



## Comments on ‘Gastroscope guidewire volvulus tube decompression’

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Dear Sir,

I read with great interest the paper by Panteleimonitis and Nash [1], which described the placement of a pediatric gastroscope through the lumen of the flatus tube and passing this single combined tube anally following decompression of sigmoid volvulus (SV). I found the idea of the authors original. Although SV is a rare colonic obstruction form worldwide, it is endemic in my practicing area, and we have a 1018-case experience with SV over a 52.5-year period. This is the largest single-center SV series over the world [2]. In the light of this comprehensive experience, I want to discuss some details of the procedure presented by the authors.

It is clear that the initial treatment of SV is endoscopic decompression in uncomplicated and non-gangrenous patients, and elective sigmoid colectomy is suggested in some selected patients with successful endoscopic decompression [3]. First of all, although some practitioners traditionally insert a flatus tube anally and keep in for some days to prevent an early SV recurrence following endoscopic decompression, the necessity and utility of this procedure are controversial [4]. In my experience, a flatus tube applied anally by sticking it to the buttocks is an uncomfortable and painful process, and almost all the patients complain about it. Additionally, it may easily be displaced during degasification and defecation and needs repeated placement. On the other side, the early SV recurrence rate is not high. In our series of 566 cases decompressed by endoscopy, early recurrence during the hospitalization period was seen in only 4.9% of the cases. In my opinion, to put about 95% of the patients through a troublesome process such as flatus tube placement to prevent a recurrence in about 5% of the cases is not rational. For this reason, I recently stopped using flatus tube placement. Instead, I prefer a second sigmoidoscopy

in recurrent SV patients, in whom early diagnosis is not difficult during medical observation.

Secondly, in my experience, when needed, introduction of a guidewire to the left colon through the working channel of the endoscope and passing the tube following the removal of the endoscope is the most practical way in the placement of a flatus tube in SV. This procedure requires neither fluoroscopy nor an additional instrument. Regarding the pediatric gastroscope used by the authors: do the authors use the same instrument in the next gastroscopy procedures? In spite of advanced cleansing and disinfecting techniques, nobody wants such an instrument, which was inserted anally before, to be used. If a pediatric gastroscope is used only for the treatment of SV, what do the authors think about cost utility under the circumstances?

Finally, as known, gentle insertion of the endoscope with rotation of the tip of the instrument with minimal air insufflation is essential in the reduction of the volvulus [5]. In my experience, even if limited, force is needed to pass the torsion line in SV. Is a pediatric gastroscope, which has a diameter of 5.9 mm, strong enough to devolve the torsion?

I congratulate the authors for their interesting technique and I await their comments on my discussions.

### Compliance with ethical standards

**Conflict of interest** The author declares that he has no conflict of interest.

**Ethical approval** This article does not contain any studies with human participants performed by any of the authors.

**Informed consent** For this form of study, formal consent is not required.

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