Editorial

The Cost of Temporary Colostomy

IN THIS ISSUE of *Diseases of the Colon & Rectum,* Smit and Walt present a computation of the costs of temporary colostomy in their institution and make pertinent suggestions for reducing these costs and the morbidity as well. Their presentation is timely, during a period when society is questioning the rising costs of medical care.

Just how far hospital expenses have risen can be appreciated by comparing Rodkey and Welch's[3] estimate of hospital costs of $3,100 for a three-stage resection for diverticulitis in 1969 with Smit and Walt's present-day finding of an average hospital cost of $5,750 for the procedure of colostomy closure alone. Though the 1969 study did not include operating room and anesthetic charges, and there has also been a considerable economic inflation since then, the increase is nonetheless quite staggering. Moreover, the latter authors found that, when complications arose, costs nearly doubled and postoperative hospital days tripled.

Since the popularization of early elective resection of uncomplicated diverticulitis, surgeons have increasingly performed primary resection without preliminary or complementary colostomy. It is also fair to say that, for a number of reasons, there has been a general decrease in the utilization of temporary colostomy in the surgical management of other colonic conditions. Considering this change, it may be no coincidence that in recent years we have seen a spate of reports describing a distressing frequency of complications following the supposedly simple operation of colostomy closure. In some of these reports, the frequency of complications actually exceeded that which ordinarily might be expected after the more extensive procedure of formal colonic resection. The cause of this anomaly seems likely to lie in a lack of appreciation for the surgical skill required and a decrease in opportunities for teaching and practicing the operation. The great danger of such reports, if not balanced by proposals aimed toward improving the results, is that some surgeons may be deterred from performing a colostomy for fear of its possible complications. The protection against life-threatening anastomotic complications provided by proximal colostomy has been well described by Smithwick,[4] as well as many others, and cannot be argued. Such reports, rather, should serve as a constructive stimulus for lessening the complications. That such improvement is possible can readily be judged by the low rate of complications after colostomy closure in the series described by Barron and Fallis[1] in 1958 and more recently by Thomson and Hawley[5] in 1972. An ideal goal would be to make colostomy and its closure so safe and free of complications that one would never hesitate to perform a colostomy if there were any suggestion of its possible need.

The pivotal role that temporary colostomy plays in determining the total costs of colonic surgery can be appreciated through the recently published study by Couch, Tilney and Moore,[2] who examined the clinical records and costs of patients admitted to an intensive care unit for treatment of complications following colonic operations. Compared with uncomplicated cases, total costs in this group of patients were increased an average of sevenfold, lengths of hospitalization fourfold, and more than half the patients died. Significantly, the most common errors implicated among the complications were failure to diagnose colonic leakage, failure to provide proximal colostomy, and faulty construction of a colostomy. Thus, while surgeons rightfully should be mindful of the added costs of colostomy, failure to provide a colostomy may exact a far greater cost, both economic and human.

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References

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