Editorial

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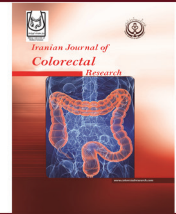

Ambulatory Colectomy

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With the development of minimal invasive colectomy, improved surgical devices, and the surgeon's experience leading to better tissue dissection, hemostasis, and more reliable anastomosis, the concept of ambulatory colectomy evolved. In addition to the mentioned factors, Enhanced Recovery after Surgery (ERAS) protocols (1) were associated with early discharging patients as previously demonstrated.

A systematic review of current reports about ambulatory colectomies showed interesting results; overall morbidity was 14%, Readmission rate was 5% and reoperation rate was 1% (1). As a colorectal surgeon, these important data remind me of the excellent rate of success with fistula surgery using a fistula plug and subsequent unplug effect. The number of reports from different centers that switch from regular colectomies to daycare colectomies is increasing. However, colorectal surgeons should pay special attention to some issues before setting up this setting.

The first issue that should be considered for ambulatory colectomy is the indication of colectomy and whether the patient had comorbidities other than colon disease. It is shown that sigmoidectomy for diverticulitis is the most appropriate indication for daycare colectomy. Diabetes and age above 65 are associated with increased complications following daycare colectomy and these patients should not be candidates for this setting (2). But if we look at the readmission rate after regular colectomies we have a 12% readmission rate and the risk factors for readmission are higher in American Society of Anesthesiologists (ASA) class, open colectomy, Having an ostomy, and tobacco use during the final year before surgery (3). It seems that more contraindications for daycare colectomy should be considered.

The other issue with ambulatory colectomy rather than health care system resources is patient satisfaction. Although most patients would do ambulatory colectomy again, the pain control (4) was less in patients undergoing ambulatory colectomy. Still, further studies are needed to improve pain control following these major operations.

I stated before that good candidates for ambulatory colectomy are benign colectomies since occurring complications might delay future adjuvant therapies in case of a malignant condition. However, reports about such patients showed that adjuvant therapy could be started within six weeks (5) of operation in case of complication, which seems to be acceptable.

Nobody could resist qualified evidence about ambulatory colectomy but more evidence is essential to establish this setting as the standard of care. Ambulatory monitoring of patients as complications

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might always occur which needs to be addressed. Patients should have limitless access to their surgeon for any complaints. We need more evidence about perioperative interventions (preoperative diet or supplements, bowel prep, pain control, anesthesia protocols, robotic vs. laparoscopic, single port vs. multiport, etc.) that reduce complications in this setting.

Finally, in a clearer atmosphere and presence of acceptable qualified evidences, surgical innovations are always encouraged.

Conflict of interest*:* None declared.

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