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Surgical Management of IBD: Goals, Benefits, & Risks

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Hi, I'm Michele Rubin from the University of Chicago IBD Center, and I'm going to talk to you today about surgical management of inflammatory bowel disease. the primary goal of surgery is to be well. We want to alleviate complications, alleviate the symptoms the patient has, and we want to give them the best possible quality of life. Now, the decision to have surgery should be discussed early on when the patient is diagnosed, not as a last resort when they're really sick and it's time to go to surgery.Multidisciplinary decision-making with the patient should always be kept in mind as to the goals that they want to achieve as well—patient engagement in decision-making, and include their preferences of timing of surgery, when it seems appropriate in their life as well, when that can be possible, because sometimes they go to surgery more urgently. Patient education is always very important, talking about the indications, surgical options, but more importantly, as well, are the expectations before and after surgery. Are they going to have a stoma? Will they have home-care needs? How much time do they need to take off of work? These are all issues that are very important—and the psychosocial component, regarding if the patient is going to have an ileostomy, that they are connected to a stoma nurse, and also, peer-to-peer can also help answer a lot of their questions and ask someone else who has gone through what they're going to be experiencing.

So, first, let's look at ulcerative colitis. When is surgery needed? One-third of ulcerative colitis patients will require surgery, either for failure or complications of medical therapy—and, for instance, steroid dependency is definitely an indication—patients who develop cancer or dysplasia, and then we have urgent referrals to a surgeon when they hemorrhage, if they have a colonic perforation or toxic megacolon develops, if they have extraintestinal manifestations, growth failure in pediatric patients, and never to forget decreased quality of life is definitely an indication.

Here's one of the surgeries for ulcerative colitis. It's called the proctocolectomy with ileostomy. As you can see here on the diagram, the entire colon, rectum and anus is removed, and they have a permanent ileostomy, and this is curative for ulcerative colitis. The second surgery is the proctocolectomy with ileal pouch anal anastomosis. It is usually done in 3 stages, And as you see here in stage 1, the entire colon is removed and the rectum remains. The rectum is remaining there as a placeholder for later on returning and having the J-pouch formed. It's attached to the anus, and they have a diverting loop ileostomy. As you can see in that previous picture, it was end. Here, it is a diverting loop, so it is bypassing 20% of the small bowel, which means the patient will have a little higher risk of developing dehydration. The last stage is taking down the ileostomy where they have continuity of stool restored.

What are the benefits and risks of ulcerative colitis surgery? The benefits: It's a cure and eliminates colon cancer. It restores health quickly. The anemia, the nutrition and their quality of life improves. With the ileoanal pouch anastomosis procedure, there's no permanent ileostomy. They have stool continuity restored through the anal area.

So, the risks in ulcerative colitis surgery are infection, blood clots–it's important to know that in IBD patients they are at a much higher risk than the normal population for developing blood clots—dehydration and a postop ileus; secondly, injury to ureters and to nerves related to urinary sexual function, and this is due to the nerves that run along the rectum get pushed aside a little bit and manipulated during surgery, but over time these issues will resolve. Delayed perineal wound healing, particularly in the proctocolectomy where the rectum is removed, can be an issue. In the ileal pouch anal anastomosis, we have risks of anastomotic leak, we have pouchitis which can develop in 50% of patients, cuffitis is 10% risk of ulcerative colitis returning in that little cuff that remains, and the possibility of developing Crohn's in the pouch, which is 10 to 15%, and this over time can result in pouch failure.

The important risks to discuss and talk about as an outcome is that the ileal pouch anal anastomosis function improves over time. At 3, 6, 9, and 12 months, I can see improvement with these patients. The higher number of stools over time decreases; potential leakage of stool can lessen over time; the perianal rash, as they decrease their number of stools and leaks, this will eventually resolve; and the pouch spasms. So, all of this improves as the pouch function improves and adjusts to the patient's way of life, so usually by 9 to 12 months, most of these issues have definitely been decreased.

So, what should J-pouch patients expect? Average of 4 to 8 stools per day (we like to keep them more around 4 to 6); liquid to pasty consistency 80% of the time (they can usually delay a bowel movement over time—they can delay it for a couple hours); little or no urgency to pass stool; usually no leakage (if leakage is present, it often can occur at night, and it usually only is a wetness, not an outpouring of stool); older patients may be a little bit more at risk, or if they have a hand-sewn anastomosis, of having a leak; use of Wet Ones and moisture barrier ointments to prevent the perianal rash which is due to the loose bowel movements or if they have leaks; and they can eventually eat most foods without any difficulty (spicy or high-roughage foods, of course, can increase stools); but it's so important to tell these patients function improves over time. A lot of patients go into this thinking the minute they have that take-down of the ileostomy that everything is going to be wonderful. No, it takes time. And with your provider working with you together, we can accomplish successful function within a shorter time period.

Quality of life definitely is impacted with an ileostomy or a J-pouch. Living and adjusting to surgery and ileostomy, the chronic disease, ileal J-pouch procedure, all of this is very challenging to a patient. The psychological issues of anxiety, depression, or posttraumatic stress syndrome need to be assessed at each visit following these patients. But what have studies shown us? That both patients with a stoma and patients with an ileal J-pouch report they are satisfied with their quality of life, and that's very important to remember.

Key points in ulcerative colitis surgery: The entire colon and rectum is removed in almost all cases. typically, there are 2 or 3 surgeries involved with a J-pouch. Usually, there is a minimum of 3 months between surgeries, and that's so that the adhesions that develop right after surgery that are normal have a time period to soften and the tissues become more pliable. That's why it can take about 3 months between them. It often involves an ileostomy, and it could be either the permanent one or a temporary loop one. Here, again, is the issue with dehydration being so important of a risk to watch for.

Crohn's disease: When is surgery recommended in Crohn's? Very similar, somewhat, to the ulcerative colitis indications—again, the steroid dependency and the hemorrhoids—but what is different is the fibrotic-obstructing strictures, the fistulas and the abscesses and the perianal complications. These are all indicative of Crohn's disease, where it is full-thickness disease. It is not a disease where it is just on the surface lining of the colon. So, malnutrition is definitely an issue here because you are dealing with small bowel resection, extraintestinal manifestations and disorders, growth failure in your pediatric patients, and again, decreased quality of life is always a reason to have surgery.

Here is a picture of a Crohn's disease segment that is resected. This is often called the ileocolonic resection or ileocecectomy. As you can see, the last part of the small bowel and the first part of the colon are resected. This is very common. This is often the site of development of Crohn's disease, always at that ileocolonic area. Bowel-sparing intestinal stricturoplasty, this is a very important procedure because no bowel is resected; and we know that in small bowel disease, if you keep resecting sections of the small bowel and taking it out, they can end up with malnutrition and decreased absorption of minerals, and they could end up on permanent TPN, so the bowel-sparing surgery is very important to Crohn's disease patients when it can be performed. And as you can see here, an incision is made lengthwise and the bowel is pulled horizontally and stitched horizontally, and therefore, the obstruction is relieved and all bowel surface is available for absorption of nutrients.

For perianal disease, here shows a fistula with an abscess, and you can see that darkened red area is the sphincter muscles. So, the surgeon will take them to surgery, find where there is the bowel leak to the abscess and to the outside of the skin, puts a seton through that fistula tract, and it will stay there for a while to relieve the abscess until the fistula can be treated medically and then later on it can be removed. One thing to keep in mind with a patient who has severe perianal disease with multiple fistula tracts and there is also scarring of the anal and perineal area, that those who undergo a diversion with an ileostomy, they have a less than 20% chance of successful restoration of intestinal continuity despite the use of biologic therapy. However, a diversion of the stool is useful to quiet the perineum and promote healing prior to repairing a rectovaginal fistula or in staging a completion proctectomy in the future.

Benefits and risks of Crohn's surgery: Removes the diseased segment, significant improvement of their symptoms, quality of life in particular. Risks: Major surgery incurs increased risk such as infection, blood clots, dehydration, ileus postoperatively and multiple surgeries—anastomotic leak is always a potential when you're putting 2 ends of bowel back together—the short gut, diarrhea stools, adhesions and obstructions and possible ostomy. But most important, surgical resection is not a cure in Crohn's disease. Postoperative recurrence is very common.

So, the key points in Crohn's disease surgery, typically only the segment of bowel affected is removed. Healthy bowel can be left behind and intact. For example, if someone has an obstruction at the terminal ileum and yet they have mild perianal disease but that is managed, they will just do the resection and they continue on with medical management for the perianal disease.

Perianal abscesses or fistula: Combination of medical and surgical treatment is important. Crohn's disease usually returns to the same location over time. Exception to this rule can be when there is Crohn's disease only involving the colon and it has never been in the small bowel, and so by removing the entire colon, rectum and anus, these patients can potentially never have Crohn's recur when they have a permanent ileostomy; and the reason being is because there is no holding of stool at the end of the small bowel, it is going into the ileostomy appliance, so in this situation sometimes it can be a cure. Bottom line here, though, is that then they need that small bowel monitored with an ileoscopy to ensure that there is no recurrence of disease.

In conclusion, here are the key points: Recognize when medications have failed and surgery is necessary, recognize complications that we've talked about today, drain abscesses preoperatively, minimize corticosteroid use, optimize nutrition, help patients quit smoking, improve the patient's quality of life and engage the patient in shared decision-making, and set postoperative expectations. Surgery is not a cure in Crohn's disease except where they have the proctocolectomy and Crohn's was only involved in the colon. Bowel function sensation may be altered. They may have more stools.

Thank you for joining me today, and for resources you can go to the Crohn's and Colitis Foundation website at www.crohnscolitisfoundation.org, and there you will find resources for providers and patients on the surgical management of IBD. Thank you.