Commentary

Systematic review and meta-analysis of laparoscopic *versus* open colectomy with end ileostomy for non-toxic colitis (*Br J Surg* 2013: 100: 726–733)

I would first like to congratulate Bartels and colleagues for this excellent paper, which confirmed the short-term benefits of laparoscopic subtotal colectomy in patients with inflammatory bowel disease (IBD). These results are consistent with those of previous studies[1], and they are of importance in confirming the role of the laparoscopic approach in acute and subacute situations. In addition to these short-term benefits, laparoscopy is a part of the surgical strategy to preserve in particular the abdominal wall in patients with IBD for present and possible future procedures. Having fewer adhesions and scars is especially important for those with Crohn's disease, who frequently undergo repeated procedures. In our experience, even with the use of new haemostatic devices (thermofusion devices, ultrasonic scalpel), laparoscopic subtotal colectomy remains more time-consuming[1] and demanding than the open approach. Ideal conditions for laparoscopic procedures comprise experienced surgeons and a high level of equipment, which is usually difficult to obtain in acute situations even in specialized centres. For these reasons, major scientific societies do not give any recommendation on the use of laparoscopy in patients with IBD[2], especially in acute and subacute situations. The publication of such work is therefore essential if we hope for the guidelines slowly to change.

As the authors state in the discussion, the major limitation of this paper is the relatively low methodological quality of the reviewed studies; there were no randomized trials, and clear definitions of the complications were lacking. Laparoscopic procedures were also probably performed by more experienced surgeons than those who performed open operations, as demonstrated by the very low conversion rate of 5·5 per cent. In most studies the patients compared were highly selected. Indeed, all the relative contraindications to laparoscopy, such as colonic dilatation, signs of shock and peritonitis, were excluded. Laparoscopic and open procedures were compared only for patients in whom laparoscopy was easy to achieve. In unselected patients, conversion rates would probably have been higher, and associated with high major complication rates, as demonstrated for converted laparoscopic colonic cancer resections[3]. Finally, subtotal colectomy has to be completed laparoscopically to allow patients with IBD to benefit from this approach. The feasibility of laparoscopy has therefore to be considered systematically and balanced against the risk of unsuccessful laparoscopies with inappropriate and delayed conversions, which have to be avoided and cannot be recommended.

R. Douard

Unité de Formation et de Recherche, Santé Médecine Biologie Humaine Léonard de Vinci, Université Paris-Nord, Bobigny, and General and Digestive Surgery Unit, Avicenne Hospital, Assistance Publique-Hôpitaux de Paris, 125 Rue de Stalingrad, 93009 Bobigny Cedex, France (e-mail: richard.douard@avc.aphp.fr)

DOI: 10.1002/bjs.9020

Disclosure

The author declares no conflict of interest.

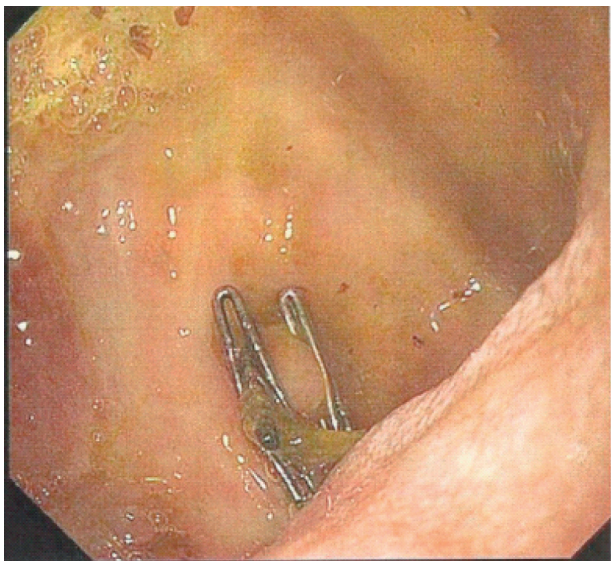
References

1 Telem DA, Vine AJ, Swain G, Divino CM, Salky B, Greenstein AJ *et al*. Laparoscopic subtotal colectomy for medically refractory ulcerative colitis: the time has come. *Surg Endosc* 2010; **24**: 1616–1620.
2 Dignass A, Van Assche G, Lindsay JO, Lémann M, Söderholm J, Colombel JF *et al*. The second European evidence-based consensus on the diagnosis and management of Crohn's disease: current management. *J Crohns Colitis* 2010; **4**: 28–62.
3 Guillou PJ, Quirke P, Thorpe H, Walker J, Jayne DG, Smith AM *et al*. Short-term endpoints of conventional *versus* laparoscopic-assisted surgery in patients with colorectal cancer (MRC CLASICC trial): multicentre, randomised controlled trial. *Lancet* 2005; **365**: 1718–1726.

Snapshot Quiz

Snapshot Quiz 13/29

Question: What is this finding on gastroscopy?



The answer to the above question is found on p. 819 of this issue of *BJS*.

[1]Fleming C, [2]Mulsow J: [1]Royal College of Surgeons in Ireland, Dublin, Ireland, and [2]Department of Surgery, University of Erlangen–Nuremberg, Erlangen, Germany (e-mail: christina.fleming49@gmail.com)

Snapshots in Surgery: to view submission guidelines, submit your snapshot and view the archive, please visit www.bjs.co.uk