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A Look at Crohn's Disease from a Surgeon's Perspective

Dr. Buch:
This is Dr. Peter Buch, your host for *GI Insights* on ReachMD. Despite significant advances in current therapy, some patients with Crohn's disease still need surgery. That's why today we're delighted to discuss Crohn's disease surgical perspectives with Dr. Randolph Steinhagen. Dr. Steinhagen is Professor of Surgery and Medical Education at Mount Sinai School of Medicine. He is also Chief of the Division of Colorectal Surgery and the Director for the Colon and Rectal Fellowship program at Mount Sinai. Welcome to the program, Dr. Steinhagen.

Dr. Steinhagen:
Thank you very much.

Dr. Buch:
Delighted to have you with us today. To start, Dr. Steinhagen, does pre-op exposure to monoclonal antibodies affect surgical outcomes?

Dr. Steinhagen:
That's an issue that we have been very concerned about for a number of years. There had been some data that had been published years ago that the monoclonal antibodies contributed to an increase in postoperative complications, including things like infections and anastomotic leaks. However, more recently, when this has been looked at in a more systematic and controlled fashion, the data seems to indicate that the medicines don't contribute to an increase in postoperative complications. So for the most part now, there had been a time when we had insisted that patients stop the medication prior to surgery, and that led to problems because the disease would often flare during a period of time that we wanted them off the medications. But more recently with the data that it really doesn't contribute to postoperative complications, we now don't take patients off medications prior to surgery. Of all the medications that seem to contribute the most, the steroids are the biggest problem related to postoperative problems, and we're all well aware of that. In general, we try to keep our patients off steroids anyway, but sometimes with the acute flares, they do end up on actually relatively high-dose steroids, and then come to a more emergent surgery and we take that into account. But the monoclonal antibodies don't seem to make that big a difference.

Dr. Buch:
Thank you very much, and as a follow-up question, how long do you wait before you restart monoclonal antibodies after surgery?

Dr. Steinhagen:
Well, that's very variable, and different gastroenterologists have different opinions about that. Some patients, especially who have had recurrent disease and have demonstrated a propensity to develop recurrent Crohn's disease, we start them quite early, within a few weeks after the surgery. But other patients often are kept off of the medications until their colonoscopies, which might be done at six months or a year, demonstrate evidence of recurrent inflammatory changes and then they'll be restarted on it. If there isn't really a strong and clear-cut guideline as to when they should be restarted, but once the patients have gone through the immediate post-operative recovery period, which is just a matter of a few weeks, really if the gastroenterologist wants to restart the medications, we don't object to that.

Dr. Buch:
Thank you. When should we consider a strictureplasty over balloon dilations for small bowel Crohn's disease?

Dr. Steinhagen:

The data is that the patients with balloon dilatation and strictureplasty seem to do pretty equally well. I think the best candidates for balloon dilatation are the patients with anastomotic strictures without evidence of a current inflammation, and that does certainly happen in some cases. I think the limitations of the balloon dilatation is that the endoscopist has to be able to reach the strictures, and in the small bowel, that can sometimes be difficult and especially if there are multiple strictures in patients who have what we term jejunoileitis, doing multiple balloon dilatations up into the small bowel can be technically very challenging. If the endoscopist can reach the stricture and dilate it, I think that the results are likely to be equal to what we can offer with strictureplasty, and I have no problem sending my patients to dilatation, and at least giving them a chance to do it once or twice, if necessary. We know that the strictures recur after balloon dilatation, but the disease recurs after strictureplasty as well, and like I said, the long-term results are relatively similar.

Dr. Buch:
And how do you weigh the pros and cons of doing an ileal pouch anal anastomosis in Crohn's disease?

Dr. Steinhagen:
That's a very controversial topic. Classically and traditionally, we have not offered ileal pouching anastomosis in patients with Crohn's disease because of the high likelihood of developing Crohn's disease at the pouch, and significant pouch dysfunction which can ultimately lead to requiring removal of the pouch.

And when you have to remove the pouch, you are gonna lose a significant amount of small bowel, and in general in Crohn's disease, our constant focus is to preserve as much viable bowel as we possibly can. The risk of multiple recurrences, multiple resections, and ultimately short bowel syndrome, which is associated with nutritional issues is something that we're very cognizant of all the time. Having said that, there certainly are some patients who we think we are doing pouches for ulcerative colitis, and then ultimately turn out to have Crohn's disease, either on the pathology at the time of the colectomy or at some time in the future, and it can certainly happen years, and sometimes a lot of years later, that someone who seemed to have classical ulcerative colitis turns out to have Crohn's disease. And that doesn't necessarily mean that they're going to have a terrible outcome. But it does mean they're likely to end up requiring medications, often monoclonal antibodies to manage the Crohn's disease of the pouch. Having said all of that, there is a small number of patients who have pure Crohn's colitis, without small bowel involvement and without perianal disease, abscesses and fistulae, who may be candidates for pouch anal anastomosis. This is something that has to be discussed at great length between the gastroenterologist, the surgeon and the patient, most especially. The patient needs to know that this is a risk, that even though they don't have evidence of small bowel disease at the time of the surgery, they may have problems with Crohn's ultimately developing in the pouch. They may require medications and they may end up losing that pouch. This is not universal by any means, but there are some surgeons who are willing to do ileal pouching anastomosis in this highly selective group of Crohn's patients, even knowing in advance that they do have Crohn's disease, but it is a risk for everyone involved.

Dr. Buch:
The essence of what you said is, "Be careful."

Dr. Steinhagen:
Yes, you have to be careful, but even with care, some of the patients that are diagnosed with Crohn's disease after colectomy and pouch anal anastomosis, they can develop this years later, and we've gone back and looked at the colectomy specimens and to see if there's any evidence of Crohn's disease in that colectomy. And very often, there's not, and the pathologist will say even in hindsight, knowing that the patient ultimately develops Crohn's disease, that they still would have called this ulcerative colitis to begin with. And I think that we've taken the position that these are patients who probably had Crohn's disease all along. We don't think that ulcerative colitis becomes Crohn's disease, and we don't think that patients can have both ulcerative colitis and Crohn's disease. Our assumption is that it was Crohn's to begin with; we just weren't smart enough to recognize it.

Dr. Buch:
For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Peter Buch, and today we're discussing surgery for Crohn's disease with Dr. Randolph Steinhagen. So, next question. Due to the multitude of medications for Crohn's disease, are some of us waiting too long before consulting colorectal surgeons?

Dr. Steinhagen:
Well, this is a problem that, from a surgeon's perspective, is something that's existed even before we had all of the medications that we now have. There's no question that we have more medications and that they are effective. The data seems to indicate that we're doing less surgery for ulcerative colitis than we did in the past, and presumably it's because patients are being better-controlled with the medications we have available, and there are new ones that seem to be coming all the time. I think that the optimal management should be the gastroenterologist and the surgeon working together to determine when is the best time for surgery. I think surgeons do feel that there are patients who would have benefited from surgery earlier. Many times when you ask patients, especially after they've had

surgery, they frequently will tell you that they wish they had had it done earlier. There's a study that was recently done in Europe where they managed early Crohn's disease with surgery rather than medicine and compared it – this was a randomized study where people had medical treatment, and some people had surgical treatment – and the overall quality of life was better in the surgical group than in the medical group. And I'm not necessarily advocating for early surgery in patients with new onset of Crohn's disease, but it's certainly something to think about and I think, too often, gastroenterologists look at the patient who they are forced to send to surgery because their disease is not being well-controlled medically and look at those patients as failures on their part. They weren't able to avoid the surgery, and I think that's the wrong attitude. There are some patients who definitely benefit from surgery, and I think that knowing when that is in any individual patient is a difficult decision, but it needs to be made with the patient, with the surgeon and I see many patients who are sent to me who I tell them that I think they would be better off continuing their medical therapy rather than having surgery, and but at least at that point, they've had the opportunity to meet with me to discuss what the surgery is, what it involves, what impact it will have on their overall quality of life, and then that helps them make a decision as well.

Dr. Buch:
And lastly, Dr. Steinhagen, is there any additional message you would like to share with our audience?

Dr. Steinhagen:
I think the best treatment for patients with inflammatory bowel disease is a multidisciplinary treatment and that decisions should be made with the gastroenterologist and the surgeon and the patient together. And then that will provide the optimal care for any individual patient.

Dr. Buch:
This has been an extremely informative discussion, and I want to thank Dr. Randolph Steinhagen for sharing his expertise. Dr. Steinhagen, it was great speaking with you today.

Dr. Steinhagen:
I enjoyed it as well. Thank you for having me.

Dr. Buch:
For ReachMD *GI Insights*, this is Dr. Peter Buch. To access this episode, as well as others from the series, visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening, and see you next time.