Intestinal Perforation: A Surgeon's Nightmare Enlightened by Scientific Research

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Intestinal perforation is a surgeon's nightmare that every colorectal surgeon has encountered once in a while, or at least a few times, during his or her career. For some, it is a dramatic victorious memory of a heroic surgeon saving a patient's life after a struggle of several hours while for some it is something never to be remembered. Either way, an intestinal perforation is an unwanted guest that drains a surgeon.

An intestinal perforation has numerous etiologies, and its clinical manifestations range from vague and mild abdominal discomfort to severe life-threatening panperitonitis [1, 2]. Moreover, its outcomes and prognosis are influenced by various factors, including the patient's medical condition and the severity of the disease [3]. Given this variety and ambiguity, the treatment strategy for a patient with an intestinal perforation, including surgical procedure, largely depends upon the surgeon's experience rather than scientific evidence.

Continuing efforts have been made to shed some scientific light on the dark area of ambiguity surrounding the management of a patient with an intestinal perforation [1, 4]. The current article entitled, "Predictors of Morbidity and Mortality After Surgery for Intestinal Perforation," needs to be read in this context [5]. The authors aimed to reveal factors that could be used to predict the outcome after surgical treatment of a patient with intestinal peritonitis. They retrospectively analyzed 117 patients who had received surgical treatment for intestinal peritonitis. In their data, the most common etiology was an endoscopic complication, followed by diverticulitis, which might reflect a biased patient popu-

lation. The mortality and the morbidity rates were 12.8% and 60%, respectively, which, as expected, were relatively low compared to the rates in previous reports. They found female gender, low estimated glomerular filtration rate, and high C-reactive protein to be significant predictive factors for postoperative morbidity. For mortality, shock status and feculent ascites were significant predictive factors.

In a broad sense, an intestinal perforation may be considered as a part of peritonitis, so the maintenance of systemic function is as important as the surgical repair of a mechanical defect of the hollow viscus. In this context, the conclusion of the current article delivers a predictive message. The future direction of further research should include the integration of previous reports to establish treatment strategies based on risk assessment. Based on the results from the current study, the treatment strategy needs to cover critical care medicine, as well as surgical procedures.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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