



Comments on 'Percutaneous gas decompression can ease endoscopic derotation in sigmoid volvulus'

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Dear Editor,

I read the article written by Uylas et al. (1) on urgent non-operative treatment of sigmoid volvulus (SV). The authors presented a practice on percutaneous needle decompression in a patient with unsuccessful endoscopic decompression before the second endoscopic trial. My comments relate to the details of urgent SV management based on our 1071-case experience treated over a 57-year period from June 1966 to July 2023, which contains the largest single-centre SV data over the world (2).

In SV, flexible endoscopic decompression is the first-line treatment option in patients without bowel ischemia and perforation (3). This procedure may be performed with 55%-94% of success, 0%-2% of mortality, and 2%-20% of morbidity rates (4). In our 777-patient endoscopy experience including 351 rigid and 426 flexible practices, the success rate is 83.4%, while mortality and morbidity rates are 0.5% and 1.8%, respectively. Patients with unsuccessful endoscopic decompression are potential candidates for urgent surgery with 1%-30% of mortality and 5%-60% of morbidity rates. In our series, these rates are 17.3% and 34.2%, respectively, in the 486-case urgent surgery group. Due to the poor prognosis of urgent surgery, percutaneous needle decompression may be an alternative option in selected patients in the management of SV, as was demonstrated by the authors.

Although percutaneous needle decompression has some advantages when admitted before surgery or endoscopy, unfortunately, patient selection criteria and technical details are still unclear (5). This procedure is not free of complications including perforation and peritonitis, which is possible due to the excessive dilatation of the sigmoid colon in addition to bleeding (1). For this reason, in my theoretical opinion and clinical experience, percutaneous needle decompression requires some practical rules mentioned below:

1. Primary SV cases are not proper candidates, while patients with unsuccessful endoscopic decompression constitute the main indication field.
2. Before the procedure, the practitioners must be sure about the absence of bowel gangrene, which requires urgent surgery without any delay.
3. Application during the first unsuccessful endoscopy instead of second procedure may prevent a repetitive preparation and practice.
4. The procedure is relatively painful, which may require deep sedation and/or local anesthesia.
5. Following the procedure, medical observation is required to see the complications on time.
6. When a perforation is suspected or determined, urgent surgery must be performed following an early and effective resuscitation.

I congratulate the authors and I look forward to their reply.

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