

Reply to the Comment of the Letter to the Editor on the Survey on Trauma Systems in Spain[☆]



Réplica al comentario de la carta al director sobre la encuesta de sistemas de trauma en España

Dear Editor,

First of all, I thank the author of the Letter to the Editor for the comments made. The article referred to is no more and no less than a glimpse of the current situation of polytrauma patient care in Spain, which is not up to par with that of other countries, such as the United States.¹

The ATLS method is likewise applicable to prehospital treatment (PHTLS), with certain nuances, but the method is essentially just as valid. Indeed, prehospital treatment is fundamental because the decisions made and steps taken are extremely important as they are part of the “golden hour” of polytrauma patient care.

It is true that several hospitals are currently starting to organize and create protocols for their polytrauma patients, and pre-hospital care is an important part of this organization.² Each hospital that organizes polytrauma patient treatment should obviously have a database. Nevertheless, the shortcoming that our health care system has not yet dealt with is, as stated by the

authors of the letter, not just pre-hospital care, but also social reintegration programs for trauma patients.

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2173-5077/

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DOI of refers to article: <http://dx.doi.org/10.1016/j.cireng.2014.03.011>

[☆] Please cite this article as: Costa Navarro D. Réplica al comentario de la carta al director sobre la encuesta de sistemas de trauma en España. *Cir Esp.* 2015;93:56.

Laparoscopic Approach to Intestinal Obstruction[☆]



Abordaje laparoscópico de la oclusión intestinal

Dear Editor,

We have read with great interest the article by Poves et al.¹ about the use of laparoscopy in the treatment of intestinal obstruction due to adhesions and internal hernias. We believe it would be useful to complement the information of the authors by reporting our experience.²

We should highlight the importance of adequate patient selection, because the success of this approach depends on it. Also, despite the fact that there are currently no randomized clinical trials, there are certain recommendations that should be considered, in addition to those described by the authors. The suspicion of a single band is the main indication for laparoscopic treatment (fundamentally in patients with embryonic adhesions or after appendectomy). However, it is also indicated in obstructions due to foreign bodies, bezoars or gallstone ileus. Contraindications include patient intolerance of anesthesia, suspicion of obstruction due to peritoneal carcinomatosis, distension of the small bowel of more than 4 cm on imaging tests and suspected dense adhesions. Likewise, the use of laparoscopy in patients with suspected

[☆] Please cite this article as: Fortea-Sanchis C, Priego-Jiménez P, Granel-Villach L, Salvador-Sanchis JL. Abordaje laparoscópico de la oclusión intestinal. *Cir Esp.* 2015;93:56–57.

ischemia or peritonitis is controversial and is considered a relative contraindication by certain groups.^{3,4}

As stated by the authors, the main argument against this procedure has been the increase in iatrogenic injuries that go unnoticed during adhesiolysis. Nonetheless, different groups^{4,5} have recently published percentages that are similar to open surgery (3%–17%), which demonstrates the safety of this approach in the hands of expert surgeons. Dissections must be done delicately, while avoiding traction on the intestinal loops and restricting the use of electrocoagulation. It is essential to avoid the placement of trocars over previous incisions. Likewise, during pre-op it is necessary to define the cause of the obstruction. If this were not possible with laparoscopy, conversion to laparotomy is required.^{3,5,6}

Laparoscopy plays a fundamental role in these cases because it prevents future adhesions, which would cause intestinal obstructions to recur, resulting in additional socio-economic costs. There have been no national reports on this factor here in Spain; in the United States; however, these costs have been estimated at some 1.3 billion dollars per year.⁶

In short, we agree with the authors about the positive results provided with laparoscopic treatment of intestinal obstruction. However, even when its use is justified, we must remember that laparotomy is still considered the treatment of choice in intestinal obstructions, and laparoscopy should be reserved for selected cases.

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2173-5077/

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Hiatal Hernias or Paraesophageal Hernias?☆



¿Hernias de hiato o hernias paraesofágicas?

Dear Editor,

Braghetto and Csendes are two prestigious authors in the world of esophagogastric surgery. They have recently published in your journal an article about when and why hiatal hernias (HH) should be treated surgically.¹ Their results are from a prospective study of 121 patients who had undergone HH hernias, who were divided into 2 groups according to age (younger and older than 70). Their conclusions support an interventionist approach to HH, and they believe that all patients should be treated surgically

as soon as they are diagnosed. Elderly patients do not need to be excluded from surgery due to the low mortality rate (<1.5%) of elective laparoscopic procedures compared with the mortality rate in cases requiring urgent surgery (>5%).

Although they present a complete series of patients operated on for HH with a predominance of type I HH with gastroesophageal reflux, I believe the article and the final conclusions mainly refer to HH in seniors, which are usually paraesophageal hernias (PH). In 2002, Stylopoulos published an article in *Annals of Surgery* that had a thought-provoking title: “Paraesophageal hernias: operation or observation?”.² They concluded that the initial treatment for asymptomatic PH patients, or those with few symptoms, should be conservative and non-surgical. To this end, they designed a study with 2 cohorts of patients with PH. The first group was treated

DOI of refers to article: <http://dx.doi.org/10.1016/j.cireng.2012.07.004>

☆ Please cite this article as: de Tomás Palacios J. ¿Hernias de hiato o hernias paraesofágicas? *Cir Esp.* 2015;93:57–58.