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Preservation of the superior rectal artery in laparoscopic colectomy for slow transit constipation: Is it really associated with better outcomes?

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Abstract

Few patients with slow-transit constipation refractory to conservative treatment can benefit with a subtotal colectomy with ileorectal anastomosis with the preservation of the superior rectal artery. In this letter to the editor some important issues were discussed. First, the study did not include a comparison group. Second, they did not present the functional results in the short or long term related to the bowel function of these patients after surgery. Finally, the authors showed that this surgical procedure was safe, and no cases of leakage were found.

Key Words: Laparoscopy; Colorectal surgery; Constipation; Colectomy

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Core Tip: Subtotal colectomy remains a treatment option for few patients with slow-transit constipation (STC) refractory to conservative treatment. A careful patient selection is important to improve benefits and reduce risk of adverse outcomes. Laparoscopically assisted subtotal colectomy with ileorectal anastomosis and preservation of the superior rectal artery may be effective for STC and can be the best surgical option in these situation.

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TO THE EDITOR

Wu *et al*[1] recently published an observational study on the largest patient sample with vascular preservation with slow transit constipation (STC) who were submitted to laparoscopically assisted subtotal colectomy with ileorectal anastomosis and preservation of the superior rectal artery (SRA). The authors concluded that this surgical approach could significantly improve bowel function with careful patient selection and that sparing the SRA may protect against anastomosis leakage. Despite the relevant information described in the study, some important issues need to be discussed.

First, the study did not include a comparison group, *e.g.*, patients undergoing the same surgical laparoscopic procedure without SRA preservation, to find out whether one procedure is advantageous over the other. Would the SRA preservation status affect the length of hospital stay, first time to flatus, leakage volume, or postoperative complication rate? Second, based on the results, the authors cannot state that the surgery "can significantly improve bowel function with careful patient selection". The authors did not present the functional results in the short or long term related to the bowel function of these patients after surgery, as other authors have[2]. Third, they cannot state that sparing the SRA may protect against anastomosis leakage. What the authors showed is that this surgery was safe, and no cases of leakage were found. Finally, why did the surgeons make a 4-5 cm Pfannenstiel incision and bring out the mobilized bowel segment? The key limitation of the work was the absence of a control group, which would enrich the important and relevant findings of their study. In our clinical practice, we try to preserve the SRA in nononcological procedures, such as for endometriosis, diverticular disease and STC, as described by other authors[3]. However, we remove the surgical specimen using a trocar in the lower right abdominal quadrant. In the other aspects of the manuscript, we agree with the authors and believe that the best surgical option in STC could be laparoscopic subtotal colectomy with ileorectal anastomosis with preservation of the SRA.

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