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Indication

- Healed distal anastomosis confirmed by endoscopic or contrast studies

Essential Steps

1. Verify anal sphincter competency by physical exam or manometric study if the index procedure involved the anal sphincter mechanism.
2. Confirm adequate healing of distal anastomosis.
3. Make an incision around the stoma.
4. Dissect circumferentially until the fascia is reached and peritoneal cavity entered.
5. Clearly identify proximal and distal limbs.
6. Debride the edges of the enterotomy.
7. Determine if primary closure is feasible or if limited resection is needed.
8. Close the enterotomy/perform primary resection and anastomosis:
 - Hand sewn.
 - Double-stapled technique.
 - Rarely, segmental resection and anastomosis are needed.
9. Close the wound:
 - Pack wound open for delayed closure.

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Note These Variations

- The stoma may be closed with sutures or staples.
- Sometimes, a limited ileal resection is required if the stoma site is in poor condition.
- Packing the wound open for delayed closure is often a prudent alternative to primary closure.

Complications

- Infection
- Bleeding
- Anastomotic leak
- Incisional hernia

Template Operative Dictation

Preoperative Diagnosis ___ months status post low anterior resection with protective loop ileostomy for colon/rectal cancer

Procedure Closure of loop ileostomy

Postoperative Diagnosis Same

Indications This is a ___-year-old *male/female* who underwent ___ with proximal diverting loop ileostomy ___ months ago. *Contrast studies revealed a securely healed distal*

anastomosis/physical exam, and manometric studies revealed an acceptable anal tone.

Description of Procedure Time-outs were performed using both preinduction and pre-incision safety checklist to verify correct patient, procedure, site, and additional critical information prior to beginning the procedure.

The patient was placed in a supine position. The procedure was performed under *local/general* anesthesia. The ileostomy bag was removed, the ileostomy site was cleaned, and then the *abdomen* was prepped and draped in a sterile manner. A time-out was completed verifying correct patient, procedure, site, positioning, and implant(s) and/or special equipment prior to beginning this procedure. An elliptical skin incision about 2 mm from mucocutaneous junction, around the ileostomy, was performed. The incision was deepened in the subcutaneous tissue until the serosa of the emerging bowel appeared. Sharp dissection was continued circumferentially in this plane, dividing the fine adhesions between the bowel and its mesentery and the subcutaneous fat until the fascia was reached and the peritoneal cavity entered; after which it was feasible to bring the emerging ileal loop through the wound, the mucocutaneous junction and the rim of the skin were excised, the everted proximal end of

the stoma was unfolded, and the edge of enterotomy was freshened. The stoma was inspected and found to be *suitable for primary closure without resection/unsuitable for primary closure, and therefore a limited resection of the stoma site was performed to permit safe closure.*

Choose One

If hand-sewn anastomosis: then a formal hand-sewn end-to-end anastomosis using seromuscular interrupted absorbable sutures was done to restore the intestinal continuity.

If stapled closure: then a transverse stapled closure of the ileal loop was done.

The site was checked for hemostasis, which was adequate, and the loop of the ileum was returned back to the abdominal cavity.

Hemostasis was secured, fascial defect was closed using continuous nonabsorbable suture, and the skin was *closed using interrupted nonabsorbable sutures/packed open for delayed primary closure.*

A debriefing checklist was completed to share information critical to postoperative care of the patient.

The patient tolerated the procedure well and was transferred to the postanesthesia care unit in stable condition.