In less rational but arguably more interesting times, purveyors of apostasy were burned at the stake. Fortunately for Dr Bucher and his coauthors, this practice is currently condemned, and so their sole punishment will consist of having this critique appended to their disquieting publication.

These authors have chosen to question the near universally held belief that mandates the usage of mechanical bowel preparation prior to elective colon procedures. Alleged benefits of this regimen include lower rates of surgical site infections, decreased anastomotic leakage rates, improved bowel handling during operation, decreased need for stoma formation, and facilitation of intraoperative colonoscopy, when this operative adjunct is indicated. Some support for the authors’ thesis is to be found in the recent literature looking at trauma patients or those undergoing emergency colon resection, where numerous studies have shown high rates of safety in those patients undergoing primary repair or resection of left- and right-sided colonic lesions.

Unfortunately, the authors try to “end run” the data via the questionable route of meta-analysis, compiling the results of 7 studies, none of which had sufficient power to detect any statistical differences between patients receiving a mechanical bowel preparation and those who did not. While I applaud the authors’ attempts to question conventional wisdom, I have real misgivings about the acceptance of their thesis. Many recent studies have disclosed superior clinical outcomes of colorectal surgery following bowel preparation performed by colorectal specialists or those in high-volume centers. While this may represent publication bias, it is also possible that outcomes in these situations would have been superior even if the bowel preparation had been omitted. To generalize the results in the 7 quoted studies to the average practicing surgeon may be stretching the point beyond the limits of safety and common sense. As the authors propose, what is needed is a prospective randomized study including sufficient numbers of patients to avoid the possibility of a statistical type II error. Having said that, I suspect such a study cannot or will not be done in the United States for 2 reasons. First, it would be a remarkably casual institutional review board that would sign off on such a study given the information currently available in the literature. Second, I can almost imagine the glee of our legal colleagues as they predictably stampede to represent those individuals receiving no colon preparation who, for whatever reason, sustain even the most trivial postoperative complication.

In summary, while the current article may provide solace to those surgeons who avoid stoma formation and perform primary anastomosis in patients undergoing emergency operations, I would at this time caution against the wholesale adoption of elective surgery without preoperative bowel preparation. The authors may be on the right track, but it seems to me that the minimal expense and discomfort of the preparation is a small price to pay for the patient undergoing an elective colon resection.

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