

letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by email to: Clinicalmedicine@rcplondon.ac.uk.

Management of intestinal obstruction in malignant disease

Editor – We were interested to read the article on management of intestinal obstruction in Malignant disease (*Clin Med*, July/August 2003, pp 311–4) but were surprised no mention was made of endoscopic endoluminal stent placement as a means of palliating large bowel obstruction.¹

We assessed the feasibility, efficacy and safety of colonic stenting in a district general hospital in a prospective study at Hinchingsbrooke Hospital, between September 1998 and January 2003.²

This consecutive series examined a total of 23 patients, median age of 71 years (range 50–90), who presented with symptoms of large bowel obstruction, ie abdominal colic, distension or both, was confirmed radiologically. In each case the decision to stent was taken either to prepare the patient for elective surgery, as a definitive treatment in incurable cancer or because of severe comorbidity.

The cause of the stenosis was malignant in 22 cases with the sites being rectal (35%), rectosigmoid (9%), sigmoid colon (39%), splenic flexure (9%), transverse colon (9%).

The strictures were stented by conventional methods. In proximal lesions, stents were usually inserted via the colonoscope channel but in the more distal lesions the stents were placed under colonoscopic vision directly over a wire. In the case of

long stenoses two stents were sometimes placed over the same wire (Fig 1). If a first attempt failed either further attempts were scheduled where possible or the patient was referred for surgical treatment.

Stent insertion was successful at the first attempt in 16 patients. Two patients were stented on subsequent procedures. The success of the procedure was assessed by technical success rate (successful first stent placement and deployment) and clinical success rate (decompression of the bowel within 96 hours without endoscopic or surgical reintervention after successful stent placement and deployment),¹ 70% and 78% respectively. All patients successfully stented had excellent symptomatic relief.

In five patients the procedure could not be performed either due to failure to identify the stenosis or failure to pass a guide wire. These patients were referred for surgery.

Only one patient suffered a complication of the procedure which was proximal stent migration leading to reobstruction.

After a median survival of nine weeks (range three days to 20 months) sixteen patients died in follow up, due to causes unrelated to stent insertion. Seven patients

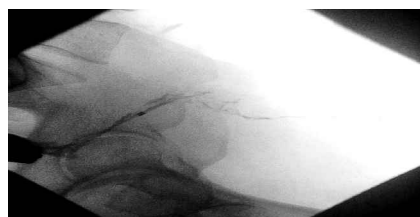


Fig 1. Radiographs showing placement of two enteral stents in series in a patient with ovarian cancer.

were alive after a median follow up of one month (range seven days to 12 months).

On the basis of this series, we believe that colonic stents have an important place in the management of large bowel obstruction and palliation of colonic carcinoma and that we have demonstrated that this technique is feasible, efficacious and safe in district general hospitals in the hands of experienced endoscopists.

References

- 1 Khot UP, Lang AW, Murali K, Parker MC. Systematic review of the efficacy and safety of colorectal stents. *Br J Surg* 2002;**89**:1096–102.
- 2 McNamara I *et al*. Clinical outcome following insertion of stents for the palliation of large bowel obstruction. A DGH experience. *GUT* 2003;**52** Supplement 1, A74.

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In addition to McNamara *et al*'s letter, correspondence was also received from Galletly NP, Bansil DS, and Thillainayagam AV, and from Tham TCK, making a similar point regarding the use of stents.

Complementary medicine: evidence base, competence to practise and regulation

Editor – The interesting article by Lewith *et al* alludes to the 'ill-informed debate that often surrounds the issues raised by CAM practice' (*Clin Med* May/June 2003, pp 235–40). Unfortunately, parts of this article could themselves be seen as misleading. In the section on 'manipulative therapies', the authors state that 'today, only extreme traditionalists are confined by these [historical] theories' on which chiropractic was founded some 100 years ago. Recent data, however, suggest that 'nearly