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Editorial

The Perspectives in the Management of Obstructive Left Colonic Carcinoma

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Editorial

Colonic carcinoma is the most frequent gastrointestinal malignancy. It is believed that almost 53% of colonic carcinoma are located on the sygmoid colon and the rectum and that around 20% of colonic carcinoma has intestinal obstruction as the first clinical symptom [1]. In the United States, colonic cancer is the third most frequent cancer, with similar incidence in men and women. Intestinal obstruction, as one of the most dangerous complications of colonic carcinoma, leads towards impaired respiratory function, and due to the stasis of faecal contents, there is also a significant possibility of infection and sepsis, as one of the most feared complication. Emergency surgery in cases like this is linked with significant morbidity and mortality, even with the most skilled surgeons.

There is still a great controversy surrounding the treatment of Obstructive Left Colonic Carcinoma (OLCC). In the case of obstructive right colonic carcinoma, right hemicolectomy with primary anastomosis is advocated. But, in the case of OLCC, there are several solutions. This urgent condition can be managed in several (surgical) ways: loop colostomy and subsequent resection, resection with end colostomy (Hartmann's procedure) and resection with primary anastomosis.

For the illustration of the degree of controversy among the surgeons when it comes to the treatment of OLCC, the Society of American Gastrointestinal and Endoscopic Surgeons conducted a poll. In this poll, 67% of surgeons voted for Hartmann's procedure, and 26% for loop colostomy [2]. There are also a few randomised trials that investigated the treatment of OLCC, which provided us with different results. Finally, in 2010, World Society of Emergency Surgery (WSES) and Peritoneum and Surgery (PnS) Society on their Consensus conference claimed that Hartmann's procedure should be preffered to loop colostomy [3,4].

Along with the development of endoscopic procedures, there is one new approach in the management of OLCC. This approach combines endoscopic and surgical procedure. The first step is to do endoscopy and simultaneously place Self-Expanding Metallic Stent (SEMS). Due to this procedure, there is no more colonic obstruction, and it clears the pathway to reestablishing bowel movement. The next stage is laparoscopic semi-elective surgery that provides better oncologic outcome, lower rate of surgical complication and surgical site infections. Laparoscopy alone cannot be used in the case of OLCC, due to the distended bowel and the possibility of significant surgical complication based on technical limitations.

Dohmoto first described the use of SEMS back in 1991 in the purpose of palliative treatment. Three years later, Tejero reported the use of SEMS as a bridge to semi-elective surgery [5,6]. Since that moment, there are a lot of studies that showed a significant improvement in the treatment of OLCC. This improvement means shorter hospital stay, lower rate of complications and better oncologic results.

This two staged procedure, like in the case of loop colostomy followed by colonic resection and primary anastomosis, has one big advantage. The first step facilitates bowel movement and provides normal gastrointestinal function. Also, with this procedure, there is enough time to prepare the patient for the second stage in the management of OLCC, in the terms of stabilizing his/her vital parameters and underlying commorbidities.

This two staged procedure raised a couple of questions among clinicians. These questions were in large reference to possible complications associated with this procedure. One of them is perforation that consequently demands urgent surgical intervention. Other, less feared complications are malposition, stent migration, bleeding and reobstruction. Several studies showed that the rate of perforation is very low, around 1.5% and thus this procedure can be considers as secure. The controversy surrounding the possibility of tumour dissemination still remains present [7]. Despite several studies showed that there is no difference in long term outcome (Dukes B and C), there is still remaining fear that SEMS placing could induce dissemination of malignant cells.

Several reports favour this two staged procedure to classical surgical approach, with the explanation of being more cost effective [8]. Only one study, conducted in Greece, showed that SEMS placing followed by laparoscopic surgical procedure is more expensive compared to classical surgical procedure [9].

And last, but not least, the use of this two staged procedure in the management of OLCC brought vast improvements in the field of the primary anastomosis. This fact has great impact on the quality of life because there is no need for stoma creation. Also, this guarantees that there is no greater rate of anastomotic dehiscence and leakage.

Finally, it can be said that the treatment of OLCC is still surrounded with several controversies. This treatment is linked with relatively high rates of perioperative complications, morbidity and mortality. On one hand, Hartmann's procedure and loop colostomy followed by resection and anastomosis, have higher rates of surgical complications compared to the two staged procedure that combines endoscopic and laparoscopic approach.

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On the other hand, the two staged approach, that involves SEMS placing, has got one big advantage-improved quality of life because of stoma absence. The purpose of all procedures is to optimize patient's health and provide better quality of life. In the case of OLCC, the treatment is, first and foremost, directed towards reestablishing bowel movement, and diminishing the risk of the above mentioned respiratory complication and potential sepsis. The fact that the procedure that involves SEMS placing offers better quality of life, and that the cost of this procedure is very similar to the cost of the classical surgical approach, we would like to recommend a wider use of the two staged treatment that combines endoscopic and surgical procedures.

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