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Commentary on: Laparoscopic Restorative Proctocolectomy Without Diverting Ileostomy

Chucheep Sahakitrungruang[1*]

[1] Department of Surgery, Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand

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Dear Editor,

The role of protective ileostomy for restorative proctocolectomy has been debated. Although anastomotic complications can be minimized with protective stoma (1), several authors have reported good outcomes in patients who have undergone restorative proctocolectomy without ileostomy (2-5). A previous report has suggested the possibility of rectal cancer development from the rectal mucosa remnants resulting from ileal pouch–anal anastomosis (IPAA) performed using the stapling technique (6). Therefore, some authors have suggested the selective use of this technique, particularly in patients with familial adenomatous polyposis with rectal sparing; while in other cases, rectal mucosectomy and hand-sewn IPAA have been recommended (7), because the functional or manometric outcome of staple and hand-sewn IPAA is not significantly different (7, 8). However, lifelong surveillance of the IPAA is essential in all patients.

The key factor to a successful operation is tension-free anastomosis with good blood supply to the ileal pouch. Therefore, ileal pouch elongation is a crucial step, particularly in patients with hand-sewn IPAA, where an additional ileal length of 3–4 cm may be required. Several techniques for ileal pouch elongation have been reported, e.g., selective division of branches of the superior mesenteric artery or division of the ileocolic artery. Some authors have advocated preserving the middle colic artery as an additional blood supply route (9). We have proposed the technique of dividing the submesenteric arcades and preserving 3 or 4 of the innermost arcades of the distal ileum as well as both the

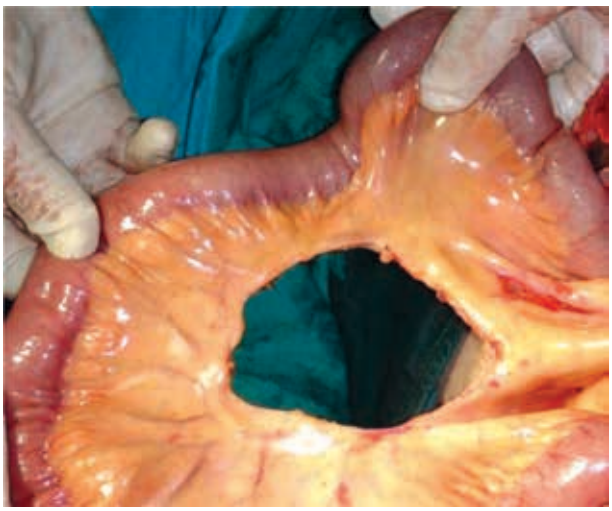

Figure. Ileal pouch elongation by dividing the submesenteric arcades

* *Corresponding author:* Chucheep Sahakitrungruang, Department of Surgery, Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand. Tel: +6-622564400, Fax: +6-622564194, *E-mail:* chucheep@hotmail.com

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superior mesenteric and ileocolic trunks (*Figure*). This procedure can be easily performed using laparoscopic surgery via a small wound opening and ensures safety during handsewn IPAA without protective ileostomy (10).

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