intracorporeal sutures, etc. This experience was also considered positive by the young surgeons. We believe that continuing with this activity could shorten the individual learning curve for each professional and avoid complications due to lack of experience. We believe that this second objective is as important as, or even more so, than the course itself and can boost surgical training in our country. In fact, there are those who support the evaluation of acquired skills. For these evaluations, virtual models as well as cadavers have been proposed, although human bodies are clearly superior. This assessment should be essential before initiating actual operations on patients.

In summary, I would like to encourage surgical teams and universities in Spain to do all they can to be able to work with cadavers, not only for training in technical advances but also for initiating young surgeons in standard techniques. The benefits far outweigh the organisational difficulties, so this possibility should no longer be underutilised.

To finish, I would once again like to thank the donors in acknowledgement of their selfless actions.

REFERENCES


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Is Pneumomediastinum and Cervical Emphysema a Sign of Poor Prognosis in Colorectal Anastomosis Leakage?*

¿Es el neumomediastino y enfisema cervical un signo de mal pronóstico en la dehiscencia de anastomosis colorrectal?*

Dear Editor,

We have read with interest the article by Dr. de la Plaza Llamas et al. about pneumomediastinum and cervical emphysema as initial signs in colorectal anastomotic dehiscence. Recently, we had the opportunity to treat a similar case, and its exceptional nature has made us inclined to share our experience and to comment on some details of the case in question.

The patient is an 85-year-old male who was being studied for iron-deficiency anaemia and was diagnosed with sigmoid adenocarcinoma. Thoracoabdominal CT scan showed no evidence of metastatic disease, with a reported radiological stage of T4N0M0. He was treated by a laparoscopic approach, involving sigmoidectomy with mechanical end-to-end colorectal anastomosis. The patient progressed favourably but presented marked supraclavicular cervical emphysema on the 4th day post-op, which extended to the upper extremities, thorax and abdomen, with no associated symptoms of abdominal pain. Thoracoabdominal CT scan demonstrated important pneumomediastinum and cervical emphysema (Fig. 1A and B), moderate abdominal pneumoperitoneum in the supramesocolic compartment (Fig. 1C), 2 minimal bubbles

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in the vicinity of the colorectal anastomosis (Fig. 1D) and no
presence of liquid or other alterations. A new laparoscopic
procedure detected a punctiform dehiscence at the anterior
side of the colorectal anastomosis, evidence of which was seen
with an air test, although there was no presence of associated
peritonitis. The anastomosis was resected and a new
mechanical end-to-end colorectal anastomosis was created.
During the postoperative period, the patient evolved favou-
rably, with spontaneous resolution of the emphysema after
having received no specific treatment. The patient was
discharged 7 days after the reoperation.

Pneumomediastinum and cervical emphysema are
uncommon signs at the onset of colorectal anastomosis
dehiscence, although they have also been observed in cases
of perforated diverticulitis and perforation after endoscopic
diverticulectomy. As indicated in the literature, a delayed
diagnosis determines the prognosis. In our case, the diagnosis
occurred in the first few days post-op, which provided for early
treatment and avoided the development of peritonitis and
associated morbidity, at which time we were able to construct
a new anastomosis. In the cited case, the fact that dehiscence
was not diagnosed until 11 days after surgery (because the
patient presented no symptoms during hospitalisation),
lengthened the hospital stay to 60 days, with what we can
only assume was important postoperative morbidity, and
made it impossible to perform an anastomosis during the
operation.

We would like to emphasise that, although pneumome-
diastinum and cervical emphysema can be the first signs of
presentation of colorectal anastomosis dehiscence, any delay
in diagnosis and intraabdominal conditions that are encoun-
tered will determine the therapeutic approach and prognosis.

This should not necessarily mean a severe condition asso-
ciated with high morbidity and prolonged hospital stay.

REFERENCES

1. De la Plaza Llamas R, Ramia Ángel JM, García Amador C,
López Marcano AJ. Neumomediastino y enfisema cervical
como comienzo de dehiscencia de anastomosis colorectal.
Cir Esp. 2015;93:e81.

2. Souche R, Bouyabrine H, Navarro F. Subcutaneous
emphysema of thorax, neck and face after elective left

3. Sarriguère Lasarte A, Martín Ortega H, Prieto Calvo M,
Fernández del Val JF. Pneumomediastino y enfisema
subcutáneo cervical por diverticulitis aguda perforada

Enfisema subcutáneo cervical y neumomediastino tras

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