Fístulas enterocutáneas posterior a cierre de ostomías terminales

To the Editor:

Recently, Dr. J.L. Martínez Ordaz and collaborators published the work “Risk Factors and Evolution of Enterocutaneous Fistulas Subsequent to Closure of Terminal Ostomies”,¹ which we consider extremely attractive and encouraged us to do an analysis of the same because it addresses one of the major problems that we continue to have with bowel surgery and which causes prolonged hospital stays and a high consumption of resources. The 293 patients included appear to us to be outstanding; however, it is very important to consider some points.

Statistical management that should be given to these types of risk factor studies falls short, only mentioning the statistical significance. The statistics of relative risk (RR) or odds ratio (OR) with its confidence interval of 95% (95% CI) would have definitely allowed us to have greater clarity on the effect that the variable considered to be a risk factor has on the outcome that we are observing. The title of the article encourages looking for this data.²

From the point of view of the information, it is unclear to me if the patients who were excluded during the surgical event were not able to be reconnected or, if in reality, the 293 patients were to be reconnected and all had intestinal reconnection performed. It is important to mention this especially in relation to a reconnection after a Hartmann procedure, which is a major surgery, finding at least in the best series 5% of patients in whom the continuity of the intestinal transit is not able to be reestablished.³

On the other hand, it seems to me that it has not been reported on how many patients who had anastomotic dehiscence had to have a stoma procedure redone or none of the 24 patients with this complication required a stoma once again. Some authors report up to 50% have a new stoma for management of anastomotic leaks.⁴ Some experts conclude that in the case of a major intraperitoneal leak it is the best option.⁵

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In our opinion, the study allows us see in an erroneous manner that the anastomotic dehiscence can be managed in all cases as controlled fistulas with low morbidity and mortality. We continue to recognize the importance and merit that involves the generation of original studies that are carried out in our country by national researchers.

REFERENCES


REPLY: LETTER TO EDITOR

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Dear Dr. Juan Antonio Villanueva Herrero and Dra. Lisbeth Alarcón-Bernés:

Thank you for your interest given to the article “Risk Factors and Evolution of Enterocutaneous Fistulas Subsequent to Closure of Terminal Ostomies”. We are replying in the order of the comments.

Regarding the risk factors that we found in relation with the formation of enterocutaneous fistulas (ECF) after intestinal reconnection, OR (95% confidence interval) found for each one was history of chronic renal insufficiency 4.75 (1.12-20.11), ASA scale III or >2.70 (1.22-5.96), interval between surgery and intestinal reconnection >365 days 2.4 (1.07-5.37), reoperation 6.51 (2.92-14-48), and dehiscence of anastomosis 71.14 (25.04-202.1).

The goal of our study was to identify the factors associated with formation of ECF after closure of terminal ostomies so that only patients in whom it was possible to carry out intestinal reconnection were included. During the study period, it was not possible to perform intestinal reconnection in one patient after a colostomy with a Hartmann’s procedure due to complicated diverticular disease. There were no postoperative complications in this patient.

With respect to the management of dehiscence of the anastomosis, we reported previously that our index of reoperation for this reason was 45%. The principal indication for reoperation was the development of signs of systemic sepsis and our response was the formation of a new ostomy for its control. In patients with dehiscence of the anastomosis and without signs of sepsis, there is the possibility of conservative management and it is in those patients where the formation of ECF is more feasible, the reason for this study. Nowhere do we recommend or suggest that management must be conservative in all cases of anastomotic dehiscence. We suggest the review of our previous study to complement the data presented here.

REFERENCES