Laparoscopic splenic preservation: author's reply

J. O. Larkin · P. A. Carroll · P. H. McCormick ·
B. J. Mehigan

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Dear Sir,

We welcome the interest in our recent technical note entitled: 'Control of splenic bleeding during splenic flexure mobilisation by devascularisation of inferior pole of the spleen' [1]. We thank Dr. Uranues for his expertise in splenic anatomy and agree that our technique is unlikely to induce infarction of the tip of the spleen but does appear to reduce perfusion sufficient to allow preservation of the injured spleen at laparoscopic anterior resection. We accept that this would not be a safe method for achieving haemostasis from a deep parenchymal laceration; however, splenic injuries at anterior resection are typically capsular traction tears. It is noteworthy that the largest published series of splenic injury during colectomy, from the Mayo clinic, reported a 76 % splenectomy rate [2]. Therefore, ongoing splenic capsular bleeding or a potentially evolving haematoma in a patient with a colorectal anastomosis is clearly unacceptable to most colorectal surgeons, and control must unequivocally have been attained by the end of the operation. So, while definitive haemostasis obviously may require splenectomy, the technique we describe facilitates the achievement of haemostasis with splenic preservation while obviating conversion to an open procedure.

We thank Drs. Shafique and Ignjatovic for once again highlighting their previous description of this technique at open surgery [3], and we agree that it is the use of an endoscopic vascular stapler at laparoscopic anterior resection, thus avoiding the conversion to open surgery, which is the novel feature of our technique. Having used this technique both at laparoscopic anterior resection and at laparoscopic splenectomy, we feel that the chance of injuring the splenic vein is minimal as the staple line extends well beyond the stapler blade's extent of division.

Conflict of interest None.

References

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J. O. Larkin (✉) · P. A. Carroll · P. H. McCormick ·
B. J. Mehigan
Department of Colorectal Surgery, St. James's Hospital,
Dublin 8, Ireland
e-mail: larkin.dundalk@gmail.com