

## Salvaging a linear staple line defect in ultra-low anterior resection

Dear Sir,

Tan et al. [1] described an excellent technique in salvaging a defect in the linear stapler line at the ultra-low anterior resection distal anorectal stump [1]. Hand suturing the defect facilitated the inclusion of the former into the donut of the intraluminal stapler to enable a safe and effective double cross stapled anastomosis [2]. I have used this technique on a few occasions previously and can confirm that this is the case. Recently, I found that this technique was also suitable with a linear staple line defect at laparoscopic ultra-low anterior resection in an obese male patient with a narrow pelvis. The rectal stump closure sutures were placed by intracorporeal suturing, thus avoiding a conversion which might have affected the non-eventful rapid postoperative recovery.

At open surgery, the technique I usually use differs slightly in that I leave the rectal stump salvage sutures long. Pulling on these sutures gently will help to 'cone' the defect so that it will be included into the double cross stapled intraluminal stapler donut. The long sutures would be closed over by the jaws of the intraluminal stapler and subsequently cut at stapler firing without any problems.

Y.-H. Ho

James Cook University, School of Medicine  
Queensland, Australia  
e-mail: yikhong.ho@jcu.edu.au

### References

1. Tan WS, NG KH, Eu KW (2007) Salvaging a linear staple line defect in ultra-low anterior resection. *Tech Coloproctol* 11:266–267
2. Griffen FD, Knight CD Sr, Whitaker JM, Knight CD Jr (1990) The double stapling technique for low anterior resection. Results, modifications, and observations. *Ann Surg* 211:745–751; discussion 751–752

## *Clostridium difficile* enteritis following total colectomy

Received: 11 June 2007 / Accepted: 11 December 2007

Dear Sir,

*Clostridium difficile* is the most common nosocomial cause of diarrhoea in surgical practice due to its increasing incidence following the use of antibiotics in high-risk patients. It often presents as severe diarrhoea and can advance to pseudomembranous colitis associated with significant morbidity and mortality [1]. Although it is a colonic organism, *C. difficile* has been isolated from the small bowel and *C. difficile* infection of the small bowel has been reported [2]. We report a case of *C. difficile* enteritis following subtotal colectomy in a young man who was successfully managed.

A 21-year-old man presented last year as an emergency with nausea, vomiting and decreased ileostomy output for a few days. The patient was discharged from the hospital two weeks prior to this presentation, where he had been treated with subtotal colectomy for medically refractory ulcerative colitis. Contrast-enhanced computed tomography (CT) of the abdomen and pelvis showed features compatible with small bowel obstruction. The patient was treated conservatively but he did not improve, and hence underwent exploration on day 8. At laparotomy, there was a pelvic abscess secondary to rectal stump blow out. This was drained and he was started on levofloxacin.

He continued to have an elevated white count (16 000 mm<sup>3</sup>) and increased ileostomy and nasogastric output. A repeat CT scan showed moderate amount of free fluid in the abdomen and pelvis. Under CT guidance, 60 cc brownish fluid was aspirated and, at this time, *C. difficile* toxin was negative from the ileostomy.

Following aspiration, the patient's condition continued to worsen. He developed a high-grade temperature and the output from both the ileostomy and the nasogastric tube continued to increase to 5–6 l and 2–3 l per day, respectively, over the next 15 days. Furthermore, the stoma output was dark in colour, non-bloody, non-bilious and with no formed stools or gas. Repeat CT scan showed features suggestive of adynamic ileus. Multiple blood cultures and ileostomy cultures for parasites and bacteria were negative. Three different *C. difficile* toxin assays were performed on the ileostomy output on days 25, 26 and 27 and one was positive. The patient was placed on vancomycin on the microbiologist's recommendation.