

CORRESPONDENCE



# Comments on 'Colonic obstruction in a tetraplegic patient: a common symptom from an uncommon cause'

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**TO THE EDITOR:**

I read with interest the article written by Pattanakuhar and Kovindha [1], who presented a patient with sigmoid volvulus (SV) complicating tetraplegia and discussed the relationship between SV and spinal cord injury (SCI). Although SV is an uncommon disease worldwide, it is relatively common in my practicing area, Eastern Anatolia [2]. We have 55-year (June 1966–July 2021) and 1040-case experience with SV, which is the largest single-center series over the world [3]. In the light of this experience, my comments relate to the pathogenesis, diagnosis, and treatment of SV in patients with SCI.

In our series, although there was no patient with tetraplegia, two forty something males (0.2%) had paraplegia arising from SCI. Abdominal pain, distention, and obstipation were the main clinical features. SV was diagnosed with clinical examination and X-ray findings before the usage of CT in a patient, whereas, CT was used in the diagnosis of the other case. We treated a patient with endoscopic decompression, while the other case required emergency surgery including sigmoid resection with Hartmann's procedure due to sigmoid gangrene.

Although the pathogenesis is not clearly identified, the role of some neurological diseases in the development of SV is not a mystery. Extra-enteric lesions at sites such as the sacral spinal cord cause chronic constipation [4]. Laxatives and enemas, which are frequently needed in patients with SCI, may also have a role [5]. Chronic constipation increases intracolonic pressure, worsens the elastogenesis of the colon wall, and causes dolichosigmoid (the elongation and dilatation of sigmoid colon), the main anatomic prerequisite for SV [6].

Abdominal pain, distention, and obstipation, which are known as 'volvulus triad' are the most common clinical features of SV [2], as was determined in the authors' case as well as in ours. Nevertheless, some symptoms of the neurological diseases as well as the difficulty in clinical examination may cloud the clinical picture and retard the diagnosis [6]. In my opinion and experience, among the symptoms, particularly constipation may mask or mimic the obstipation in such patients. Although X-rays suspect SV by demonstrating a dilated sigmoid colon, current diagnosis of SV depends on CT findings, which contain mesenteric whirl sign and/or dilated sigmoid segments [2], as was demonstrated in the author's case as well as in one of ours. As an alternative, MRI may be used in pregnant women with similar findings [7].

Regarding the treatment options in SV, endoscopic decompression is the optimal choice in patients without peritonitis

and perforation, while surgical treatment is required in patients with abovementioned adverse factors in addition to unsuccessful decompression [8, 9], as was applied in the authors' case and ours. On the other hand, percutaneous endoscopic colostomy may be a rationalist alternative in high-risk, bed-bound, and elderly patients [10], which may be preferred in selected patients with SCI.

I congratulate the authors for their informative presentation and I await their reply on comments.

Sabri Selcuk Atamanalp <sup>1</sup>✉

<sup>1</sup>Department of General Surgery, Faculty of Medicine, Ataturk University, Erzurum, Turkey. ✉email: [ssa@atauni.edu.tr](mailto:ssa@atauni.edu.tr)

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**COMPETING INTERESTS**

The author declares no competing interests.

**ADDITIONAL INFORMATION**

**Correspondence** and requests for materials should be addressed to Sabri Selcuk Atamanalp.

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