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Preservation of the Mesorectum in Proctectomy for Crohn's Disease Does Not Compromise Outcome

We read with interest the paper from de Groof et al. It fits comfortably with the current trend that it is the mesentery in Crohn's that is driving the disease, with some mechanistic plausibility (ref coffey etc). However, this is predominantly a retrospective case series with limited numbers and shouldn't alter surgical practice at this point. There are many potential confounders and integral biases, including disease activity, medical therapy (beyond current or prior use of anti-TNF), and a number of new drugs have come to market since 2012.

We were also concerned as the practice in our unit tends towards close rectal dissection, and this study suggests harm related to this practice. This prompted our unit to analyse our own data for patients undergoing proctectomy for Crohn's disease. Over a 5 year period 35 patients underwent this procedure. The surgeons at our institution vary between those routinely carrying out a perirectal excision preserving the mesorectum and those carrying out a 'total mesenteric excision' (TME); all perform intersphincteric dissection. The characteristics of this cohort of patients were similar to the published article. All patients were all operated on for proctocolitis refractory to medical treatment or severe perianal fistulating disease. 21 (60%) had undergone a previous subtotal colectomy. Contrary to the results from de Groof et al the patients undergoing TME in our cohort tended to have more perineal wound issues than the patients undergoing a close mesenteric ligation, although this was not statistically significant (62.5% vs 31.6% respectively, $p=0.09$ Fishers exact test). In this small sample we haven't seen a difference in the number of patients requiring surgery for persistent perineal sinus: close dissection 21.1% vs TME 31.2% ($p=0.70$ Fishers exact test).

Whilst we accept that this data has similar inherent biases to the article published in JCC, it does highlight the need for further research before recommending any change in practice by the advocates of removal of all the mesorectum. The same might be said for the data from Coffey advocating radical mesenteric excision for ileocaecal crohn's based on a cohort comparison with an historical control (ref). Whilst an exciting concept, further quality prospective studies with full characterisation of patients and description of surgical intervention is required to guide our practice.

Yours faithfully

Steven R Brown, Matthew J Lee