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# Intestinal Fistulas and the Open Management of the Septic Abdomen

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## Abstract

*To the Editor.*—In the June 1989 issue of the Archives, Mastboom et al<sup>1</sup> described what they call "noniatrogenic" small-bowel perforations of "unknown or uncertain" cause, which developed in 14 patients treated by open treatment who underwent 3 to 17 laparotomies, and claim that the "occurrence of intestinal perforation during open treatment has not been described so far."

In fact, the article by Mastboom et al deals with a well-known and documented entity. Intestinal fistulas commonly develop in the frequently laparotomized abdomen due to the repeated mobilization and separation of bowel involved in the obliterative process. Commonly, the end result of repeated explorations is an abdominal-wall defect with multiple intestinal fistulas in its base. SitgesSerra et

al<sup>2</sup> pointed out the poor prognosis of this entity, which in their experience carried a mortality rate of 60%. Levy et al<sup>3</sup> reported 120 cases of "exposed" intestinal fistulas opening into

## Books

**Lung Cancer Chronicles**, by John A. Meyer, 233 pp, with illus, \$35 (cloth), \$10 (paper), New Brunswick, NJ, Rutgers University Press, 1990.

John A. Meyer, PhD, has written an up-to-date and informative book about lung cancer intended for the layman. The book is a combination of case histories, science, opinions, epidemiology, and the fictional physician Bill Hunter. While it contains fictional characters, the book is not a novel; it has no plot, beginning, or end. Treatment modalities presented in the text follow epidemiologic data, and clinical relationships are presented through the interspersing of anecdotal cases from the beginning of the book.

In his book, Meyer places great emphasis on the hazards of smoking. He points out that most lung cancers are preventable, preferably by never smok-

ing rather than by stopping once one has started, although the latter is beneficial. He mentions the financial and political aspects of growing tobacco and summarizes in chapter 16, perhaps too briefly, some of the court cases relating to product liability and the tobacco industry.

The statistical explanations throughout the text are often oversimplified. Some discussions of principles seem convoluted. The book is referenced like a medical journal article. The appendixes and glossary are useful but are more suggestive of beginning science than anything else.

As a minor criticism, I take issue with the evaluation of some of Meyer's fictional patients. Mediastinoscopy is carried out far too often, even in one situation where there is already widespread

metastatic disease. Magnetic resonance imaging gets nary a mention.

This book contains a good deal of pertinent information. Patients with lung cancer or their families might find the book useful. As Meyer correctly points out, however, "Its words should not ever be relied upon above or in place of the advice of a personal physician." The book seems very appropriate for a high school student looking for source material for a report on lung cancer, and a wider lay audience will appreciate it. It is too elementary for thoracic surgeons or pulmonologists, but other physicians who treat patients with lung cancer may find it useful.

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## Correspondence and Brief Communications

### Intestinal Fistulas and the Open Management of the Septic Abdomen

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In fact, the article by Mastboom et al deals with a well-known and documented entity. Intestinal fistulas commonly develop in the frequently laparotomized abdomen due to the repeated mobilization and separation of bowel involved in the obliterative process. Commonly, the end result of repeated explorations is an abdominal-wall defect with multiple intestinal fistulas in its base. Sitges-Serra et al<sup>2</sup> pointed out the poor prognosis of this entity, which in their experience carried a mortality rate of 60%. Levy et al<sup>3</sup> reported 120 cases of "exposed" intestinal fistulas opening into an abdominal evisceration, including 24 "wall-to-bowel" fistulas secondary to external trauma on a superficial intestinal loop. Similarly, "spontaneous" intestinal perforations are dreaded

used by Mastboom and associates, has minimized the risk of fistulization. However, fistulization does occur, particularly when there is delay in mesh removal and skin grafting.<sup>5</sup> Recently, we reported our experience with 43 cases of gastrointestinal fistulas associated with a large abdominal-wall defect; in 19 cases, this defect was created intentionally by open treatment.<sup>6</sup> Intestinal leaks occur, in such a set-up, as a result of exposure injury, dehiscence of preexisting suture lines (even after many days), and trauma of abdominal reentry.

I must also disagree with the therapeutic recommendations suggested by Mastboom et al, who claimed that resection of the intestinal defects with primary anastomosis resulted in the "success" of 18% recurrences, followed by an overall mortality rate of 65%. I believe that the distance of the fistulous opening in the bowel from the surface of the abdominal-wall defect and the condition of the peritoneal cavity have bearing on the treatment modalities. When the intestinal perforation is located in the depth of the infected abdominal defect, the prolonged contact of large peritoneal surfaces with gastrointestinal contents allows increased absorption of toxic products perpetuating the septic state and organ failure. In such a situa-

tion, the patient is treated from the defect, with a proximal enterostomy. In patients who present, usually later, with "exposed fistulas" near the surface of the defect and in whom the peritoneal cavity is clean and sealed away from the intestinal contents, the expectant approach is indicated. Early resection and the creation of anastomoses (as suggested by Mastboom et al), leaving the suture-line exposed or under the skin grafts, carries disastrous results. Consequently, my approach is to leave these patients "untouched" for at least 6 months receiving total parenteral nutrition. Reestablishment of gastrointestinal continuity is undertaken in an anabolic patient through a healed and pliable abdominal wall; easy and safe resection and anastomoses of the fistulating bowel are performed after the dissolution of the peritoneal obliterative process. In addition, the bowel remains well covered by the abdominal wall, which is reconstructed at the same time.

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1. Mastboom WJB, Kuypers HHC, Schoots FJ, Wobbes T. Small-bowel perforation complicating the open treatment of generalized peritonitis. *Arch Surg*. 1989;124:689-692.

2. Sitges-Serra A, Jaurrieta E, Sitges-Creus A. Management of postoperative enterocutaneous fistulas: the roles of parenteral nutrition and surgery. *Rev J Surg*. 1989;60:147-150.

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