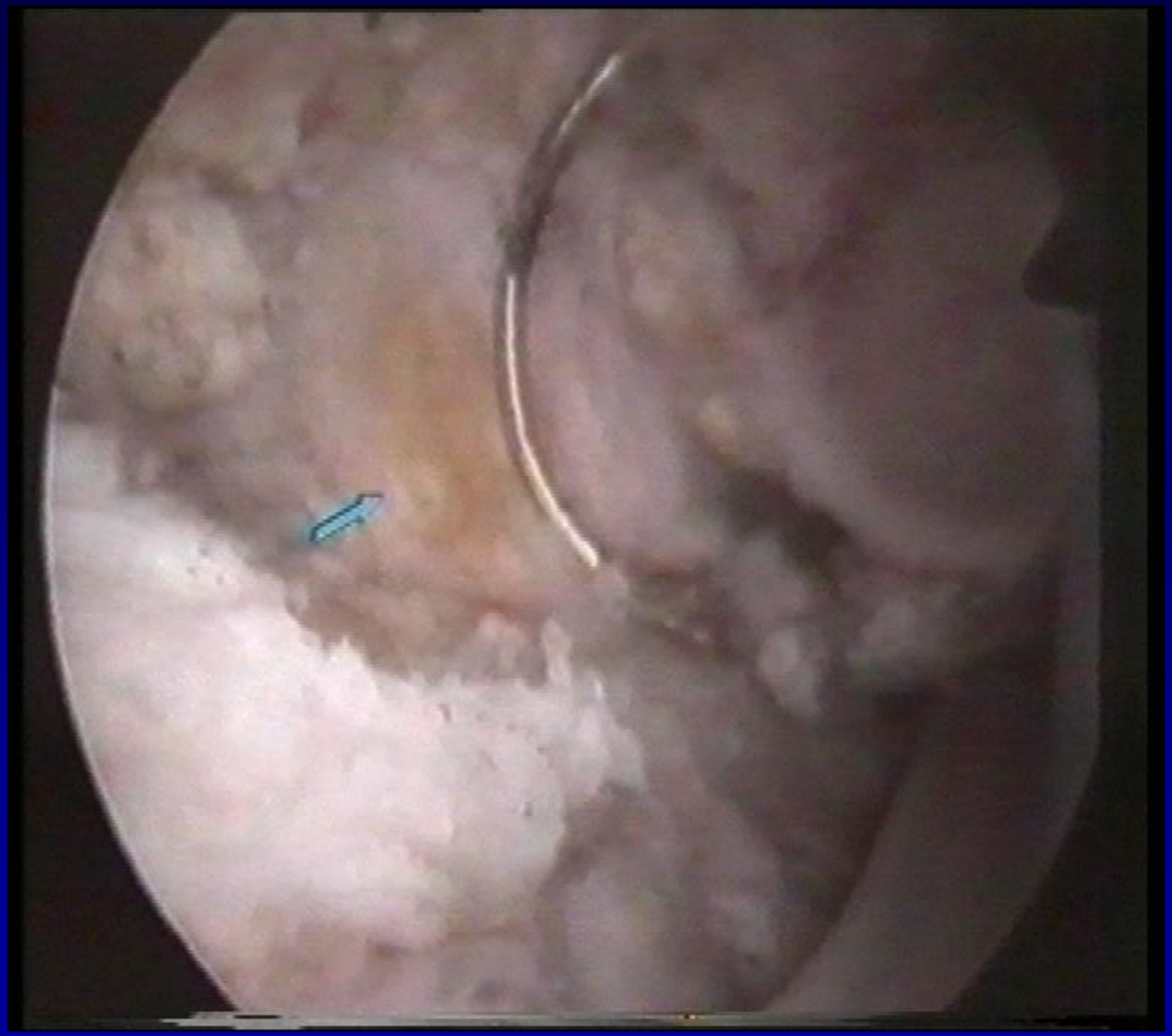








CHIRURGIE COLORECTALE
Vers un plus grand respect de l'intégrité corporelle

ETAR

Quand faut-il y penser ?

CHIRURGIE COLORECTALE
Vers un plus grand respect de l'intégrité corporelle

ETAR

- Pour toute tumeur « palliative » du rectum:
  - Métastases généralisées
  - Occlusion
  - Rectorragie
  - Ténesme
  - Emission de mucus +++

ENDOSCOPIC TRANS-ANAL RESECTION: ETAR

RESULTS : PALLIATION

N° time	Author	Year	Pat.	Procedures	Morbidity	Mortality	Symptom Relief	Median survival
1.	HAMY	2003	46	76	6 (8%)	1 (2%)	87%	14 mo.
2.	SUTTON	2002	17	30	2 (12%)	1 (6%)	76%	
3.	CHEN	2001	24	70	1 (4%)	1 (4%)	75%	6 mo.
4.	ZIANI	2001	37	60	6 (10%)	1 (2,7%)	86%	14 mo.
5.	ARNAUD	1996	24		18,5%	0 (0%)	89%	

CHIRURGIE DU CANCER COLORECTAL

O. CHIMIO HYPERTHERMIE INTRA-PERITONEALE: CHIP

CANCER DU COLON

CARCINOSE PERITONEALE

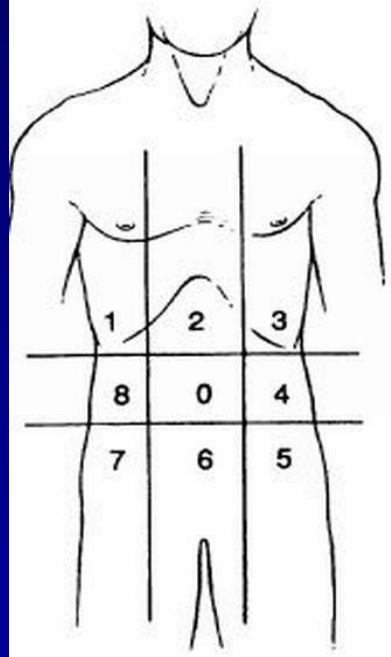
- « CYTOREDUCTION » chirurgicale complète
- Chimio-Hyperthermie Intra-Péritonéale:

  = CHIP

  - Oxaliplatine
  - 43 °C
- Survie : 35% - 45% à 5 ans

PCI Sugarbaker

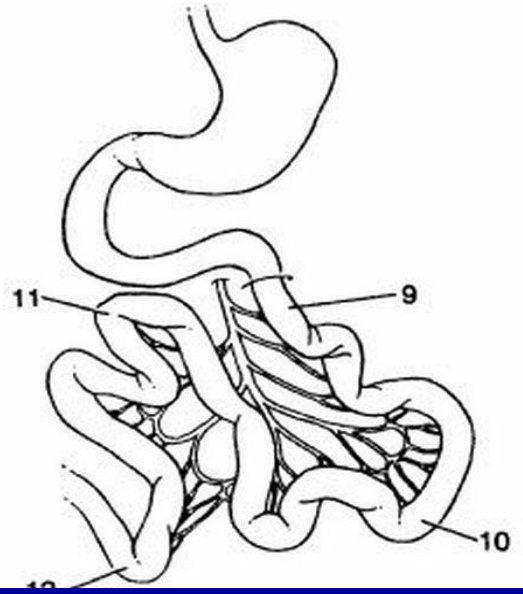
Peritoneal Cancer Index

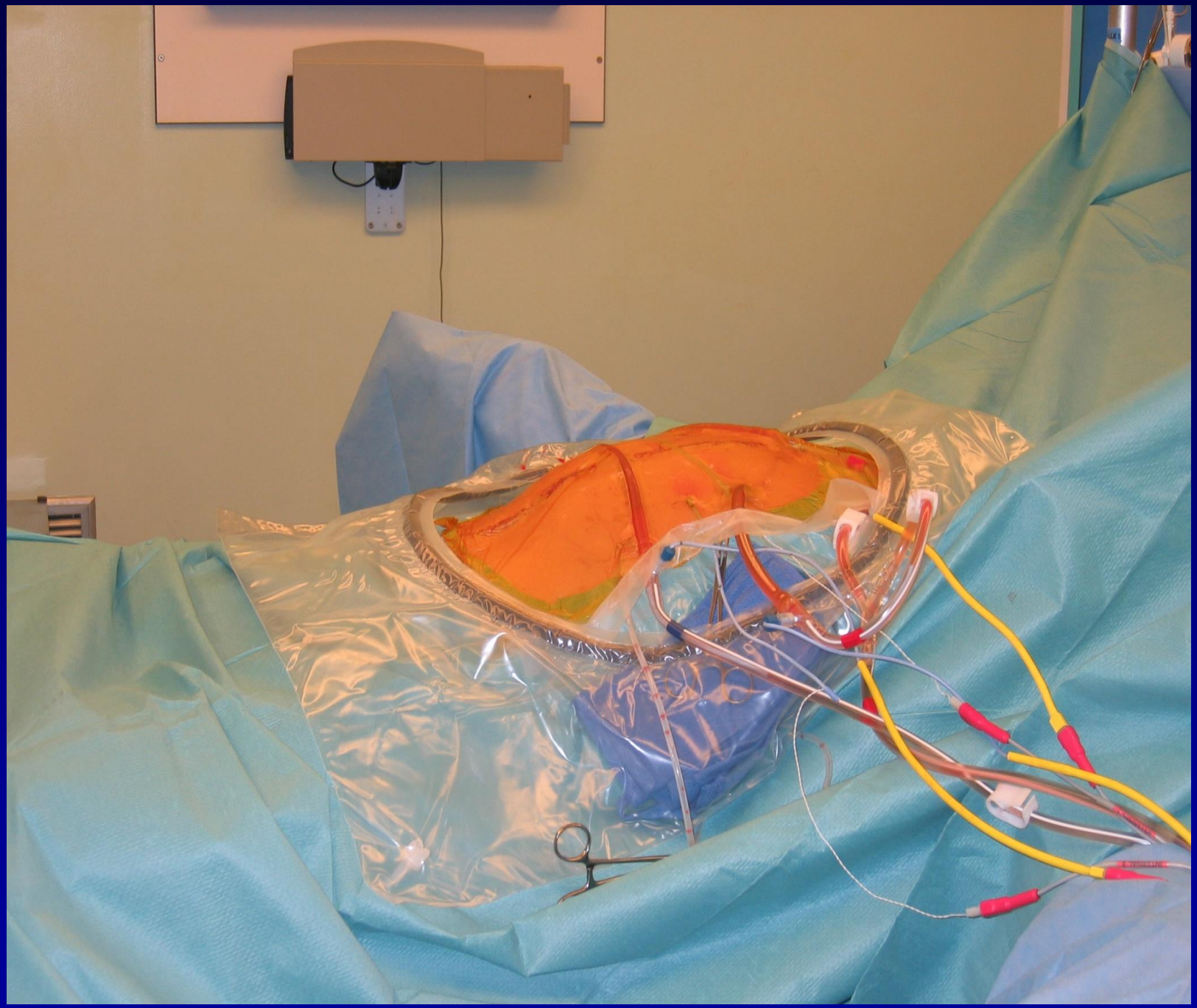


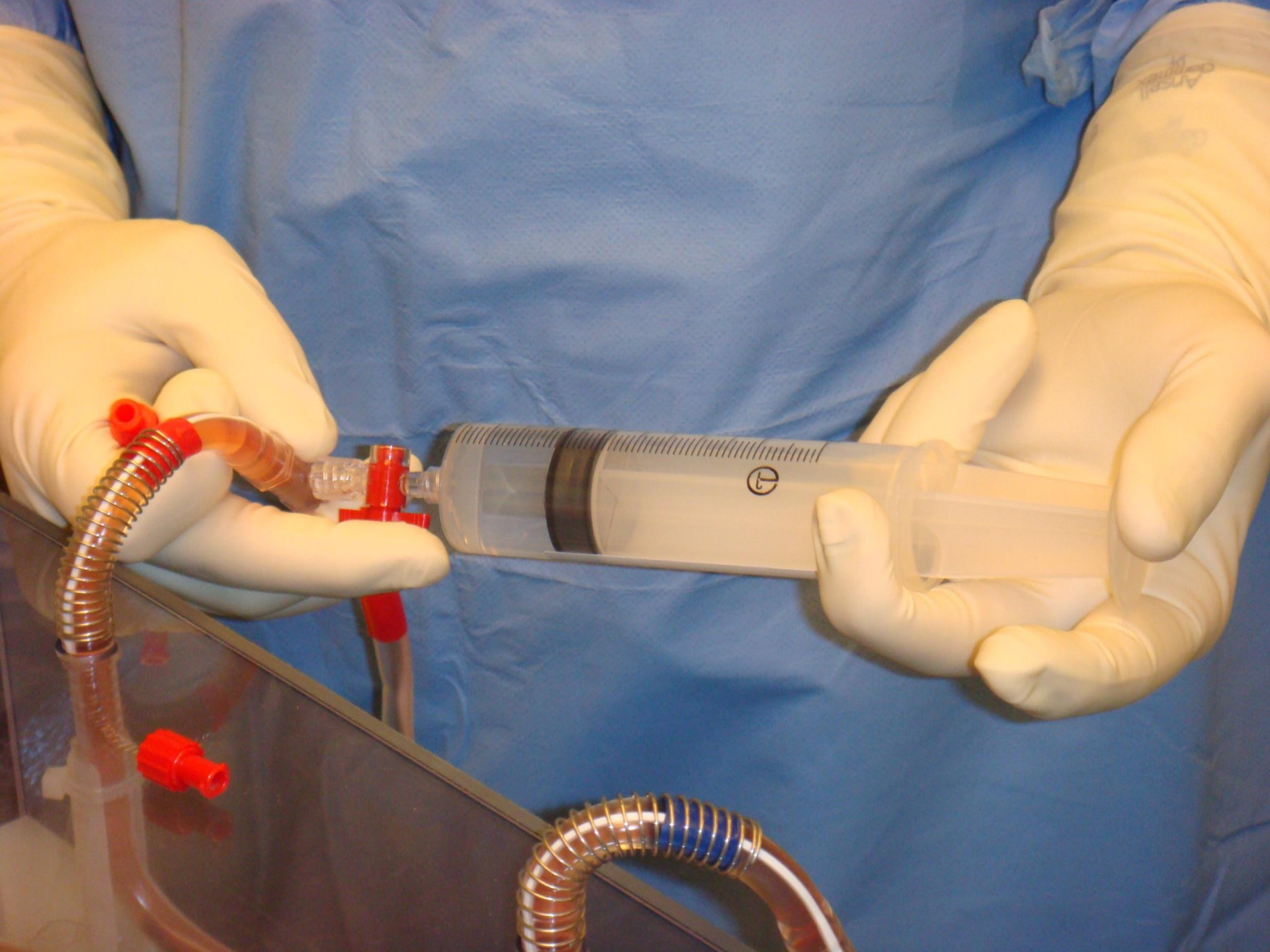
Regions	Lesion Size
0 Central	____
1 Right Upper	____
2 Epigastrium	____
3 Left Upper	____
4 Left Flank	____
5 Left Lower	____
6 Pelvis	____
7 Right Lower	____
8 Right Flank	____
9 Upper Jejunum	____
10 Lower Jejunum	____
11 Upper Ileum	____
12 Lower Ileum	____
PCI	☐

Lesion Size Score

LS 0 No tumor seen
LS 1 Tumor up to 0.5 cm
LS 2 Tumor up to 5.0 cm
LS 3 Tumor > 5.0 cm or confluence







CANCER COLORECTAL : PROGRES RECENTS

Prognostic Similarities and Differences in Optimally Resected Liver Metastases and Peritoneal Metastases From Colorectal Cancers

Dominique Elias, MD, PhD, Matthieu Faron, MD,* Bogdan Stan Iuga, MD,* Charles Honoré, MD,* Frédéric Dumont, MD,* Jean-Louis Bourgain, MD,§ Peggy Dartigues, MD,‡ Michel Ducreux, MD, PhD,† and Diane Goéré, MD, PhD**

D. Elias et al., Annals of Surgery, 2015

CANCER COLORECTAL : PROGRES RECENTS

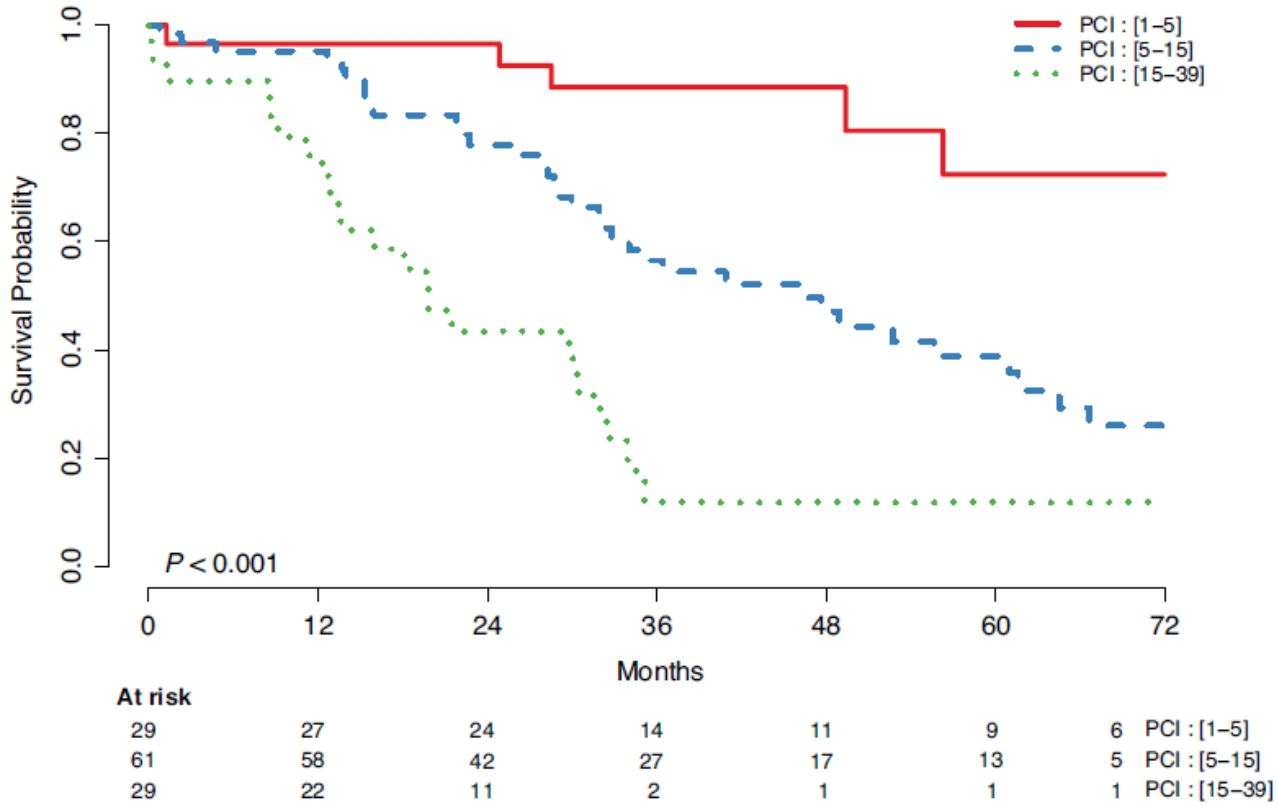


FIGURE 3. Overall survival rates of the 119 patients treated with CCRS plus intraperitoneal chemotherapy according to the PCI score.

D. Elias et al., Annals of Surgery, 2015

CHIRURGIE DU CANCER COLORECTAL

Prophylo-CHIP: 2nd look

Concept du « 2nd look »

ORIGINAL ARTICLE

Results of Systematic Second-look Surgery Plus HIPEC in Asymptomatic Patients Presenting a High Risk of Developing Colorectal Peritoneal Carcinomatosis

D Elias, MD, PhD, C Honoré, MD,* F Dumont, MD,* M. Ducreux, MD, PhD,† V. Boige, MD, PhD,† D. Malka, MD, PhD,† P. Burtin, MD,† C. Dromain, MD,‡ and D. Goéré, MD**

Elias D et al., Ann Surg 2011

CHIRURGIE DU CANCER COLORECTAL

CHIP « Palliative »: PIPAC

CHIRURGIE DU CANCER COLORECTAL

PIPAC

PRESSURIZED
INTRA-
PERITONEAL
AEROSOL
CHEMOTHERAPY

CHIRURGIE DU CANCER COLORECTAL

PIPAC

Ann Surg Oncol (2013) 20:3504–3511
DOI 10.1245/s10434-013-3039-x

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – GASTROINTESTINAL ONCOLOGY

Pressurized Intraperitoneal Aerosol Chemotherapy (PIPAC): Occupational Health and Safety Aspects

Wiebke Solaß, MD[1], Urs Giger-Pabst, MD[2], Jürgen Zieren[2], and Marc A. Reymond[2]

[1]Department of Pathology, Ruhr University Bochum, Bochum, Germany; [2]Department of Surgery, Ruhr University Bochum, Bochum, Germany

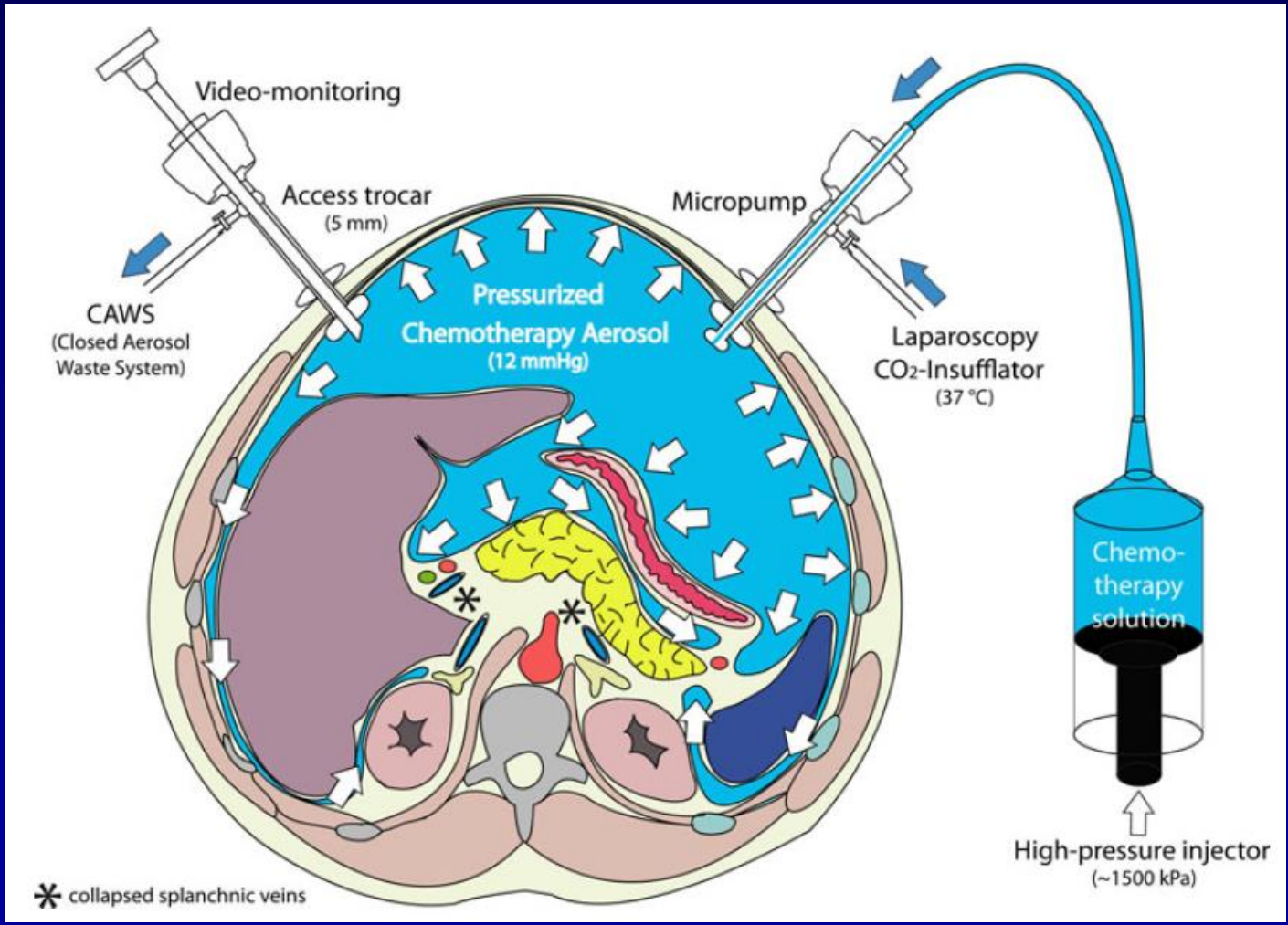
CHIRURGIE DU CANCER COLORECTAL

PIPAC

- **Indications:**
  - **Carcinose péritonéale non-opérable**
  - **En néo-adjuvant avant CHIP**

CHIRURGIE DU CANCER COLORECTAL

PIPAC



CHIRURGIE DU CANCER COLORECTAL

Conclusions

CHIRURGIE COLORECTALE
Vers un plus grand respect de l'intégrité corporelle

- **1900 – 1980 :**

Chirurgie Colorectale

=

Chirurgie « mutilante »

CHIRURGIE COLORECTALE
Vers un plus grand respect de l'intégrité corporelle

- **1990 – 2016 :**

  Evolution vers une chirurgie plus carcinologique et en même temps…

CHIRURGIE COLORECTALE
Vers un plus grand respect de l'intégrité corporelle

- **1990 – 2016 :**

  …une évolution inéluctable vers un plus grand respect de l'intégrité corporelle

En 2016, la chirurgie reste la pierre angulaire du traitement du cancer colorectal…

…mais elle ne peut plus se concevoir en dehors d'une approche pluridisciplinaire.