Treatment

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For sigmoid volvulus the initial management is non-operative decompression using either a rigid sigmoidoscope or a colono - scope. Direct vision allows assessment of mucosal viability and derotation. With successful derotation a well-lubricated flatus tube should be inserted and left for 2–5 days. Bloody bowel It contents or discoloured mucosa suggest ischaemia and the need f or urgent surgery . Attempted derotation in this situation should be abandoned as it could lead to circulatory collapse and death. Careful consideration of definitive surgery on a case-by-case basis in this, often elderly and frail, patient group is required. - Although they would be subject to significant perioperative risk there is a very high recurrence rate f or sigmoid volvulus. Such surgery should involve at least resection of the whole of the sigmoid colon and can be carried out laparoscopically . Given that there is very little need for colonic mobilisation and a large utility incision is required because of the bowel size, some of - the benefits of a laparoscopic approach are negated. It is there - fore reasonable to carry out surgery through a minilaparotomy incision with the same recovery outcomes. An alternative to surgical resection in the very unfit patient is a percutaneous endoscopic colostomy , using a colonoscope to place a drainage tube through the abdominal wall into the sigmoid to fix the bowel in an untwisted position. In the emergency situation where there is evidence of necrosis it may be wise to ligate the mesenteric vessels before untwisting the volvulus to theoretically avoid the systemic release of ischaemic toxins. It may also be prudent to a anastomosis. Instead, a Hartmann’s-type approach or a Paul– Mikulicz double-barrelled stoma should be considered. For caecal volvulus endoscopic decompression is often unsuccess ful and leads to treatment delay . Instead, urgent right hemicol ectomy is indicated.

Figure 77.17 Plain abdominal radiograph showing colonic distension associated with a sigmoid volvulus (courtesy of Dr Rajpal Dhingsa, Nottingham University Hospitals, Nottingham, UK).

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