at that time. This finding, together with the fact that all 4 patients with malignancy also did not have previous CRC screening, underscores the importance of age-appropriate screening. We therefore recommend endoscopy-naïve patients undergo follow-up endoscopic evaluation. On the other hand, if a patient already had high-quality colonoscopy with no evidence of polyp within a reasonable time before diverticulitis was diagnosed, it is conceivable that a repeat colonoscopy would be redundant.

One of the strengths of this study is the use of a provincial cancer registry to capture any CRC that may have risen since the diagnosis of acute diverticulitis. Absence of additional cases of CRC in the registry among those who did not have follow-up endoscopy lends support to the idea that not all patients with acute diverticulitis require follow-up endoscopy to rule out underlying malignancy.

Based on the results of our study, we recommend selective endoscopic evaluation in the following patient populations after a diagnosis of acute diverticulitis on high-resolution CT scan: patients ≥ 50 years of age who are due for CRC screening/polyp surveillance in the form of colonoscopy based on recommended intervals,³ and those with suspicious CT findings, such as a mass lesion with obstruction.

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References

1. Ou G, Rosenfeld G, Brown J, et al. Colonoscopy after CT-diagnosed acute diverticulitis: Is it really necessary? *Can J Surg* 2015;58:226-31.
2. Niv Y, Hazazi R, Levi Z, et al. Screening colonoscopy for colorectal cancer in asymptomatic people: a meta-analysis. *Dig Dis Sci* 2008;53:3049-54.
3. Lieberman DA, Rex DK, Winawer SJ, et al. Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. *Gastroenterology* 2012;143:844-57.

OPERATIVE OR NONOPERATIVE MANAGEMENT OF HINCHEY III PURULENT ACUTE DIVERTICULITIS?

We read with interest the article by Dr. Vennix and colleagues¹ published in *Lancet* that rekindles the debate on management of severe acute diverticulitis (Hinchey III); the lower early morbidity of surgical resection reported by the authors definitely challenges the recent trend toward mini-invasive management by laparoscopic lavage (LL).^{2,3}

Interestingly, in the authors' whole series, major morbidity and 12-month mortality reached 30% and 11% (14% in the resection group [RG]), respectively. Overall, patients underwent 157 operations (88 primary surgeries, 40 reoperations and 29 stoma reversals), accounting for a ratio of 1.8 operations per patient (1.9 in the RG). Moreover, 52% of patients underwent ileo-/colostomy (68% in the RG), which was never reversed in 27% of cases. Finally, 15% of patients had fascial dehiscence within 1 year.

Also considering that patients with stercoral peritonitis (Hinchey IV) were excluded, results of surgery in the studied population seem poor and possibly caused by the emergency setting, rather than the purpose of surgery (resection s. nonresection). Admitting that LL is not superior because no difference is recorded between the 2 groups does not mean that performing an emergency sigmoidectomy is the best option in a septic patient with an ongoing acute peritonitis. The real, upcoming question seems to be whether Hinchey III patients (whose results are poor regardless of the performed procedure) really need emergency surgery. Since the study does not include a conservative management group, efficacy of antibiotics alone is not assessed.

We recently reported a 92% successful conservative management of hemodynamically stable patients with diverticulitis-associated pneumoperitoneum and no diffuse colonic perforation at CT (82% and 72% presenting free intraperitoneal fluid and clinical signs of diffuse

acute peritonitis, respectively).⁴ None died, 3 were reoperated and 7 required percutaneous drainage, which was considered a successful, nonoperative management, and we concluded that most non-Hinchey IV patients may be managed conservatively. Moreover, only 19 patients underwent delayed elective sigmoidectomy (with 2 reoperations), whereas 17 patients completely avoided surgery, with an overall ratio of 0.6 operations per patient.

In accordance with Vennix and colleagues, we believe that an accurate preoperative diagnosis should improve Hinchey III patient selection, not to undergo laparoscopic drainage, but rather to avoid an unnecessary surgery.

Randomized multicentre trials, comparing a surgical and a conservative approach to patients affected by non-Hinchey IV acute diverticulitis are needed to assess if, in this class of patients, less is more.

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References

1. Vennix S, Musters GD, Mulder IM, et al. Laparoscopic peritoneal lavage or sigmoidectomy for perforated diverticulitis with purulent peritonitis: a multicentre, parallel-group, randomised, open-label trial. *Lancet* 2015;386:1269-77.
2. Bretagnol F, Pautrat K, Mor C, et al. Emergency laparoscopic management of perforated sigmoid diverticulitis: a promising alternative to more radical procedures. *J Am Coll Surg* 2008;206:654-7.
3. Rossi GL, Mentz R, Bertone S, et al. Laparoscopic peritoneal lavage for Hinchey III diverticulitis: is it as effective as it is applicable. *Dis Colon Rectum* 2014;57:1384-90.