

Primary Repair of Colonic Injuries

SAFDAR ALI KHAN, ISHTIAQ AHMAD, EJAZ AHMED*

ABSTRACT

Aim: Types of operative measures adopted and prognosis of patients with perforating injuries to colon.

Methods: This descriptive study was carried out in the Department of General Surgery, Multan Medical & Dental College/Ibn e Siena hospital & Research institute, Multan, during the period from June 2009 to December 2013. All 100 patients were admitted in emergency ward with trauma to abdomen, and routine investigations were carried out.

Results: Majority of the patients i.e. 51 (85%) were injured by gunshot. Fifty five (90%) patients were male. For more extensive contamination colostomy gave complication rate 20% in grade 2 and 25% in grade-3. Patients who were anastomosed, 15% developed leakage. Out of 60 patients, 15(25%) patients had injury at right colon, 16 (28%) had at transverse colon, 28 (46%) patients at left colon and remaining 11(18%) patients had injury at sigmoid colon. Out of 60 patients, 10(16%) patients were found in injury grade-1, 44(74%) patients in grade-2 and 6(10%) patients in injury grade-3 were involved. Majority of the patients i.e. 44(74%) had more complications. There was no difference between these two groups with respect to grade of colon injury according to the colon injury severity scale or location of injury.

Conclusion: It was observed from data that selective primary repair may be used in a significant proportion of colon wounds. It was based on classification system that employs an assessment of the extent of tissue injury, degree of fecal contamination, assessment of associated injuries; estimates of the influences of delay between injury and definitive therapy and hemorrhagic shock.

Keywords: Contamination colostomy, Anastomosis, Colon.

INTRODUCTION

The mortality of colorectal injury was higher than 90% during the U.S. Civil War (1861-1865), and it decreased to 40% during the Second World War (1941-1945) and noticeably to less than 10% through the Vietnam War. In the recent 100 years, the management of traumatic injury to the colon and the rectum was improved greatly. Nonetheless, the mortality rate is still 3%, and the abdominal sepsis rate is higher than 20%, proving that the management of colon injury is one of the important fields of trauma medicine that still requires further studies¹. Colon and rectal injuries occur upto 10% of patients that suffer penetrating or severe blunt abdominal trauma. In blunt abdominal trauma splenic injury was found to be the commonest with 56% of laparotomies. The liver was the second most organ involved (21%)². The majority of colon injuries are diagnosed intra-operatively following a penetrating abdominal injury³.

Management of penetrating colonic injuries requires urgent continuous vigilant care of patient. In the past, changes in the management policies evolved as a result of large therapeutic experience

gained during the time of military conflict. Surgical care in case of traumatic injury to colon has changed significantly. During the world war-II, diversion was the dictum; current trends favour the primary repair⁴.

During the World War-I, the average mortality rate reported was 60%. Surgeon General of United States issued a letter that all the injuries to the colon would be treated by performing a colostomy⁵. Based on this philosophy the rate fell to 30% during the world war-II. The mortality rate fell to 10-15% during the Korea and Viet Nam conflict. Colostomy is increasing reserved for rectal injuries and destructive colon injuries. Peri-operative antibiotics and early celiotomy with intra-abdominal exploration and primary repair of the colon injury usually provide excellent results⁷.

In colonic injury hypovolemia and sepsis are common causes of morbidity and mortality. These patients need extra care. Primary repair was used safely in most cases of civilian penetrating colon injuries. Colostomy was performed for selected cases of colon wounds associated with shock, multiple blood transfusions; multiple other injuries⁸. Iatrogenic abdominal colonic perforation is a rare but very dangerous complication of colonoscopy⁹. Perforation of colon and rectum during barium enema examination contributes a surgical emergency. Prompt diagnosis of the colonic injury and early

Department of Surgery, Multan Medical & Dental College, Multan,

**Department of Physiology, Sharif Medical and Dental College, Lahore*

Correspondence to Dr. Safdar Ali Khan, Assistant Professr

management is vital in decreasing morbidity and mortality¹⁰.

In addition to the above, low-speed bullets are causing major colon injuries in peace time, and the trend toward increasingly performing a proximal diversion for traumatic colon injury has continued without scientific evidence. This phenomenon is due to surgeons who returned from war and who had become too familiar with war-time guideline and had accepted the proximal diversion as the standard treatment for traumatic colorectal injury, even during peace time.

MATERIAL AND METHODS

This descriptive study was carried out in the Department of General Surgery, Multan Medical & Dental College/Ibn e Siena hospital & Research institute, Multan, during the period from June 2009 to December 2013. All 60 patients were admitted in emergency ward with trauma to abdomen, and routine investigations were carried out.

RESULTS

Out of 100 patients 85 (85%) were injured by gunshot while stab wound was found in 15 (15%) of the patients.

Ninety (90%) patients were male and 10 (10%) were female patients. Out of 100 patients, 70 (70%) had mild contamination, 15 (15%) had moderate and 15 (15%) had severe contamination. Majority of the patients i.e. 74% had grade-2 according to Flint injury scale.

Out of 100 patients, 25(25%) patients had injury at right colon, 28 (28%) had at transverse colon, 46(46%) patients at left colon and remaining 18 (18%) patients had injury at sigmoid colon (Table 1). Majority of the patients i.e., 74(74%) had more complications (Table 2). Small bowl injuries were found in 60 patients, duodenum in 18 patients, stomach in 12 patients and liver was found injured in 10 patients (Table 3). There was no difference between these two groups with respect to grade of colon injury according to the colon injury severity scale or location of injury. The majority of injury was grade-3 and 4. There was no grade1 colon injury in either group as shown in table 4.

Table 1: Location of injury

Site	n	%age
Right colon	25	25
Transverse colon	28	28
Left colon	46	46
Sigmoid colon	18	18

Table 2: Grades of injury versus complications (n=100)

Grades	n	%age	Complications
1	16	16	0
2	74	74	20
3	10	10	30

Table 3: Associated intra-abdominal injuries (n=100)

Injury	Primary repair	Diversion
Small bowel	30	30
Duodenum	10	08
Stomach	06	06
Liver	04	06

Table 4: Colon injuries severity scale (n=100)

Grades on injury	Primary repair	Diversion
1	0	0
2	08	04
3	24	30
4	10	10
5	08	06

DISCUSSION

During one year period 60 patients with penetrating injury to the colon were observed under prospective study. Most of these patients were male. Primary repair gave better results while colostomy was considered for severe cases. Primary repair of the colon perforation due to penetrating injury is most frequently possible following a low velocity injuries (penetrating stab wounds) where associated organ systems are injured and contaminated minimally.

Patients with gunshot wounds were 54 (90%) and stab wounds were 6 (10%). 50% were incised (laparotomy) while within 8 hours and 50% patients were incised after 8 hours but within 12 hours. In the unstable patients by doing the minimum necessary to control exsanguinations and prevent the spillage of intestinal contents and urine into peritoneal cavity. Re-operation for definitive surgery, undertaken after optimum stabilization of physiological parameters in an intensive care ward. Of the injury severity indices estimated, the PATI most reliably produced complications and specifically identified patients whose outcome would be good for primary repair. These results suggest that the use of primary closure should be expanded in civilian penetrating colon trauma that even with moderate degree of colon injury. Primary closure provides an outcome equal to that provided by colostomy. In addition to the predictive value of PATI suggests that it should be included along with other injury severity indices in trauma databases.

Ninety percent of patients were brought to surgery within hours of injury. The time from pick up ambulance to incision was 7 hours. Because higher

degree of trauma was seen in the colostomy patients, comparisons were stratified according to index of injury to reduce this bias. Factors contributing to lower morbidity and mortality for improvement are:-

- a. Evacuation time from accidental point to stable tactical situation or hospital.
- b. Anesthesia and antibiotics regimens.
- c. Resuscitation.

Mortality rate rose progressively with the severity of injury (4% in grade 1, 31% for grade 3). While septic complications were similar for grade-2 and 3. Isolated colonic injuries, with minimum blood loss, operated upon within 08 hours were associated with less than 10% mortality.

Colon wounds of gunshot= 91%

Stab wounds=09%

Delay of laparotomy > 8 h= 50%

Major morbidity was defined as septic or non septic complications that resulted in significant change in treatment, outcome or hospital stay. One of these is abdominal wound disruption¹¹.

Colon related morbidity, including intra abdominal abscesses, systemic sepsis, colonic fistula, major wound infection, dehiscence or major osteomyelitis infection, but excluding pneumonia and urinary tract infection, because these were not considered to be colon injury related complications. All abdominal organ injured were evaluated accordingly. The small intestine was the other organ injured most commonly. Mortality otherwise for the randomized colostomy was tenfold greater than if the primary closure has been performed. Average postoperative stay was six days longer ($p < 0.01$) if the colostomy has been created, exclusive of subsequent hospitalization for colostomy closure.

Primary repair was used safely in most cases of penetrating colon injuries. Colostomy was performed in selected cases on wound associated with shock, multiple blood transfusion, multiple other injuries, extensive contamination and high velocity weapons in the absence of these associated factors, primary repair approved justified. Patients were divided according to grades of injury.

It was observed from data that selective primary repair may be used in a significant proportion of colon wounds. It was based on classification systems that employ an assessment of the extent of tissue injury, degree of fecal contamination, assessment of associated injuries; and estimates of the influences of delay between injury and definitive therapy and hemorrhage shock. There was no difference in outcome between patients who had primary repair and those undergoing diverting colostomy. Results

obtained in 60 patients eligible for randomization revealed that primary closure in 30 patients had a lower infection rate of incision (46% vs. 56% $p > 0.05$) and is still lower infection rate for the abdomen proper (15% vs. 30% , $p < 0.05$) in comparison to 30 patients with randomized colostomy. Morbidity otherwise for the randomized colostomy was tenfold greater than in a primary closure had been performed. Average postoperative stay was 6 days longer ($p < 0.01$) if the colostomy has been created, exclusive of subsequent hospitalization for colostomy closure. Repair was safer with low associated risk factors. Resection and anastomosis carried out with low leak risk in these patients.

CONCLUSION

Ideally an individual management strategy would be developed for each patient suffering from colorectal injury

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