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Coloproctologie

Postoperatief gebruik anti-TNF therapie van patiënten met colitis ulcerosa geassocieerd met toegenomen aantal complicaties

Association of Preoperative Anti-Tumor Necrosis Factor Therapy With Adverse Postoperative Outcomes in Patients Undergoing Abdominal Surgery for Ulcerative Colitis, Kulaylat A.S., JAMA surg aug 2017 152(8):e171538. Pubmedid 28614561

Importance

Despite the increasing use of anti-tumor necrosis factor (TNF) therapy in ulcerative colitis, its effects on postoperative outcomes remain unclear, with many patients requiring surgical intervention despite optimal medical management.

Objective

To assess the association of preoperative use of anti-TNF agents with adverse postoperative outcomes.

Design, Setting, and Participants

This analysis used insurance claims data from a large national database to identify patients 18 years or older with ulcerative colitis. These insured patients had inpatient and/or outpatient claims between January 1, 2005, and December 31, 2013, with Current Procedural Terminology codes for a subtotal colectomy or total abdominal colectomy, a total proctocolectomy with end ileostomy, or a combined total proctocolectomy and ileal pouch-anal anastomosis. Only data regarding the first or index surgical admission within the time frame were abstracted. Use of anti-TNF agents, corticosteroids, and immunomodulators within 90 days of surgery was identified using Healthcare Common Procedure Coding System codes. Inclusion in the study required the patient to have an International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code for ulcerative colitis. Exclusion occurred if the patient had a secondary ICD-9-CM diagnosis code for Crohn disease or if the patient was not continuously enrolled in an insurance plan for at least 180 days before and after the index surgery. Data were collected and analyzed from February 1, 2015, to June 2, 2016.

Main Outcomes and Measures

Outcomes included 90-day complications, emergency department visits, and readmissions. Multivariable logistic regression was used to model covariates, including anti-TNF agent use, on the occurrence of outcomes.

Results

Of the 2476 patients identified, 1379 (55.7%) were men, and the mean (SD) age was 42.1 (12.9) years. Among these, 950 (38.4%) underwent subtotal colectomy or total abdominal colectomy, 354 (14.3%) underwent total proctocolectomy with end ileostomy, and 1172 (47.3%) received ileal pouch-anal anastomoses. In univariate analyses, increased postoperative complications were observed among patients in the ileal pouch cohort who received anti-TNF agents preoperatively vs those who did not (137 [45.2%] vs 327 [37.6%]; $P = .02$) but not among those in the colectomy or proctocolectomy cohorts. An increase in complications was also observed on multivariable analyses among patients in the ileal pouch cohort (odds ratio, 1.38; 95% CI, 1.05-1.82).

Conclusions and Relevance

Unlike preoperative anti-TNF agent use among patients who underwent colectomy or total proctocolectomy and experienced no significant increase in postoperative complications, anti-TNF agent use within 90 days of surgery among patients who underwent ileal pouch-anal anastomosis was associated with higher 90-day postoperative complication rates.

Meer risico op iatrogeen darmletsel in laparoscopische benadering bij patiënten met een strengileus

Laparoscopic Surgery for Adhesive Small Bowel Obstruction Is Associated With a Higher Risk of Bowel Injury: A Population-based Analysis of 8584 Patients. Behman R., Annals of Surgery; August 2017 – Volume 266 – Issue 3 – p 489-498

PMID: 28657949

Objective

We set out to compare the incidence of bowel repair and/or resection in a large cohort of patients with adhesive small bowel obstruction (SBO) managed operatively.

Background

increase the risk of bowel injury given the distended and/or potentially compromised small bowel.

Methods

We used administrative discharge data derived from a large geographic region, identifying patients who underwent surgery for their first episode of aSBO during 2005 to 2014. Procedure codes were used to determine the exposure: either an open approach or a laparoscopic approach (including procedures converted to open). The primary outcome was incidence of bowel intervention, defined as intraoperative enterotomy, suture repair of intestine, or bowel resection. We estimated the odds of bowel intervention after adjusting for patient and clinical factors.

Results

A total of 8584 patients underwent operation for aSBO. Patients undergoing laparoscopic procedures were younger with fewer comorbid conditions. The rate of laparoscopic approaches increased more than 3-fold during the study period (4.3%–14.3%, $P < 0.0001$). The incidence of bowel intervention was 53.5% versus 43.4% in laparoscopic versus open procedures ($P < 0.0001$). After adjustment for potential confounders, the odds of bowel intervention among patients treated laparoscopically versus open was 1.6 (95% confidence interval: 1.4–1.9).

Conclusions

Laparoscopic procedures for aSBO are associated with a greater likelihood of intervention for bowel injury and/or repair. This increase might be due to challenges inherent with laparoscopic approaches in patients with distended small bowel. Surgeons should approach laparoscopic lysis of adhesions with a higher level of awareness and use strategies to mitigate this risk.

UPPER GI

Buismaagnecrose na oesofagectomie ivm oesofaguscarcinoom mogelijk veroorzaakt door pre-existente truncus coeliacus stenose

Preoperative imaging and prediction of oesophageal conduit necrosis after oesophagectomy for cancer. Lainas P., BJS Sep 2017 – Volume 104 – Issue 10 – p 1346-1354

Pubmedid 28493483

Background

Oesophageal conduit necrosis following oesophagectomy is a rare but life-threatening complication. The present study aimed to assess the impact of coeliac axis stenosis on outcomes after oesophagectomy for cancer.

Method

The study included consecutive patients who had an Ivor Lewis procedure with curative intent for middle- and lower-third oesophageal cancer at two tertiary referral centres. All patients underwent preoperative multidetector CT with arterial phase to detect coeliac axis stenosis. The coeliac artery was classified as normal, with extrinsic stenosis due to a median arcuate ligament or with intrinsic stenosis caused by atherosclerosis.

Results

Some 481 patients underwent an Ivor Lewis procedure. Of these, ten (2.1 per cent) developed oesophageal conduit necrosis after surgery. Coeliac artery evaluation revealed a completely normal artery in 431 patients (91.5 per cent) in the group without conduit necrosis and in one (10 per cent) with necrosis ($P < 0.001$). Extrinsic stenosis of the coeliac artery due to a median arcuate ligament was found in two patients (0.4 per cent) without conduit necrosis and five (50 per cent) with necrosis ($P < 0.001$). Intrinsic stenosis of the coeliac artery was found in 11 (2.3 per cent) and eight (80 per cent) patients respectively ($P < 0.001$). Eight patients without (1.7 per cent) and five (50 per cent) with conduit necrosis had a single and thin left gastric artery ($P < 0.001$).

Conclusion

This study suggests that oesophageal conduit necrosis after oesophagectomy for cancer may be due to pre-existing coeliac axis stenosis.

HPB

Geen bewijs dat intra-peritoneale drainage klinische uitkomsten verbeterd in patiënten met een distale pancreatectomie

*A Prospective Randomized Multicenter Trial of Distal Pancreatectomy With and Without Routine Intraperitoneal Drainage. Van Buren, G.I.I., Annals of Surgery; August 2017 – Volume 266 – Issue 3 – p 421-431
Pubmedid 28692468*

Objective

The objective of this study was to test the hypothesis that distal pancreatectomy (DP) without intraperitoneal drainage does not affect the frequency of grade 2 or higher grade complications.

Background

The use of routine intraperitoneal drains during DP is controversial. Prior to this study, no prospective trial focusing on DP without intraperitoneal drainage has been reported.

Methods

Patients undergoing DP for all causes at 14 high-volume pancreas centers were preoperatively randomized to placement of a drain or no drain. Complications and their severity were tracked for 60 days and mortality for 90 days. The study was powered to detect a 15% positive or negative difference in the rate of grade 2 or higher grade complications. All data were collected prospectively and source documents were reviewed at the coordinating center to confirm completeness and accuracy.

Results

A total of 344 patients underwent DP with (N = 174) and without (N = 170) the use of intraperitoneal drainage. There were no differences between cohorts in demographics, comorbidities, pathology, pancreatic duct size, pancreas texture, or operative technique. There was no difference in the rate of grade 2 or higher grade complications (44% vs. 42%, $P = 0.80$). There was no difference in clinically relevant postoperative pancreatic fistula (18% vs 12%, $P = 0.11$) or mortality (0% vs 1%, $P = 0.24$). DP without routine intraperitoneal drainage was associated with a higher incidence of intra-abdominal fluid collection (9% vs 22%, $P = 0.0004$). There was no difference in the frequency of postoperative imaging, percutaneous drain placement, reoperation, readmission, or quality of life scores.

Conclusions

This prospective randomized multicenter trial provides evidence that clinical outcomes are comparable in DP with or without intraperitoneal drainage.

Lange termijn follow-up pancreascysten nodig, na vijf jaar blijft risico op kanker driemaal hoger dan populatierisico

*Should Patients With Cystic Lesions of the Pancreas Undergo Long-term Radiographic Surveillance?: Results of 3024 Patients Evaluated at a Single Institution. Lawrence S.A., Annals of Surgery; August 2017 – Volume 266 – Issue 3 – p 536-544
Pubmedid 28657939*

Objective

In 2015, the American Gastroenterological Association recommended the discontinuation of radiographic surveillance after 5 years for patients with stable pancreatic cysts. The current study evaluated the yield of continued surveillance of pancreatic cysts up to and after 5 years of follow up.

Methods

A prospectively maintained registry of patients evaluated for pancreatic cysts was queried (1995–2016). Patients who initially underwent radiographic surveillance were divided into those with <5 years and ≥5 years of follow up. Analyses for the presence of cyst growth (>5 mm increase in diameter), cross-over to resection, and development of carcinoma were performed.

Results

A total of 3024 patients were identified, with 2472 (82%) undergoing initial surveillance. The ≥5 year group (n = 596) experienced a greater frequency of cyst growth (44% vs. 20%; $P < 0.0001$), a lower rate of cross-over to resection (8% vs 11%; $P = 0.02$), and a similar frequency of progression to carcinoma (2% vs 3%; $P = 0.07$) compared with the <5 year group (n = 1876). Within the ≥5 year group, 412 patients (69%) had demonstrated radiographic stability at the 5-year time point. This subgroup, when compared with the <5 year group, experienced similar rates of cyst growth (19% vs. 20%; $P = 0.95$) and lower rates of cross-over to resection (5% vs 11%; $P < 0.0001$) and development of carcinoma (1% vs 3%; $P = 0.008$). The observed rate of developing cancer in the group that was stable at the 5-year time point was 31.3 per 100,000 per year, whereas the expected national age-adjusted incidence rate for this same group was 7.04 per 100,000 per year.

Conclusion

Cyst size stability at the 5-year time point did not preclude future growth, cross-over to resection, or carcinoma development. Patients who were stable at 5 years had a nearly 3-fold higher risk of developing cancer compared with the general population and should continue long-term surveillance.

Thoracale epiduraal anesthesie tijdens grote HPB ingrepen zorgt voor verbeterde pijncontrole en minder gebruik andere narcotica, zonder toegenomen opnameduur of complicaties

*A Randomized Controlled Trial of Postoperative Thoracic Epidural Analgesia Versus Intravenous Patient-controlled Analgesia After Major Hepatopancreatobiliary Surgery. Aloia T.A., Annals of Surgery; August 2017 – Volume 266 – Issue 3 – p 545-554
Pubmedid 28746153*

Objective

In 2015, the American Gastroenterological Association recommended the discontinuation of radiographic surveillance after 5 years for patients with stable pancreatic cysts. The current study evaluated the yield of continued surveillance of pancreatic cysts up to and after 5 years of follow up.

Methods

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Een derde van de klierpositieve patiënten met pancreascarcinoom kunnen worden gedownstaged met preoperatieve chemotherapie

*Value of lymph node positivity in treatment planning for early stage pancreatic cancer. Hop S., Annals of Surgery; Surgery: September 2017 Volume 162, Issue 3, Pages 557–567
Pubmedid 28666686*

Objective

In 2015, the American Gastroenterological Association recommended the discontinuation of radiographic surveillance after 5 years for patients with stable pancreatic cysts. The current study evaluated the yield of continued surveillance of pancreatic cysts up to and after 5 years of follow up.

Methods

A prospectively maintained registry of patients evaluated for pancreatic cysts was queried (1995–2016). Patients who initially underwent radiographic surveillance were divided into those with <5 years and ≥5 years of follow up. Analyses for the presence of cyst growth (>5 mm increase in diameter), cross-over to resection, and development of carcinoma were performed.

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Conclusion

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LEVERCHIRURGIE

Parenchymsparende hepatectomie vergeleken met een formele hepatectomie in tumoren met betrokkenheid van de hepatocavale confluence kan veilig worden verricht

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Techniques of parenchyma-sparing hepatectomy for the treatment of tumors involving the hepatocaval confluence: A reliable way to assure an adequate future liver remnant volume, Urbani, L., Surgery: September 2017 Volume 162, Issue 3, Pages 483–499

Pubmedid 28549521

Background

Parenchyma-sparing hepatectomy techniques allow a lesser volume resection (<3 adjacent segments) for tumors involving the hepatic veins at the hepatocaval confluence, assuring adequate volume of the future liver remnant. We report the ability to perform parenchyma-sparing hepatectomy as planned from the preoperative imaging and the type of vascular intervention used to preserve hepatic outflow.

Methods

We analyzed 60 consecutive parenchyma-sparing hepatectomies in 54 patients for 7 primary and 53 metastatic tumors (48 colorectal), located in segments I, VII, VIII, or IVa and involving the hepatocaval confluence. Patients had a median of 2 (range: 1–18) lesions with median diameter of 4 cm (range: 1.2–16.5), which were bilateral in 43%.

Results

A parenchyma-sparing hepatectomy was performed in all of the 60 cases, only one case required the resection of 3 adjacent segments. In 16 (27%) hepatic veins-resections, the outflow was assured by preservation of the inferior-right-hepatic veins in 3 (5%), of the communicating-veins in 4 (7%), of the middle-hepatic veins in 3 (4%; middle-hepatic veins patch-reconstruction in 2 cases), by polytetrafluoroethylene-grafts in 4 (7%), and by hepatic veins-anastomosis in 2 (3%). In 15 (25%) cases, the hepatic veins were resected tangentially and reconstructed by direct suture venorrhaphy. In 29 (48%) cases, the hepatic veins were skeletonized from the tumor. Grade IIIb to IV complications occurred in 7%, median hospital-stay was 9 days, and 90-day mortality occurred in one cirrhotic patient. Median overall and disease-free survivals were 72 and 16 months (median follow-up: 34 months).

Conclusion

A lesser volume parenchyma-sparing hepatectomy rather than a formal major hepatectomy for tumors involving the hepatocaval confluence can be performed with a low rate of major complications (7%). Parenchyma-sparing hepatectomy should be considered in highly selected patients when evaluating liver resection for tumors involving the hepatocaval confluence based on appropriate and accurate preoperative imaging.

Levertransplantatie geeft verbeterde overleving in patiënten met metastasen van neuro-endocriene tumoren in de lever

Liver transplantation in patients with liver metastases from neuroendocrine tumors: A systematic review, Dimitrios M., Surgery: September 2017 Volume 162, Issue 3, Pages 525–536

Pubmedid 28624178

Background

Cirrhosis is associated with blood loss during liver resection and postoperative complications. The liver

stiffness measurement has recently become available for assessment of liver fibrosis.

Methods

This prospective study was performed to predict postoperative outcomes of liver resection. The liver stiffness measurement was measured prospectively using magnetic resonance elastography for patients who had undergone liver resection for malignancy. We investigated whether the liver stiffness measurement by magnetic resonance elastography is correlated with liver fibrosis and postoperative outcomes.

Results

The median liver stiffness measurement by magnetic resonance elastography in 175 patients was 3.4 (range: 1.5–11.3) kPa, and the pathologic grade of liver fibrosis was significantly correlated with the liver stiffness measurement ($r = 0.68$, $P < .001$). The median blood loss during transection per unit area was 4.1 mL/cm² (range: 0.1–37.0 mL/cm²), and the frequency of major complications was 16.0%. The liver stiffness measurement was the only independent prognostic factor for both blood loss (regression coefficient: 1.14, 95% confidence interval: 0.45–1.83, $P = .001$) and major complications (odds ratio: 2.14, 95% confidence interval: 1.63–2.93, $P < .001$). Receiver operating characteristic curve analysis indicated a significant correlation between the liver stiffness measurement and major complications with calculated area under the curve of 0.81 ($P < .001$), and the sensitivity and specificity for prediction of major complications (cutoff value: 5.3 kPa) were 64.3% and 87.8%, respectively. On the other hand, the amount of blood loss was significantly correlated with the frequency of major complications ($P = .003$).

Conclusion

The liver stiffness measurement by magnetic resonance elastography could be used as a predictive marker for the risk of major complications due to blood loss during liver resection

BARIATRISCHE CHIRURGIE

Lekkage en stenose sleeve gastrectomie benodigd in de meeste gevallen een rescue operatie, welke in de meeste gevallen succesvol is

*Management of leakage and stenosis after sleeve gastrectomy. El-Sayes I.A.; Surgery: September 2017 Volume 162, Issue 3, Pages 652–661
Pubmedid 28693759*

Background

Sleeve gastrectomy is one of the most commonly performed procedures in obesity and metabolic operation with leakage and stenosis being serious complications. The management of these complications is challenging, with different operative options available. The aim of our study was to evaluate the incidence and management strategies of leakage and stenosis after sleeve gastrectomy at our institution and to compare our outcomes with those previously reported in the literature.

Methods

We conducted a retrospective analysis of the medical records of 49 patients treated for leakage and/or stenosis after laparoscopic sleeve gastrectomy at our Centre of excellence for bariatric and metabolic operation, including 25 patients referred to our department from other hospitals. Outcomes were evaluated using descriptive statistics.

Results

Our study cohort consisted of 49 obese patients, 33 females (66%), with a mean \pm standard deviation age of 50 ± 11 years, and body mass index at the time of laparoscopic sleeve gastrectomy, 51 ± 8 kg/m². Postsleeve gastrectomy leakage was identified in 27 patients (55%), stenosis in 13 (27%), and combined leakage and stenosis in 9 (18%). Leakage, stenosis, and combined leakage/stenosis were managed successfully by interventional methods in 85%, 15%, and 22% of cases, respectively. Conversion into another procedure provided a successful rescue operation for other patients. We had a 0% mortality rate.

Conclusion

Most patients with leakage were managed successfully with interventional methods. The majority of patients with stenosis or both leakage and stenosis required rescue operation.