120 LAPAROSCOPIC SIGMOIDECTOMIES IN DIVERTICULITIS: A 9 YEARS EXPERIENCE.

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Background: Laparoscopic colonic resection for benign disease tends to be a standard procedure. In this study we reviewed a retrospective continuous series of patients with complicated diverticular disease treated by laparoscopic colectomy. Methods: All charts were reviewed for age, sex, indications, operative findings, operative time, conversions to laparotomy, duration of postoperative ileus, hospital stay, complications and mortality. 120 patients were operated on between 1991 and 2000. There were 72 males and 48 females. The mean age was 60 years (range 31-83). To compare results of our early experience and our current results, patients were split into two groups: patients operated on before 1996 (group A = 53 patients) and after 1996 (group B = 67 patients). Surgery was performed in patients with two or more onsets of diverticulitis or in young patients with a severe first acute onset. There was no emergency surgery. Results: Nine patients were operated on with enteric fistula. All patients underwent sigmoïdectomy (120). The left colon was also resected in 32 patients (26.7%). The colo-rectal anastomosis was performed in all cases without colostomy. Conversion to laparotomy was necessary in 24 cases (20%). Causes of conversion were adhesions (13), haemorrhage (4) colonic ischemia (1) and other technical problems (6). Conversion rate was statistically higher in patients who presented several onsets compared to those with a severe first onset ($p<0.001$). Also, the conversion rate was statistically higher in our previous experience (Group A) than in our current experience (Group B): respectively 30% and 12%. Mean operative time was 182 minutes (range 15-480). Operative time was significantly reduced in group B ($p<0.05$). There were 11 complications (9.2%) and 3 patients were reoperated. There was no anastomotic fistula. The complication rate was statistically lower in group B compared to group A ($p<0.05$). Mean hospital stay was 5.8 days. Patients started to take fluid on day 3 and were allowed to eat on day 4. Comparison of groups A and B demonstrate a significant shorter delay for fluid intake, food intake and hospital discharge. There was no mortality. In conclusions, our study confirms the concept of learning curve in laparoscopic surgery, especially for conversion rate, operative time, complications and hospital stay. Enteric fistulas are not contra-indication for laparoscopic surgery. Laparoscopic sigmoidectomy allows early oral intake and hospital discharge. Currently, in experienced teams, this procedure is associated with a low morbidity and no mortality and should be routinely proposed to patients undergoing surgery for diverticulitis.