LETTERS TO THE EDITOR

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Comments on clinical outcomes of sigmoid colon volvulus: identification of the factors associated with successful endoscopic detorsion

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I read with interest the article by Iida et al.[1] who reported the factors affecting the success of endoscopic detorsion in sigmoid volvulus (SV). The subject raised by the authors is extremely interesting. Among a large number of evaluated criteria, the absence of abdominal tenderness, the use of laxatives, and the history of open abdominal surgery have been reported as predictive factors for successful endoscopic detorsion.

I practice in eastern Turkey, which is an endemic SV area.[2] My clinic has 51 years of history and 1,000 cases of endoscopic and/or surgical experience with SV. This is the largest single-center SV series in the world according to the literature in major research databases, including Web of Science[3] and PubMed.[4] In our series, the success rate of endoscopic detorsion is 77.5%, and increases to 82.4% when gangrenous cases are excluded. In my experience, in addition to the elements presented by Iida et al.,[1] there are 3 important factors causing unsuccessful endoscopic detorsion: a prolonged symptomatic period, the presence of over-rotation, and the co-occurrence of ileosigmoid knotting (ISK). It is well known that these factors also lead to the development of bowel gangrene in SV.[5]

Although ISK, which is a complex volvulus of ileum and sigmoid colon, is a component of SV, it is generally considered a different entity, and is not evaluated in SV series. ISK is principally treated with emergency surgery, and when diagnosed accurately using CT or MRI, endoscopic detorsion is not tried.[6] Consequently, there are no ISK cases in the series presented by Iida et al.[1] Nevertheless, I really wonder about the role of the prolonged symptom period and over-rotation in the failure of endoscopic detorsion in their series. In my opinion, the presence of a long period between the onset of symptoms and endoscopy may cause bowel and mesentery edema, which theoretically may hinder detorsion. I think that the records of symptom duration should be re-evaluated in the retrospective series presented by Iida et al.[1] Finally, in my opinion, the presence of over-rotation, which is described as rotation greater than 360°, may block detorsion mechanically, and may cause an endoscopic washout. As discussed by Iida et al.,[1] abdominal CT has been used in the diagnosis of these patients. In my experience, although the amount of rotation is best determined via surgery, it can also be estimated via CT. I hope these 2 subjects will be re-evaluated by the authors. If not possible, I would at least appreciate the authors' thoughts on my comments.

I congratulate the authors on their interesting study and look forward to their reply.

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