

Some authors¹ specify that sternotomy should be used in cases with previous cervical thyroidectomy, invasive carcinoma or ectopic goiter. If possible, there are those who prefer cervical approaches in select cases.^{2,3} Nevertheless, the future is moving toward minimally invasive procedures, and there are reports of ectopic mediastinal goiter resection with thoracoscopic surgery and even da Vinci robotics.^{4,5} Since 2005,^{6,7} several articles have been published about the single-port approach in the thorax, and recently there have even been reports of major lung resections performed through a single incision.^{8,9}

However, we were not able to find any reports of the use of single-port VATS in this pathology. In our case, the fourth intercostal space provided better exposure and access to the apical region, and the anterior axillary line optimized the visualization of the superior-posterior mediastinum. A 30° thoracoscope was not necessary; instead, a 0° thoracoscope provided easier and more intuitive resection. We chose to use a single-port procedure, since one of the advantages over multiport surgery is that only one intercostal space is involved, which causes less postoperative pain.¹⁰ And, in the interest of pain reduction, we preferred to use a single 20 Fr tube to lessen the trauma to soft tissue compared to other larger tubes. The hospital stay was very short and there were no complications.

The use of plastics to protect the port is well known, and there are manufacturers with more expensive and less expensive versions of the same product. The most basic, cheapest solution is a sterilized plastic sandwich bag. But, our idea of using the plastic covering from the light wand and using it to protect the port incision is a readily accessible resource as it is in the operating room, providing clean optics and maximizing efficiency.

In conclusion, thoracoscopic single-port resection for ectopic mediastinal goiter is another option to consider when defining an approach to this pathology because, as we have described, it is possible and allows for a shorter hospital stay, with the consequent resource savings.

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Elisabet Arango Tomás*, Carlos Baamonde Laborda, Francisco Javier Algar Algar, Ángel Salvatierra Velázquez

Unidad de Gestión Clínica de Cirugía Torácica y Trasplante Pulmonar, Hospital Universitario Reina Sofía, Córdoba, Spain

*Corresponding author.

E-mail address: eli_piano@hotmail.com (E. Arango Tomás).

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Simultaneous Colectomy and Nephrectomy in Synchronic Tumours[☆]

Colectomía y nefrectomía simultánea en tumores sincrónicos



Colorectal cancer (CRC) is one of the most frequent neoplasms in both men and women. It is the fourth cause of cancer death in

our setting. Meanwhile, renal cancer represents 2% of all tumors, and renal cell carcinoma (RCC) is the most frequent type.¹

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Table 1 – Cases Reported.

Patient	1	2	3	4
Age	63	67	71	62
Sex	Male	Male	Male	Male
Diagnosis	Sigmoid cancer, 18 cm from AM+renal mass of the left superior pole (6×4 cm)	Sigmoid cancer, 21 and 38 cm from AM+colon polyposis+renal neoplasms, right (8×7 cm) and left (3 cm)	Rectal cancer, 9 cm from AM+left renal neoplasm (5 cm)	Right ureteral tumor+right colon neoplasm
Surgery	Sigmoidectomy+left nephrectomy	Partial left nephrectomy by retroperitoneoscopy (1st stage) subtotal colectomy+right heminephrectomy (2nd stage)	LAR+left nephrectomy	Right nephroureterectomy+extended right hemicolectomy
Intraoperative bleeding	0 cc	900 cc	–	300 cc
Surgical time	300 min	420 min	–	360 min
Days of hospitalization	6	12	12	30
Morbidity	0	0	0	Intraabdominal abscess,
AP colon tumor	Moderately differentiated ADC TNM pT4N0	3 infiltrating ADC+1 ADC in situ+multiple tubulovillous TNM pT3, pT2, pT1, pTis	Moderately differentiated ADC TNM pT3 N0	Infiltrating ADC+1 villous adenoma+multiple tubular adenomas TNM pT2 N0
AP renal tumor	Papillary renal cell carcinoma type 2 TNM pT1bNx	Cystic renal cell carcinoma (left) TNM pT1 Renal clear cell tumor (right) TNM pT3	Papillary renal cell carcinoma, type 2	Transitional cell carcinoma of the urethra TNM pT3 Nx

AM: anal margin; ADC: adenocarcinoma; AP: anatomic pathology; LAR: lower anterior resection.

The simultaneous presentation of renal cell and colorectal cancer is exceptional, with a prevalence that ranges between 0.03% and 4.85%.² The systematic use of non-invasive imaging tests like computed tomography (CT) has increased the diagnosis of asymptomatic renal tumors. This favors subclinical diagnosis at early stages of the disease.³

Currently, the laparoscopic approach of CRC and RCC is well established. Simultaneous colectomy and partial nephrectomy have been achieved anecdotally. Below, we present 4 clinical cases, which are included in Table 1.

The association between CRC and RCC is uncommon. There is no correlation, except in so-called hereditary conditions, such as Lynch syndrome, although none of our patients met the criteria.

In our series, both the ipsilateral and contralateral approaches were used. The latter posed greater technical difficulties, including the change in the position of the trocars and the patient. One patient was diagnosed with colon cancer and double kidney cancer, which has not been previously reported in the literature.^{2,4-7} In this case, partial left nephrectomy was performed by retroperitoneoscopy, with the intention of leaving the peritoneal cavity untouched for the following intervention. This approach was not recommended in the right tumor due to its large size, which made it technically more complex (especially because renorrhaphy using a retroperitoneal approach is more complicated due to the lack of space and triangulation). Few days later, laparoscopic subtotal colectomy was performed in supine decubitus, and subsequently the position was changed to left

lateral decubitus for right partial nephrectomy. In spite of the tumor size and due to the surgical history in the contralateral kidney, nephron-sparing surgery was considered to preserve renal function (Fig. 1).

Most of our patients presented a postoperative period without complications, except for the last patient who presented intraabdominal abscesses, which made us suspect possible anastomotic dehiscence. The patient was treated conservatively and had a favorable recovery.

One of the advantages of the procedure is being able to treat 2 neoplasms at the same time. In this manner, treatment of the second neoplasm would not be delayed if postoperative complications were to appear after the first surgery. Furthermore, simultaneous treatment avoids a second anesthetic procedure and reduces discomfort for both patients and family members. And, as a second hospitalization is avoided, it is also a more cost-effective option.

Nonetheless, combined surgery in 2 different organs poses tactical difficulties. A synchronous approach is a greater biological aggression than performing two separate interventions, and hospitalization is lengthened. It is possible though, especially when both procedures are simple, as documented in other series,⁸⁻¹⁰ or when done at a high-level hospital centers with resources for satisfactory management.

Thus, simultaneous laparoscopic treatment of renal and colon cancer is feasible and reproducible. The greatest advantage of this technical option is that it allows for both lesions to be treated at the same time, thereby

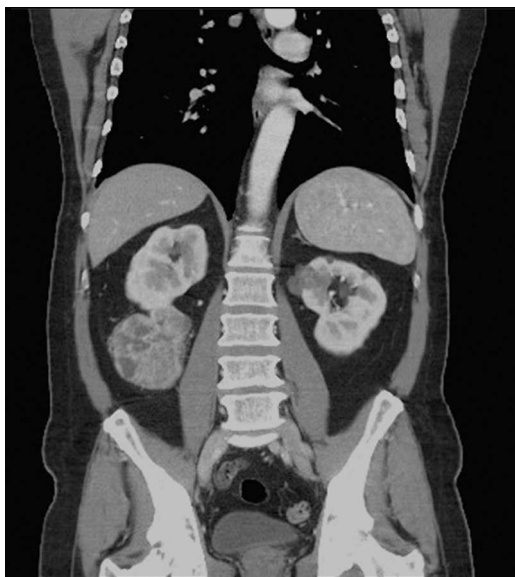


Fig. 1 – Abdominal-pelvic computed tomography: coronal slice showing a solid mass on the lower right renal pole measuring 8×7 cm and another lesion measuring 3 cm in the superior left renal pole.

eliminating the delay of treating the lesions in sequential surgeries.

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Ana Belen Martin Arnau^{a,*}, Carolina Ochoa Vargas^b, Jose Antonio Peña Gonzalez^b, Eduardo María Targarona Soler^a

^aServicio de Cirugía General, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain
^bServicio de Urología, Fundación Puigvert, Barcelona, Spain

*Corresponding author.
 E-mail address: belen_marar@hotmail.com
 (A.B. Martin Arnau).

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