Dear Editor,

Re: Entrapment is an essential feature of sigmoid volvulus

I read the paper by Dahlberg and Everhov on the anatomopathology of sigmoid volvulus (SV). My comments relate to the authors’ interesting interpretation.

First, the authors state that the rotation of 180° or even 360° is commonly seen without strangulation or symptoms. In SV, when torsion exceeds 180°, luminal obstruction occurs, and if it passes over 360°, bloodstream is blocked. Hence, among the surgically treated 476 patients of our 1028 cases, which comprises the largest single-centre SV series over the world, volvulus degrees were 180°, 270°, 360° and >360° in 19.7%, 8.9%, 49.6% and 21.8% of patients, respectively.

Second, as the authors declared, anteroposterior abdominal radiography helps the diagnosis in 57–90% of patients, as was demonstrated in 68.1% of our patients. According to the authors, this diagnostic accuracy is a consequence of the sigmoid segments being adjacent in coronal plane, which implies a rotation of n × 180°. In my opinion, the diagnostic ability of the abdominal radiography is not an undisputed indicator for a rotation of n × 180°. Hence, the above-mentioned ratios in our patients with a rotation of 270° and >360° support my idea.

Third, the authors think that decompression is a key to derotation; additionally, it is the direct consequence of the intervention, not derotation. Endoscopic derotation by using minimal force and air insufflation is the main step in the treatment of SV. In my experience, to obtain a decompression without a derotation is technically difficult, or even impossible. For this reason, according to me, the actual key is derotation.

Finally, in SV, following twisting, untwisting of the enlarged sigmoid colon requires much more force in addition to its need for a wider intra-abdominal volume, which is described as ‘entrapment’ for a long time.

I congratulate the authors and look forward to their replay.

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At our institution, the most common treatment of sigmoid volvulus is decompression under fluoroscopy. Only in a minority of cases decompression is unsuccessful, and once decompression is achieved, subacute recurrences are relatively rare. Similar experiences have been reported recently. Thus, we do not recognize the clinical problem presented by Professor Atamanalp of careful derotation as being a key step in managing sigmoid volvulus, as this is not achieved in fluoroscopic decompression.

The letter was motivated by the discrepancy in the management of sigmoid volvulus at different institutions, and we welcome the discussion on the mechanism of the disease.

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Re: Gunshot wounds to the colon: predictive risk factors for the development of postoperative complications, an experience of 172 cases in 4 years

Dear Editor,

I read the article with interest by Elfaedy et al. I have three relevant observations about this study: first, the Libya conflict was never a traditional war (TW); second, it seems that the casualties were treated in a tertiary hospital; and, third, the time from injury to operation was short (<200 min). The whole dynamic of a TW and the casualties’ management is different from that of civil injuries, terrorist attacks, civil wars, guerrilla warfare and even short-term one-sided wars. One crucial factor is the chance of quick evacuation of casualties to a tertiary centre. This comparison is based on my past experience 40 years ago as a surgeon assigned to establish and run the first advanced surgical centre in a big TW that lasted 8 years. In a TW, the battle would continue during daylight, and casualties could typically only be evacuated from the fire lines and trenches during dark hours — which is when our work would begin. This means a delay in transfer, sometimes for up to 12 h, results in associated blood loss. The medics at the very front line would be instructed to insert an intravenous cannula and run continuous fluids until the patient arrived. Immediate laparotomy was always needed to control bleeding. The delay in transfer also meant more contamination from bowel injury; accordingly, colonic primary repair (PR) was not popular. One of the more commonly adopted procedures was to simply exteriorize the affected large bowel as a colostomy. This procedure minimized the chances of a peritoneal leak, peritonitis and peritoneal collections. In TW, there are more massive, and possibly daily, casualties. This leads to additional pressure on frontline hospitals to vacate beds as early as possible, and as such they could not afford to have any of these early complications. After a few days, the post-operative patients were then transferred to a base hospital for further care using buses converted into large ambulances capable of carrying many patients at once. Reports of colonic gun injury-related surgeries during conflicts in the last three decades have shown a shift towards PR, possibly due to the majority of reports not being based on TW. Colostomy versus PR, however, remains an unsettled controversial issue. Some have recommended a compromise, which involves exteriorizing the PR and has thus far shown promising results.

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Dear Editor,

Re: Gunshot wounds to the colon: predictive risk factors for the development of postoperative complications, an experience of 172 cases in 4 years

This notable series of colorectal gunshot wounds offers a unique perspective, sitting half way between military surgery with mechanisms of injury, and civilian trauma surgery with staff and infrastructure. Ever since the ‘mandatory stoma days’ of World War 2, civilian trauma systems have gradually worked towards defining those penetrating colorectal injuries that can safely be managed without a stoma. Apart from extraperitoneal rectal injury and the presence of a few well-defined risk factors, diversion is now the exception rather than the rule. However, in the military setting, diversion continues to remain commonplace. In this mixed series of