



Comments on “Surgical Management of Sigmoid Volvulus: A Multicenter Observational Study”

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To the Editor,

I read the article written by Lee et al. [1], who reported the surgical outcomes of 74 patients with sigmoid volvulus (SV). Although SV is a rare clinical entity worldwide [2], it is relatively common in my practicing area, Turkey [3]. We have the largest single-center SV series over the world [2], which includes a 1,036-case experience with SV over a 54.5-year period from June 1966 to January 2021. Under favor of this experience, my comments relate to some details of the treatment of SV.

First, as the authors declared, the nonrandom grouping of the patients treated with emergency or elective surgery, which results from the retrospective nature of the study, is the major limitation of the presented study [1]. Compared with elective surgery group, patients in emergency surgery group have significantly worse American Society of Anesthesiologists (ASA) physical status (PS) classification. Most likely for this reason, in the same group, morbidity rate is higher, discharge destination is longer, and need for stoma, which is an undesired but a lifesaver procedure, is more common. It should come as no surprise that, the prognosis of the emergency surgery is worse than that of the elective surgery [4, 5]. In our series, the mortality, morbidity, and recurrence rates are 16.9%, 34.3%, and 4.1%, respectively, in 478 patients treated with emergency surgery, while 0.0%, 11.4%, and 0.0%, respectively, in 114 patients treated with elective surgery. In my opinion and experience, neither emergency nor elective surgery is actually an alternative to each other, and indications for each procedure are relatively well described.

Second, according to the current practice, in SV, endoscopic de-

compression is the first-line therapy in patients without peritonitis and perforation, while emergency surgery is required in patients with the abovementioned adverse events in addition to unsuccessful decompression. Additionally, following a successful endoscopic decompression, selected nonelderly and well-conditioned patients are treated with elective surgery, while percutaneous endoscopic colopexy (PEC) is recommended in elderly or bed-conditioned patients [6-9]. Regarding the objective criteria, I prefer elective surgery in patients younger than 70 to 75 years old and with ASA PS classification I to III, while I suggest PEC in cases older than 75 years old or with ASA PS classification IV [10].

I congratulate the authors and wait for the authors' opinion on my comments.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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