

Improved Results for Endoscopic Colorectal Stenting with Establishment of a Common Endoscopic Centre for Gastroenterologists and Surgeons

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Opinion

Endoscopic stenting for malignant colorectal obstruction has become a common therapeutic advancement in clinical practice [1-5]. We report our experience with 200 patients in 18 years. All procedures were performed in a close collaboration between surgeons and gastroenterologists. All procedures were approved by the Department Council and all patients gave and signed informed consent.

the obstruction, due to sharp angulation of the obstruction. After consulting a surgeon, the procedure was not continued. Surgical colorectal resection appeared a more appropriate procedure. Clinical success was obtained in 92% of the patients. In 4 patients with ascites and peritoneal implants, despite technical success of stent placement, symptoms of obstruction persisted. In another 10 patients, with ascites and stage IV colorectal cancer, placement of a stent was not considered appropriate (Figure 1A & 1B).



Figure 1A: Use of thin pediatric nasogastroscope to pass the colorectal obstruction.



Figure 1B: Use of thin pediatric nasogastroscope to pass the colorectal obstruction.

There was no case of postoperative mortality or major morbidity. Technical success was obtained in 95% of the patients. In 8 patients it was not possible to pass the guidewire through

During the same time period, 35 patients with stage IV colorectal cancer and 25 patients with acute obstruction, underwent surgical colorectal resection. After consultation between surgeons and

gastroenterologists, the option of surgery was considered the safest and best option. The initial therapeutic option was changed in 60 patients. In thirty five patients, initially considered candidate for stenting, surgery was considered a more appropriate choice. Twenty five patients, initially considered candidates for surgery, had endoscopic stenting (Figure 2).



Figure 2: Colorectal stent in a patient with bleeding, obstructing colorectal cancer.

SEMS placement represents an important tool to treat patients with obstructing colorectal cancer and complications after colorectal

resection. In patients with malignant colorectal obstruction, the therapeutic options, including endoscopic placement of a stent, should be based on a careful analysis of the different risk factors. In this scenario, a close collaboration among specialists is essential and brings to better results.

References

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