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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Insights on the Surgical Management of IBD

Dr. Buch:
Welcome to GI Insights on ReachMD. I'm Dr. Peter Buch, and on today's program, we have the opportunity to do something a little different. Instead of focusing on the medical approach to inflammatory bowel disease, we have the chance to better understand the surgical perspective. And joining us to share this perspective is Dr. Amanda Ayers, who is a colorectal surgeon in private practice in Connecticut. She also holds teaching appointments at both the University of Connecticut School of Medicine and the Frank H. Netter MD School of Medicine. Welcome to the program, Dr. Ayers.

Dr. Ayers:
Thank you for having me. It's pleasure to be here today.

Dr. Buch:
So let's just dive right in. How do you decide on what procedure is the most appropriate for an elderly patient who has ulcerative colitis?

Dr. Ayers:
So it's a complex discussion obviously with both between you and the patient. And there are three options surgically. One would be the total proctocolectomy with an ileoanal J-pouch, either a two-stage or three-stage. So two-stage being colectomy pouch creation, diverting ileostomy, and then ileostomy reversal. Three-stage being colectomy, second stage is the proctectomy with pouch creation, diverting ileostomy. And the third stage is the ileostomy closure. You can do total proctocolectomy with end ileostomy or rarely a total abdominocoletomy with an ileorectal anastomosis, which typically requires close observation.

So I think rather than age as an independent number, you really need to look at a bunch of different things. So there's a lot of discussion in the surgical literature looking at frailty and things that better define sort of the patients, not just their age but how well they can tolerate surgery and how well they're going to tolerate the outcomes.

So with ulcerative colitis, we really have to focus on the functional outcomes. And so with an ileoanal J-pouch, which is sort of the Olympic gold medal in colorectal surgery, the best case scenario is that these patients are going to have about six to eight bowel movements usually have a semi-liquid, kind of mushy type consistency. And many patients will have some urgency with that as they don't have the capacity to hold a large volume of stool.

So as patients age, you really have to think about, for example, their orthopedic issues. Do they have significant hip, knee issues that would limit their ability to ambulate and get to the bathroom quickly in the right amount of time? Do you have to worry about them falling trying to get up and rush to the bathroom? You need to worry about their risk of incontinence, particularly in women. So risk, you look at their birthing history, prior anorectal surgery. Are they going to be at risk for incontinence? And looking at their baseline continence. And then talking with the patient about what their ultimate goals are. So if the goal is for the patient to do a lot of traveling, a pouch may not be the best option because it does limit your ability to be away from a bathroom for long periods of time.

So you really need to kind of take all of those things in and have a discussion with the patient. I think 75 is typically an age we really, really start to worry about creating a pouch in a patient. But I've seen plenty of 75-year-olds that are healthier than 60-year-olds from an overall medical comorbidity standpoint.

So I think it's a complex decision that involves both your input as well as what's the patient's desires are.

Dr. Buch:
Thank you very much for that. That's wonderful insight.

Let's move on to this. There's a higher recurrence rate after surgery for Crohn's disease. So how do you follow these patients?

Dr. Ayers:
So this is where you know all inflammatory bowel disease really needs to be multidisciplinary care. And I'll tell you that every gastroenterologist that I have mutual inflammatory bowel disease patients, we have each other's cell phones, and text or call about issues so that we can coordinate. And a lot of times after they are either surgically cured or surgically managed, we'll refer them back to their primary gastroenterologist. And we tend to be in close communication about post-surgical complications and when they can resume often their biologics and remain in close communication with them regarding their endoscopic findings, usually at six months.

So as the surgeon, we're going to follow them clinically with close communication with their gastroenterologist.

Dr. Buch:
Let's continue our discussion with Crohn's disease and stricturing. What governs whether you will use balloon dilation, stricturoplasty, or resection for these patients?

Dr. Ayers:
So again, also complex decision-making and looks at a bunch of different factors and again, close communication with their primary gastroenterologist. So balloon dilation, traditionally noninflammatory short segments or less than 5 centimeter, disease that does not have penetration. So no fistula disease, no abscess. And usually only small bowel or an anastomotic strictures. And I think really in true clinical practice, most of us are only using them for an anastomotic strictures with the knowledge that at least half to a little bit more than that are going to require repeat dilation when we follow them out to five years. And about a third of them are going to need surgery at the two to five-year mark after dilation. So the balloon dilation is really I think more of a temporizing measure to delay the need for further surgery.

Stricturoplasty I think is most commonly in the surgical world used in conjunction with resection. So I think it's relatively uncommon, except in rare instances, that you go in purely to do a stricturoplasty unless this is a repeat resection patient. The goal of it is for bowel preservation so for those at risk for short bowel. But most commonly, it's actually used in conjunction with resection. So you go in to operate on a patient with a clear ileocolic stricture or TI stricture, and you resect that and then find other strictures and use a stricturoplasty in combination to limit the number of resections and preserve bowel length.

And then resection, we're going to use in the setting of clear fibrostenotic disease. So not ones that appear to be responsive to steroids or have an inflammatory component because we're going to try and maximize that medical therapy. And when we clearly see that this is fibrostenotic, so proximal bowel dilation, you don't see a lot of inflammation there, you just see kind of that short segment disease. And typically also resection for complex fistulas. So those you know, to the bladder or other organs.

And then in the setting of the colon, any colon stricture that can't be adequately surveilled should be resected. There's really no rule there for balloon dilation or stricturoplasty for colonic strictures.

Dr. Buch:
Thank you for that insight.

For those just joining us, this is GI Insights on ReachMD. I'm Dr. Peter Buch, and today we are discussing surgery and inflammatory bowel disease with Dr. Amanda Ayers.

Dr. Ayers, with the ever-expanding array of medications to treat IBD, are you finding a delay in patients getting in touch with you?

Dr. Ayers:
So we are certainly not seeing these patients typically primarily meaning they are first diagnosed and sent to the surgeon, but we are seeing them. I think our local GI colleagues are very efficient at getting these patients into at least establish care with us so that we've met them, we've had a conversation. For a lot of these patients, particularly in younger patients with UC who might be contemplating proctocolectomy and a pouch it's often a several month process to talk about it, what the risks and benefits are, what the options are for an ileorectal anastomosis in young women to talk about what their risk of long-term fecundity is. All of those things are not a one-visit plan surgery situation.

So I think we are fortunate in the northeast that we have close communication. I think we're seeing these patients early enough to have that conversation and establish a therapeutic relationship with the patient before we're heading into surgery. I can't speak about the rest of the country, and certainly in areas where there's a smaller concentration of providers, I think that's probably happening less frequently.

I think in our experience, COVID has probably played more of a role than the biologics and getting patients to come see us as patients

have delayed care and things like that.

We definitely are waiting longer to offer surgery. There is often another biologic that can be tried or a different regimen. So in general, we're getting these patients later, but I think that's actually a very good thing, particularly in Crohn's disease because our ultimate goal for everyone is to avoid or delay surgery as long as possible in the setting of Crohn's.

In UC, I think it's a little more complicated to make those decisions about whether it's better to be on a long-term anti-TNF for biologic agent versus surgery. But for young patients not having surgery and being able to maintain on a biologic if their symptoms are well controlled is probably a better quality of life in the short term.

Dr. Buch:
Thank you. Would you comment on whether there is an increased risk of infections after operations for those patients on immunosuppression?

Dr. Ayers:
Well, this is a can of worms kind of question and is pretty complicated. There are a lot of attention recently and some conflicting and varying information, partly because we have so many biologics. So it's really difficult, I think, to sort through the literature. I think overall, as the surgeon, what we need to look at is the overall additive effects of immunosuppression, as well as the patient's health. So for example, if a patient's on high-dose steroids and a biologic and an immunomodulator and has an albumin below 3 and is a low BMI, those additively are very high-risk for post-op complications. It gets a little trickier when you have a patient on a little bit of steroids and a biologic and their albumin is borderline. What do you do with those patients is always tricky, but as the surgeon you have to kind of take all of those things into effect.

It also seems that the indication for surgery, so Crohn's versus UC, does play a role. There are some studies that have shown that a total proctocolectomy and a pouch has an increased risk of post-operative complications in the setting of anti TNFs. But biologics alone don't clearly increase the risk except in a pouch. And Crohn's overall seems to have an increased risk which is also propagated by the number of resections or repeat resection in and of itself increases the risk for post-operative complications. And then if you add to that steroids in a biologic agent, things like that.

Smoking cessation plays a huge role. So the immunosuppression aside, we spent a fair bit of time getting these patients trying to quit smoking if we can prior to surgery because it is a huge risk for post-operative complications. And if they continue to smoke, that definitely pushes me to a higher likelihood of giving that patient a stoma. In general though I think with the immunosuppression, we would ideally hold it for about four weeks prior to surgery if we can and optimize their nutrition, get them to quit smoking. And hopefully do all of the other things we do from a surgical standpoint, mechanical bowel preparation, perioperative antibiotic prophylaxis, enhance recovery protocols to sort of get them through surgery as expeditiously and quickly as possible so they get back to treatment.

Dr. Buch:
And when do you feel comfortable resuming immunosuppression post-op?

Dr. Ayers:
So typically, in a patient who has an uneventful post-operative course, I think a month is fine so if they don't have perioperative complications. I do think that in the setting of Crohn's disease, so ileocecectomy for Crohn's, we may see some delayed complications. So a usual patient who might have an anastomotic leak or an abscess at the typically 5 to 10 to 12-day timeframe, we might see that delayed in Crohn's disease. But I think in about a month, they should be out of that concerning window. If they do very well or are diverted, then I think two to three weeks as soon as they're well enough to be eating and drinking well and back to reasonably normal activities, then that can be started sooner if they're diverted.

Dr. Buch:
Before we conclude, is there anything else you wish to share with our audience?

Dr. Ayers:
So I think that the most important thing is that as the surgeon when you take care of these patients, you need to have a really good relationship with your gastroenterologist and be able to have good communication back and forth about what the options are and what our concerns are from the surgical world in terms of the risks of perioperative complications. And biologics play a huge role, but so do all of the other things: nutrition, smoking, patient support systems; patients who have no support, but need major abdominal surgery, that's a difficult recovery for them. So we really need to be in close communication. And while I guess my personal feeling is that while a pouch is always, like I said, it's like the Olympic gold medal in colorectal surgery, it's kind of the thing that we always talk about and it's sort of the apex procedure it isn't always the best option for every patient. So I think having a conversation with patients about what their goals

are and what they want their life on the other side of surgery to look like is a really important conversation to have.

Dr. Buch:
That brings us to the end of today's program. I want to thank Dr. Amanda Ayers for sharing her insights on the surgical management of inflammatory bowel disease. Dr. Ayers, it was a great pleasure speaking with you today.

Dr. Ayers:
Thanks so much for having me. I appreciate it.

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