

Comments on “Clinicopathological Features of Elderly Patients with Colonic Volvulus”

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Dear Editor,

A recent article “*Clinicopathological features of elderly patients with colonic volvulus*” by Gül et al. [1] evaluated some epidemiologic, diagnostic, therapeutic, and prognostic characteristics of 44 patients with colonic volvulus including sigmoid volvulus (SV). I thank the authors for their interesting research [1]. I would like to make some additional contributions on this clinically valuable topic.

Eastern Anatolia, where I practice, is an endemic area of SV, which is the most common type of colonic volvulus [2]. My colleagues and I have 57.5-year (between June 1966 and January 2024) and 1,076-case experience with SV, which comprises the largest single-centre SV data over the world [3]. Based on this comprehensive experience, my comments relate to some characteristics of SV.

First, the authors presented no demonstrative blood test in patients with SV [1]. Although high white blood cell count and neutrophil ratio may suspect bowel ischemia, and electrolyte imbalance may reflect an obstruction, there is no routine blood test to diagnose SV [4, 5]. Abdominal X-ray radiographs suggest SV by demonstrating omega-like dilated sigmoid segments (Fig. 1.a) with 57%-90% of diagnostic success rate and computed tomography (CT) helps to diagnosis by presenting mesenteric whirl sign in addition to X-ray findings (Fig. 1.b) with 85%-98% of diagnostic accuracy rate, both of which used by the authors [2, 5]. However, magnetic resonance imaging (MRI) is a critical alternative to CT in pregnant women by presenting similar findings (Fig. 1.c) and correct diagnosis rates [2, 6]. Similarly, endoscopy, preferably flexible procedure, is not only a therapeutic but also a diagnostic procedure by demonstrating a spiral-like obstructive sigmoid lumen (Fig. 1.d) in 75%-98% of SV cases [2, 7]. In our series, X-ray radiographs were diagnostic in 68.8% (636/925) of the patients, while the diagnostic accuracy rates of CT, MRI, and endoscopy were 98.0% (147/150), 95.7% (43/46), and 98.7% (150/152), respectively.

Second, although the authors demonstrated statistically higher mortality rates in patients with American Society of Anesthesiologists (ASA) score 4 when compared with that of cases



with ASA scores 2 and 3 (57.9% vs. 0% and 9.5%, $p < 0.05$), they presented no statistically significant relations between mortality and age, comorbidity, and bowel perforation [1]. However, advanced age, comorbid diseases, and peritonitis arising from bowel perforation are well-known bad prognostic factors in SV [8-10]. Hence, in our series, among decedent 85 (17.4%) of surgically treated 488 patients, 66 patients (77.6%) were over 60 years old, and 39 cases (45.9%) were older than 70 years. Similarly, serious comorbidity and bowel perforation were determined in 58 (68.2%) and 8 (9.4%) of our deceased cases, respectively.

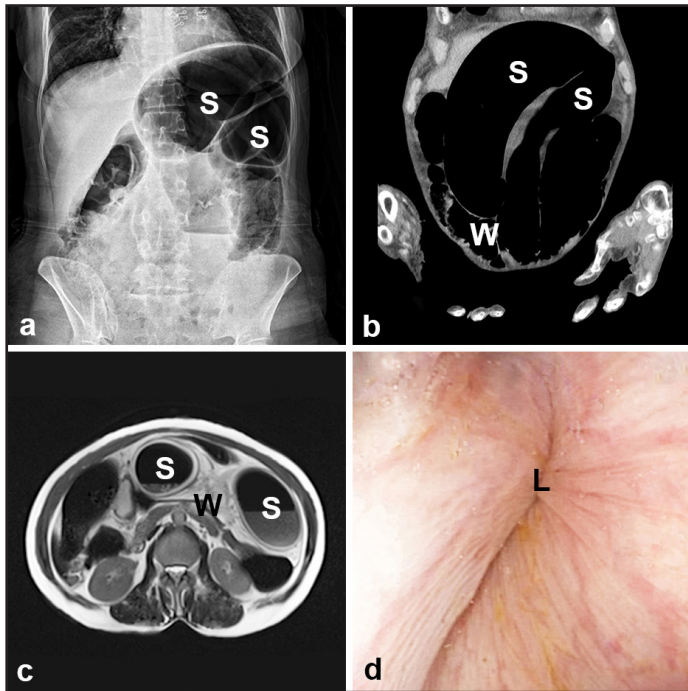


Figure 1. a. Abdominal X-ray radiograph of sigmoid volvulus b. Abdominal coronal computerized tomography image of sigmoid volvulus. c. Abdominal axial magnetic resonance image of sigmoid volvulus. d. Endoscopic appearance of sigmoid volvulus (S: dilated sigmoid colon segments, W: mesenteric whirl sign, L: Spiral-like obstructive sigmoid lumen).

As a result, I suggest diagnostic endoscopy in colonic obstruction-suspected cases as the primary diagnostic procedure, while I offer MRI in the diagnosis of pregnant women with clinical features of colonic obstruction. Additionally, I think that serious comorbidity and related high ASA scores as well as advanced age and bowel perforation are non-ignorable parameters affecting poor diagnosis.

Best Regards,

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