OCLUSIÓ DE CÒLON

CIRURGIA PRIMÀRIA

VS

STENT

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De què estem parlant?

OCLUSIÓ DE CÒLON:

Causa més freqüent : **NEOPLÀSIA DE CÒLON**
Altres: Compresions extrínseques
Lesions benignes (diverticulitis, vòlvul)

Pacient amb oclusió intestinal de còlon:

- Deshidratació
- Alteracions hidroelectrolítiques
- Mucosa còlon alterada per la distensió

Kleespies A, Fuessl KE, Seeliger H, et al. Determinants of morbidity and survival after elective non-curative resection of stage IV colon and rectal cancer. Int J Colorectal Dis 2009;24:1097–109.
Breitenstein S, Rickenbacher A, Berdajs D, Puhan M, Clavien PA, Demartines N. Systematic evaluation of surgical strategies for acute malignant left-sided colonic obstruction. Br J Surg. 2007;94:1451–1460.
T

De què estem parlant?

NEOPLÀSIA DE CÒLON OCLUSIVA:

Presentació inicial 7-29% dels càncers de còlon
Localització més freqüent: **SIGMA** (> 75% distals a l´angle esplènic)

Oclusió intestinal per neoplàsia de còlon:

- Factor que empitjora pronòstic
- Augmenta morbimortalitat en comparació amb cirurgia el.lectiva

Kim JS, Hur H, Min BS, et al. Oncologic outcomes of self-expanding metallic stent insertion as a bridge to surgery in the management of left-sided colon cancer obstruction: comparison with non obstructing elective surgery. World J Surg 2009;33:1281–6.
Tan CJ, Dasari BV, Gardiner K. Systematic review and metaanalysis of randomized clinical trials of self-expanding metallic stents as a bridge to surgery versus emergency surgery for malignant left-sided large bowel obstruction. Br J Surg. 2012;99:469–476.
M cArdle CS, Hole DJ. Emergency presentation of colorectal cancer is associated with poor 5-year survival. Br J Surg. 2004;91:605–609.

Factors pronòstics de mala evolució cirurgia oclusiva de còlon

First author, year	Study population	Results	Study design Level of evidence
Tekkis, 2004[18]	Patients undergoing surgery for acute colorectal cancer obstruction (n = 1046)	Multivariate analysis of in-hospital postoperative mortality: - Age <65 years: 5.4% - Age 65-67 years: 13.1%; OR 2.97 (95%CI 1.26-7.08) - Age 75-84 years: 21.9%; OR 4.31 (95%CI 1.83-10.05) - Age ≥ 85 years: 27.0%; OR 5.87 (95%CI 2.27-15.14) - ASA I: 2.6% - ASA II: 7.6%; OR 3.32 (95%CI 0.73-15.18) - ASA III: 23.9%; OR 11.73 (95%CI 2.58-53.36) - ASA IV-V: 42.9%; OR 22.33 (95%CI 4.58-109.68)	Nonrandomized prospective UK multicenter study High quality evidence
Biondo, 2004[17]	Patients undergoing emergency surgery for acute large-bowel obstruction (n = 234) Colorectal cancer 82.1% Extracolonic cancer 4.7% Benign lesions 13.2%	Univariate analysis of 30-day postoperative mortality: - Age ≤70 years: 10.7% (14/131) - Age >70 years: 29.1% (30/103); $P < 0.001$ - ASA I-II: 8.1% (9/111) - ASA III-IV: 28.5% (35/123); $P < 0.001$ Multivariate analysis of 30-day postoperative mortality: - Age >70 years: OR 2.05 (95%CI 0.92-4.60) - ASA III-IV: OR 2.86 (95%CI 1.15-7.11)	No description of study design, most likely retrospective Moderate quality evidence
Tan, 2010[19]	Patients who underwent operative intervention for acute obstruction from colorectal malignancy (n = 134)	Perioperative morbidity rate: 77.6% Perioperative mortality rate: 11.9% Multivariate analysis of worse outcome (grade III-V complications, including death): - Age >60 years: OR 4.67 (95%CI 1.78-12.25) - ASA III-IV: OR 8.36 (95%CI 3.58-19.48)	Retrospective analysis Low quality evidence

CI, Confidence interval; *OR*, odds ratio.

Edat : > 70 anys
ASA III-IV

De què estem parlant?

OCLUSIÓ CÒLON

- Edat
- Comorbilitat
- Malaltia avançada
- Condicions mèdiques
  - Deshidratats
  - Alt. hidroelectrolítiques
- Còlon no preparat
- Dilatació intestinal

Cirurgia Urgent Còlon
Mortalitat: 15-20%
Morbilitat: 40-50%
(programada : Mortalitat 0.9-6%)

Factor cirurgià
- Experiència
- Laparoscòpia
- Contemporització

Ressecció lesió i estoma
HARTMAN
"permanent" 40-60%
Reconstrucció:
morbilitat: 5-57%
mortalitat: 0-34%

Procediments
Esglaonats

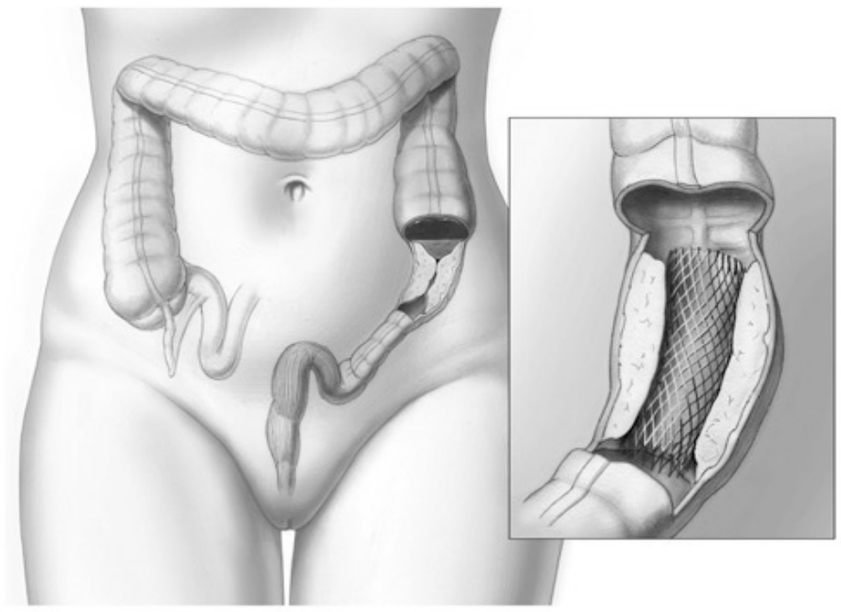
STENT CÒLON

Kim JS, Hur H, Min BS, et al. Oncologic outcomes of self-expanding metallic stent insertion as a bridge to surgery in the management of left-sided colon cancer obstruction: comparison with non obstructing elective surgery. World J Surg 2009;33:1281–6.
Tan CJ, Dasari BV, Gardiner K. Systematic review and metaanalysis of randomized clinical trials of self-expanding metallic stents as a bridge to surgery versus emergency surgery for malignant left-sided large bowel obstruction. Br J Surg. 2012;99:469–476.
M cArdle CS, Hole DJ. Emergency presentation of colorectal cancer is associated with poor 5-year survival. Br J Surg. 2004;91:605–609.

Stent còlon

1990 - Dohomoto: Descriu l´us d´stent còlon com a mètode de tractament d´oclusió de còlon pal.liativa per evitar estoma

1994 - Tejero utilitza l´stent com a “pont” previ a la cirurgia



Dohomoto M. New method-endoscopic implantation of rectal stent in palliative treatment of malignant stenosis. Endoscopia Digestiva 1991;3:1507–12.
Tejero E, Mainar A, Fernández L, Tobío R, De Gregorio MA. New procedure for the treatment of colorectal neoplastic obstructions. DCR 1994;37:1158–9.

Stent còlon

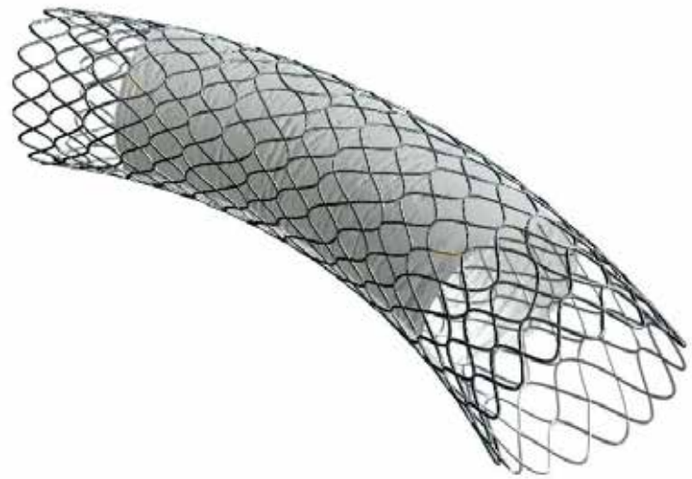
AVANTATGES COL.LOCACIÓ STENT

Preparació mecànica de còlon

Estabilització mèdica del pacient
- Correcció alteraciones hidroelectrolítiques
- Optimització comorbilitats

Estadiatge malaltia
- Colonoscòpia o Colono-Tc: lesions sincròniques

Tumoracions rectals: Permet neoadjuvància



INCONVENIENTS COL.LOCACIÓ STENT

Experiència del qui els posa
Complicacions relacionades
Tipus d´stent (coberts o no)
Empitjora pronòstic (perforació?)
Contraindicacions:
- Lesions baixes (Tenesme)
- Peritonitis o perforació

Stent còlon

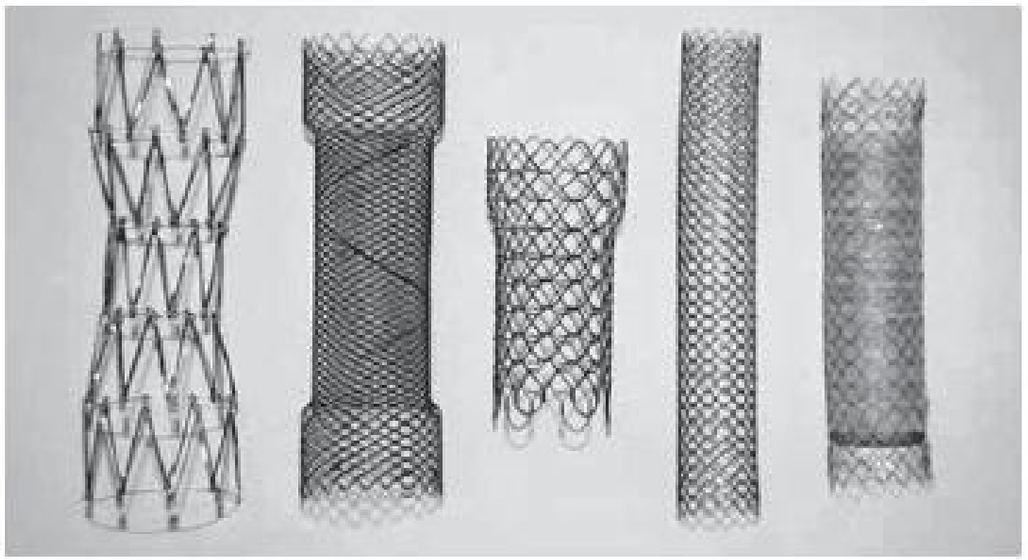


Figure 6. Colorectal stents, from left to right: Colonic Z (Cook), Evolution colonic (Cook), Wallflex (Boston), D-type Colonic not covered (Taewoong), D-type colonic covered (Taewoong).

Tipus d´stent:

- COBERTS:
  - Més duració
  - No permeten creixement
  - Més migració

- NO COBERTS:
  - Creixement al seu través
  - Menys migració

Stent còlon

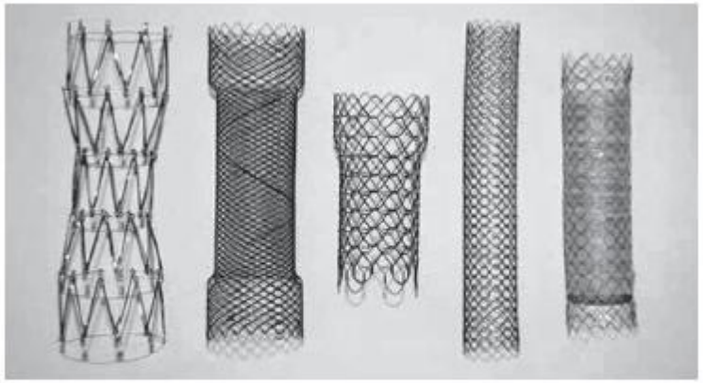


Figure 6. Colorectal stents, from left to right: Colonic Z (Cook), Evolution colonic (Cook), Wallflex (Boston), D-type Colonic not covered (Taewoong), D-type colonic covered (Taewoong).

y available self-expandable metal stent for malignant colonic obstruction

Manufacturer model	Delivery system	Diameter (mm)	Flares/flanges	Length (mm)	Covered/uncovered
WallFlex[1] (Boston Scientific)	TTS	22/27	Present	60, 90, 120	Uncovered
Ultraflex Precision[1] (Boston Scientific)	OTW	25/30	Present	57, 87, 117	Uncovered
Wallstent endoprosthesis[1] (Boston Scientific)	TTS	20, 22; no flare	Absent	60, 90	Uncovered
D-Enteral Colonic Stent (Taewoong Medical)	TTS/OTW	18, 20, 22, 24, 26	Absent	60, 80, 100, 120, 140, 150	Uncovered
Comvi Colonic Stent (Taewoong Medical)	TTS/OTW	18, 20, 22, 24, 26, 28	Absent	60, 80, 100, 120	Partially Covered
S-Enteral Colonic Stent (Taewoong Medical)	TTS/OTW	18, 20, 22, 24, 26, 28	Present	60, 80, 100, 120, 140, 150, 230	Fully and Partially Covered
Evolution Colonic Stent (Cook Endoscopy)	TTS	25	Present	60, 80, 100	Uncovered
Colonic Z-Stent[1] (Cook Endoscopy)	TTS	25	Present	40, 60, 80, 100, 120	Uncovered
Hanarostent (M.I.Tech)	TTS/OTW	20, 22, 24	Present	60, 70, 80, 90, 100, 110, 120, 130, 140, 150, 160, 170, 180	Uncovered, Fully Covered
Enterella (ELLA-CS)	OTW	22, 25, 30	Absent	75, 82, 88, 90, 112, 113, 123, 135, 136	Uncovered, Covered
Bonastent (EndoChoice)	TTS	22, 24, 26	Absent	60, 80, 100	Uncovered, Partially Covered
Aixstent (Leufen Medical)	TTS/OTW	25, 30	Present	80, 100	Uncovered, Partially Covered
Micro-Tech (MICRO-TECH Europe)	TTS/OTW	20, 25, 30	Present	60, 80, 100, 120	Uncovered, Partially Covered, Fully Covered

[1]Colonic stents availabe in the United States. TTS: Through-the-scope; OTW: Over-the wire.

Stent còlon

Experiència (endoscopista /radiòleg)

- Èxit tècnic: 92-93%
- Resposta clínica: 89-88% (Pont cirurgia : 72-85%)

Efectes adversos:

- Sagnat
- Perforació (4%)
- Obstrucció (7-10%)
- Migració (coberts) (10-12%)

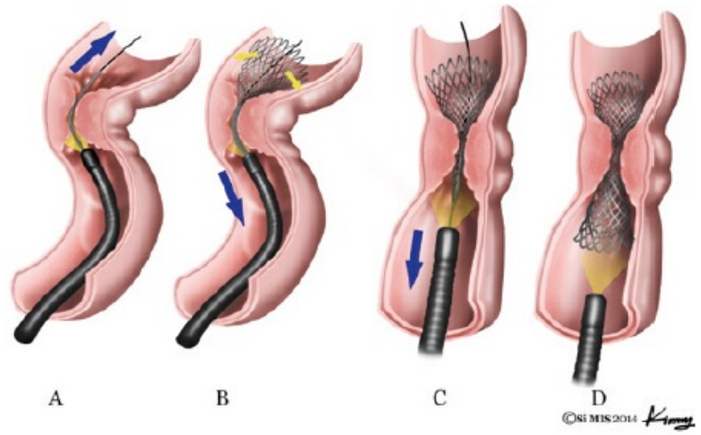


Figure 1 Technique of SEMS placement in acute colorectal obstruction. A: Passing stent and guide wire through lesion with contrast injection. B: Partial stent deployment. C: Pull back stent and scope until fair part of stent reach upper border. D: Fully deployment of SEMS.

Pronòstic:

- Empitjorament relacionat amb la perforació

Sebastian S, Johnston S, Geoghegan T, Torreggiani W, Buckley M. Pooled analysis of the efficacy and safety of self-expanding metal stenting in malignant colorectal obstruction. American Journal of Gastroenterology 2004;99:2051–7.
Khot UP, Lang AW, Murali K, Parker MC. Systematic review of the efficacy and safety of colorectal stents. British Journal of Surgery 2002;89:1096–102.
Baron TH, Kozarek RA. Endoscopic stenting of colonic tumours. Best Practice and Research Clinical Gastroenterology 2004;18:209–29.

Stent còlon

Indicació PAL.LIATIVA:

- Estància hospitalària: menor
- Morbilitat: menor
- Estomes : no
- Inici quimioteràpia: precoç (Antiangiogènics¡¡¡)
- Supervivència : ? no queda clar
- Qualitat de vida : millor que estoma

Fiori E, Lamazza A, De Cesare A, et al. Palliative management of malignant rectosigmoidal obstruction. Colostomy vs. endoscopic stenting. A randomized prospective trial. Anticancer Res 2004;24:265–8.
Xinopoulos D, Dimitroulopoulos D, Theodosopoulos T, et al. Stenting or stoma creation for patients with inoperable malignant colonic obstructions? Results of a study and cost-effectiveness analysis. Surg Endosc 2004;18:421–6.
van Hooft JE, Fockens P, Marinelli AW, et al. Early closure of a multi center randomized clinical trial of endoscopic stenting versus surgery or stage IV left-sided colorectal cancer. Endoscopy 2008;40:184–91.

Situació ideal

	CIRURGIA URGENT	CIRURGIA DIFERIDA (STENT)
Estoma		MENOR
Anastomosi primària		MAJOR
Temps quirúrgic		MENOR
Morbilitat		MENOR
Mortalitat		MENOR
Estada hospitalària		MENOR

ELSEVIER

Critical Reviews in Oncology/Hematology 88 (2013) 387–403

CRITICAL REVIEWS IN Oncology Hematology Incorporating Geriatric Oncology

www.elsevier.com/locate/critrevonc

A meta-analysis of endoscopic stenting as bridge to surgery versus emergency surgery for left-sided colorectal cancer obstruction

Antonella De Ceglie [a], Rosa Filiberti [b], Todd H. Baron [c], Marcello Ceppi [b], Massimo Conio [d,*]

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[d] Department of Gastroenterology, General Hospital, Sanremo, Italy

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ISSN 1007-9327 (print) ISSN 2219-2840 (online)

BRIEF ARTICLE

Colonic stenting *vs* emergent surgery for acute left-sided malignant colonic obstruction: A systematic review and meta-analysis

Guang-Yao Ye, Zhe Cui, Lu Chen, Ming Zhong

Surg Laparosc Endosc Percutan Tech • Volume 24, Number 1, February 2014

Meta-Analysis of Complications of Colonic Stenting Versus Emergency Surgery for Acute Left-sided Malignant Colonic Obstruction

Zhihua Liu, Liang Kang, Chao Li, Meijin Huang, Xingwei Zhang, and Jianping Wang, PhD, MD

No ofereix avantatges

Disminueix estada, temps quirurgic i pèrdues sanguínies

Colorectal stents for the management of malignant colonic obstructions (Review)

THE COCHRANE COLLABORATION®

Sagar J

Systematic review

British Journal of Surgery 2012; 99: 469–476

Systematic review and meta-analysis of randomized clinical trials of self-expanding metallic stents as a bridge to surgery *versus* emergency surgery for malignant left-sided large bowel obstruction

C. J. Tan, B. V. M. Dasari and K. Gardiner

Colorectal Unit, Royal Victoria Hospital, 274 Grosvenor Road, Belfast BT12 6BA, UK
Correspondence to: Mr C. J. Tan (e-mail: cjtan99@hotmail.com)

Major taxa d´anastomosi primària
Igual morbimortalitat

J Gastrointest Surg (2014) 18:584–591
DOI 10.1007/s11605-013-2344-9

ORIGINAL ARTICLE

SSAT The Society for Surgery of the Alimentary Tract

Preoperative Colonic Stents Versus Emergency Surgery for Acute Left-Sided Malignant Colonic Obstruction: A Meta-analysis

Xuan Huang · Bin Lv · Shuo Zhang · Lina Meng

Millora la cirurgia en un pas.
Disminueix tasa d´estoma permanent, infecció

Situació ideal

	CIRURGIA URGENT	CIRURGIA DIFERIDA (STENT)	
Estoma		MENOR	✓
Temps quirúrgic	IGUAL O MENOR		✓
Anastomosi primària		MAJOR	✓
Morbilitat	IGUAL O MENOR		✓
Mortalitat	IGUAL O MENOR		✓
Estada hospitalària	IGUAL O MENOR		✓
Temps lliure de malaltia	IGUAL O M		
Supervivència	IGUAL O M		
Recidiva local	IGUAL O M		

Nº i volum centres participants
Estadiatge malaltia
Experiència col.locació stent
Experiència quirúrgica
Meta-anàlisi: criteris inclusió, diseny, qualitat, estudis analitzats

10è CONGRÉS CATALÀ DE CIRURGIA

Surg Endosc (2013) 27:3121–3128
DOI 10.1007/s00464-013-2865-z

Oncologic safety of stent as bridge to surgery compared to emergency radical surgery for left-sided colorectal cancer obstruction

Hun Jin Kim · Jung Wook Huh · Wu Seong Kang · Chang Hyun Kim · Sang Woo Lim · Young Eun Joo · Hyeong Rok Kim · Young Jin Kim

No hi ha diferències entre cirurgia urgent i stent en quant a SUPERVIVÈNCIA TEMPS LLIURE DE MALALTIA

Original article

Colorectal Disease © 2014 The Association of Coloproctology of Great Britain and Ireland. **16,** 788–793

Long-term outcome of stenting as a bridge to surgery for acute left-sided malignant colonic obstruction

F. A. Quereshy*, J. T. C. Poon† and W. L. Law†

*Department of Surgical Oncology, University Health Network, University of Toronto, Toronto, ON, Canada and †Department of Surgery, University of Hong Kong, Queen Mary Hospital, Hong Kong, Hong Kong

Long-term mortality and recurrence after colorectal cancer surgery with preoperative stenting: a Danish nationwide cohort study

Endoscopy 2015; 47: 517–524

Authors: Rune Erichsen[1], Erzsébet Horváth-Puhó[1], Jacob Bonde Jacobsen[1], Tove Nilsson[1], John A. Baron[1,2], Henrik Toft Sørensen[1]

Institutions:
[1] Department of Clinical Epidemiology, Aarhus University Hospital, Aarhus, Denmark
[2] Department of Medicine, Center for Gastrointestinal Biology and Disease, University of North Carolina School of Medicine, Chapel Hill, North Carolina, USA

Original article

British Journal of Surgery 2013; **100**: 1805–1809

Local recurrence after stenting for obstructing left-sided colonic cancer

K. J. Gorissen[1], J. B. Tuynman[1], E. Fryer[2], L. Wang[2], R. Uberoi[3], O. M. Jones[1], C. Cunningham[1] and I. Lindsey[1]

Original article

BJS 2014; **101**: 1751–1757

Oncological outcome of malignant colonic obstruction in the Dutch Stent-In 2 trial

D. A. M. Sloothaak[1], M. W. van den Berg[2], M. G. W. Dijkgraaf[3], P. Fockens[2], P. J. Tanis[1], J. E. van Hooft[2] and W. A. Bemelman[1] on behalf of the collaborative Dutch Stent-In study group

[1]Department of Surgery, [2]Department of Gastroenterology and Hepatology, and [3]Clinical Research Unit, Academic Medical Centre, Amsterdam, The Netherlands

Correspondence to: Professor W. A. Bemelman, Department of Surgery, Academic Medical Centre, PO Box 22660, 1100 DD Amsterdam, The Netherlands (e-mail: w.a.bemelman@amc.uva.nl)

L´STENT augmenta el risc de RECIDIVA LOCAL (perforació i disseminació) INDICAT EN SITUACIONS DE PACIENTS AMB ALT RISC DE COMPLICACIÓ EN CIRURGIA URGENT

Surg Endosc
DOI 10.1007/s00464-015-4100-6

Published online

Colonic perforation either during or after stent insertion as a bridge to surgery for malignant colorectal obstruction increases the risk of peritoneal seeding

Su Jin Kim · Hyung Wook Kim · Su Bum Park · Dae Hwan Kang · Cheol Woong Choi · Byeong Jun Song · Joung Boom Hong · Dong Jun Kim · Byung Soo Park · Gyung Mo Son

Situació ideal

	CIRURGIA URGENT	CIRURGIA DIFERIDA (STENT)	
Estoma		MENOR	✓
Temps quirúrgic	IGUAL O MENOR		✓
Anastomosi primària		MAJOR	✓
Morbilitat	IGUAL O MENOR		✓
Mortalitat	IGUAL O MENOR		✓
Estada hospitalària	IGUAL O MENOR		✓
Temps lliure de malaltia	IGUAL O MENOR		? ✓
Supervivència	IGUAL O MENOR		? ✓
Recidiva local	IGUAL O MENOR		? ✗

NCCN Guidelines®

Recommendations

- If considering the use of a colonic stent in patients presenting with acute large bowel obstruction offer CT of the chest, abdomen and pelvis to confirm the diagnosis of mechanical obstruction, and to determine whether the patient has metastatic disease or
- fluoroscopic equipment and trained support staff should insert colonic stents.
- If a self-expanding metallic is suitable, attempt insertion urgently and no longer than 24 hours after patients present with colonic obstruction.

Valoració stent per cirurgià colorrectal juntament amb especialista
Ressucitació pacient i valorar stent
No stent: lesions rectals, lesions dretes, perforació o peritonitis
No dilatació tumor abans col.locació stent
Col.locació stent per experts
No col.locar stent més enllà de les 24h del diagnòstic de l´oclusió

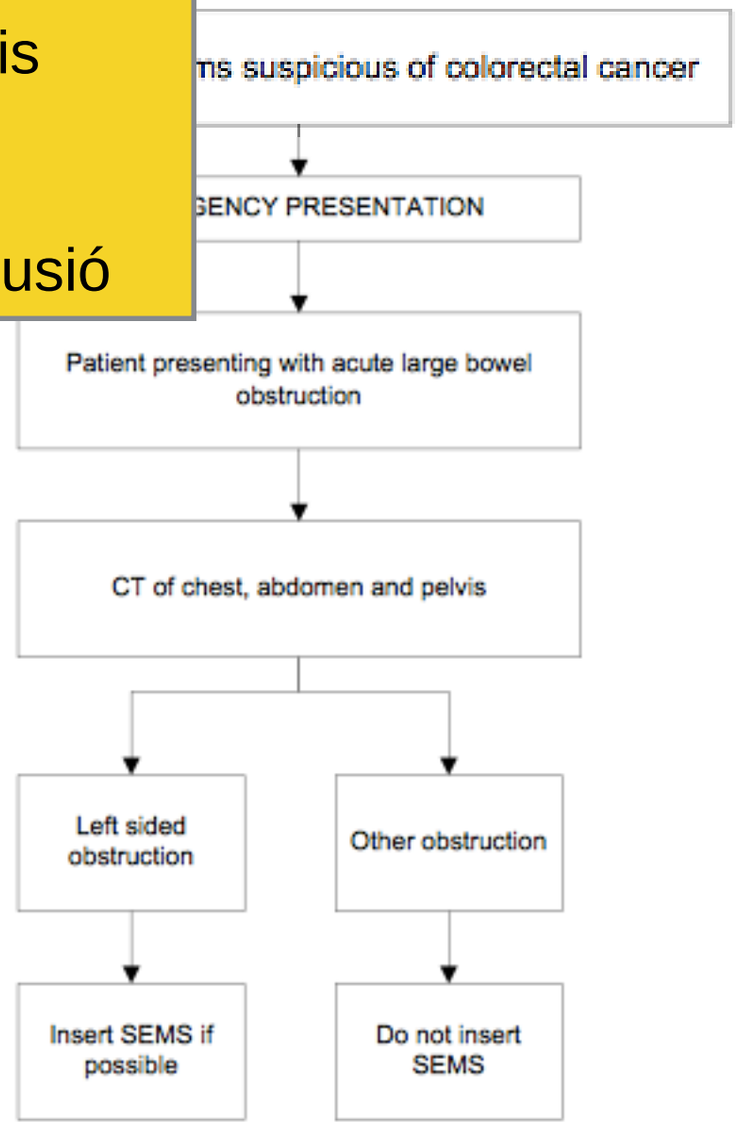
For patients with acute left-sided large bowel obstruction caused by colorectal cancer that is potentially curable, and for whom surgery is suitable:

1. **Resuscitate patients and explain to them and their family members or carers (as appropriate) that acute bowel obstruction can initially be managed either with emergency surgery or a colonic stent, and that there is no clear evidence that one treatment is better than the other. [new 2014]**

2. **Offer patients the chance to take part in a randomised controlled trial[c] (if available) that compares emergency surgery with colonic stent insertion to initially manage acute bowel obstruction. [new 2014]**

3. **Resuscitate patients with acute large bowel obstruction, then consider placing a self-expanding metallic stent to initially manage a left-sided complete or near-complete colonic obstruction. [2011]**

4. **A consultant colorectal surgeon should consider inserting a colonic stent in patients presenting with acute large bowel obstruction. They should do this together with an endoscopist or a radiologist (or both) who is experienced in using colonic stents. [2011]**



MAIN RECOMMENDATIONS

The following recommendations should only be applied after a thorough diagnostic evaluation including a contrast-enhanced computed tomography (CT) scan.

No s´aconsella col.locació stent en pacients no ocluïts.

La col.locació d´stent com a “pont” per la cirurgia no és un procediment estandaritzat.

Oclusió còlon potencialment curable: es pot considerar l´stent com alternativa a la cirurgia urgent en pacients amb alt risc quirúrgic (ASA > III , edat >70 anys).

Es recomana l´stent com a tractament pal.liatiu excepte en pacients que poden rebre tratament amb angiogènics.

(strong recommendation, high quality evidence), except in patients treated or considered for treatment with antiangiogenic drugs (e.g. bevacizumab) (strong recommendation, low quality evidence).

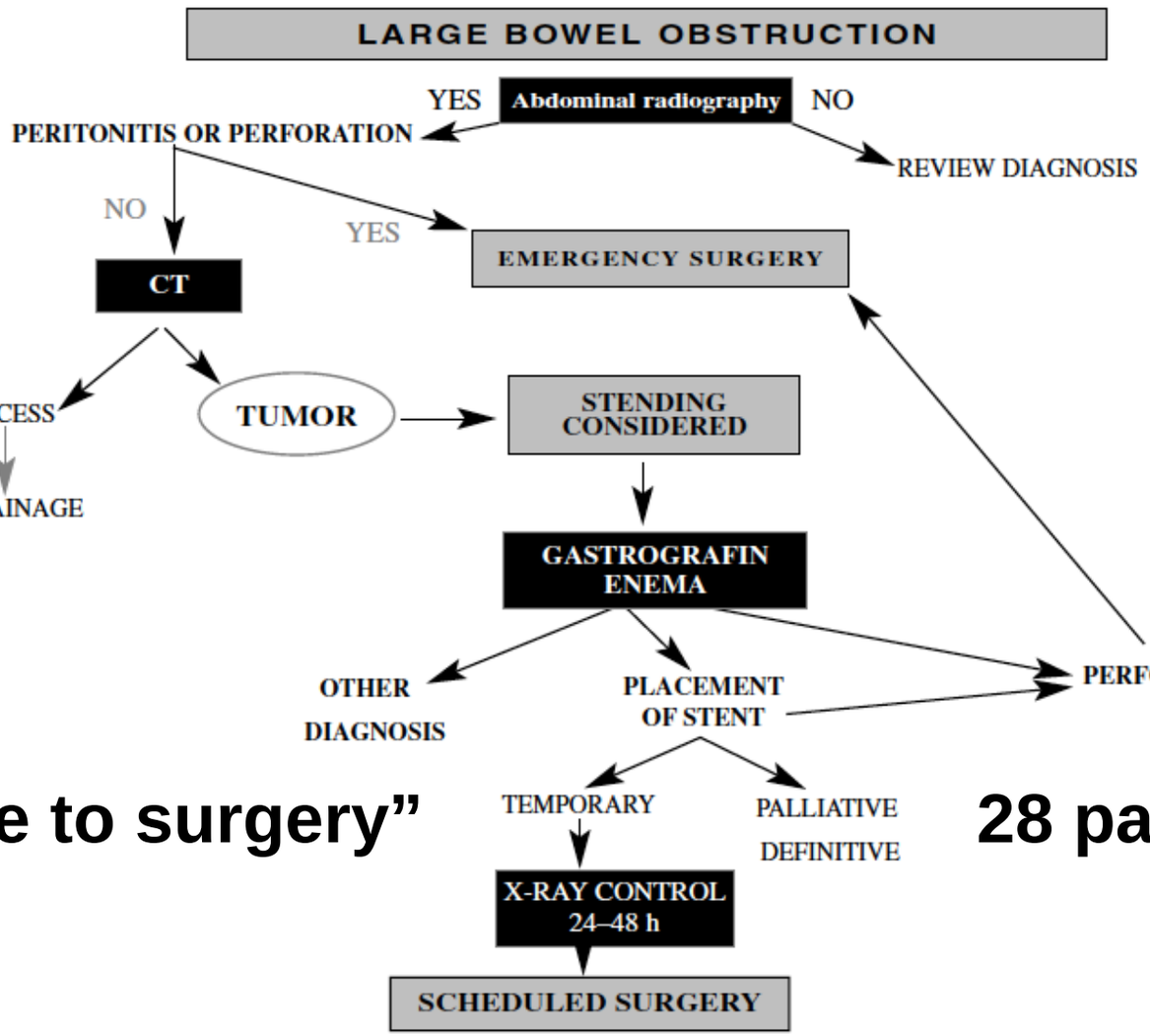
Tech Coloproctol (2007) 11:…–…
DOI 10.1007/s10151-007-…

ORIGINAL ARTICLE

M. Alcantara • X. Serra • J. Bombardó • J. Falcó • J. Perandreu • I. Ayguavives
L. Mora • R. Hernando • S. Navarro

Colorectal stenting as an effective therapy for preoperative and palliative treatment of large bowel obstruction: 9 years' experience

Experiència del nostre grup



67 "bridge to surgery" **28 pal.liació**

Table 2 Complications due to stenting and their outcomes

Complication	Patients, n (%)
Perforation	4 (3.8)
Migration	4 (3.8)
Obstruction	4 (3.8)
Fecalomas	3
Tumor progression	1
Tenesmus	1 (1)
Resolution	
Successful re-insertion of stent	
Migration	3 of 4
Obstruction	4 of 4
Emergency surgery	
Perforation	4
Migration	1

Èxit tècnic: 95% (90/95)

Table 3 Results of the 67 patients who underwent stenting as "bridge to surgery" (group A)

Clinical and technical success	64 (95%)
Deferred surgery (n=64)	
Resection and primary anastomosis	59 (92%)
Hartmann's procedure	5 (8%)
Abscessed neoplasia	2
Incomplete resection	2
Prior radiotherapy	1
Emergency surgery (Hartmann) (n=3)	
Migration of stent	1
Perforation from stent	2

World J Surg
DOI 10.1007/s00268-011-1139-y

World Journal of Surgery

Prospective, Controlled, Randomized Study of Intraoperative Colonic Lavage Versus Stent Placement in Obstructive Left-sided Colonic Cancer

M. Alcántara · X. Serra-Aracil · J. Falcó · L. Mora · J. Bombardó · S. Navarro

Table 1 Patients' demographic data and tumor characteristics

	Group 1 ($n = 15$)	Group 2 ($n = 13$)	p
Mean (standard deviation) age (years)	71.9 (8.96)	71.15 (9)	0.821
Sex ratio (M:F)	5:10	7:6	0.445
Median duration (interquartile range) of obstruction (days)	4 (4)	4 (3)	0.484
Site of tumor (%)			0.086
Splenic flexure	2	4	
Descending colon	1	2	
Sigmoid colon	11	4	
Rectosigmoid junction	0	3	
Rectum 1/3 sup	1	0	
ASA			0.247
I-II	5	1	
III	8	9	
IV	2	3	
Stage (AJCC) [27]			0.269
II	2	5	
III	11	6	
IV	2	2	
Pathological findings			
Distal resection margin cm (standard deviation)	7.5 (3.8)	7.5 (4.3)	0.998
Number of retrieved lymph nodes (standard deviation)	17.7 (7.1)	24.2 (11.5)	0.099
Positive lymph node, median (interquartile range)	2.5 (10)	1 (17)	0.172

Table 2 Types of operation

	Group 1 ($n = 15$)	Group 2 ($n = 13$)
With primary anastomosis		
Left hemicolectomy	4	6
Sigmoid colectomy	7	4
High anterior resection	3	3
Without anastomosis		
Hartmann's operation	1	0

Score operatiu: Urgent vs el.lectiu

	Group 1 ($n = 15$)	Group 2 ($n = 13$)	p
Risk scoring system			
POSSUM physiological score (standard deviation)	17.13 (3.09)	19.15 (5.8)	0.252
CR-POSSUM physiological score (standard deviation)	9.73 (2.57)	10.62 (4.01)	0.489
POSSUM operative severity score (interquartile range)	15 (2)	19 (3)	**0.000**
POSSUM predicted morbidity rate (standard deviation)	42.02 (10.7)	66.35 (21.35)	**0.002**
POSSUM predicted mortality rate (interquartile range)	7.6 (3)	15.1 (30)	**0.001**
P-POSSUM predicted death rate (interquartile range)	2.1 (2)	3.70 (14)	**0.032**
CR-POSSUM operative severity score (standard deviation)	8.6 (6)	14 (18)	0.209
CR-POSSUM (standard deviation)	9.8 (1.9)	10.92 (2.7)	0.854
Operation time (interquartile range)	130 (70)	180(123)	0.308
Overall complication (%)	2/15 (13.3)	7/13 (53.8)	**0.042**
Global-Surgical Space Infection (SSI) (%)	2/15 (13.3)	6/13 (38.5)	**0.096**
Superficial (%)	2/15 (13.3)	2/13 (15.4)	1
Deep (%)	0/15 (0)	0/13 (0)	1
Organ space (%)	0/15 (0)	4/13 (30.7)	**0.035**
Anastomotic leakage (%)	0/15 (0)	4/13 (30.7)	**0.035**
Seroma (%)	0/15 (0)	1/13 (7.7)	0.464
Ileus (%)	0/15 (0)	2/13 (15.4)	0.206
Evisceration (%)	0/15 (0)	1/13 (7,7)	0.464
Reoperation (%)	0/15 (0)	4/13 (30.7)	**0.035**
Hospital mortality (%)	0/15 (0)	1/13 (7.7)	0.464
Median (interquartile range) postoperative stay (days)	8 (3)	10 (10)	**0.05**
Median (interquartile range) hospital stay (days)	13 (3)	10 (10)	0.105
Economic cost			
Common cost in € (interquartile range)	4 510 (1.380)	4 630 (2.290)	0.927
Final cost in € (interquartile range)	6 610 (940)	4 930 (2.340)	0.009

Home, 62 anys
Enol lleu, HTA, VHB

Dolor abdominal i distensió 5d

A/S: 13L (90%N); 11Hb; 502 Plaq
Gluc 127; U/Cr 35/.0.86 Na 138; K 4.8
Ttpa 1.21 TP 1.22

Colectomia subtotal (3/2012)
ADK pT3N2 (0/20)

Hepatectomia D

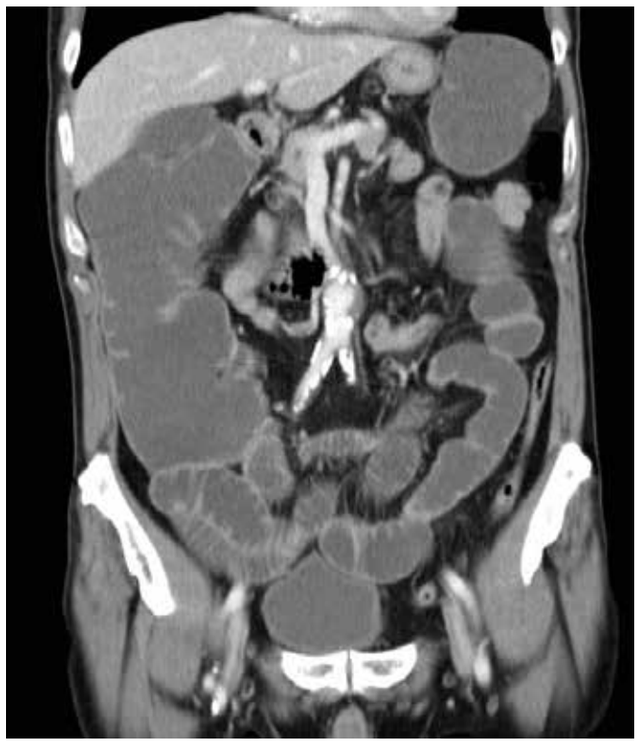
Portador ileostomia
Pendent de reconstrucció

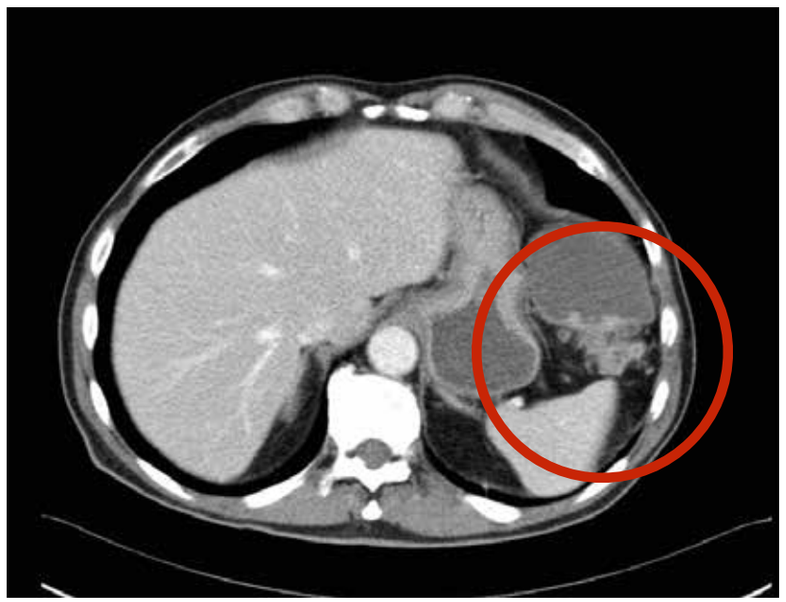
Home 72 any
No AMC, No AP

Dolor abdominal còlic.
N i V. No deps
Anorèxia

EF: TA : 156/78 FC: 80p/min
Molèsties a HCE. No peritonisme

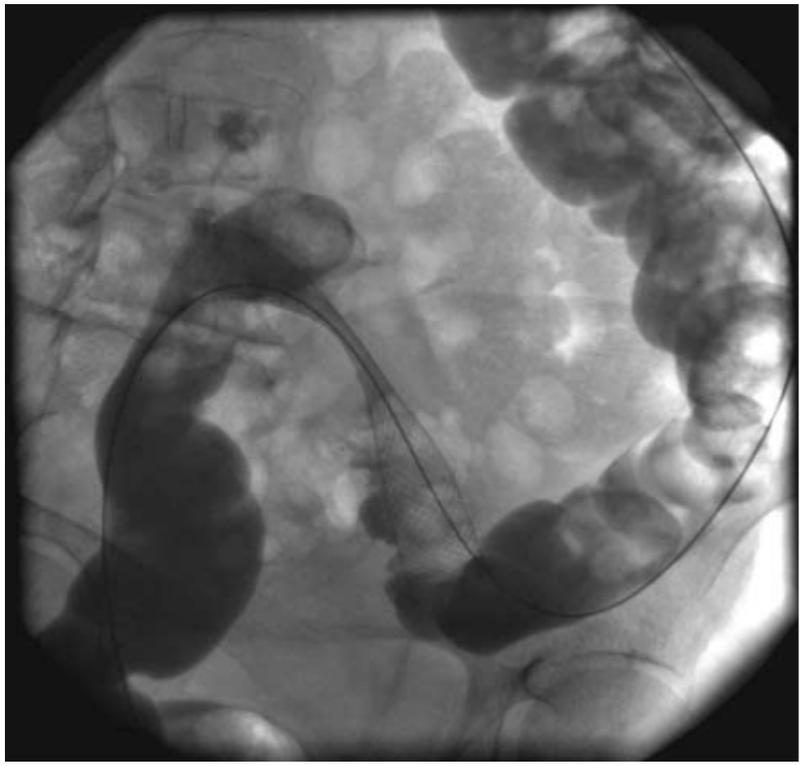
A/S: 12.2 L (81%N) **Hb 17**; Plaq 273
Gluc 154; **U/Cr 92/2.3** Na: 137 ; **K: 5.3**





Stent
Hemicolectomia esq. 5è d ingrés (1/2011)
Anastomosi primària - Alta al 7è dia posotp.
ADK pT4N0(4/40)
Neoadjuvància
Últim control: lliure de malaltia


www.arionauro.com.br




10è CONGRÉS
CATALÀ DE CIRURGIA

CONCLUSIONS:

- EXPERIÈNCIA DEL QUI COL.LOCA STENT

- STENT COM A TRACTAMENT PAL.LIATIU

- **“PONT” CIRURGIA:**

. Cirurgians experimentats: temps quirúrgic, anastomosi primària, laparoscòpia

. Morbimortalitat

. Resultats oncològics ?