Colon injury Part 3

Decision making in the field

Primary repair Vs delayed closure

In war / MSF context/ crowded settings, anastomotic leaks after primary colonic repair are more often and not easy to diagnosed early !!

Do you agree?

Anastomotic leaks after primary colonic repair in war / MSF context/ crowded settings are more often and not easy to diagnosed early

Please
Put your
comments in

Forms

In war / MSF context/ crowded settings, anastomotic leaks after primary colonic repair are more often and not easy to diagnosed early !!

Why?

- Shortage of diagnostic tools
- Nursing issues
- Busy hospitals
- ICU care
- Patient general condition
- No parenteral feeding
- More ….

Mortality of faecal peritonitis

reflect our environment of an aging society. The according hospital (28.7 %) and 6-month (31.6 %) mortality rates are not low, but by far no reason for a fatalistic approach to patients

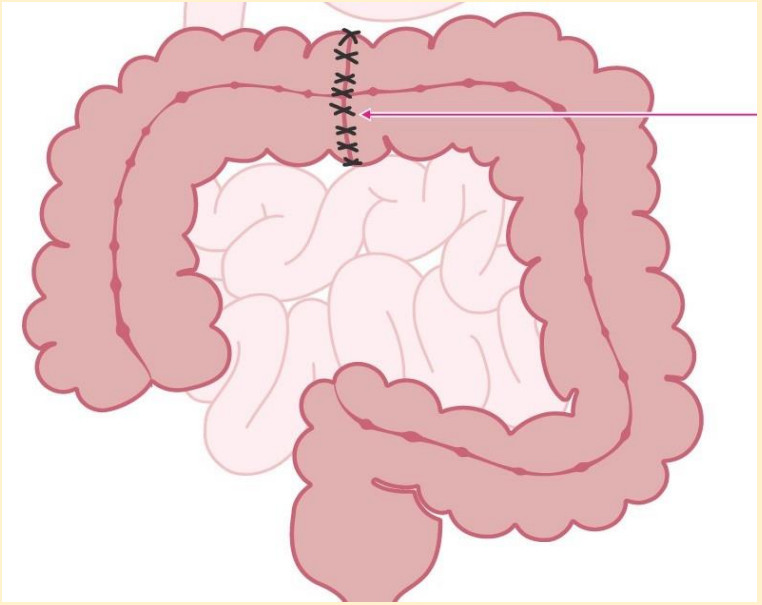
Overall postoperative mortality rate was 22.4%. Se

peritoneal soiling. The administration of no treatment resulted in 100% mortality (14 of 14). Parenteral cefotetan 25 mg/kg intramuscularly (IM)

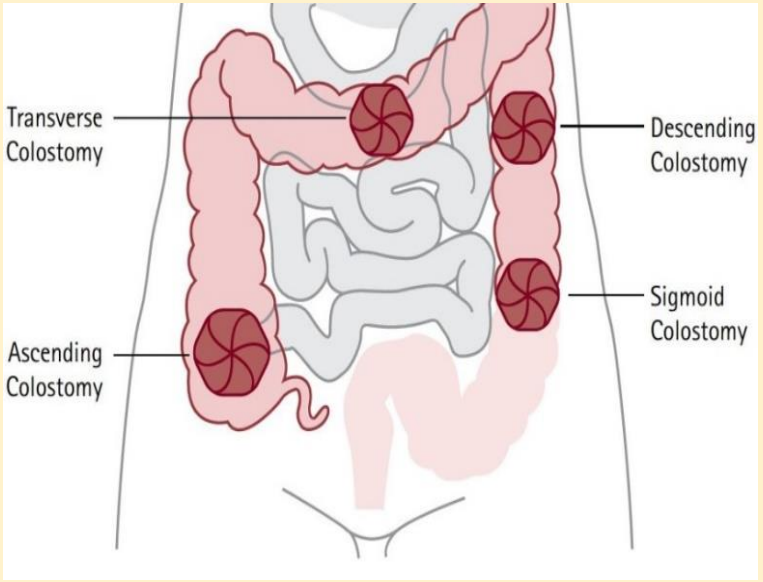
Together we can decrease the mortality after colonic injury ?



100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

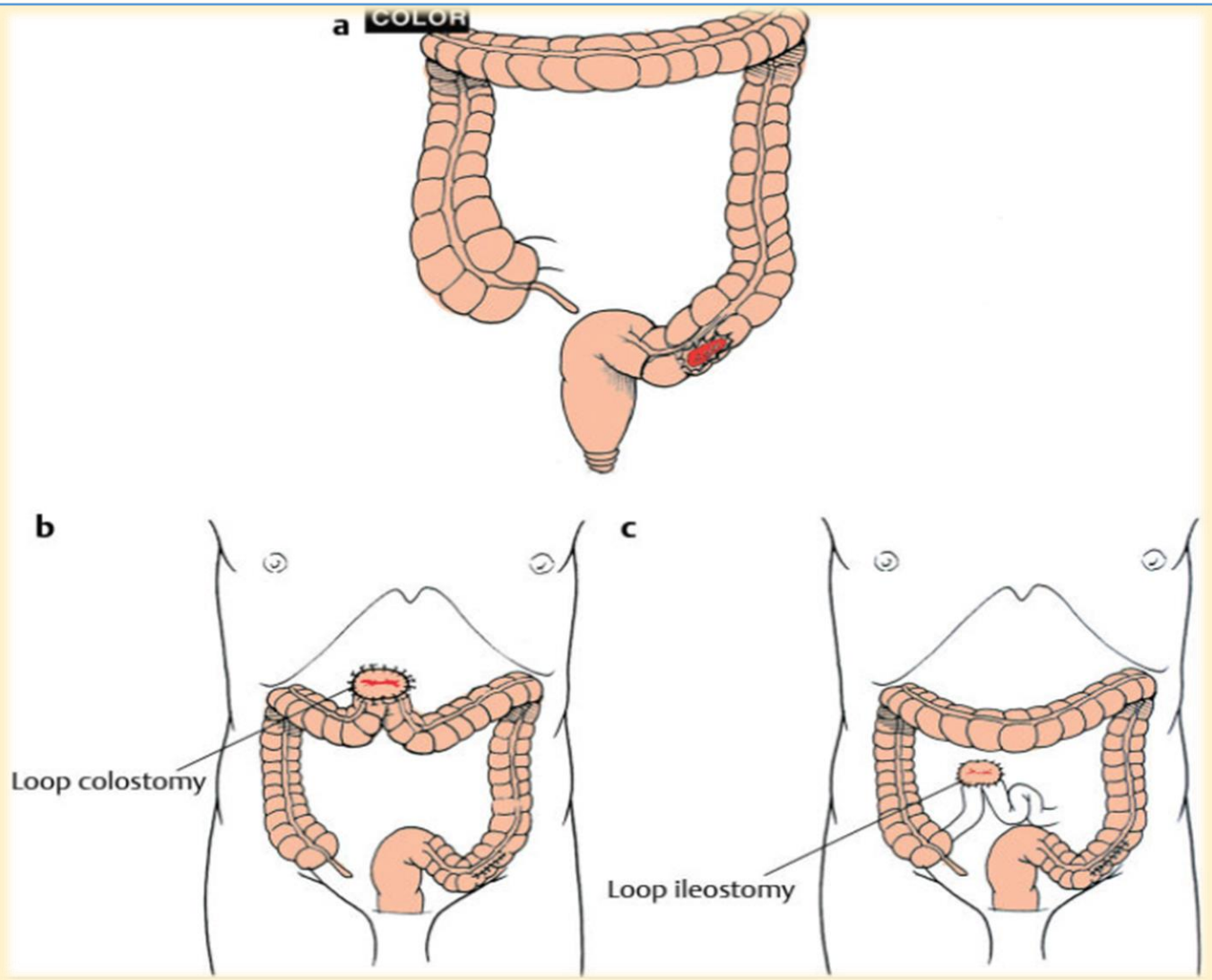


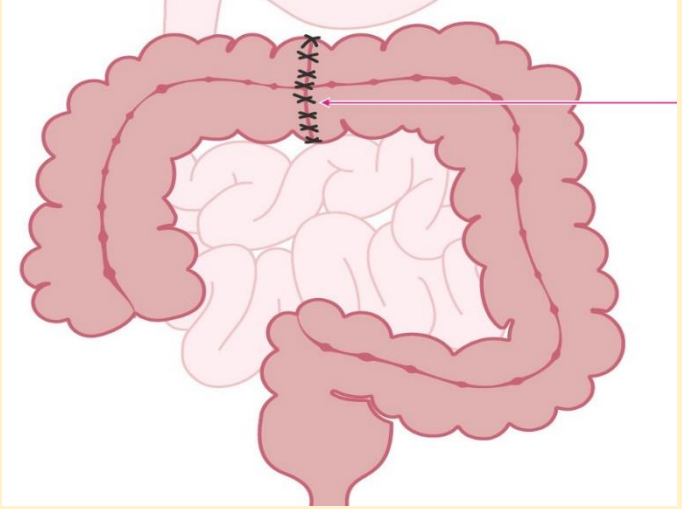
1. Primary repair

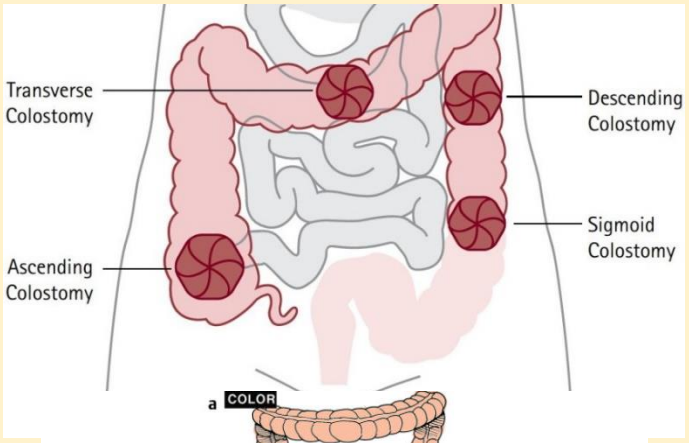


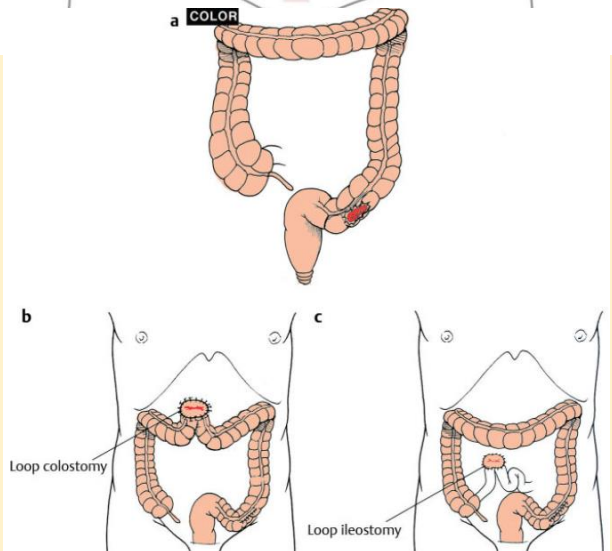
2. Diversion

3. Repair + diversion





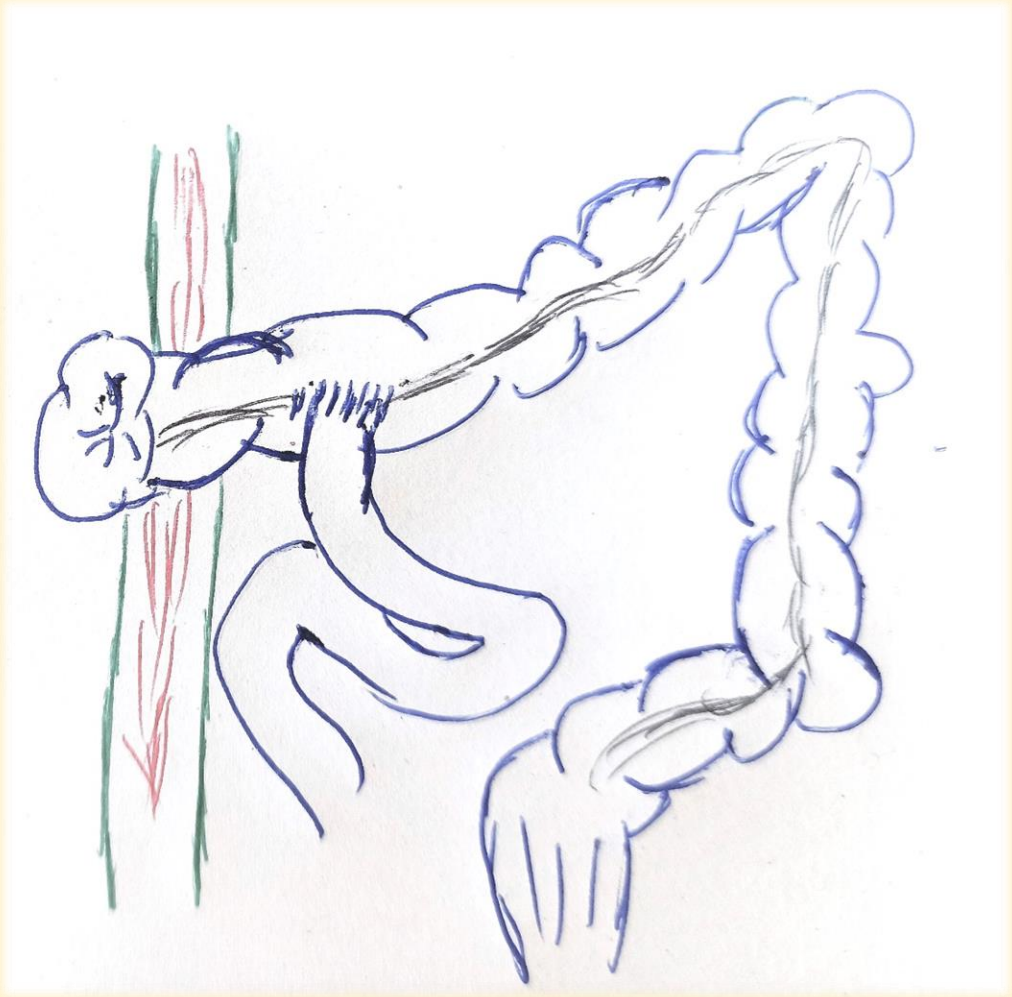




1. Primary repair

2. Diversion

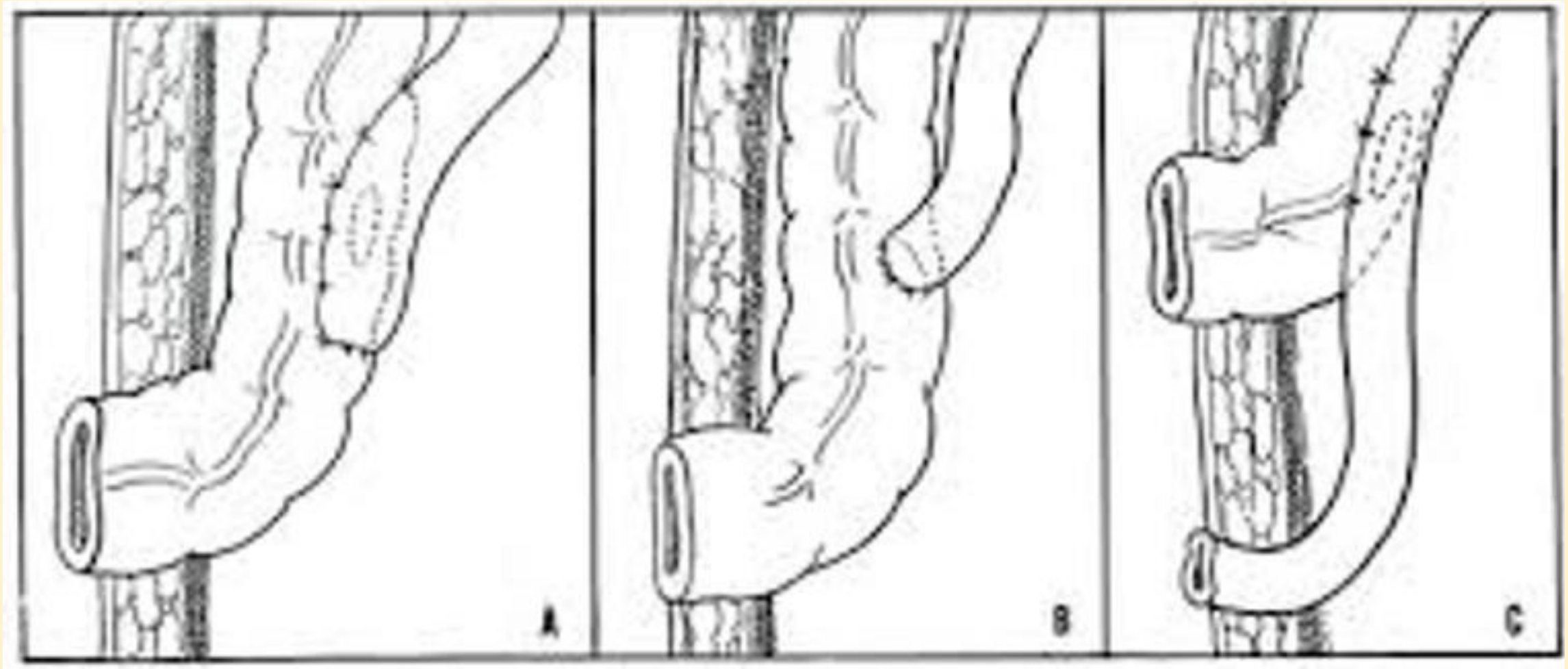
3. Repair + diversion



End-to-side ileocolic anastomosis +stoma



Tube cecostomy


A
B
C

What are the factors that make you decide to do colostomy instead of primary repair?

Please
Put your comment in

Forms

- Right colon or left colon.
- Size and nature of the lesion: small puncture, large destructive laceration.
- Mechanism of injury: knife, small fragment, bullet with cavitation effect, or blast.
- Number of injuries.
- Time of the injury.
- Blood loss, shock, and haemodynamic stability.
- Injury to the mesocolon.
- Patient age.
- Nutritional status.
- Medical comorbidities.
- Degree of faecal contamination.
- Number, extent and nature of other abdominal organs injured.
- Mass casualties.
- Extra-abdominal injuries.

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Number of injuries

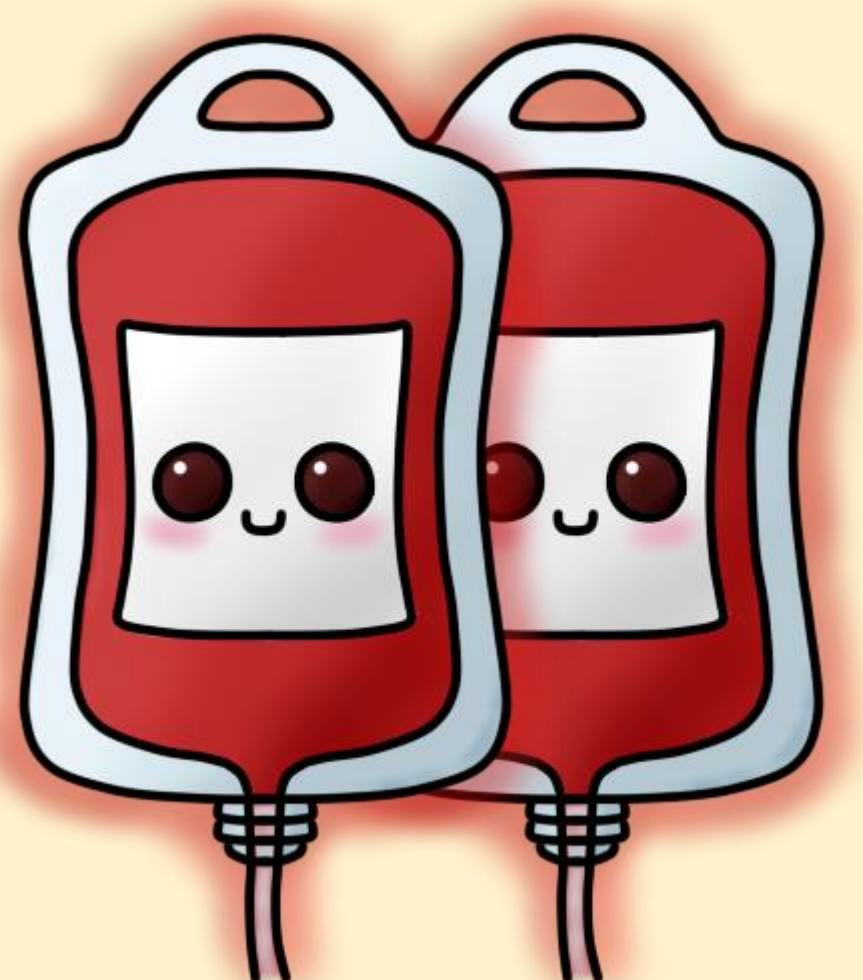
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➢Time of the injury.



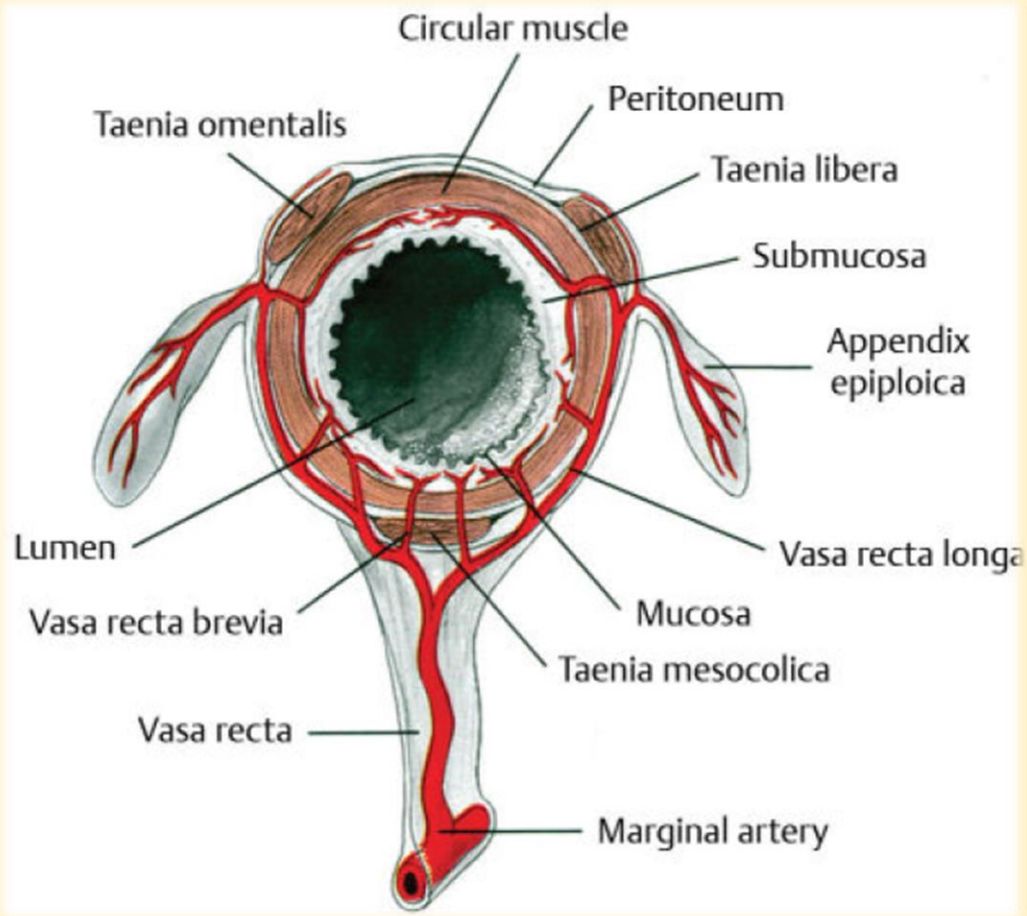
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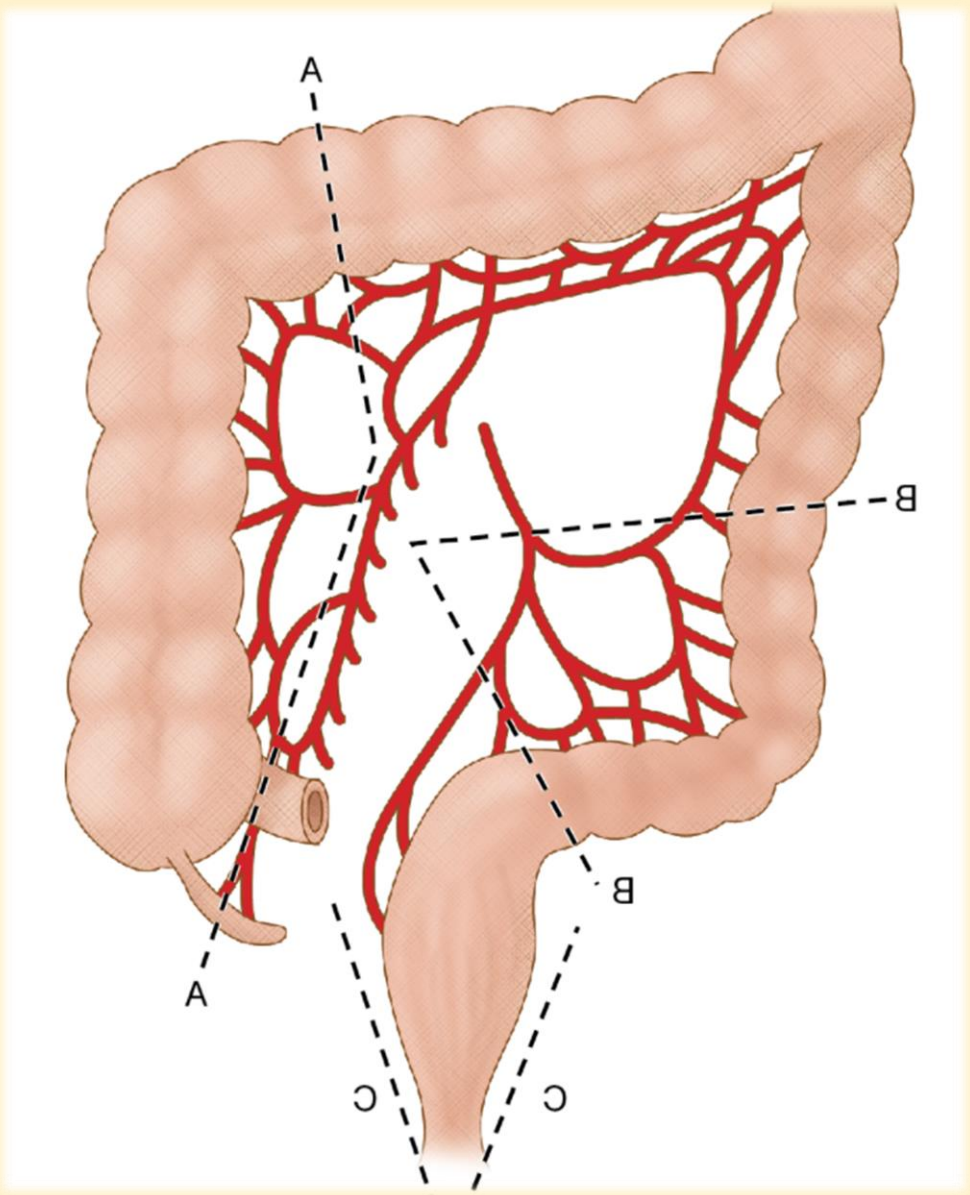
➢Blood loss, shock, and haemodynamic stability.



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➢Injury to the mesocolon.





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➢Patient age.

mortality was 31.6%. The most consistent predictors of mortality across all time points were increased age, development of acute renal dysfunction during the first week of admission, lower haematocrit and hypothermia on day 1 of ICU admission.

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➢Nutritional status.

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➢Medical comorbidities.

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➢Degree of faecal contamination.

Forty-one (26.9 %) patients had gross fecal contamination. Patients who had fetal contamination had a higher Mannheim peritonitis index (31.3 ± 5.1 vs. 21.9 ± 7.2, $p < 0.001$), higher organ failure rate (53.7 vs. 24.3 %, $p = 0.001$), and longer operating time (168.8 ± 49.9 vs. 144.8 ± 66.1 min, $p = 0.036$) than patients without fecal contamination. Early

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- **Extra-abdominal injuries.**

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