

Surgical Quality Collaborative should continue to focus on this important infection prevention strategy.

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Ileostomy: Still a Problem with Hopeful Perspectives



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We read with interest the article by Jae Moo Lee and colleagues,¹ which focused on a safe alternative to primary anastomosis with a diverting loop ileostomy in patient with acute diverticulitis. The authors compared 30-day outcomes of patients undergoing emergency Hartmann's procedure and primary anastomosis with a diverting loop ileostomy.

Although ileostomy can be considered a safe technique to protect intestinal anastomosis after Hartmann's procedure, there is great risk of morbidity. In fact, a great number² of this stoma remain functioning for all life of the patient.

In low-risk patients, a "virtual ileostomy" (ie a proximal intra-abdominal closed loop ileostomy fixed to the abdominal wall using a vessel loop),³ which can be converted into a real ileostomy in case of anastomotic leak, could be a valid technique to avoid ileostomy.

An improvement of this technique has been published recently.⁴ It consists of early postoperative endoscopy that could reveal anastomotic colorectal leak before the onset of symptoms, thereby reducing the associated morbidity.

The protocol followed in this study involves postoperative dosing of C-reactive protein and procalcitonin and routine endoscopy on postoperative day 3. In case of leak, conversion to a real loop ileostomy is indicated, irrespective of clinical symptoms.

This technique can be a valid tool for the outcomes of these patients, as ileostomy can be done in suitable clinical conditions before symptoms appear, avoiding the risk of life-long ileostomy.

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Changing Culture of Managing Acute Diverticulitis In Reply to Palumbo and Colleagues



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We appreciate the comments by Palumbo and colleagues about our article comparing 30-day mortality and morbidity of acute diverticulitis patients undergoing emergent Hartmann's procedure vs primary anastomosis with diverting loop ileostomy.¹ Dr Palumbo and colleagues proposed the use of "virtual ileostomy" (VI) for low-risk patients to avoid ileostomies and associated morbidity in the future, and even suggested a role for routine early endoscopy to diagnose subclinical leaks that would prompt maturing the ostomy.

Although we are also cautiously excited for the potential value of VI in preventing unnecessary ileostomies, it is important to note 2 points. First, our study did not include any VIs, and our algorithms were clearly in detecting patients who underwent either Hartmann's procedure or primary anastomosis with diverting loop ileostomy on the initial procedure. In other words, none of our patients who underwent primary anastomosis with diverting loop ileostomy had the colon resection and the ileostomy in 2 separate procedures. Second, although