5. References


Dear Editor:

We were interested to read the article, “Laparoscopic ileostomy and colostomy,” by Lyerly and Mault.1 The laparoscopic technique for creating stomas is not difficult and reduces morbidity and discomfort when compared with open laparotomy. We previously have reported on our technique of laparoscopic loop ileostomy.2 We find it unnecessary to mature the stoma site before placing the trocar as described by Lyerly and Maul.1 If the stoma is first matured down to the peritoneum, there is a risk of losing the pneumoperitoneum or dislodging the cannula while looking for the section of bowel to be matured. We place the cannula through the stoma site and grasp the distal ileum with a Babcock. A circle of skin around the cannula is excised, and the cannula is withdrawn, leaving the Babcock and bowel in place, while the fascia is incised to allow two fingers to pass. Then the Babcock with the ileum is brought out through this opening, and the pneumoperitoneum is re-established. The bowel then is matured to the skin. Aside from this minor difference in technique, we agree with the authors that the laparoscopic technique of stoma creation is not difficult and is associated with minimal morbidity.

References


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June 1, 1994

Dear Editor:

We appreciate the nice comments from Drs. Khoo and Cohen regarding our article, “Laparoscopic Ileostomy and Colostomy.”1 They have also published a fine article regarding the use of a laparoscope to create a loop ileostomy for temporary fecal diversion.2 We agree on the usefulness of the technique, but have found that for certain indications, especially in the oncologic patient, some foresight in the creation of the stoma is required.

Clearly, in patients with ascites, preparing the stoma site before releasing the pneumoperitoneum prevents large amounts of ascitic fluid from exiting from the peritoneal cavity. This may represent the situation in those patients with benign or malignant ascites; however, because it works so well in this situation, we find it applicable to many patients. We have no difficulty in maintaining the pneumoperitoneum by not dividing the peritoneum until necessary.

Another indication in which foresight in the creation of the stoma is useful is when we completely divide the intestine to create an end colostomy and a mucous fistula. In these circumstances, having the stomas prepared minimizes the loss of pneumoperitoneum. During a loop ileostomy, the intestine

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Dear Editor:

We appreciate Dr. Woods’ thoughtful and supportive discussion of our article. Although we did not make a categorical recommendation for routine preoperative angiography, that sentiment was implicit in our conclusion that in such patients “preoperative visceral angiography is of inestimable value.” Moreover, we suggested that “a lateral projection of the celiac axis (and superior mesenteric artery) should be an integral part of that study . . . .”1 The review of preoperative angiography for patients undergoing Whipple procedures cited by Dr. Woods provides additional evidence supporting these conclusions.

Dr. Woods delineates two specific examples, gastric ischemia and failure of the hepaticojejunostomy, amplifying our general concern that uncorrected celiac artery insufficiency after pancreaticoduodenectomy, would “likely [result] in serious morbidity and mortality.”1 We are, however, less sanguine than he that hepatic ischemia is of little concern. Ordinarily, hepatic artery ligation is well tolerated by virtue of the rapid and extensive arterial collateralization that ensues. However, when celiac stenosis complicates pancreaticoduodenectomy, alternative routes for arterial ingress for hepatic collateralization may be impaired by arterial disease or further disrupted at operation, e.g., by splenic artery ligation. Hence, we are reluctant to assume that hepatic ischemia, particularly of the magnitude observed in our two cases, would be without consequence if not relieved.

Reference


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