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## Case Report

# Transanal Minimally Invasive Surgery (TAMIS), First in Kuwait: A Case Report

Abdullah A. AlHaddad<sup>1</sup>, Ali S. Mouzannar<sup>1</sup>, Bader Marafi<sup>1</sup>, Ibtisam Albader<sup>2</sup>,  
Mosa A. Khoursheed<sup>2</sup>, Ali Sayed Ahmed Alsayed<sup>1</sup>

<sup>1</sup>Mubarak Al Kabeer Hospital, Kuwait City, Kuwait, <sup>2</sup>Kuwait Medical School, Al Jabriah, Kuwait.

### Abstract:

Transanal Minimally Invasive Surgery (TAMIS) is a one of new platform used to help and achieve better outcome in using transanal approach for the treatment of rectal neoplasm.

High definition camera and high tech equipment are used to perform this kind of surgery. The main benefit of using this approach is to provide the best outcome or the patient compared to the traditional transanal approach.

This platform can be used for a variety of cases, benign and malignant tumor and for the benign condition.

We report the first TAMIS performed in the Kuwait and probably in the Middle East with 2 years of follow up. We had no complication and patient returned home and to normal activity in next day. More studies needed to validate this technique

**Keywords:** TAMIS, Kuwait, Transanal, Minimally invasive, Rectal neoplasm

### Introduction

Transanal endoscopic surgery (TES) was first described by Buess <sup>(1)</sup> in 1984. Transanal minimally invasive surgery was introduced as an alternative in 2009 <sup>(2)</sup>. It is performed by using different platforms and laparoscopic instruments via a minimally invasive access to the rectum. Since its introduction, different procedures were able to be achieved trans-anally or using a hybrid approach.

We report the first TAMIS performed in the Kuwait and probably in the Middle East with 2 years of follow up.

### Case Scenario

The patient is a 53 years old female. She presented with intermittent generalized abdominal pain, nausea, and dyspepsia for 6 months. Her past medical history includes hypertension and bronchial asthma. She had no previous surgeries. Clinical examination including digital rectal exam was unremarkable. Colonoscopy revealed wide base sessile rectal polyp at 10 cm from the anal verge. Partial polypectomy showed tubulovillous adenoma with low-grade dysplasia. MRI pelvis revealed well circumscribed mass (3 x 2.8 x 2.9 cm) arising from the wall of the upper third of the rectum with mild peri-rectal fat stranding giving the impression of rectal wall invasion by the villous adenoma.

The patient underwent TAMIS for the large rectal polyp on August 2014 not meanable for endoscopic resection.

### Operative technique

Patient was evaluated by anesthesia and cleared for surgery. She had bowel preparation the day prior to surgery. In the day of surgery, she had DVT and systemic antibiotics prophylaxis. Patient was placed in the lithotomy position since the patient had the rectal polyp which was posteriorly located at 10 cm from the anal verge. Gel Point Applied medical platform was used and ligasure sealing device was used. 3 Ports were used; 5 mm 30-degree camera lens and 5 mm normal laparoscopic instruments were used. Normal Laparoscopic CO2 insufflation was used without air seal. The aim was to achieve full thickness resection of the rectal polyp.

After identifying the polyp marking was done circumferentially using diathermy. Using the ligasure device the polyp dissected and excised with complete full thickness through to the serosa to the mesenteric fat. The defect was closed using V lock suture running in transverse fashion. Inspection of the suture line was done and the transanal platform was removed.

**Corresponding Author:** Abdullah Ahmed AlHaddad, MD, FACS, FRCSC, FASCRS, Consultant General Surgeon and Colorectal Surgeon, Mubarak Al Kabeer Hospital/ Dar Alshifa Hospital, Kuwait City, Kuwait. P.O Box 20991 Safat, 13070, Kuwait. Tel: (965) 97681212 Fax: (965) 25359229. Email : hadad006@yahoo.com

The patient had uneventful postoperative period. She was restarted on oral fluids on POD 1 discharged after 3 days. Final histopathology revealed tubulovillous adenoma with high-grade dysplasia with free margins. She was under the follow up since then for 2 years, she had seen and evaluated by colonoscopy after 2 years and no recurrence seen.

## Discussion

Transanal minimally invasive surgery was introduced in 2009<sup>(2)</sup>. It has been used to treat benign and selected malignant rectal lesions. TAMIS platform uses any of the several available single incision laparoscopy surgery (SILS) ports. By using this port, conventional laparoscopic instrumentation including the camera can be used to perform the procedure. Several investigators are designing the TAMIS platform so that the procedure can be performed with the assistance of the Da Vinci® robot<sup>(3)</sup>.

Transanal endoscopic surgery has many advantages over conventional transanal excision, which include: lower incidence of margin positivity, reduced specimen fragmentation, local recurrence, and morbidity. Also, transanal endoscopic surgery has revealed superior to advanced colonoscopic mucosal and submucosal resection in terms of local recurrence.

TAMIS, when compared to Trans anal endoscopic microsurgery (TEM), is easier to use, less expensive, with equivalent results. Additionally, it was shown that identical oncological results and even better outcomes regarding morbidity and mortality can be achieved for selected early rectal cancer, when compared to radical surgery<sup>(4,5)</sup>. Also, Trans anal excision (TAE) has its own limitation and it is not applicable for high rectal lesion. The selection criteria for TAMIS includes the following: the lesion has to be a way from the puborectalis sling for at least 2–3cm, benign lesion endoscopically unresectable, T0 or Tis lesions, well-to-moderately differentiated T1 cancer, the absence of lymphovascular or perineural invasion, and tumor less than 3 cm in diameter occupying less than one third of the circumference of the rectal lumen. In addition, patient with T2 cancer who are not candidate for total mesorectal excision, local excision can be used following neoadjuvant therapy for rectal cancer may considered in the setting of clinical trial.

Albert et al<sup>(2)</sup> has reviewed fifty patients who underwent TAMIS between 2009 and 2011. Twenty-five patients had benign disease, 23 had malignant tumors, and 2 of them had neuroendocrine tumors. The average distance from the anal verge was 8.1 cm (up to 14 cm). The average length of stay was 0.6 days. Only 3 patients had positive margins on pathological examination. Recurrence rate

was 4%. There were no long term complications on median follow-up of 20 months.

A review was done by Keller et al<sup>(6)</sup> on 75 cases who underwent TAMIS for benign and malignant lesions with median follow up of 39 months, the median lesion distance from the anal verge was 10 cm. The mean operative time was 76 min and three patients had intraperitoneal entry for which 2 of them required ileostomies.

Five patients had positive margins which were treated by radical surgery. Postoperatively, 3 patients had complications (bleeding, rectal stricture, and recto-vaginal fistula), and all were managed non-operatively.

Transanal minimally invasive surgery is a viable option for excision of benign or early stage rectal masses, with mid-term oncologic outcomes comparable to that of radical resection.

Martin-Perez<sup>(6)</sup> had done a systemic review of all TAMIS cases over 4 years since inception of the procedure. A comprehensive search of PubMed, EMBASE, the Cochrane Library, and Web of Knowledge was performed. Since the inception of TAMIS in 2009, 33 retrospective studies and case reports, and 3 abstracts have been published on TAMIS for local excision of rectal neoplasms, which represents a combined n = 390. A total of 152 lesions were excised for benign disease including adenomas and high-grade dysplasias (39%), 209 for malignancy for carcinomas in situ and adenocarcinomas (53.5%). Twenty-nine of TAMIS resections were for other pathology, of which the majority (23/29) were neuroendocrine lesions. Robotic-TAMIS has also been reported, however, data are extremely limited as there are only 7 case reports (combined n = 11) in the published literature. Complications following the TAMIS procedure are infrequent with an overall rate of 7.4%. The conversion rate in 390 cases performed for both benign and malignant lesions was 2.3%. Inadvertent peritoneal entry during TAMIS was reported in 1% of cases and in some cases, the closure of the rectum was successful transanally. In malignant polyps, the rate of positive margins was 4.4% and the rate of tumor fragmentation was 4.1%.

Systemic review by Hong<sup>(7)</sup> found twelve studies including 155 patients were identified. The weighted mean size of rectal lesions was 3.3 cm (range 0.2–10 cm) and the weighted mean distance from the anal verge was 7.4 cm (range 0–20 cm). Six studies enrolled only the patients with low and mid rectal lesions mainly to avoid peritoneal entrance during excision. TAMIS seems effective and safe treatment for benign and malignant rectal lesions.

Furthermore, transanal total mesorectal (TaTME) excision using multiple TAMIS platforms is flourishing

and multiple studies is coming up supporting that and the oncological resection is comparable or even better in some studies <sup>(8)</sup>.

Management of rectal injury through the trans anal approach is well-known, however complication such as leak, wound disruption, abscess and bleeding should be considered with a liberal use of stool diversion especially in severe rectal injury.

## Conclusion

To our knowledge, this was the first TAMIS case done in Kuwait and probably in the Middle East. There is increasing literature that supports the feasibility of TAMIS and other types of hybrid procedures for selected rectal cancer and other diseases. TAMIS is a valuable option and safe specifically for high rectal lesions where conventional transanal approach is not applicable based on the evidence from a limited number of studies. However, the clinical outcome of TAMIS according to the location of the rectal lesions needs to be clarified. More clinical trials are required to further study this new approach and support its safety and excellent oncological outcomes.

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## Case Report

# Tumor Recurrence at Donor Site of Pectoralis Major Myocutaneous Flap with Tumor-free Primary Oral Carcinoma

Rakesh Kain, Suvashis Dash

Department of Burns, Plastic and Maxillofacial Surgery, Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi, India

## Abstract

Pectoralis major myocutaneous flap is an important option for post onco reconstruction in head and neck region. Among the several complications mentioned in the literature, tumor recurrence at the donor site of flap is late and rare complication. Tumor implantation at the donor site of flap is a possible explanation. The occurrence of this type case is rare. We are reporting a case of tumor

recurrences of pectoralis major myocutaneous flap donor site without presence of index tumor or detectable systemic disease. The recurrence was operated in our case. Clinicians should be aware of this condition for better management of patients with similar presentation.

**Keywords:** Pectoralis major flap; Pectoralis major myocutaneous flap; Flap complication; tumor recurrence; Head and neck reconstruction.

## Introduction

In the era of microvascular reconstruction pectoralis major myocutaneous flap is still considered as a work horse flap for head and neck reconstruction. The various factors due to which this flap is still preferred are ease of dissection, reliable vascular supply, with little donor site morbidity and cost effective in austere condition. However, this flap can present with common complications like flap hematoma, necrosis and dehiscence. But recurrence of tumor at the donor site of flap along its margin is a rare complication. Although the mechanism of tumor recurrence is unknown, tumor implantation is the possible cause of this pathology.<sup>(1,2)</sup>

## Case Report

A 50-year-old male with diagnosis of moderately differentiated squamous cell carcinoma of right side floor of mouth was operated with wide local excision of carcinoma, segmental mandibulectomy and type 1 right side modified radical neck dissection.

This gentleman with 2-month history of an ulceroproliferative mass in right side of floor of mouth presented to our center. On examination patient had no palpable neck nodes or any external visible swelling over neck. Mouth opening was normal. Tongue was normal and mobile. The lesion was ulceroproliferative type and of size 2x3 cm present over right side floor of mouth. Clinically, it appeared to involve the tooth socket and mandible margin

covered with sloughs. Palate, uvula and anterior pillar was normal. Nasoendoscopy, laryngoscopy was normal

After CT scan and other relevant investigations patient was planned for surgery. Patient has undergone wide local excision of tumor and type 1 MRND in December 2016 using modified Schobinger incision. Tumor along with 2 cm normal tissue margin was taken during excision and segmental mandibulectomy done. Level I, II, III, IV, V, VI lymph node groups were removed. Specimens were sent for histopathology. Post resection the defect was reconstructed with microvascular fibula flap reconstruction.

On 3rd post-operative day, free fibula flap showed congestion and even after exploration flap could not be salvaged. Debridement of the necrotic flap and reconstruction plate was removed.

After 1 week of initial surgery the mucosal defect was covered with pedicle pectoralis major myocutaneous flap. Wound healed in 2 weeks. Patient was consulted with oncologist for adjuvant therapy.

Histology of the tumor showed moderately differentiating squamous cell carcinoma of right alveolus.

**Corresponding Author:** Suvashis Dash, H 2, first floor,  
Green Park Main, New Delhi –110016  
Mobile +919999082897.  
Email: suvashis.dash@gmail.com