The First Transanal Excision of a Pseudosarcomatous Myofibroblastic Proliferation of the Rectum

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Purpose/ Background

Pseudosarcomatous myofibroblastic proliferation (PMP) is a benign tumor with malignant potential derived from fibroblasts and myofibroblasts. It is mainly reported in the urinary system. Other sites include the head, neck, pelvic cavity, retroperitoneum. There are no known rectal PMP cases.

Case: A 65-year-old nonverbal male presented from a group home with hematochezia. A colonoscopy demonstrated a rectal lesion, biopsied.

- **Markers:** ALK + , desmin+, actin + (weak) S100
- Discussion with expert pathologists at outside institution: final diagnosis of PMP.
- DRE, flex sig and MRI performed by CRS.
- **Tumor board** recommended minimally invasive or open transanal excision vs. low anterior resection +/- DLI

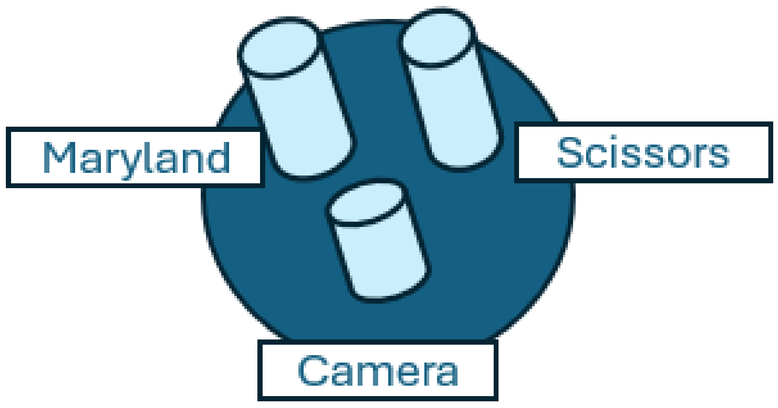


Fig 3. Schematic of GelPort Transanal platform

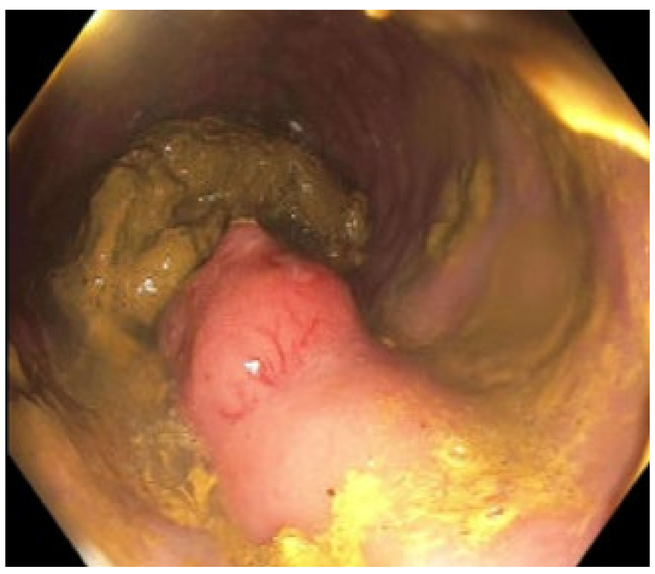


Fig 1. Flex sig: 4 cm anterior soft rectal mass

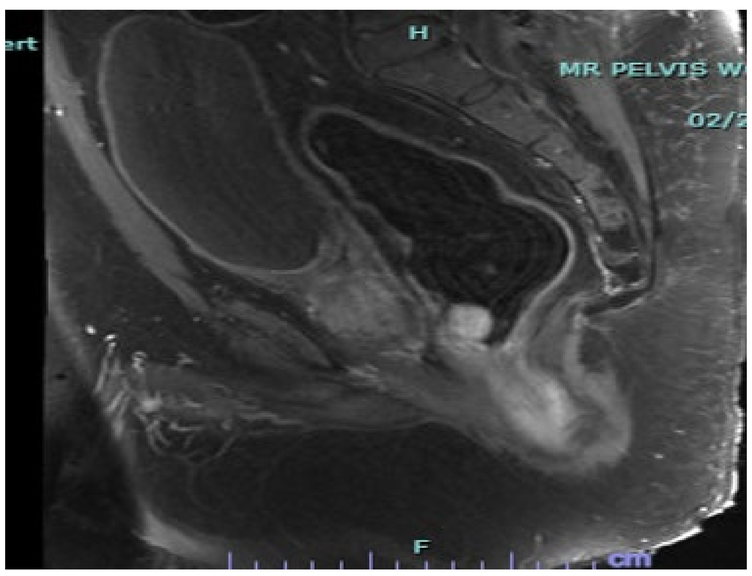


Fig 2. MRI (T1, sag): Polypoid, 3.6 cm left anterior mid rectal mass, (T1/early T2).

Robotic assisted TAMIS converted to transanal excision

- Lithotomy positioning. Prone was discouraged by PCP due to glaucoma and elevated IOP.
- Placed self-effacing 0-vicryl CT-1 sutures around anus
- Manually dilated the anus
- Placed the GelPort transanal platform.
- Secured the platform with 3 robotic trocars: Maryland bipolar, 30-degree camera, monopolar scissors
- Visualized lesion with the robotic camera but had difficulties crossing instruments and breaking insufflation seal.

Converted to transanal excision

- Marked out the periphery with Bovie electrocautery, established full-thickness plane into perirectal fat.
- Lesion removed in its entirety and oriented for path
- Defect closed with interrupted 2-0 prolene stitches transversely

Results/Outcomes:

Postop, patient had CHF exacerbation and left pleural effusion requiring thoracentesis. Discharged POD7.

Final pathology: PMP with tumor invading through muscularis propria. No tumor on inked margin.

Recommended 6-month surveillance CT and flex sig. Ultimately lost to follow-up. No known recurrence to date.

Conclusions:

1. Most reports of PMPs are in the urinary tract. To our knowledge, this is first reported rectal PMP.

2. Full thickness transanal excision of rectal PMP is an alternative to a more invasive LAR.

3. To optimize success at Robotic TAMIS, we recommend preoperative bowel preparation and prone positioning when feasible.

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