TREATMENT OF ACUTE LARGE BOWEL OBSTRUCTION

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Large bowel obstruction is caused by an underlying carcinoma or less commonly diverticular disease and presents in an acute or chronic form. The condition of pseudo-obstruction should always be considered and excluded by a limited contrast study or CT scan to confirm mechanical obstruction. After full resuscitation, the abdomen should be opened through a midline incision. Care should be taken to ensure that the loss of tamponade of the abdominal wall does not lead to increased caecal distension and rupture (this starts with splitting along the line of the taenia coli on the antimesenteric border). Distension of the caecum will confirm large bowel involvement. Identification of a collapsed distal segment of the Harry C Bishop , 1921–2009, Professor of Surgery , University of Philadelphia, Philadelphia, PA, USA. Charles Everett Koop , 1916–2013, paediatric surgeon and public health administrator, served as the 13th Surgeon General of the USA (1982–1989). Frank Thomas Paul , 1851–1941, surgeon, The Royal Infirmary , Liverpool, UK. Johann von Mikulicz-Radecki , 1850–1905, Professor of Surgery , Breslau, Germany (now Wroc ł aw , Poland). - els are - - large bowel and its sequential proximal assessment will readily lead to identification of the cause. As surgery for malignant bowel cancer is technically challenging, wherever possible a suitably trained surgeon should perform the procedure. When - a removable lesion is found in the caecum, ascending colon, hepatic flexure or proximal transverse colon, an emergency right hemicolectomy should be performed. A primary anasto - mosis is safe if the patient’s general condition is reasonable (see Chapter 77). If the lesion is not resectable a proximal stoma (colostomy or ileostomy if the ileocaecal valve is incompetent) or ileotransverse bypass should be considered. Obstructing lesions at the splenic flexure should be treated by an extended right hemicolectomy with ileo-descending colonic anastomosis. For obstructing lesions of the left colon or rectosigmoid junction, immediate resection should be considered unless there are clear contraindications. In rare instances or when caecal perforation is imminent, additional time to improve the patient’s clinical condition can be bought by performing an emergency caecostomy or loop transverse colostomy (loop ileostomy in the presence of an incompetent ileocaecal valve). In the absence of senior clinical sta ff , it is safest to bring the proximal colon to the surface as a colostomy . When pos - sible the distal bowel should be brought out at the same time (Paul–Mikulicz procedure) to facilitate subsequent closure. In the majority of cases , the distal bowel will not reach and is

Ileostomy End-to-side ileoileostomy Figure 78.18 Bishop–Koop operation. This shows the completed pro

cedure after a grossly distended ileum has been resected. Because intestinal continuity is preserved, early closure of the ileostomy is not essential.

A second-stage colorectal anastomosis can be planned when the patient is fit. If an anastomosis is to be considered using the proximal colon, it may be decompressed and cleaned by an on-table colonic lavage. In a palliative situation or if a patient is unfit for major surgery insertion of a self-expanding metal stent may be pref erable as it o ff ers reduced mortality and morbidity and stoma formation (see Chapter 77). Technical and clinical success ra tes for stenting are of the order of 80–90% (Figure 78.19 For patients with potentially curative disease, stenting as a bridge to surgery (usually performed 1–4 weeks post stent ing) has been shown to reduce stoma forma tion but not to reduce postoperative mortality . Recent guidelines from the European Society of Gastrointestinal Endoscopy recommend stenting as a bridge to surgery to be discussed, within a shared decision-making process, as a treatment option in patients with potentially curable left-sided obstructing colon cancer as an alternative to emergency resection. This is a strong recom mendation based on high-quality evidence. Colonic stenting should be performed or directly supervised by an operator who can demonstrate competence in both colonoscopy and fluoroscopic techniques and who performs colonic stenting on a regular basis. A time interval of 2–4 w eeks is generally employed prior to definitive surgery . This period allows treat ment of comorbidities and completion of staging investiga tions. A decompressing stoma as a bridge to elective surgery is a valid option if the patient is not a candidate for colonic stenting or when stenting expertise is not available.

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