DIVERTICULAR DISEASE: PRIMARY RESECTION, PRIMARY ANASTOMOSIS?

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While treatment of uncomplicated or Hinchey I or II diverticular disease of the sigmoid colon is universally straightforward, controversy remains as to how to best treat complicated diverticular disease, and in particular, the best way to manage generalized peritonitis complicating sigmoid diverticulitis (GPSD). As concerns the latter, the literature suggests a clear advantage of primary resection (PR) over secondary resection (SR), both in terms of immediate mortality and morbidity: the only prospective randomized, monocenter, trial published before our study concluded that SR was better. The French Associations for Clinical Research’s controlled randomized trial (comparing PR to SR) included 105 patients (53 females and 52 males), mean age: 66 ± 14 years (range: 32–91 years), stratified according to age > 65 years vs. < 65 years. Two randomized patients were withdrawn from analysis because they had malignant colonic tumors, leaving 55 patients treated by PR and 48 by SR. The main end point was the occurrence of generalized or localized postoperative peritonitis (POP). The Mannheim peritonitis index (MPI) was calculated for each patient. Both groups were comparable concerning pre and intraoperative data. POP occurred less often in PR than in SR whether considering the first procedure only (1 vs. 10) (p < 0.01) or all procedures as a whole (1 vs. 11 (p < 0.001)). Likewise, early reoperations were performed significantly less often in PR than in SR (2 vs. 9 (p < 0.02) and 2 vs. 11) (p < 0.01), respectively. There were more procedures (p < 0.05) and longer intervals between operations associated with SR. Consequently, the median length of hospital stay was significantly shorter in PR (27 days) than in SR (40 days) (p < 0.02). Seven patients had permanent colostomies. No statistically significant difference was found whether taking into account the operative policy (PR 22% vs. SR 21%) or the type of peritonitis (fetal 27% vs. purulent 19%). On the other hand, overall mortality was significantly higher in patients: a) ≥ 65 years old (34% vs. 4.5%) (p < 0.001); b) of female gender (32% vs. 12%) (p < 0.05); c) with one or more preoperative organ failures (42% vs. 7%) (p < 0.001); d) with a MPI score ≥ 21 (50% vs. 5%) (p < 0.01); and e) with persisting POP (38% vs. 7%) (p < 0.03). In this study, we concluded that PR was superior to SR in the treatment of GPSD. As to whether primary anastomosis should be performed during PR, several prospective, non-controlled trials seem to indicate that it can. Last, should diverticular disease be treated laparoscopically and are there any scientific arguments in favor of this policy? Few randomized controlled trials have dealt with comparing laparoscopic procedures to laparotomy for sigmoid resection in diverticulitis, and most, indirectly. There are therefore no or little scientific arguments of any founded value for advocating sigmoid resection in this disease. However, arguments in favor of the laparoscopic approach would be decreased postoperative pain, more rapid return to intestinal activity and oral feeding, decreased hospital stay, reduction of abdominal scar and earlier return to physical and professional activities.

Against this would be the duration and the direct costs of operation, the high rate of failure (30%) leading to conversion and specific morbidity during the so-called learning curve. Each and every one of these advantages and disadvantages may be discussed. Analysis of results of laparoscopic treatment does not often include the patients who failed and therefore analysis with intention to treat is often lacking.

THE PHILOSOPHY OF MEDICAL MANAGEMENT OF IBD

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Inflammatory bowel disease, whether Crohn’s disease or ulcerative colitis, is probably the greatest clinical challenge facing gastroenterologists - a chronic disease of unknown cause, with an uncertain prognosis, associated with considerable morbidity and occasional mortality. Yet the physician should convey optimism to the IBD patients - although there may be a range of problems and set backs, most patients do enjoy prolonged episodes of remission. Life-expectancy is not reduced. Most patients do reasonably well.

The physician must have a protocol for managing fulminating inflammatory bowel disease.

But above all, the physician must be available. A patient with a relapsing disease feels very vulnerable. The physician must be available at times of relapse, to exclude infection, and to provide speedy treatment.

The physician should be problem-orientated. Although there may be only one diagnosis, many things can need attention - not only the IBD inflammation itself, but also infection, malnutrition, anaemia, or surgical problems.

The physician must be cautious - we now have a range of potent interventions, and we must avoid iatrogenic damage. Steroids, immunosuppression, parenteral feeding, monoclonal antibodies, radical surgery - all can be used inappropriately.

A physician can provide confidence through information - patients want to know about their disease, they may want to meet other patients, they may want to take part in research, they need to be empowered to take difficult decisions - for example, about surgery or using azathioprine.

The physician must make the case for maintenance treatment, as a way of decreasing morbidity - especially using mesalazine and azathioprine.

The physician must have a protocol for managing fulminating inflammatory bowel disease.