Operative or nonoperative management of Hinchey III purulent acute diverticulitis?

We read with interest the article by Dr. Vennix and colleagues published in Lancet that rekindles the debate on management of severe acute diverticulitis (Hinchey III); the lower early morbidity of surgical resection reported by the authors definitely challenges the recent trend toward mini-invasive management by laparoscopic lavage (LL).\(^1,2\)

Interestingly, in the authors’ whole series, major mortality and 12-month mortality reached 30% and 11% (14% in the resection group [RG]), respectively. Overall, patients underwent 157 operations (88 primary surgeries, 40 reoperations and 29 stoma reversals), accounting for a ratio of 1.8 operations per patient (1.9 in the RG). Moreover, 52% of patients underwent ileo-/colectomy (68% in the RG), which was never reversed in 27% of cases. Finally, 15% of patients had fascial dehiscence within 1 year.

Also considering that patients with stercoral peritonitis (Hinchey IV) were excluded, results of surgery in the studied population seem poor and possibly caused by the emergency setting, rather than the purpose of surgery (resection s. nonresection). Admitting that LL is not superior because no difference is recorded between the 2 groups does not mean that performing an emergency sigmoidectomy is the best option in a septic patient with an ongoing acute peritonitis. The real, upcoming question seems to be whether Hinchey III patients (whose results are poor regardless of the performed procedure) really need emergency surgery. Since the study does not include a conservative management group, efficacy of antibiotics alone is not assessed.

We recently reported a 92% successful conservative management of hemodynamically stable patients with diverticulitis-associated pneumoperitoneum and no diffuse colonic perforation at CT (82% and 72% presenting free intraperitoneal fluid and clinical signs of diffuse acute peritonitis, respectively).\(^4\)

None died, 3 were reoperated and 7 required percutaneous drainage, which was considered a successful, nonoperative management, and we concluded that most non-Hinchey IV patients may be managed conservatively. Moreover, only 19 patients underwent delayed elective sigmoidectomy (with 2 reoperations), whereas 17 patients completely avoided surgery, with an overall ratio of 0.6 operations per patient.

In accordance with Vennix and colleagues, we believe that an accurate preoperative diagnosis should improve Hinchey III patient selection, not to undergo laparoscopic drainage, but rather to avoid an unnecessary surgery.

Randomized multicentre trials, comparing a surgical and a conservative approach to patients affected by non-Hinchey IV acute diverticulitis are needed to assess if, in this class of patients, less is more.

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It is extremely rare, for an article dealing with the lowly hernia to provoke a tremor in the world of surgery. Malik and colleagues\(^1\) have just managed that seismic quality and they are to be congratulated and celebrated.

For 20 years, synthetic meshes have become the mainstay of hernia surgery, thanks to an industry that fostered conferences, societies and free courses, but also flagrant and undaunted marketing. The drawbacks of meshes were always vague and nebulous.\(^2,3\) The current generation of surgeons can truly be said to have been formed by the industry!

Mesh-based repairs are touted as the ideal in the guidelines of the European, Danish and Swedish Hernia Societies.\(^4\) The American Hernia Society has found no reason to disapprove.

The Shouldice repair, a pure tissue repair, rated a mention only when infected mesh was removed! Sadly, no one performs or knows how to perform a Shouldice repair outside Thornhill. A repair which, barely 20 years ago, was considered the “gold standard.”

The world literature is now replete with publications on chronic postherniorrhaphy inguinodynia, a condition unknown before the introduction of mesh. In 1964, in Nyhus’ classic hernia, postherniorrhaphy pain did not rate a mention in its copy, there has been no reduction in the incidence of hernia repairs and who may consider a tailor approach.

To answer our respected authors, mesh is used in 3% of the cases at the Shouldice Hospital. Around the world, mesh is used in 90%–97%.\(^6\)

The better results of the Shouldice repair are not due to legerdemain. Their surgeons truly know anatomy. More so than surgeons who do an average of 50 cases a year. In the Swedish registry, 50% of the surgeons did fewer than 7 cases a year. The hackneyed aphorism with vendors that... “with mesh, you do not need to know anatomy” is simply untrue.

Professor Volcker Schumpelick, Editor in Chief of the *Hernia*, in his address to the American Hernia Society (2005) stated that “despite the introduction of mesh and laparoscopic copy, there has been no reduction in the incidence of hernia recurrences in the last 30 years. That incidence worldwide is 14%.”\(^7\) Why are the European guidelines rushing to be launched as World guidelines?

This thorough, objective, generously followed, massive population-based analysis by our Toronto colleagues has already reached *Hernia* and the European Hernia Society. The “tailored approach” concept is rather new. This paper will help nail that merciful concept. The figure estimated at 10%–20% could be brought to a mere 5% with simple emphasis of anatomy. The Shouldice Hospital already demonstrated, 20 years ago, that 1%–5% is the magic number depending on the type of hernia.\(^9\)

This paper will become a classic, cited beyond the wildest dreams of its authors. It will awaken many residents to ask why it takes 4–6 years of surgical training if the industry can do it, through vendors, in a matter of minutes.

I would like to think that my learned and respected colleagues of the University of Toronto have revealed a good omen for a return to a saner algorithm and a harbinger of what I like to call a timely revival of a “greener operation.”

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