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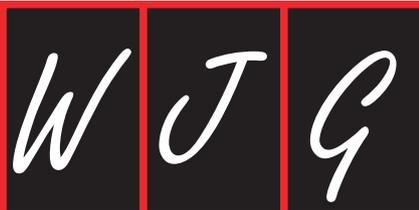
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Extended pelvic side wall excision for locally advanced rectal cancers

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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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