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Research Letter

Endoscopic stenting for left-sided obstructing colorectal cancer

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Dear Editor

The results of the trial performed by the CReST collaborative group were recently published in *BJS*[1]; in a multicentre study involving 39 centres, 245 patients with left-sided colonic obstruction were randomized to endoluminal stenting using a combined endoscopic/fluoroscopic technique followed by elective surgery 1–4 weeks later, or surgical decompression with or without tumour resection. Of the 245 patients, 217 were treated with curative intent and there were no significant differences in 30-day postoperative mortality or duration of hospital stay between stenting followed by delayed elective surgery and emergency surgery. Among patients undergoing potentially curative treatment, stoma formation occurred less frequently in those allocated to stenting than those allocated to immediate surgery (47 of 99 *versus* 72 of 106). Overall mortality and 3-year recurrence rates were similar in the two groups. The improved results of endoscopic stenting in comparison with those of a previous trial[2] testify to advanced expertise and appropriate selection of the patients, including mainly those with obstructing sigmoid cancer.

Several factors should be taken into consideration before accepting endoscopic stenting in an endoscopic centre, including the importance of appropriate training. The authors recently undertook a survey and found that less than 20 per cent of the endoscopic centres in Italy have adequate experience with endoscopic stenting for obstructing colorectal cancer. In these centres, surgical resection or a temporary stoma is a more appropriate choice. Endoscopic stenting requires appropriate training, as shown by the high complication rates reported in the initial trial[2].

Another significant aspect to be considered is the general medical situation. During the pandemic, the number of patients who received a self-expanding metallic stent (SEMS) for malignant colorectal obstruction increased in this department by 50 per cent in comparison with the previous years (23 during 2020–2021; 12 during 2018–2019). In 15 patients with stage IV colorectal cancer, SEMS represented a definitive form of treatment. In eight patients the SEMS was a bridge to surgery, which was performed when the outbreak ended[3,4], with only one health worker contracting a moderate form of COVID-19 infection.

The location of the tumour is an important point to consider. Obstructing colorectal cancers more often occur in the sigmoid colon. In complete obstruction with a sharp angle of the rectosigmoid junction, the guidewire used to place the stent may perforate the colonic wall, which is thin, dilated, and partially ischaemic above the obstruction. If the patient does not have major clinical problems, and the colon above the obstruction is not very dilated, surgical resection is a simple and straightforward procedure. Alternatively, a diverting colostomy may be a simple temporary solution. In the other situations (middle–lower rectum or inferior aspect of the rectosigmoid junction), stent placement is much easier, reducing stoma formation and significant discomfort for the patient and the family.

Another aspect to consider is the importance of appropriate follow-up. Even though rarely reported, more than 20 per cent of patients develop faecal obstruction of the stent. This complication is easily resolved endoscopically; however, if untreated, it leads to significant discomfort for the patient with rapid deterioration of general condition.

Stenting as a bridge to resection is just one of several therapeutic solutions for patients with left-sided malignant colorectal obstruction, which may be chosen according to the characteristics of the patients and the specific experience and attitude of the surgical team[5].

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Disclosure

The authors declare no conflict of interest.

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