Acute colonic obstruction is frequently caused by colorectal cancer and is a common emergent clinical issue for the surgeon. The appropriate management of the patient will depend on his/her overall condition and the pathologic stage of the tumor. The availability of qualified specialists to offer a full range of options is also an important issue. Traditionally, the surgical issues have revolved around whether to perform a 3-stage approach with an initial proximal diversion followed by resection and then reconstruction, a 2-stage approach such as the Hartmann procedure, or primary resection and anastomosis in appropriately selected patients. There are a number of controversies around when and how to perform a primary resection, the issue of intraoperative bowel preparation, segmental versus total colonic resection, whether or not to use proximal diversion, and, more recently, the role of laparoscopy.

The ability to stent colonic strictures via colonoscopy has been present for 20 years. This would appear to be a very useful procedure for acute left-sided malignant colonic obstruction. It would palliate patients with unresectable disease. Stent placement could also serve as a bridge to convert an emergent procedure into an elective one. This would permit optimization of the patient’s medical condition, completion of oncologic staging including the evaluation of synchronous colon lesions, decreased need for a stoma, and avoidance of multi-stage operations. This approach may also facilitate laparoscopic resection. Stenting presumably would decrease morbidity and mortality.

As noted in the systematic review on the current management of acute malignant large bowel obstruction in this issue of The American Journal of Surgery, all of these issues remain controversial. In particular, colonic stenting does not always achieve the goals noted earlier. Although many series report a high technical success rate with the placement of stents, in some hands, it is much less successful. It has been associated with a significant risk of colonic perforation. Stenting does not always lead to resolution of the obstruction and stabilization of the patient. Importantly, many patients with stent placement are not able to go on to resection with primary anastomosis after such stabilization. Finally, there are lingering concerns as to whether the stent approach compromises the oncologic outcome.

The authors of the current article have done a fairly exhaustive search of the literature on this topic, and I believe they have analyzed it fairly. They conclude the review with several observations. CT scan with venous and rectal contrast has emerged as the most common procedure to evaluate left-sided colon obstruction and has high specificity and sensitivity. They favor segmental resection in the treatment of left-sided obstruction to avoid the functional problems associated with a subtotal colectomy. The authors suggest that the Hartmann procedure is still a reasonable alternative, particularly in patients who are at high risk for postoperative morbidity and mortality. Resection and primary anastomosis would be the ideal technique if it can be done in such a way that the risk of an anastomotic leak is not prohibitive. It is not clear that primary anastomosis with a proximal diversion has a significant advantage over the Hartmann procedure in high-risk patients. Despite the intuitive logic, mechanical decompression or intraoperative irrigation is not clearly established to be beneficial.
Thus, most of the controversies in the management of malignant left colon obstruction have not been resolved. The role of endoluminal stents as definitive treatment in palliative patients or as a bridge to surgery will need further evaluation, particularly related to the oncologic safety. Although distal colonic obstruction remains an important clinical problem, clinical decision making continues to require an individually tailored approach for each patient. This includes not only patient-related factors but also the availability and outcomes achieved by the practitioners taking care of the patient.

References