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Letter to the Editor

Left colon volvulus following sigmoidectomy

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Dear Editors,

Sigmoid volvulus is the torsion of the sigmoid colon resulting in a closed-loop intestinal obstruction [1]. Although sigmoid volvulus is the most common type of colonic obstruction with an incidence of 1.67 per 100,000 person-year in the United States, it is more common in Turkey, particularly in Eastern Anatolia with an incidence of 4.2 patients per 100,000 persons per year [2]. Sigmoid volvulus is a relatively well-defined clinical entity with its diagnostic, therapeutic, and prognostic features [3]. However, a semi-mystical clinical description in association with sigmoid volvulus, neo left colon volvulus, gained wide currency in recent years [4].

Due to the easy and early diagnosis of colorectal malignancies as well as sigmoid volvulus under auspices of flexible endoscopes and developed radiological techniques, sigmoidectomy via open or preferably laparoscopic surgery increased in number in recent times. It is clear that, the de-peritonization of the descending colon or even the resection of the left flexura is frequently required for a tension-free anastomosis to restore the intestinal continuity following sigmoidectomy. In the end, the descending colon becomes like an intraperitoneal vessel instead of its original anatomical position in retroperitoneal area. Most practitioners currently renames this new anatomical stricture as 'neo left colon', while some others traditionally prefer the 'descending colon' term as the previous description. In the end, no matter what is its name, the new bowel is under the risk of volvulus [4,5].

Sigmoid volvulus is not a mystery for most practitioners due to its relatively high incidence. However, following sigmoidectomy for colorectal malignancies or sigmoid volvulus, a new or repetitive bowel volvulus, neo left colon volvulus or metachronous descending colon volvulus, may come a revelation to some inexperienced practitioners. To prevent or reduce the poor prognosis arising from late diagnosis, the description of the new clinical entity becomes crucial. The most important detail is the presence of a previous left colon surgery in the medical history of such patients. Abdominal pain, distention, and obstipation are the main symptom and signs. Although plain abdominal X-ray radiographs causes a suspicion of intestinal obstruction by demonstrating air-fluid levels, the current diagnostic procedure is computed tomography with mesenteric whirl sign in addition to X-ray findings. Endoscopy, preferably flexible procedure is both diagnostic by demonstrating a spiral obstruction line in the bowel and therapeutic by allowing for decompression in uncomplicated patients. In cases with peritoneal irritation findings, unsuccessful endoscopic detorsion, or un-definitive diagnosis require emergency surgery including resection or fixation of the new colon. To prevent or reduce a recurrence risk, operative or endoscopic percutaneous colopexy may be used [6,7].

I think that, to be on alert for neo left colon volvulus or metachronous descending colon volvulus in patients with intestinal obstruction symptoms and signs will be beneficial in cases with previous medical history of left colon surgery.

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The datasets created and/or analyzed during the current study are not publicly available, but are available from the corresponding author upon reasonable request.

Ethics Approval and Consent to Participate

Not applicable.

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