



Robots for rectopexy: probably hindrance... till now!

Jean-Luc Faucheron^{1,2}, Bertrand Trilling^{1,2}, Fabian Reche^{1,2}

¹Colorectal Unit, Department of Surgery, Michallon University Hospital, Grenoble, France; ²Grenoble Alps University, UMR 5525, CNRS, TIMC-IMAG, Grenoble, France

Correspondence to: Prof. Jean-Luc Faucheron, Colorectal Unit, Department of Surgery, Michallon University Hospital, CS 10217, 38043 Grenoble cedex, France. Email: JL.Faucheron@chu-grenoble.fr

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We thank Doctors Ian Lindsey and Aisling M. Hogan for their comments concerning our article recently published in *Techniques in Coloproctology* (1) they published in *Annals of Laparoscopic and Endoscopic Surgery* under the title “robots for rectopexy: help or hindrance?” (2).

We disagree with the assumption that no clear algorithm exists as to how best manage external rectal prolapse or posterior colpocele: since 1999 in our institution, monthly multidisciplinary meetings for pelvic floor disorders exist that involve colorectal surgeons, radiologists, gastroenterologists, urologists, gynaecologists, and physiotherapists. In summary, laparoscopic or robotic ventral rectopexy is recommended for external rectal prolapse and deep enterocele (3,4) or hydrocele (5). Isolated rectocele and internal rectal prolapse are for us best managed by stapled transanal rectal resection (STARR) procedure (6) or perineal approach. Rectocele without enterocele and internal rectal prolapse without deep Douglas pouch, associated with severe dyschezia which are often the cause of the organic condition rather than the consequence, should not be treated by rectopexy, even the ventral one, because of the risk of increasing the defecation disorder. Dynamic cystocolpoproctography, that is superior to functional pelvic MRI, is of great help in diagnosing these posterior pelvic floor disorders (7).

We also disagree with the argument that “like laparoscopy thirty years ago, the flat earth, antediluvians among us were sceptical of its advantages”: at that time, we were on the contrary enthusiastic on offering the patients smaller incisions, less pain, quicker recovery, and cosmetic advantages, as we are for fast-track surgery nowadays (8). Moreover, we published positive results using a miniaturized robotic laparoscope-holder for rectopexy, so proving we are

not “against breakthroughs” (9).

Our group stopped temporary fixation of the sigmoid colon (or uterus) to anterolateral abdominal wall 19 years ago, that is 3 years after starting the laparoscopic approach for rectopexy (3): adding a fourth 5 mm port often accelerates the procedure that is now performed in less than an hour, allowing the operation to be performed as day-case procedure.

Doctors Ian Lindsey and Aisling M. Hogan must agree that using the actual Robot Da Vinci necessitates bigger ports (8 mm instead of 5 mm), supplementary one to introduce meshes and possibly staplers, fixed table tilting all along the procedure, and longer time to complete the procedure (the first assistant should be at least as good surgeon as the main surgeon).

We are then convinced that in 2017, the use of the expensive robot for simple, well defined procedure as the ventral rectopexy is should not be systematic. In our institution, best indications for using the Da Vinci robot are low rectal cancer in male patients, complex endometriosis pelvic operations, and bariatric surgery.

Michelanelo also said “*On a fragile craft, through a stormy sea, the course of my life is already reached this common port where we are going to make a harsh account of any work, bad and good*”... I agree with Doctors Ian Lindsey and Aisling M. Hogan we should continue to innovate and strive to improve patients journeys in every way, except in case where innovation afford no advantage with higher cost.

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