



Letter to the editor regarding “Novel self-reversing tube ileostomy as an alternative for conventional loop ileostomy for fecal diversion”

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Dear Editor,

We read with great interest the article by Antony et al. (1) entitled “Novel self-reversing tube ileostomy as an alternative for conventional loop ileostomy for fecal diversion.” The authors should be commended for addressing the clinically significant issue of ileostomy- and stoma closure-related morbidity and for proposing an alternative technique. Given the well-recognized burden of stoma-related complications and their impact on patient outcomes, the search for safer and more effective diversion techniques remains highly relevant (1).

However, several methodological aspects of the study may limit the interpretation of the findings.

First, the heterogeneity between the comparison groups is noteworthy. In particular, the markedly higher proportion of emergency procedures in the loop ileostomy group [40.9% (18/44) vs. 9.1% (4/44)] raises concern that the observed outcomes may be influenced not only by the diversion technique but also by baseline patient characteristics and surgical context. It is well established that factors such as elevated body mass index, comorbidities, and operative urgency significantly affect postoperative outcomes. For instance, obesity has been associated with a significantly increased risk of stoma-related morbidity (odds ratio≈2.01) (2).

Second, complications following ileostomy closure are inherently multifactorial, yet these variables do not appear to be adequately balanced or controlled. Previous studies have demonstrated that postoperative complication rates after ileostomy closure may reach 37.4% (3). Moreover, overall morbidity rates as high as 45.7% have been reported, including clinically significant adverse events such as adhesion-related small bowel obstruction, need for reoperation, and prolonged hospitalization (3). These findings underscore the critical importance of proper patient selection and group comparability in studies evaluating diversion techniques.

Third, the relatively short follow-up duration of six months limits the assessment of late complications, particularly adhesive small bowel obstruction. Adhesions are responsible for approximately 60% of small bowel obstruction cases, and only around 30% of these events occur within the first year after surgery, with a substantial proportion developing later (4). Therefore, longer follow-up is essential, especially for techniques such as tube ileostomy, which involve fixation of the bowel to the abdominal wall and may theoretically influence adhesion formation.

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Finally, although tube ileostomy appears to be a promising alternative, the relatively high rates of technical complications—such as tube obstruction (40.9%) and peritubal leakage (15.9%) raise concerns regarding its reliability and generalizability. Additionally, delayed stoma closure has been associated with significantly increased complication and readmission rates (26.3% vs. 8.2%), further emphasizing the importance of timing and patient selection in optimizing outcomes (5).

In conclusion, while this study provides valuable preliminary insights, its methodological limitations necessitate cautious interpretation. Therefore, before advocating routine clinical adoption, these findings should be validated through well-designed randomized controlled trials with adequate patient stratification and long-term follow-up.

Sincerely,

Footnotes

Author Contributions

Surgical and Medical Practices - E.T.; Concept - E.T.; Design - E.T.; Data Collection or Processing - E.T., O.C.; Analysis or Interpretation - E.T., O.C.; Literature Search - E.T.; Writing - E.T., O.C.

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