New Insights into Autonomic Nerve Preservation in High Ligation of the Inferior Mesenteric Artery in Laparoscopic Surgery for Colorectal Cancer

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Abstract

Aim: To take a deeper insight into the relationship between the root of the inferior mesenteric artery (IMA) and the autonomic nerve plexuses around it by cadaveric anatomy and explore anatomical evidence of autonomic nerve preservation in high ligation of the IMA in laparoscopic surgery for colorectal cancer. Methods: Anatomical dissection was performed on 11 formalin-fixed cadavers and 12 fresh cadavers. Anatomical evidence-based autonomic nerve preservation in high ligation of the IMA was performed in 22 laparoscopic curative resections of colorectal cancer. Results: As the upward continuation of the presacral nerves, the bilateral trunks of SHP had close but different relationships with the root of the IMA. The right trunk of SHP ran relatively far away from the root of IMA. When the apical lymph nodes were dissected close to the root of the IMA along the fascia space in front of the anterior renal fascia, the right trunk of SHP could be kept in suit under the anterior renal fascia. The left descending branches to SHP constituted a natural and constant anatomical landmark of the relationship between the root of IMA and the left autonomic nerves. Proximal to this, the left autonomic nerves surrounded the root of the IMA. Distally, the left trunk of the SHP departed from the root of IMA under the anterior renal fascia. When high ligation of the IMA was performed distal to it, the left trunk of SHP could be preserved. The distance between the left descending branches to SHP and the origin of IMA varied widely from 1.3 cm to 2.3 cm. Conclusions: The divergences of the bilateral autonomic nerve preservation around the root of the IMA may contribute to provide anatomical evidence for more precise evaluation of the optimal position of high ligation of the IMA in the future.

Keywords: Autonomic nerves preservation - inferior mesenteric artery - high ligation - colorectal cancer - anatomy

Introduction

Based on the oncological, technical and anatomical considerations, the position of ligation of the IMA has been debated on performing “high ligation” and “low ligation” in surgeries for the tumor of left colon and rectum (Lange et al., 2008; Titu et al., 2008; Cirocchi et al., 2012). Though there is still no consistent evidences of the survival benefits (Hida and Okuno, 2013), it is proved that high ligation of the IMA may improve lymph node removal rates (Adachi et al., 1998), accuracy of tumor staging (Titu et al., 2008). Though high ligation of the IMA causes a reduction of blood supply to distal colon (Seike et al., 2007; Tsujinaka et al., 2012), it simultaneously contributes to low anastomosis with no tension in low anterior resection of rectal cancer (Buunen et al., 2009; Hida and Okuno, 2013). In fact, the rate of ischemic necrosis of anastomosis is very low in clinical observations (Tsujinaka et al., 2012; Park et al., 2012) and no statistically significant difference between the high and low ligation of the IMA is found in the rate of anastomotic leakage (Rutegard et al., 2012; Polistena et al., 2013). In recent decades, laparoscopic surgery becomes more and more popular in surgeries for gastrointestinal cancer (Biondi et al., 2013; Liao et al., 2013). High ligation of the IMA is proved much easier than low ligation with no prolonged operative time or bleeding during the medial-to-lateral dissection (Sekimoto et al., 2011; Kim et al., 2013). Therefore, nowadays high ligation of the IMA is still preferred for most surgeons in surgeries for colorectal cancer.

However, it is widely accepted that high ligation of the IMA takes a risk of damage to the autonomic nerve plexuses around it (Moszkowicz et al., 2011; Acar and Kuzu, 2012) which may cause postoperative urogenital dysfunction (Liang et al., 2007). One common view on preservation of the autonomic nerve plexuses in high ligation of the IMA is preserving the pre-aortic connective tissue intact and dissecting the root of the IMA a certain distance away from its origin. However the distance varies widely from 0.5cm to 2cm in literatures (Morino et al.,

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From May 2012 to March 2013, based on the photographs by a digital camera (Canon Eos40D). Ligation of the IMA at any position proximal to the origin of the left colic artery is often vaguely described as high ligation in the literatures (Lange et al., 2008; Rutegard et al., 2012). Conversely, limited anatomical researches on the relationships between the root of the IMA and the autonomic nerves around it present different opinions. Some researches proposed that the origin of the IMA was the only safe position of high ligation of the IMA with no risk of damage to the autonomic nerves (Nano et al., 2004; Zhang et al., 2006). But Höer believed that high ligation of the IMA led to damage of the sympathetic nerves because the IMA was surrounded by the dense and netlike inferior mesenteric plexus to a distance of 5 cm from its origin on the aorta (Hoer et al; 2000). To date, further anatomical researches focusing on the controversies are lacking.

Therefore, in the present study we aimed to take a deeper insight into the relationship between the root of the IMA and the autonomic nerve plexuses around it by anatomical observation on formalin-fixed and fresh cadavers and explore the anatomical evidences about whether the autonomic nerves can be preserved in high ligation of the IMA in laparoscopic surgeries for colorectal cancer.

Materials and Methods

More or less, the anatomical information from cadavers may be different with that in surgeries. In order to get the anatomical information approaching the real condition in surgeries, the morphology of the autonomic nerve plexuses and their relationships with the fascia around the root of the IMA were observed on both formalin-fixed and fresh cadavers in the present study. In this study, 11 formalin-fixed cadavers (6 male and 5 female) and 12 fresh cadavers (6 male and 6 female) who had passed away due to extra-abdominal conditions and were donated to Southern Medical University were dissected by macroscopic anatomy with the assistance of a BH-2 double-eyepiece standard dissection microscope (Olympus, Tokyo, Japan). The mean age of death was 76.7 years (range: 22–89). The cadavers with deformities, previous operations, abdominal conditions and were donated to Southern Medical University were dissected by macroscopic anatomy with the assistance of a BH-2 double-eyepiece standard dissection microscope (Olympus, Tokyo, Japan).

The mean age of death was 76.7 years (range: 22–89). The cadavers with deformities, previous operations, other pathological changes and obvious adhesion in the abdominopelvic and retroperitoneal spaces were excluded. The formalin-fixed cadavers had been fixed via arterial ligation of the IMA in laparoscopic surgeries for colorectal cancer.

The Data were presented as mean ± SD and the descriptive characteristics of the subjects were compared by two-sample t test. Values for \( P < 0.05 \) were considered statistically significant.

Results

Anatomical observations

It was shown in the meticulous anatomical dissection that the abdominal aortic plexus (AAP), superior hypogastric plexus (SHP), inferior mesenteric plexus (IMP) and the bilateral L1-L3 lumbar splanchnic nerves (LSNs) converged around the root of the IMA and connected with each other. The AAP, also named as “intemesenteric plexus” situated at the level between the origins of superior mesenteric artery and IMA. The SHP located at the level between the origin of IMA and the position where the SHP branched into bilateral hypogastric nerves (HGN) around the sacral promontory. As the main component of the vascular sheath, the IMP surrounded the root of IMA and its branches. The bilateral L1-L3 LSNs deriving from the sympathetic trunks ran from the posterolateral side to the anterior surface of the abdominal aorta in an oblique course and combined with some descending branches of AAP to form the bilateral trunks of SHP around the origin of the IMA. The bilateral trunks of SHP ran obliquely and caudally along the anterior surface of the abdominal aorta and converged with the counterpart below the aortic bifurcation to form the bunchy-like presacral nerves in the interiliac triangle. Fine communicating neural fibers or ganglions connected the bilateral trunks of SHP. As the origination of the presacral nerve and HGNs, the bilateral trunks of SHP had close relationships with the root of the IMA.

The IMA originated from the anterior surface of the abdominal aorta at the level about 5 cm away from the bifurcation of abdominal aorta and ran ventrally and laterally into the sigmoid mesocolon. The anatomical relationships between the lateral trunks of SHP and the root of IMA were different bilaterally. On the right side of the IMA, the thick right L1-L2 LSNs combined with some fine descending branches of AAP to form the right trunk of SHP which ran relatively far away from the root of IMA. The right L1-L2 LSNs contributed most to the right trunk of SHP. Some fine branches originating from the right trunk of SHP ran caudally and ventrally to join the IMP along the root of the IMA, which we temporarily named as “the right ascending branches to IMP” (Figure 1a, 1c). In fresh cadavers, when the left mesocolon was freed from the fascia space between the anterior renal...
fascia and the left mesocolon and retracted ventrally, it was shown that the right ascending branches to IMP were tented simultaneously to run across the fascia space and the right trunk of SHP still attached to the anterior surface of the abdominal aorta under the anterior renal fascia (Figure 1b). Different from the right side, the left descending fibers of AAP were much thicker. The descending fibers of AAP and the left L1-L2 LSNs attached closely to the left side of the IMA and mingled with the IMP. Proximal to the origin of the left colonic artery, some neural branches departed from IMP on the left side of the IMA and ran caudally and dorsally to join the left trunk of SHP. The most distal descending neural branches were temporarily named as “the left descending branches to SHP” (Figure 2a, 2c). The left descending branches to SHP were a natural landmark of the anatomical relationship between the IMA and the autonomic nerve plexuses on the left side of it. Proximal to it, the left descending fibers of AAP, the left L1-L2 LSNs and the IMP mingled on the left side of IMA. But distal to it, the left trunk of SHP and the IMP were separated completely into different fascia spaces. In fresh cadavers, when the left mesocolon was freed from the fascia space between the anterior renal fascia and the left mesocolon and retracted ventrally, the left descending branches to SHP were tented across the fascia space and could be identified clearly running caudally and dorsally from the left side of the IMA to the left trunk of SHP under...
### Table 1. The Distances from the Left Descending Branches to SHP to the Origins of IMA and the Left Colic Artery in Both Sexes

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Male (cm)</th>
<th>Female (cm)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>1.93±0.27</td>
<td>1.91±0.24</td>
<td>1.92±0.25</td>
</tr>
<tr>
<td>b</td>
<td>0.87±0.25</td>
<td>0.90±0.21</td>
<td>0.88±0.22</td>
</tr>
</tbody>
</table>

This distance was measured as Figure 2c. a, the distance between the origin of IMA and the left descending branches to SHP. b, the distance between the origin of the left colic artery and the left descending branches to SHP. Data are reported as means ± SD (cm)

### Table 2. The Details of Patients and Tumors

| Parameter                  | Value
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of cases</td>
<td>22</td>
</tr>
<tr>
<td>Age (years)</td>
<td>64.7±5.5</td>
</tr>
<tr>
<td>Sex (M/F)</td>
<td>12/10</td>
</tr>
<tr>
<td>Body mass index (weight/height, kg/m²), mean (range)</td>
<td>Male 26.1 (20.9–33.6) Female 25.8 (21.7–34.2)</td>
</tr>
<tr>
<td>Laparoscopic curative resection</td>
<td>Sigmoid colon cancer 7 Rectal cancer 15</td>
</tr>
<tr>
<td>TNM stage (pathologic)</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>2</td>
</tr>
<tr>
<td>II</td>
<td>9</td>
</tr>
<tr>
<td>III</td>
<td>11</td>
</tr>
</tbody>
</table>

*a* Data are presented as mean ± SD

The medial approach was adapted in the 22 laparoscopic curative resection of colorectal cancer. The surgical procedures of the preservation of the autonomic nerves in high ligation of the IMA were as follows: By gentle retracting the sigmoid mesocolon ventrally, the root of the sigmoid mesocolon was identified clearly. Then the retroperitoneum was incised about 1 cm away from the right side of the root of the sigmoid mesocolon at the level between the origin of the IMA and the sacral promontory. Surgical dissection was performed carefully in the fascia space between the retroperitoneum and the anterior renal fascia. In front of the abdominal aorta and in the interiliac triangle above the sacral promontory, at least, part of the lateral trunks of SHP or the presacral nerves which appeared compact, bunchy-like and in silvery white color with nourishing capillaries overlaying its surface could always be identified through the fine and semitransparent anterior renal fascia even in obese patients. Once the SHP was identified, the correct surgical plane was confirmed. Surgical dissections continued upward following the fascia space. On the right side of the IMA, dissection was performed close to the right side of the root of the IMA and the lymph nodes in the accumulated fat around the root of the IMA were removed to the origin of the IMA with the anterior renal fascia intact. Sometimes the tented right ascending branches to IMP could be identified through the fine overlaying fascia. Subsequently, meticulous dissection continued laterally to the left side of the IMA in this fascia space. The left descending branches to SHP which appeared uniquely in silvery white color with nourishing capillaries overlaying its surface could be identified tenting across the fascia space and ran from the left side of IMA to the left trunk of SHP under the anterior renal fascia. Finally, take it as the anatomical landmark, and the root of the IMA was ligated distal to the position where the left descending branches to SHP departed from the left side of the IMA (Figure 3).

### Figure 3. Photo-documentation of the Landmark and Position for the Preservation of the Autonomic Nerves during High Ligation of the IMA in Laparoscopic Surgery for Colorectal Cancer

1. inferior mesenteric artery; 2, landmark of high ligation of the IMA, i.e. the left descending branches to SHP; 3, the left trunk of SHP; 4, communicating branches of bilateral trunks of SHP. Green arrowhead, mesocolon; yellow arrowhead, anterior renal fascia. Blue dotted line, the position of high ligation of the IMA.

#### The surgical outcomes

Guided by the detailed anatomical information from the cadaver dissections, the autonomic nerves preservation in high ligation of the IMA was successfully performed on all 22 patients in laparoscopic curative resection of colorectal cancer. The important anatomical landmarks, i.e. the left descending branches to SHP and the SHP in front of the abdominal aorta and in the interiliac triangle could be identified in all the cases under the well-illuminated and magnified view of laparoscopy. The mean operation time which was calculated from opening the retroperitoneum on the right side of the root of the sigmoid mesocolon to high ligation of the IMA was 22.8±3.3 min (range, 17–32 min). The mean blood loss during the high ligation of the IMA was 16.0±6.8 (range, 10–30 ml), and no intraoperative complications was found. The details of the patients and tumors were shown in Table 2.
Discussion

With the improvement of oncologic results (Heald et al., 1998; Okamoto et al., 2006; Park et al., 2013), the autonomic nerves preservation becomes more and more important for better postoperative quality of life in surgeries for colorectal cancer (Fukunaga et al., 2007; Nagpal and Bennett, 2013). Though the root of inferior mesenteric artery (IMA) is widely accepted as one of the crucial areas at risk of damage to the autonomic nerves (Moszkowicz et al., 2011; Acar et al., 2012), reliable surgical techniques of the autonomic nerves preservation in high ligation of the IMA has been vague for lacking of definite anatomical evidences. It is demonstrated in the present study that the relationships between the root of the IMA and its bilateral autonomic nerve plexuses are different and guided by the anatomical evidence, the bilateral autonomic nerves can be preserved clearly in high ligation of the IMA in laparoscopic surgeries for colorectal cancer.

The AAP, SHP, IMP and bilateral L1-L3 LSNs connect with each other like a network around the root of the IMA, but it is clear that the presacral nerve is the downward continuation of the bilateral trunks of SHP and branches into bilateral HGNs below the sacral promontory (Paraskevas et al., 2008; van Schaik et al., 2001). Intraoperative damage of the SHP and HGNs may lead to the postoperative ejaculative and voiding disorders (Maurer, 2005; Liang et al., 2008). Therefore, it is critically important to preserve the bilateral trunks of SHP in high ligation of the IMA. In previous literatures, the descriptions of the relationships between the bilateral trunks of SHP and the root of the IMA are limited and vague. The bilateral trunks of SHP are named arbitrarily as the inferior mesenteric plexuses (Liang et al., 2008), paraaorta trunks (Nano et al., 2004), preaorta plexus (Hida et al., 1999), lateral trunks of SHP (Paraskevas et al., 2008) or sympathetic trunks at the IMA level (Cheung et al., 2009). In Grey’s anatomy, there is no definite nomination and descriptions about the bilateral trunks of SHP. According to their formation and course and in order to avoid misunderstanding with other autonomic nerve plexuses, we are in agreement with Paraskevas (Paraskevas et al., 2008) to name them as the lateral trunks of SHP. Definite nominations and locations of the autonomic nerve plexuses around the root of the IMA may contribute to a consistent anatomical description of their relationships with the root of the IMA.

It is shown in the previous anatomical observations on formalin-fixed cadavers that the autonomic nerve plexuses around the root of the IMA including the bilateral trunks of SHP are all tented around the root of the IMA when the left mesocolon is retracted ventrally (Hoer et al., 2000; Zhang et al., 2006; Acar and Kuzu, 2012). So Höer believed that high ligation of IMA would damage the sympathetic autonomic nerves (Hoer et al., 2000) and Acar proposed that high ligation should be done 1-2cm distal from the origin of the IMA (Acar and Kuzu, 2012). In the present study, in addition to the morphology of the autonomic nerves around the root of the IMA, their relationships with the surgical plane were observed. It is
present study, we can make the following conclusions: (1) if high ligation of the IMA is performed at its origin on the aortic artery, the right trunk of SHP can be preserved safely, but the autonomic nerves on the left side of the IMA will be inevitably damaged. (2) according to the results of our measurement, the distance between origins of the IMA and the left descending branches to SHP varies widely. So if high ligation of the IMA is performed at the position a certain distance from its origin, it may be unreliable to protect the autonomic nerves on the left side of the IMA. Moreover, a residual root of the IMA may decrease the extent of en bloc dissection of the apical lymph nodes metastasis to the origin of the IMA.

The debate on the optimal position of high ligation of the IMA in surgeries for colorectal cancer may attribute to hoping to keep a balance between radical dissecting apical lymph nodes metastasis and preserving the autonomic nerves to avoid the postoperative urogenital dysfunction. However, because the positions of high ligation of the IMA are inconsistent, the extent of apical lymph nodes dissection is consequently different which may disturb the accurate evaluation of the clinical value of the apical nodes dissection. Moreover the reliability of autonomic nerve preservation is unclear for lacking of the definite anatomical evidences in the previous literatures. So it is very hard to evaluate the optimal position of high ligation of the IMA. In the present study, this is the first time to give the detailed anatomical evidences of the different bilateral preservation of the autonomic nerves in high ligation of the IMA in surgeries for colorectal cancer. Based on the divergences of the relationships between the root of the IMA and the bilateral autonomic nerves, more precise evaluation are expected to clarify the optimal position of high ligation of the IMA in laparoscopic surgery for colorectal cancer in the near future. Can the urogenital function be preserved if only the right trunk of SHP is preserved with high ligation at the origin of the IMA? Will the radicality of the colorectal cancer be disturbed if bilateral autonomic nerve preservation is preserved completely with high ligation of the IMA distal to the left descending branches to SHP?

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References


