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World J Gastroenterol 2017 December 14; 23(46): 8109-8262



**REVIEW**

- 8109** Relation of the IGF/IGF1R system to autophagy in colitis and colorectal cancer

Sipos F, Székely H, Kis ID, Tulassay Z, Múzes G

MINIREVIEWS

- 8120** Retreatment of patients with treatment failure of directacting antivirals: Focus on hepatitis C virus genotype 1b

Kanda T, Nirei K, Matsumoto N, Higuchi T, Nakamura H, Yamagami H, Matsuoka S, Moriyama M

ORIGINAL ARTICLE**Basic Study**

- 8128** Structural shift of gut microbiota during chemo-preventive effects of epigallocatechin gallate on colorectal carcinogenesis in mice

Wang X, Ye T, Chen WJ, Lv Y, Hao Z, Chen J, Zhao JY, Wang HP, Cai YK

- 8140** miR-192-5p regulates lipid synthesis in non-alcoholic fatty liver disease through SCD-1

Liu XL, Cao HX, Wang BC, Xin FZ, Zhang RN, Zhou D, Yang RY, Zhao ZH, Pan Q, Fan JG

- 8152** *In vivo* hepatic differentiation potential of human umbilical cord-derived mesenchymal stem cells: Therapeutic effect on liver fibrosis/cirrhosis

Zhang GZ, Sun HC, Zheng LB, Guo JB, Zhang XL

- 8169** Pharmacokinetics and pharmacodynamics of Shengjiang decoction in rats with acute pancreatitis for protecting against multiple organ injury

Zhu L, Li JY, Zhang YM, Kang HX, Chen H, Su H, Li J, Tang WF

Retrospective Cohort Study

- 8182** Prevalence of- and risk factors for work disability in Dutch patients with inflammatory bowel disease

Spekhorst LM, Oldenburg B, van Bodegraven AA, de Jong DJ, Imhann F, van der Meulen-de Jong AE, Pierik MJ, van der Woude JC, Dijkstra G, D'Haens G, Löwenberg M, Weersma RK, Festen EAM; PARELSNOER Institute and the Dutch Initiative on Crohn and Coliti

Retrospective Study

- 8193** Endoscopic ultrasound staging for early esophageal cancer: Are we denying patients neoadjuvant chemo-radiation?

Luu C, Amaral M, Klapman J, Harris C, Almhanna K, Hoffe S, Frakes J, Pimiento JM, Fontaine JP

- 8200 Early gastric cancer frequently has high expression of KK-LC-1, a cancer-testis antigen

Futawatari N, Fukuyama T, Yamamura R, Shida A, Takahashi Y, Nishi Y, Ichiki Y, Kobayashi N, Yamazaki H, Watanabe M

- 8207 Diagnostic classification of endosonography for differentiating colorectal ulcerative diseases: A new statistical method

Qiu EQ, Guo W, Cheng TM, Yao YL, Zhu W, Liu SD, Zhi FC

Clinical Trial Study

- 8217 Characteristics of fecal microbial communities in patients with non-anastomotic biliary strictures after liver transplantation

Zhang J, Ren FG, Liu P, Zhang HK, Zhu HY, Feng Z, Zhang XF, Wang B, Liu XM, Zhang XG, Wu RQ, Lv Y

Observational Study

- 8227 Balloon dilatation for treatment of hepatic venous outflow obstruction following pediatric liver transplantation

Zhang ZY, Jin L, Chen G, Su TH, Zhu ZJ, Sun LY, Wang ZC, Xiao GW

Prospective Study

- 8235 Efficacy of noninvasive evaluations in monitoring inflammatory bowel disease activity: A prospective study in China

Chen JM, Liu T, Gao S, Tong XD, Deng FH, Nie B

CASE REPORT

- 8248 Are liver nested stromal epithelial tumors always low aggressive?

Meletani T, Cantini L, Lanese A, Nicolini D, Cimadamore A, Agostini A, Ricci G, Antognoli S, Mandolesi A, Guido M, Alaggio R, Giuseppetti GM, Scarpelli M, Vivarelli M, Berardi R

- 8256 Combined thoracoscopic and endoscopic surgery for a large esophageal schwannoma

Onodera Y, Nakano T, Takeyama D, Maruyama S, Taniyama Y, Sakurai T, Heishi T, Sato C, Kumagai T, Kamei T

LETTER TO THE EDITOR

- 8261 Extended pelvic side wall excision for locally advanced rectal cancers

Shaikh IA, Jenkins JT

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Extended pelvic side wall excision for locally advanced rectal cancers

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Abstract

Extended pelvic side wall excision is a useful technique for treatment of recurrent or advanced rectal cancer involving sciatic notch and does not compromise the dissection of major pelvic vessels and vascular control.

Key words: Recurrent rectal cancers; Extended pelvic side wall excision; Pelvic side wall excision; Advanced rectal cancers

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Core tip: Extended pelvic side wall excision technique does not compromise the dissection of major pelvic vessels and vascular control during pelvic side wall clearance for recurrent/advanced rectal cancer.

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TO THE EDITOR

We read with interest the manuscript published by Lee *et al*^[1], titled "Advances in surgical management for locally recurrent rectal cancer: How far have we come?" published in *World Journal of gastroenterology*. The authors have attempted to appraise the current evidence for the management of locally advanced recurrent rectal cancer. We congratulate them for the exhaustive summary of various techniques employed to achieve R0 resection in these technically challenging

recurrent cancers.

We agree with authors review of the literature on the complexity of managing pelvic recurrence particularly on the side wall involving sciatic nerves, pelvic sidewalls or extending through the sciatic notch. The authors have referenced our report on the novel technique called extended lateral side wall excision (ELSiE) described at St Mark's Hospital^[2]. This particular technique was described to increase R0 resection rate for the rectal cancers involving sciatic nerve, piriformis muscle or the tumours extending through the sciatic notch. In their review authors mention that with this technique it is not possible to control the iliac vessels. We wish to clarify the author's misinterpretation of our reported technique.

ELSiE technique has two stages: (1) Dissection in prone position; and (2) completion of the excision in supine position. The procedure starts in the prone position to dissect piriformis muscle and excise the ischial spine and isolate/excise the sciatic nerve as required. In our experience, this approach gives excellent views of sciatic notch, sacrospinous ligaments, and outer pelvic sidewall^[3]. We believe that this approach also gives better control of the vessels around the sciatic notch and piriformis muscle which are otherwise potentially difficult to control from the abdomino-pelvic approach. The subsequent dissection

of the pelvic side wall *via* abdominal approach remains as described by Austin *et al*^[4], and referenced in the review. By starting in prone position, it does not make any difference to abdominal iliac vascular dissection. Since our original description of the technique, we are in the process of reporting our long term results of more than 50 such procedure and dissection in the prone position has not jeopardised subsequent iliac vascular dissection. We believe this technique offers an additional approach to manage the complex scenario where cancer involves the pelvic sidewall.

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