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Evaluating & Managing Pouchitis: What Do the Latest Guidelines Recommend?

Dr. Nandi:
Pouchitis. For a significant portion of our patients this condition can be a frustrating and trying condition plagued with urgent diarrhea, incontinence, and even complications of fistula and stricture. Fortunately, a group of clinicians have gathered together to develop consensus guidelines on the endoscopic evaluation and clinical management of pouchitis and its potential complications. Joining me today on this program is one of those authors, Dr. Jason Schairer, at the Henry Ford in Division of Gastroenterology and Hepatology. He is the Co-Director of the Inflammatory Bowel Diseases Center as well. Jason, we're excited to have you on the program. Welcome to the show.

Dr. Schairer:
Thanks, Neil. I'm actually excited to be here. This is my very first podcast. So this is all new to me.

Dr. Nandi:
Fantastic. Now Jason, you and an all-star cast of IBD clinicians have recently published in *The Lancet* an "Endoscopic Evaluation of Surgically-Altered Bowel and Inflammatory Bowel Diseases, A Consensus Guideline from the Global Interventional Inflammatory Bowel Disease Group." Congratulations, one, and I'm hoping to tap into your mind and garner some insights on pouchitis. First off, how should we define pouchitis? We should start with that basic premises.

Dr. Schairer:
So the first we have to do is just say, well, what's a normal healthy J-pouch look like and behave like, right? And this is important to establish with the person before they even go back for surgery. For instance, I tell patients after you have a J-pouch made, you can reasonably expect to have four to eight bowel movements a day, and they're going to be fairly loose to begin with. Now getting up at nighttime, having nocturnal bowel movements, you know, once maybe twice a night could also be a standard outcome for a healthy well-performing J-pouch. But there's other things that shouldn't be present, for instance, you should not have much urgency, you should not have bleeding, you should not have obstructive symptoms, and you shouldn't have pain. So going with what that baseline is, we really have to talk to the individual and say, 'Well, what is this? And how is this different from what you're used to?' For instance, if I said four to eight bowel movements a day is normal and yet you're normally having four or five bowel movements a day and now you're having eight with a lot of urgency, that would be different. And that's when we start that workup, looking to even see, does this person have pouchitis?

Dr. Nandi:
So you know, that's really helpful. And I think this we can go back further in time when we're talking to our patient that we have to set up expectations before surgery, right and show them that we're treating one state of being for another state of being, and what those pros and cons are for the patient, lack of bleeding and pain hopefully, so that if they know that going in what pouchitis may be like and they're not alarmed with all these symptoms they weren't educated with, that will also influence subjectively what they're telling the doctor about their symptoms too.

Dr. Schairer:
Exactly, and just the quality of life after surgery. If your medications aren't working, and you go in, 'I'm ready for surgery, I have six bowel movements a day and I get up once a night to have bowel movements.' you go, 'Well, we hope we can make that better. But we might end up with basically the same symptom complex. And even though we got rid of all the inflammation and you came off the medications,' some people look at that and go, 'I feel the same, this is not better.' So setting expectations early is the best way to ensure that the patient is satisfied with the outcome.

Dr. Nandi:
Absolutely. Now moving on, we know that not all pouchitis is just pouchitis. Once you've established that they have some form of pouchitis, it's a nonspecific term, and the work of Bo Shen, yourself, many other colleagues have been able to identify certain etiologies, right? We can mechanistically or categorically break down the cause of pouchitis. Can you relay what are the general categories or mechanistic categories that cause pouchitis?

Dr. Schairer:
So obviously, anything with an itis is just a catch-all term to describe what's happening, but not why it's happening. Right? And in medicine, we always care about why because when we understand that, we can pick the appropriate therapy, we can have the appropriate expectations of what the outcome should be. So pouchitis just means inflammation. But when we're looking at the pouch, the most common reason for pouch dysfunction associated with inflammation is just going to be a bacterial pouchitis.

So when we talk about microbiome, which is like this big hot topic for the past several years in IBD, I think that there's this general view that we're all supposed to have fairly similar microbiomes. But our microbiome is a function of everything in our life. It's a function of the food that we eat, the water that we drink and what we put into it for, you know fluoride and pH and things like that. It's a function of people that we interact with and shake hands with, where we live, the inflammation in our GI tract. And so my microbiome, Neil, in Detroit is probably grossly different than yours over in Philadelphia.

But we look at a pouch. Now we know that the colon has a microbiome, but the colon's gone, and the J-pouch is made from the ileum, which usually has a valve, it's going to keep that microbiome from getting back into the ileum. And it has a almost continuous flow of gastric secretions, bile, food, et cetera, that kind of flushes out bacteria that gets into it. So our small intestine by comparison is almost sterile compared to the colon. But now, for a very good reason, we've taken that small intestine and we've dragged it down the anus, made it continuous with the outside, we have turned it into a reservoir where instead of just passing things from point A to point B, it's supposed to hold on to the stool until we have a socially acceptable time to have a bowel movement. And all of that leads to a microbiome that wasn't supposed to be there originally.

So when we talk about a bacterial pouchitis, it's not that these are necessarily bad bacteria, it's just we're asking the ileum to do something that was never designed to do. And some people just really don't respond well to that.

So to say that there's this one bad bacteria that's causing it, or I'm sure you've seen those holistic doctors with like six pages of multicolored labs that come in going, 'Well, I have this bad bacteria.' I don't know if that necessarily applies to a J-pouch because I don't know what bacteria is supposed to be in your J-pouch.

Dr. Nandi:
100%. Totally agree and there's no doubt of dysbiosis and we have to recognize that it was never ever, ever meant to house or serve that function, that ileal pouch. So you know, dysbiosis is one of those mechanisms which can create the pouchitis. What are the other things that clinicians should consider?

Dr. Schairer:
So it's not just that there are bacteria or bad populations of bacteria. The other big one that we're always looking for is Crohn's disease, right? We blame Crohn's for everything. And that is a really hard thing to differentiate, Crohn's from bacterial pouchitis.

But just go through the differential before we separate those two things out. A skinny pouchitis is a big one. Okay, so often we're putting these pouches in a fairly malnourished, thin person because the medications are failing the person. And they get better, and they gain weight, and all of a sudden, the surgeon who designed this pouch for 160-pound person, the person now weighs 200 pounds and it's just hard to make everything reach. So ischemic pouchitis can be one issue.

Autoimmune pouchitis, and this would be more common in people who have autoimmune cholangiopathy or PSC. We can also find the autoimmune reaction, the IgG4 population in the J-pouch itself.

Those will get you through most things. Bacterial pouchitis, Crohn's pouchitis, or Crohn's disease or the pouch ischemic, and autoimmune pouchitis.

Dr. Nandi:
Yeah, I think those are some big categories that we all need to think of. I think some of the other ones that come to mind are also CMV or viral infections that can happen in some of our immunosuppressed patients especially. And then functional pouchitis, IPS, or irritable pouchitis syndrome, and even pelvic dysmenorrhea.

Dr. Schairer:
Okay, so let's talk about that for a second. Right? So another one my little soapboxes is irritable bowel syndrome or irritable pouch

syndrome, right? And we're talking about the inflammation of the pouch. And you can go look and see and say, 'This doesn't look like healthy tissue.' But I think for someone like myself, an area that we really have underrecognized over the years is the actual mechanical dysfunction of the pouch, right? And that can go into several things. That can go into the construction of the pouch, right? I did three pouchoscopies yesterday, and one of those pouch bodies was about 10 centimeters long. That person just doesn't have a big reservoir, so they're going to go to the bathroom more frequently than someone that had a 15- or 20-centimeter-long reservoir at the end of their GI tract.

And then we talked about the pelvic floor and what goes into having a bowel movement, right? We talk about the relaxation of the anus, the pelvic floor descent, we talk about in a person with a rectum, how the muscles will bring the rectum into a more vertical position to facilitate having a bowel movement. And when the surgeon goes in and makes a J-pouch, do those things still happen the same way? We've severed some connections, the nerves may not necessarily connect, and so biofeedback therapy is kind of an underrecognized or underutilized way to help people with some of these pelvic floor dysfunctions.

And then there's all sorts of other mechanical things associated with just the surgery itself that can happen. You know, if we have too much mesentery that's mobilized, the pouch may flop around a little bit so we have floppy pouch complex. That can lead to outlet obstruction. We can have stenosis at the surgical site, so again, like that rectal pouch body anastomosis can have a stenosis that causes outlet obstruction. So there's a lot of mechanical things that can go wrong with a pouch besides just the inflammation.

And then if you've ruled out infections and you've looked for inflammation, and there's none, and you've made sure that the mechanical or physiological functions of the pouch are happening appropriately, then we can get the irritable pouch syndrome. But again, that's like the thirteenth thing on the list. And I'm always hesitant to give that diagnosis to someone until I've really had a chance to rule out all those other things.

Dr. Nandi:
Yeah, 100%. It has to be like IBS, it has to be a diagnosis of exclusion to some degree. I hate using that phrase, but you have to look hard for other organic causes before you settle on it, but you certainly can't see it. And I'm glad that we're able to highlight the pelvic dyssynergia as being something that we can utilize biofeedback therapy.

For those just tuning in, you're listening to *GI Insights* on ReachMD, and I've been speaking with Dr. Jason Schairer on the approach to pouchitis and management of some of its complications.

Can you briefly review what should be the endoscopic assessment of a pouch? What should we measure? What should we define? And then two, what patterns of inflammatory distribution may signal ischemia versus pouchitis versus other?

Dr. Schairer:
When we are in the J-pouch, well, even before we get to that part, it just starts with a good perianal examination. I'm always telling the fellows just take a moment, spread the gluteal cleft, use the light from the scope and just take a survey of what you're seeing because something like an anal fissure after you've done a rectal exam and you put lubrication in there may be very hard to find. So look for your fissures, look for your fistula external openings before you even start.

Once we're in the J-pouch, I'm just going to start upstream and kind of work my way out. So we want to go into the afferent limb as deeply as we possible - not just 10 centimeters, but we want to get into that neoterminal ileum, and if possible, identify that previous stoma site, right? So again, yesterday I was looking, I got to the previous stoma site, we checked to make sure that there's not a stenosis, a mechanical obstruction there, and I did see a fair amount of alterations just upstream to the anastomosis, which is something that we see in a lot of surgeries in IBD.

As you start to come distally from that stoma site towards the pouch body, we're looking to see if there's a presence of inflammation. And one of the biggest ways to differentiate Crohn's disease of the pouch from other pouchitises is that the more proximal from the pouch you get, if you have inflammation, the more suspicious that it's Crohn's disease, right? So, 5, 10 centimeters north of a J-pouch, that could just be wash-back bacterial pouchitis. But 15, 20, 30 centimeters upstream, that's more likely to be Crohn's disease.

After we've left the stoma, we're coming down the afferent limb, we get to the inlet, which is the surgical part where the ileum is reflected upon itself, and going from one site to the next, we have the inlet to the pouch, the owl's eyes, which is that little reflection in the middle, it just looks like an owl's eyes, and then the tip of the J. And that inlet we really want to evaluate for things like inflammation and stricture. That stricture again can be suggestive of Crohn's of the pouch, but again, bacterial pouchitis, NSAID enteropathy can both cause strictures in that area.

As you're looking at the J-pouch itself, it should not just be a straight shot, you shouldn't be just sitting at the anus looking directly to the owl's eyes. There should be a little bit of a turn in the middle there. And I always say 15 to 30 degrees seems pretty normal and healthy.

And when you're looking at the owl's eyes, and you see that reflection, you can look in on the top part of the pouch and the bottom part of the pouch, there's is going to be a thin raised line. This can be the suture line or the anastomotic line where they staple the pouch together. That's an important place to identify because when you're doing biopsies, if you're looking for Crohn's, I don't know, Neil, about your pathologists, but my pathologists love to talk about granulomas and label everything with a granuloma, Crohn's disease, right? Well, we've got all this foreign body here in the pouch. And if we biopsy by that, we're likely to find more granulomas, and since not every granuloma's Crohn's disease, we're creating false positives in that scenario.

Dr. Nandi:
No, that's a great point. And we do see that sometimes for sure.

Dr. Schairer:
So we keep coming back on we're about to leave the pouch, and we see another anastomotic line between the pouch body and the rectal cuff. And we want to examine, obviously, for stenosis here, but also just the length of the rectal cuff. So a typical cuff should be about 2, maybe 3 centimeters. And if the surgeon went too low, and again, there's probably a good reason why they had to do it, but if they went too low, and there's only maybe a centimeter of rectal cuff, well, there may not be as much proprioception as needed. And now the patient may have issues with urgency or stress incontinence when they cough or laugh or things like that.

And if they leave too much cuff behind, if they've got 5 or 6 centimeters of rectal cuff left behind, then you're just leaving untreated ulcerative colitis there.

And so another thing in the guidelines was just the definition that cuffitis is ulcerative colitis or Crohn's disease of the cuff that can lead to a lot of our symptoms.

And then the last thing to focus on in this endoscopic exam, and this is really where we just tell our fellows to slow down. We're not starting a lawnmower here, come back slowly, and look at the anal canal itself. Identify that dentate line because if you separate the folds of the hemorrhoids and you look at the dentate line, you can often find the internal os of a lot of these fistulas. And again, not every fistula is Crohn's disease, some are cryptoglandular. But again, finding that os, identifying fistulas in conjunction with other findings, like afferent limb, ileitis, and inlet stenosis would push you towards a diagnosis of Crohn's disease. I think I got it all.

Dr. Nandi:
Jason, thank you so much. That was a great summary of the endoscopic approach to pouchitis. And I hope our clinicians are listening closely because that helps guide what the etiology is, what's the cause of the pouchitis so we can get the right treatment for the right patient. Jason, thank you so much for joining us on *GI Insights*. Any last closing remarks or comments about pouchitis?

Dr. Schairer:
I want to remind everyone that most J-pouches work wonderfully. They change patient's lives and they are so much better off because they went for the surgery. But as a gastroenterologist, we only see the ones that don't work well. So just remember our inherent biases. Remember that surgery is a valid therapy for many people living with ulcerative colitis and that we are just talking about the minority of people who we can help get to a better quality of life.

Dr. Nandi:
Thank you very much, Jason.

To access the highlighted article in *The Lancet* and more on Dr. Schairer's work please, visit the podcast link in the show notes. For ReachMD.com, I'm Dr. Neil Nandi. To access this episode and others from *GI Insights*, please visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening.