Protective ileostomy in all casaes or only in selected cases

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Diverting ileostomies are widely used in colorectal surgery to protect a low rectal anastomoses, especially in techniques such as low anterior resection and restorative protocolectomy.

Although their presence **does not reduce the total incidence of anastomotic leakage**, but it **reduce the related morbidity & mortality** and also the **need for reoperation** in those patients.

However, ileostomies are not without their drawbacks such as:

- reduction in the patients' quality of life.

- Various complications, such as hydroelectrolyte imbalance, bowel obstruction, surgical wound infection, parastomal hernias, etc.

Also closure of diverting ileostomies should not be considered as a complication-free minor surgical procedure.

Despite of existing beneficial evidence, there is no established indication for performing protective ileostostomies.

Therefore, creating a protective ileostomy is left at the surgeon's criterion and based on factors such as:

- type and locoregional conditions of the anastomosis.

- Difficulties arising during surgery.
- Associated patient morbidity etc.

Moreover, the surgeon must take into account on one hand the potential benefit of the ileostomy in protecting the anastomosis.

But on the other hand the drawbacks involved, such as the reduced life quality of ostomy patients and the morbidity and mortality associated with the future closure of the ostomy must be put in our consideration.

One of the controversial points is the optimum time interval between the creation of the ileostomy and the time of closure.

There are groups that incline towards an early stoma closure during hospital admission (days 8 and 10) with a view to improving the patients' quality of life and preventing possible stomal complications.

However, most surgeons favour a late closure, between two and six months after surgery.

they encounter a higher morbidity rate both in closures done before 2 months (due to oedema and still-firm intraabdominal adhesions) and in closures performed after the sixth month postoperatively.

Delayed closure of the ileostomy is often related to the adjuvant chemotherapy that many of these patients receive.

In conclusion, the creation of diverting loop ileostomies implies paying the price associated with the complications of the future surgical closure.

The decision, therefore, to create and subsequently close an ileostomy should not be considered a minor surgical procedure.

Surgeon should take into account which patients will really benefit from it (cases of low anastomoses, presence of adverse conditions for healing of the anastomosis, etc.) and compensate for the risks involved with closure.

Thank you