LAPAROSCOPIC MANAGEMENT OF LATERALLY SPREADING CECAL POLYPS

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INTRODUCTION

Laterally spreading polyps of the cecum can be challenging to remove endoscopically when involving the appendiceal orifice. These polyps have a low risk of harbouring malignancy when they are homogeneous, granular, and without areas of ulceration or depression. While some patients get a segmental bowel resection, recent reports suggest that a combined laparoscopic/endoscopic approach works well. The purpose of this retrospective review is to showcase that laparoscopic cecal resection without endoscopic assistance is a successful treatment option for laterally spreading polyps with low-risk features.



Figure 1: Colonoscopy image from Case 1 showing lateral spreading polyp near the appendiceal orifice.

METHODS

This is a retrospective review of two cases of laterally spreading cecal polyps (Paris IIa) managed using laparoscopic cecal resection without endoscopic assistance. Both cases are from the same institution and completed by the same surgeon.



Figure 2: Gross specimen from Case 2 showing successfully resected laterally spreading polyp.

CONCLUSION

Laparoscopic cecal wedge resection of laterally spreading tumors of the cecum involving the appendiceal orifice is a safe, effective management option for tumours greater than 1 cm from the ileocecal valve. Endoscopic assistance during surgery is unnecessary and a more invasive segmental resection can be avoided.

RESULTS

Patients were both older males with lateral spreading polyps involving the appendiceal orifice. Based upon colonoscopic findings, both polyps had a granular, homogeneous appearance measuring between 3 and 5 cm in maximum diameter (Figure 1). Both polyps were over a centimeter from the inferior border of ileocecal valve accommodating placement of a linear stapler. Laparoscopic wedge resection of the cecum was performed using 4 ports (one 10mm, one 12mm, and two 5mm) to lyse adhesions, fully mobilize the cecum, and to staple/divide the cecum intracorporeally with a linear stapler. Both specimens were placed in a plastic bag and removed through the umbilical port site. Specimens were opened after removal to confirm clear margins (Figure 2). One patient was discharged home on the same day of surgery and the other was discharged on postoperative day one. There were no intraoperative or postoperative complications. The final pathology report confirmed tubulovillous adenomas with clear margins in both cases.