

Letters

COMMENT & RESPONSE

Decompressing Stoma vs Stent in Left-Sided Obstructive Colon Cancer

To the Editor I read with much interest the article by Veld et al.¹ The authors analyzed 3253 patients with left-sided malignant colorectal obstruction collected from the Netherlands national data operated from January 2009 to December 2016. In a propensity score-matching analysis, they compared 121 patients who had stenting vs 121 patients who had proximal diverting stoma as a bridge to colorectal resection. Patients undergoing stenting had more primary anastomoses, more postresection stomas, fewer major complications, and more subsequent interventions, including stoma reversal. After diverting stoma and stenting, the 3-year locoregional recurrence rates were similar, with a 3-year overall survival rates of 78.0% and 71.8%, respectively.

The results of the study may be seen by an alternative point of view. The overall results reported by Veld et al¹ are much better than those reported in the pre-stenting era.²⁻⁴ The study clearly shows the high level of independent thinking by surgeons who have the general wise attitude to consider each patient in her/his individuality, adapting the different therapeutic solutions in this complex clinical scenario (diverting stoma, resection, or stenting) to specific clinical and anatomic details. Stenting as a bridge to resection is just one of the several therapeutic solutions, which may be chosen according to the characteristics of the patients and the specific experience and attitude of the surgical team.

The location of the tumor is an important point to be considered. Obstructing colorectal cancers occur more often in the sigmoid colon. In complete obstruction with a sharp angle of the recto-sigmoid junction, the guide wire used to place the

stent may perforate the colonic wall, which is thin, dilated, and partially ischemic above the obstruction. If the patient does not have major clinical problems, and the colon above the obstruction is not very dilated, surgical resection is a simple and straightforward procedure; eventually, a protective diverting proximal colostomy will be closed easily 2 weeks later under local anesthesia. Alternatively, a diverting colostomy may be a simple temporary solution. In the other cases (middle-lower rectum or inferior aspect of the recto sigmoid junction), stent placement is much easier, preventing stoma formation, prolonged hospital stay, and significant discomfort for the patient and the family.

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