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ERRATUM

Robot-assisted laparoscopic surgery of the infrarenal aorta

The early learning curve

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The following changes need to be implemented:

On 2nd page, 3rd paragraph, 3rd sentence, add: ''and had preoperatively been diagnosed with either TASC (Trans-Atlantic Inter-society Consensus) type C or D lesions (Table 2)''

On same page and paragraph, after 4th sentence insert: ''Pre-operative clinical condition was described using the American Society of Anesthesiologists classification (ASA-classification, Table 2).''

On same page 4th paragraph should read:

''Details of different surgical techniques have been described elsewhere [1, 3, 5, 8, 10, 11, 18]. We initially used a transabdominal approach with the ''apron technique'' as described by Dion et al. [10]. In this approach, a peritoneal ''flap'' is dissected laparoscopically and subsequently used to ''suspend'' the intestines onto the abdominal wall from inside the abdominal cavity with stitches, in order to keep a clear operative field. We also have used a retroperitoneal approach [18], in which a retroperitoneal space is created by digital dissection, followed by use of a dissection balloon. However, we encountered problems with both these techniques, ie, ''tearing'' of the peritoneal flap in the ''apron'' approach (which lead to loss of visibility) and loss of visibility after suction in the retroperitoneal approach. Finally, we preferred the transabdominal approach with extreme patient-rotation as described by Coggia et al. [5]. In short, under general anesthesia, the patient is positioned supine with a Pelvic Tilt pillow (O.R. Comfort, LLC, Branchburg, NJ, USA) under the left flank. Via small groin incisions, the common femoral arteries are exposed on both sides.''

On same page, 6th paragraph should read:

''The surgeon stands at the right side of the patient, facing the patient's abdomen and the video monitor, which is located at the patient's left side. After a pneumoperitoneum (14 mmHg) is achieved, six 12 mm trocars are inserted as shown in Figure 1. One trocar is placed at the left anterior axillary line, 3 centimeters below the costal margin, to insert a 30 degree endoscope (Storz Endoskop Produktions GmbH, Tuttlingen, Germany). Subsequently, additional trocars are placed under direct videoscopic vision 7 centimeters supraumbilically and 11 centimeters below the costal margin, just lateral to the left anterior axillary line. These will be used by the surgeon during dissection and by the robotic instruments during the anastomosis. A trocar for retraction of the bowel is placed left paraumbilically and assistant ports are placed 6 centimeters under the navel and in the left lower abdomen at midclavicular level.''

On same page 7th paragraph should read:

''Dissection of the left colon is performed and a fan retractor is placed into an Endoscope Holding system (Karl

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Table 2 Parameters per patient

	ASA	TASC	OR time (min)	Blood loss (ml)	Clamp-time (min)	Anastomosis time (min)	ICU stay (days)	Hospital stay (days)	Conversion	Follow-up (months)
1	II	D	290	200	104	74	1	4	No	48
2	III	D	260	200	90	60	1	6	No	48
3	II	D	380	700	125	65	1	8	No	36
4	II	D	420	1,000	175	85	1	4	No	36
5	III	D	455	800	205	110	3	3	No	36
6	III	C	589	5,800	105	40	16	57	Yes	24
7	II	C	390	1,650	117	60	1	6	No	24
8	II	C	495	3,000	85	X	1	10	Yes	24
9	III	C	335	1,000	25	X	1	11	Yes	18
10	II	C	260	1,150	70	30	1	4	No	12
11	II	D	465	900	130	40	3	15	No	12
12	II	D	355	1,100	55	25	1	4	No	12
13	II	D	388	600	60	69	1	4	No	12
14	II	D	343	1,350	55	39	1	4	No	12
15	III	C	310	600	60	36	1	4	No	6
16	II	C	225	100	35	22	1	4	No	6
17	II	C	365	1,800	86	41	1	4	No	6

OR: operating room; ICU: intensive care unit

Storz GmbH & Co. KG, Tuttlingen, Germany) to keep the bowel from migrating into the operative field. The lumbar arteries are clipped with a Ligasure ™ Vessel Sealing System (Valleylab, Boulder, CO, USA), and the inferior mesenteric artery is temporarily occluded.''

On same page 9th paragraph, 1st sentence should read:

''Aortic clamps are placed in position; the proximal clamp is inserted through an incision in the abdominal wall, just below the xyphoid, and the distal clamp is inserted through an earlier placed trocar (Figure 1).''