Response to "Comments on 'Colectomy for caecal and sigmoid volvulus: a national analysis of outcomes and risk factors for postoperative complications'"

doi:10.1111/codi.14901

Dear Editor,

I thank Professor Atamanalp for the thoughtful discussion regarding our paper entitled 'Colectomy for caecal and sigmoid volvulus: a national analysis of outcomes and risk factors for postoperative complications' [1]. We would like to congratulate him on his cited work of 1026 patients with sigmoid volvulus as this is the largest series in the published literature [2]. We appreciate his attentive consideration of our data and would like to respond.

First, with regard to the lack of randomization of the patients, as pointed out, this is not possible given the retrospective nature of our review. As patients present during varying stages of disease progression, the status of their disease dictates the selected treatment and does not afford randomization due to clinical equipoise. Patients presenting later in the course of disease, potentially *in extremis*, would require an emergent laparotomy, whereas those presenting earlier in the course of the volvulus may undergo immediate endoscopic detorsion and be candidates for laparoscopic procedures. While ideally we would be able to perform a randomized trial, the goal of this paper was to assess the current status of national practice patterns and outcomes.

Second, our report of a lower mortality rate of 3.4% is comparable to a similar rate reported by Dolejs *et al.* of 5% [3]. Although the data were similar for years, we included slightly different Current Procedural Terminology (CPT) codes that probably account for the absolute difference in morbidity and mortality rates. We opted to include patients who underwent total colectomy with end ileostomy. Surprisingly, our reported mortality rate was lower. The various reported mortality rates have a broad range, including in our study. Given the preoperative counselling that occurs, often with the patients' families rather than the patients themselves, our study aimed not only to describe the general outcomes on a national level but also to provide surgeons with an understanding of risk factors for untoward outcomes. This may help with patient stratification and assist in the perioperative counselling for these patients, many of whom have multiple medical comorbidities and dependent functional status.

Again, I thank Professor Atamanalp for his engaging comments.

A. R. Bhama
Department of Colorectal Surgery, Cleveland Clinic, Cleveland, Ohio, USA
E-mail: anuradha.bhama@gmail.com

Received 19 September 2019; accepted 18 October 2019; Accepted Article online 8 November 2019

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Laparoscopic sigmoidectomy for perforated diverticulitis with purulent peritonitis – a video vignette

doi:10.1111/codi.14881

Dear Editor,

Acute diverticulitis with colonic perforation is common. Most surgeons would agree that surgery is indicated in the presence of peritonitis and sepsis. In this situation, most surgeons would avoid a primary anastomosis and consider open surgery to be necessary [1–5].

This video (Video S1 in the online Supporting Information) illustrates a laparoscopic approach in a case of acute perforated diverticulitis of the sigmoid colon in which we performed a primary anastomosis.

The operation commenced with an exploratory laparoscopy which revealed the presence of purulent peritonitis. We mobilized the splenic flexure to facilitate identification of the perforation. Colon mobilization was medium to lateral. The inferior mesenteric vein and artery were not dissected at their origin. We proceeded to the mesocolon section once the colon was mobilized. The sigmoid colon was divided using a linear stapler at the level of the sacral promontory. A primary anastomosis was performed and reinforced using interrupted sutures. We did not routinely perform a defunctioning ileostomy.

This video suggests that a laparoscopic approach is feasible if appropriate facilities and expertise are available [6].

Conflicts of interest

There are no conflicts of interest to declare.

F. Coratti*, T. Nelli†, C. Maggioni†, C. Mongelli† and F. Cianchi†
*AOUC, Firenze, Italy, and †Università degli Studi di Firenze, Firenze, Italy
E-mail: corattif@gmail.com

Received 16 August 2019; accepted 18 September 2019; Accepted Article online 22 October 2019

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Supporting Information

The video may be found in the online version of this article and also on the Colorectal Disease Journal YouTube and Vimeo channels:

Video S1. Laparoscopic sigmoidectomy for perforated diverticulitis.

Rectovaginal fistula repair – a video vignette

doi:10.1111/codi.14882

Dear Editor,

The case of a 34-year-old lady with a rectovaginal fistula following instrumental vaginal delivery is described in Video S1. On examination, there was a 2-cm-diameter defect just above the anal sphincter. Endoanal ultrasound showed a less than one quadrant full thickness scarring of the external and internal anal sphincter.

Following multidisciplinary discussion, a transperineal approach using a posterior fourchette incision was utilized, with direct repair of rectal and vaginal wall defects. An anterior levatorplasty was used to interpose healthy tissue. Intra-operatively, the external anal sphincter appeared grossly intact and did not require repair.

The posterior fourchette approach facilitates early wound closure and reduces the risk of postoperative wound breakdown compared to conventional perineal approaches, anteriorly to the anal verge [1].

The rectovaginal septum was opened and the plane was dissected to 2 cm above the level of the fistula. Primary repair of the fistula was performed using 2/0 Vicryl™ (Johnson & Johnson, Philadelphia, Pennsylvania, USA) interrupted stitches. A levatorplasty, when the adjacent tissues are easily opposable, or a Martius flap is used to reinforce the primary suture and separate the rectal and vaginal sutures. In this case, anterior levatorplasty was performed with full thickness 2/0 PDS™ (Johnson & Johnson) interrupted sutures. A further advantage of performing levatorplasty is that the sequential sutures towards the perineum naturally lead to the deep external anal sphincter, which can be plicated or repaired as indicated.

Conflicts of interest

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

Author contributions

Study concepts: Hanly AM, O'Connell PR. Study design: Climent M, McCawley N, Hanly A, O'Connell PR. Data acquisition: Climent M, O'Connell PR. Manuscript preparation and editing: Climent M, McCawley N, Hanly A, O'Connell PR. Manuscript review: Climent M, O'Connell PR.

M. Climent, N. McCawley, A. M. Hanly and P. R. O'Connell
Centre for Colorectal Disease, St Vincent's University Hospital, Dublin, Ireland
E-mail: martacliment@gmail.com

Received 18 July 2019; accepted 30 September 2019; Accepted Article online 22 October 2019