Fri. Nov 14, 2025

Special Program

Fri. Nov 14, 2025 8:30 AM - 10:00 AM JST | Thu. Nov 13, 2025 11:30 PM - 1:00 AM UTC Room 1

[SP1] Special Program 1 (English Slide)

司会：秋吉 高志(がん研有明病院大腸外科), 的場 周一郎(東邦大学医療センター大森病院一般・消化器外科)

[SP1]

No cut video: Surgical Technique for Automatic Nerve-Guided Total Mesorectal Excision for Rectal Cancer

Jun Watanabe (Department of Colorectal Surgery, Kansai Medical University)

Special Program

Fri. Nov 14, 2025 10:10 AM - 11:40 AM JST | Fri. Nov 14, 2025 1:10 AM - 2:40 AM UTC Room 1

[SP2] Special Program 2 (English Slide)

司会：吉田 直久(京都府立医科大学大学院消化器内科学)

[SP2]

No cut video: Endoscopic Submucosal Dissection (ESD)

Kouichi Nonaka (Department of Digestive Endoscopy, Tokyo Women's Medical University Hospital)

Special Program

Fri. Nov 14, 2025 2:05 PM - 3:35 PM JST | Fri. Nov 14, 2025 5:05 AM - 6:35 AM UTC Room 1

[SP3] Special Program 3 (English Slide)

司会：黒柳 洋弥(虎の門病院), 大植 雅之(大阪国際がんセンター消化器外科)

[SP3]

No cut video: Lateral Lymph Node Dissection for Advanced Lower Rectal Cancer

Shunsuke Tsukamoto, 田藏 昂平, 加藤 岳晴, 永田 洋士, 高見澤 康之, 森谷 弘乃介, 金光 幸秀 (Department of Colorectal Surgery, National Cancer Center Hospital)

Sat. Nov 15, 2025

Special Program

Sat. Nov 15, 2025 8:30 AM - 10:00 AM JST | Fri. Nov 14, 2025 11:30 PM - 1:00 AM UTC Room 1

[SP4] Special Program 4

司会：岡本 康介(松島病院大腸肛門病センター), 東 光邦(東肛門科胃腸科クリニック肛門科胃腸科)

[SP4]

No cut video: Fundamental Proctologic Procedures :Ligation and Excision for Hemorrhoids, and Fistulotomy for Anal Fistula

Kinya Okamoto (Department of Coloproctology, Tokyo Yamate Medical Center)

Special Program

Sat. Nov 15, 2025 1:30 PM - 3:00 PM JST | Sat. Nov 15, 2025 4:30 AM - 6:00 AM UTC Room 1

[SP5] Special Program 5 (English Slide)

司会：惠木 浩之(北里大学メディカルセンター外科), 藤田 文彦(久留米大学外科)

[SP5]

No cut video: Right hemicolectomy, surgical trunk dissection (+ intracorporeal anastomosis)

Hiroyasu Kagawa, 杉下 哲夫, 鳴海 絢, 原田 紡, 伊藤 望, 勝谷 俊介, 西山 優, 池田 晋太郎, 國本 真由, 後藤 佳名子, 中田 美佳, 三浦 竣助, 青柳 康子, 山本 雄大, 山内 慎一, 花岡 まりえ, 絹笠 祐介 (Department of Gastrointestinal Surgery, Institute of Science Tokyo)

Special Program

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[SP1]

No cut video: Surgical Technique for Automatic Nerve-Guided Total Mesorectal Excision for Rectal Cancer

Jun Watanabe (Department of Colorectal Surgery, Kansai Medical University)

Special Program

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[SP1] No cut video: Surgical Technique for Automatic Nerve-Guided Total Mesorectal Excision for Rectal Cancer

Jun Watanabe (Department of Colorectal Surgery, Kansai Medical University)

本邦において直腸癌に対するロボット支援手術は2018年4月に直腸切除・切断術において保険収載され，手術件数は大幅に増加している． また、臨床使用できるロボット支援手術機器も増加し、複数機種が消化器外科領域で臨床使用が可能となっている。直腸癌手術において従来の腹腔鏡手術では，狭い骨盤内で鉗子の自由度が制限される中、自律神経を確実に温存し適切な剥離層に沿って直腸を剥離・授動することは難易度が高い手技であった。一方、多関節、モーションスケール、手ブレ防止などの機能を有しているロボット支援手術は、腹腔鏡手術の動作制限を克服し、より繊細な全直腸間膜切除（total mesorectal excision: TME)や側方郭清が施行できるもとして、臨床的，腫瘍学的，機能温存に対しての有用性が期待されている。

ロボットTMEにおける手術手技の工夫は、1．腹膜反転部までの腹膜切離先行TME、2．自律神経ガイドTME、3．前回りのTMEである。１．腹膜反転部までの腹膜切離先行TMEでは、後壁の剥離に先行して腹膜切離を行う。左右前側壁において男性では直腸膀胱ひだ（膀胱仙骨靭帯）、女性では直腸子宮ひだ（子宮仙骨靭帯）をメルクマールとすることによって、腹膜反転部以深において神経血管束と直腸間膜の間に大きくずれることなく、剥離ラインを設定することが可能である。2．自律神経ガイドTMEでは、確実な自律神経の温存と、直腸間膜に切り込まない質の高いTMEが可能となる。3．前回りのTMEは、ロボット手術の利点を最大限に生かした剥離の手順である。中直腸動脈深枝と下腹神経下群を切離することが肝要である。術野展開が最小限となることによって手術時間の短縮に寄与する。また、放射線化学療法やTotal Neoadjuvant Therapy (TNT)などの浸出液の非常に多い術前治療症例に特に有効である。

今回、上記ポイントを解説しながら、直腸癌に対する自律神経ガイドTMEの手術手技をノーカットビデオで供覧する。

Special Program

Fri. Nov 14, 2025 10:10 AM - 11:40 AM JST | Fri. Nov 14, 2025 1:10 AM - 2:40 AM UTC Room 1

[SP2] Special Program 2 (English Slide)

司会：吉田 直久(京都府立医科大学大学院消化器内科学)

[SP2]

No cut video: Endoscopic Submucosal Dissection (ESD)

Kouichi Nonaka (Department of Digestive Endoscopy, Tokyo Women's Medical University Hospital)

Special Program

Fri. Nov 14, 2025 10:10 AM - 11:40 AM JST | Fri. Nov 14, 2025 1:10 AM - 2:40 AM UTC Room 1

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司会：吉田 直久(京都府立医科大学大学院消化器内科学)

[SP2] No cut video: Endoscopic Submucosal Dissection (ESD)

Kouichi Nonaka (Department of Digestive Endoscopy, Tokyo Women's Medical University Hospital)

本企画では、近年進歩が著しい大腸ESDにおける実際の手技を、編集のないノーカット映像で提示し、術者の戦略的判断や細やかな工夫を解説する。90分間で3症例を取り上げ、部位や病変の特性、線維化の程度に応じたアプローチを紹介する。各症例では、牽引法やアタッチメントの使い方、mucosal flapの迅速な作成、剥離操作の安定化に注目し、安全性と確実性を両立させる技術を共有する。また、想定外の事態への対応や、穿孔リスクを最小限に抑える工夫についても映像を通して実感できる内容とした。これから大腸ESDを習得する医師、あるいは更なる技術向上を目指す術者にとって、実践的かつ学びの多いセッションとなることを期待する。

Special Program

Fri. Nov 14, 2025 2:05 PM - 3:35 PM JST | Fri. Nov 14, 2025 5:05 AM - 6:35 AM UTC Room 1

[SP3] Special Program 3 (English Slide)

司会：黒柳 洋弥(虎の門病院), 大植 雅之(大阪国際がんセンター消化器外科)

[SP3]

No cut video: Lateral Lymph Node Dissection for Advanced Lower Rectal Cancer

Shunsuke Tsukamoto, 田藏 昂平, 加藤 岳晴, 永田 洋士, 高見澤 康之, 森谷 弘乃介, 金光 幸秀 (Department of Colorectal Surgery, National Cancer Center Hospital)

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[SP3] No cut video: Lateral Lymph Node Dissection for Advanced Lower Rectal Cancer

Shunsuke Tsukamoto, 田藏 昂平, 加藤 岳晴, 永田 洋士, 高見澤 康之, 森谷 弘乃介, 金光 幸秀 (Department of Colorectal Surgery, National Cancer Center Hospital)

Background: The aim of lateral lymph node dissection for advanced lower rectal cancer is to reduce local recurrence after surgery. However, the anatomy of the lateral pelvic space is complex, and it is crucial to properly expose the tissue during surgery in order to identify the target structures.
Surgical Procedure: Our department follows these steps: 1.Preservation of the ureter and autonomic nerves. 2. Identification and dissection of the internal iliac arteries and veins. 3. Dissection of medial to the inferior vesical arteries and veins. 4. Dissection along the medial edge of the obturator cavity. 5. Dissection on the distal side of the obturator cavity. 6. Determination of the resection line along the lateral and proximal sides of the obturator cavity. 7. Preservation of the obturator nerve. 8. Dissection of the floor of the obturator space. To make it easier to understand, these procedures can be divided into two parts: steps 1 to 3 are considered the dissection of the medial side of the internal iliac vessels, while steps 4 to 7 pertain to dissection of the obturator cavity.
Surgical Key Points: To avoid vascular injury, dissection should be performed along the vessels, and the lymphatic tissue should be removed as en bloc by dissecting along the surgical plane. Since each type of forceps has different characteristics, the retraction forceps should be used to strongly retract the tissue to expand the surgical field, while the left-hand forceps should gently grasp the tissue to avoid fat tissue compression.
Conclusion: In order to safely and reliably perform the difficult lateral lymph node dissection under robot-assisted surgery, it is essential to master the basic robotic surgical techniques and ensure proper exposure of the surgical field.

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司会：岡本 康介(松島病院大腸肛門病センター), 東 光邦(東肛門科胃腸科クリニック肛門科胃腸科)

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No cut video: Fundamental Proctologic Procedures :Ligation and Excision for Hemorrhoids, and Fistulotomy for Anal Fistula

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[SP4] No cut video: Fundamental Proctologic Procedures :Ligation and Excision for Hemorrhoids, and Fistulotomy for Anal Fistula

Kinya Okamoto (Department of Coloproctology, Tokyo Yamate Medical Center)

No-cut surgical videos allow clear demonstration of fundamental procedures in proctology. This presentation features two standard operations: hemorrhoidectomy by ligation and excision for hemorrhoids, and fistulotomy for anal fistula. Both remain essential treatments for common anorectal disorders, despite new minimally invasive options. Step-by-step footage highlights patient positioning, anatomical landmarks, dissection, and hemostasis. Technical refinements for the prevention of postoperative bleeding, reduction of pain, and minimization of recurrence are emphasized. In the fistulotomy video, principles of tract identification, secure opening, and creation of an appropriate drainage wound are demonstrated. By presenting unedited surgical videos, this session provides trainees and surgeons with practical insights into reliable operative strategies for daily proctologic practice.

Special Program

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[SP5] Special Program 5 (English Slide)

司会：惠木 浩之(北里大学メディカルセンター外科), 藤田 文彦(久留米大学外科)

[SP5]

No cut video: Right hemicolectomy, surgical trunk dissection (+ intracorporeal anastomosis)

Hiroyasu Kagawa, 杉下 哲夫, 鳴海 絢, 原田 紡, 伊藤 望, 勝谷 俊介, 西山 優, 池田 晋太郎, 國本 真由, 後藤 佳名子, 中田 美佳, 三浦 竣助, 青柳 康子, 山本 雄大, 山内 慎一, 花岡 まりえ, 絹笠 祐介 (Department of Gastrointestinal Surgery, Institute of Science Tokyo)

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Radical surgery for right colon cancer entails Complete Mesocolic Excision (CME) with D3 lymph node dissection, defined by the left border of the superior mesenteric vein (SMV). A medial approach is usually performed, with the inferior approach reserved for select cases.
The procedure begins by tensioning the mesentery and aligning the SMV. Using TIP-UP forceps, the mesentery near the ileocolic artery is grasped, the mesentery is incised, and the retroperitoneal plane is identified. Dissection proceeds cranially while safeguarding the duodenum. Lymph nodes are dissected with coordinated traction: the assistant retracts laterally while the surgeon applies countertraction. Lymphatic tissue over the anterior SMV is divided with monopolar curved scissors at low energy.
Once the SMV plane is defined, cranial dissection continues. The ileocolic artery and vein is divided at its root. Dissection proceeds along the SMV. Further continuing the medial approach toward the duodenum and pancreas, with the right limit marked by the pancreatic branch and the right colic vein from the gastrocolic trunk.
Lymph node dissection of the middle mesenteric artery is performed, and the artery (root or right branch) and middle mesenteric vein are divided. The gastrocolic trunk is addressed last, completing mesocolon mobilization. Hepatic flexure and lateral attachments are divided to finalize mobilization and lymph node dissection.
Intracorporeal anastomosis is usually performed using the overlap method, ensuring a ≥10 cm tumor margin. The mesentery is divided with advanced bipolar energy, bowel ends resected with a stapler, and the entry hole closed with stapler or running suture. A surgical video will be presented.