

Condition for Good Quality of Life after Surgery for Slow Transit Constipation

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We were able to identify subgroups of patients by using physiologic tests that accurately predicted those who would respond well to surgery [1]. Only those patients documented, by using a marker transit study or by using scintigraphic transit, as having slow-transit constipation were deemed to be candidates for surgery, and the success rate of a colectomy for colonic inertia was significantly higher in patients who underwent a repeat transit study confirming inertia than in patients who underwent a colectomy based on a single study. Thus, consideration should be given to repeating the colonic transit study before a colectomy to help secure the diagnosis and to improve the outcome [2].

Surgeons have performed a total abdominal colectomy with ileorectal anastomosis and a subtotal colectomy with ileosigmoid or cecorectal anastomosis for colonic inertia. A cecorectal anastomosis, while preserving the ileocecal valve with the theoretical advantage of water preservation, is often complicated by cecal distention. Sigmoid preservation also predisposes patients to postoperative constipation. Today, a total abdominal colectomy remains the treatment of choice for colonic inertia. However, despite its excellent success rate, postoperative morbidity remains a discouraging problem. The incidence of abdominal pain and bloating are less likely to subside after a colectomy perhaps because of irritable bowel syndrome [3]. A long-term follow-up study reported a slight decrease in bowel frequency, a change in stool consistency (semi-liquid to semi-solid), and a decreased incidence of fecal incontinence, possibly because of small-bowel adaptation [4]. In summary, I agree

with the author's opinion, and I think a total abdominal colectomy can be recommended to patients with well-established colonic inertia.

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