

The total laparoscopic operative time was 4 h out of the 10 h of anaesthesia time. Final histopathological examination showed residual viable adenocarcinoma (pT2N0), negative circumferential resection margin and acellular mucin in the prostate and seminal vesicles, suggesting a good response to chemoradiotherapy. The patient was discharged on postoperative day 9 without any significant morbidity.

Laparoscopic total PE, although technically challenging, can be safely performed in high-volume centres with acceptable morbidity in experienced hands. The long-term oncological benefit of such extended resections remains questionable and deserves well-conducted phase 3 studies.

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Laparoscopic repair of right congenital diaphragmatic hernia with intrathoracic kidney – a video vignette

Dear Editor,

A congenital diaphragmatic hernia is caused by failure of the postero-lateral diaphragmatic foramina to close and it usually therefore presents in the neonatal period. Adult cases are rare, with a frequency of 0.17–6% of all diaphragmatic hernias [1,2]. Mini-invasive surgery helps in clearly delineating the anatomy and helps with early recovery [3–5].

A 61-year-old woman presented to hospital with non-specific epigastric pain. There was no history of intervention or major trauma. A CT scan revealed that the right hepatic flexure, the omentum and the right kidney had herniated into the thorax. Surgery was indicated because of the persistent stretch of the renal pedicle due to its high position in the thorax. The patient underwent laparoscopic hernia repair. The herniated contents were carefully reduced into the peritoneal cavity without damaging the kidney or its pedicle. After placing the herniated organs into the abdominal cavity, a primary closure of the diaphragmatic defect with non-absorbable sutures was performed. Synthetic mesh was placed over the defect and fixed with metallic clips.

Postoperative recovery was uneventful. The patient was discharged home 8 days after the procedure with normal renal and pulmonary function. After 3 months, physical and radiological examination showed no signs of recurrence and her symptoms had improved.

Laparoscopic diaphragmatic hernia repair appears to be a safe and feasible procedure and is a good option even with large defects and herniation of intra-peritoneal and retro-peritoneal organs.

Conflict of Interest

Authors declare that they have no conflicts of interest to disclose.

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Identification of the ureter during robotic colorectal surgery using lighted stents – a video vignette

Dear Editor,

The incidence of ureteric injury during colorectal surgery is reported to be 0.28%–7.6% [1,2]. Although there is no evidence that ureteric stents reduce the incidence of injury, they may assist early intra-operative identification of injury and thus enable immediate repair to be undertaken which reduces long-term complications [3,4]. In open surgery, ureteric stents may enable the surgeon to identify the ureter by palpation. In minimally invasive colorectal surgery there is less tactile feedback and more dependence on visual identification of ureters to avoid iatrogenic injury. We describe the use of advanced infrared technology to identify and manage the ureters during robotic colorectal surgery.

A 72-year-old man underwent a robotic high anterior resection for a colovesical fistula secondary to diverticular

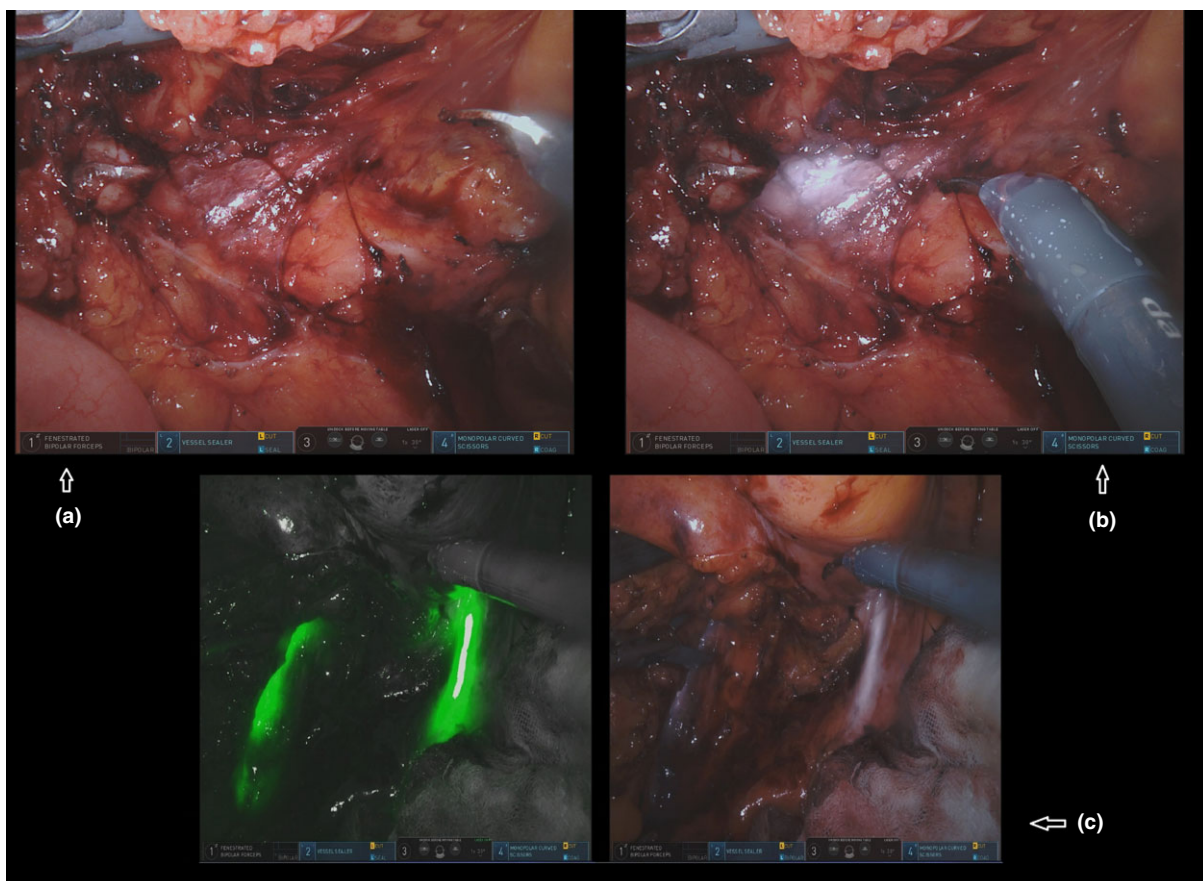


Figure 1 Several views of lighted ureteric stents seen robotically. (a) left ureter barely seen with Stryker camera and LUS off (b) left ureter illuminated with LUS on (c) both ureters seen with LUS on with Firefly [green light] and without mode.