



## Original Article

# Impact of a Diverting Stoma in an Enhanced Recovery Programme for Rectal Cancer<sup>☆</sup>



Verónica Gumbau,<sup>a</sup> Juan García-Armengol,<sup>a,b</sup> Antonio Salvador-Martínez,<sup>a</sup> Purificación Ivorra,<sup>a</sup> María José García-Coret,<sup>a</sup> Vicente García-Rodríguez,<sup>a</sup> José Vicente Roig<sup>a,b,\*</sup>

<sup>a</sup> Unidad de Coloproctología, Consorcio Hospital General Universitario, Valencia, Spain

<sup>b</sup> Unidad de Coloproctología, Hospital Nisa 9 de Octubre, Centro Europeo de Cirugía Colorrectal, Valencia, Spain

## ARTICLE INFO

## Article history:

Received 9 February 2014

Accepted 30 March 2014

Available online 2 December 2014

## Keywords:

Loop ileostomy

Rectal cancer

Anterior rectal resection

Total mesorectal excision

Multimodal rehabilitation program

## A B S T R A C T

**Purpose:** The association of a loop ileostomy decreases the severity of complications after rectal surgery but can increase the postoperative stay. The aim of this study is to investigate if a diverting ileostomy influences the postoperative outcomes in a series of patients included in a multimodal rehabilitation program (MMRP).

**Methods:** We analysed a series of 104 patients that underwent elective surgery with primary anastomosis for rectal adenocarcinoma using a MMRP: 66 men and 38 women, with a median age of 64 (IQR: 55–75) years. Group A included patients with an associated loop ileostomy, and Group B, those without a protective stoma.

**Results:** Group A=58, group B=46 patients with neither differences in age, ASA, BMI and other risk factors nor in the surgical approach (laparoscopic in 34%), although there were more neoadjuvant treatments in group A: 77.5 vs 36.9%;  $P=.001$ . In group A, the most common operation was total mesorectal excision (96%) and in the group B, a subtotal mesorectal excision (90%). There were no differences in postoperative complications (Group A 34.4 vs group B 28.2%;  $P=.322$ ), anastomotic leaks (8.3 vs 10.8%;  $P=.475$ ), or postoperative ileus (20.7 vs 10.9%;  $P=.140$ ), neither in postoperative stay (7.9 vs 6.9 days;  $P=.058$ ), readmissions (7 vs 13.6%;  $P=.22$ ) nor postoperative stay including readmissions (8.4 vs 9.1 days;  $P=.49$ ).

**Conclusions:** The association of a loop ileostomy does not extend the length of stay nor increases the rate of complications in patients that underwent a rectal resection with anastomosis included in a MMRP.

© 2014 AEC. Published by Elsevier España, S.L.U. All rights reserved.

<sup>☆</sup> Please cite this article as: Gumbau V, García-Armengol J, Salvador-Martínez A, Ivorra P, García-Coret MJ, García-Rodríguez V, et al. Impacto del estoma derivativo en un protocolo de rehabilitación multimodal en cirugía de recto. Cir Esp. 2015;93:18-22.

\* Corresponding author.

E-mail address: roigvila@telefonica.net (J.V. Roig).

## Impacto del estoma derivativo en un protocolo de rehabilitación multimodal en cirugía de recto

### RESUMEN

#### Palabras clave:

Ileostomía derivativa  
Cáncer de recto  
Resección anterior de recto  
Excisión total del mesorrecto  
Rehabilitación multimodal  
perioperatoria

**Objetivo:** La asociación de ileostomía disminuye la gravedad de las complicaciones tras anastomosis rectal baja pero puede alargar la estancia postoperatoria. El objetivo del presente estudio es averiguar si un estoma derivativo modifica la estancia postoperatoria o las complicaciones, en pacientes intervenidos bajo un régimen de rehabilitación multimodal perioperatoria (RHMM).

**Métodos:** Analizamos a 104 pacientes intervenidos de resección con anastomosis por adenocarcinoma rectal con cuidados de RHMM: 66 varones y 38 mujeres, mediana de edad de 64 años (RIQ: 55-75). En el grupo A, se incluyó a los que se asoció ileostomía derivativa y en el B a aquellos sin ileostomía.

**Resultados:** Grupo A = 58, grupo B = 46 pacientes sin diferencias en edad, ASA, IMC, factores de riesgo, ni en el tipo de abordaje, laparoscópico en un 34%, si bien hubo más neoadyuvancia en el grupo A: 77,5 frente a 36,9%. En este grupo, la intervención habitual fue la exéresis total del mesorrecto (96%) y en el B la subtotal (90%). No hubo diferencias en las complicaciones postoperatorias (34,4 frente a 28,2%;  $p = 0,322$ ) ni en la de dehiscencias anastomóticas (8,3 frente a 10,8%;  $p = 0,475$ ), o íleo prolongado (20,7 frente a 10,9%;  $p = 0,140$ ). Tampoco las hubo en la estancia postoperatoria (7,9 frente a 6,9 días;  $p = 0,058$ ), reingresos (7 frente a 13,6%;  $p = 0,22$ ), o en la estancia total incluyendo reingresos (8,4 frente a 9,1 días;  $p = 0,49$ ).

**Conclusiones:** La asociación de una ileostomía no alarga la EP ni incrementa las complicaciones en pacientes intervenidos de resección rectal en régimen de RHMM.

© 2014 AEC. Publicado por Elsevier España, S.L.U. Todos los derechos reservados.

## Introduction

Resection with anastomosis is currently the most widely used technique in the surgical treatment of rectal cancer, and it achieves the preservation of anal sphincter function in more than 70% of cases.<sup>1</sup> However, the lower the anastomosis, the higher the anastomotic leak rate is, and performing a diverting stoma (generally an ileostomy) reduces morbidity,<sup>2-4</sup> although it has been reported to increase postoperative stay.<sup>5</sup> Given that colorectal surgery has been amongst the first to implement perioperative care encouraged in a standardised way, with the consequent reduction of complications and length of stay,<sup>6-9</sup> one should question if performing a diverting stoma influences the postoperative progress and stay in patients who receive this care after having undergone rectal cancer surgery, which is the aim of our study.

## Methods

We retrospectively analysed a prospective database of patients who had undergone elective surgery involving primary colorectal or coloanal anastomosis due to rectal adenocarcinoma from January 2007 to November 2011. All patients underwent the surgery in two centres of reference (one of them a university hospital), by the same surgical team. Patients were divided into group A, including those patients who had an associated stoma, and group B, which included those without stoma.

We estimated sample size assuming that patients with an associated stoma would have a mean stay two days longer than those without stoma. Thus, considering a 5% statistical significance with an 80% power, 50 patients were required per arm.

All patients followed a perioperative multimodal rehabilitation programme (MMRP) protocol and a clinical pathway previously approved by the local Clinical Research Ethics Committee (Table 1), and the specific information regarding the chances of performing a stoma and its marking was provided by a colorectal surgeon and a stomatherapist, respectively. Surgical procedures were performed or supervised directly by surgeons devoted specifically to coloproctology (European Board). Patients who underwent an abdominoperineal amputation, a Hartmann's procedure or transanal endoscopic microsurgery were excluded. The stoma was constructed when a total mesorectal excision (TME) was performed and, at the surgeon's discretion, when an increased risk of anastomotic leak was estimated.

Prospective general data on demographics, comorbidities, tumour-related variables, operating parameters, morbidity and length of stay were obtained. Such data were collected and analysed using the statistical programme SPSS (version 20) for Windows (SPSS, Inc., Chicago, IL, U.S.A.). The statistical analysis was performed using the Student's t-test for independent data or Mann-Whitney U test for numerical variables, as appropriate, and the chi-square test or the Fisher's exact test for qualitative variables. A P-value < .05 was considered statistically significant.

Download English Version:

<https://daneshyari.com/en/article/4254868>

Download Persian Version:

<https://daneshyari.com/article/4254868>

[Daneshyari.com](https://daneshyari.com)