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Key Insights on Endoscopic Strictures in Crohn's Disease

Dr. Nandi:
The treatment of a patient with fibrostenotic Crohn's disease can be challenging. We often see this with ileal disease or even in certain pouches. It can be challenging to understand what is the right approach and when to refer for a balloon dilation.

Welcome to IBD Crosstalk for *GI Insights* on ReachMD. I'm your host, Dr. Neil Nandi. And joining me to discuss ileal strictures and pouch strictures and treatment thereof is Dr. Gursimran Kochhar, the Division Chief of the Department of Gastroenterology and Hepatology and the Medical Director of Endoscopic Innovations at Allegheny Health Network in Pittsburgh, PA.

Dr. Kochhar, welcome to the program.

Dr. Kochhar:
Thank you so much, Neil. It's a pleasure and an honor to be here with you guys.

Dr. Nandi:
We're lucky to have you. I mean, I know that you are, in fact, one of the co-authors of 'The Practical Guidelines on Endoscopic Treatment for Crohn's Disease Strictures' that was published recently, and a lot of people are looking with interest at these guidelines. You did a systematic review and came up with consensus from multiple specialists, as yourself, so let's dive right into it.

When a GI clinician is looking at imaging modalities to really characterize a stricture, what's the best modality? What should they pick?

Dr. Kochhar:
So I think that's a very good question. We get that question asked quite a lot, actually, and it almost depends on patient factors. For example, if you have a patient who is in a very acute phase of, you know, symptom-wise, then obviously, obtaining a CT enterography is much easier than obtaining an MR enterography, so you should order a CT enterography. However, if you have time on hands and, you know, we want to avoid radiation exposure, then obviously MR enterography is a preferable modality. MR enterography is also very helpful if we are suspecting a fistula, you know, right at the site of stricture, so MRI in those regards does much better than a CT enterography, but the idea is—and we mentioned this in the guidelines—we should have some imaging modality to guide us, preferably MR or CTE. It also depends where you are practicing, what patient insurance factors are there, so I leave it up to the practitioners to choose. But they should at least obtain one of these. Small bowel follow-through has kind of, you know, fallen out of favor. Especially, you know, there are a lot of factors that preclude its use, like can the contrast reach all the way until the TI to give you accurate assessment and things like that.

Dr. Nandi:
Gursimran, now, when you're looking at the imaging, what are the characteristics that you want to know about? What are the things that go through your mind in evaluating the candidacy for a stricture for balloon dilation?

Dr. Kochhar:
Yes. So I think when we review the imaging, and I encourage this more for the fellows, and residents listening to our talk, that try and review your imaging first yourself, and then obviously send with the radiologist. So, location of the stricture, a stricture in the mid ileum versus a stricture in the terminal ileum, you know, is going to be different management.

The second thing that we have to look for is the length of the stricture. We have pretty good data saying that if the strictures are longer in length, especially when they start getting longer than 5, 6, 7 centimeters in length, they are less likely to respond to endoscopic therapy. If there is a very significant prestenotic dilation prior to the stricture, which, you know, we define as more than 5 centimeters on

the imaging, that tells you that this stricture is also less likely to respond to endotherapy. In those cases, I think it's reasonable to have a discussion with the patient, especially if they have poor nutritional status, that 'Listen, we can do endotherapy; let's bridge you for a possible surgery.' But most likely endotherapy won't work because you have a stricture that's 7 centimeters in length, for example, or you have, you know, 'a lot of very significant prestenotic dilation.' The presence of fistula and abscess very important because if I do see a fistula right with the stricture, I tend not to dilate those strictures. In fact, presence of a fistula we also mention in the guidelines should be almost taken as a, you know, contraindication for a balloon dilation because theoretically you may then increase the size of the fistula from a small opening to a bigger opening.

If a patient has a lot of inflammation, a lot of transmural edema that you see, then I think in those patients there is a case, an argument to be made. Should I optimize my medication regimen first before I take them for the procedure? You know, because in some of those instances, the stenosis, especially if it's all inflammatory, might just be resolved with the use of medications.

Dr. Nandi:
When you have swollen tissue and you're trying to dilate that, there's a perforation risk, and if you haven't maximized your advanced therapeutic, your biologic or what have you, then you might be putting the patient at risk. How would you make that more precise in your opinion, Gursimran?

Dr. Kochhar:
So I think the way I look at it is this. If there is an inflammation complement in a stricture, then, yes, we should judiciously push the biologics and other medications so that we can achieve healing, because you are right. Risk of perforation in, you know, inflamed tissue is very difficult to manage endoscopically. However, there is another point I would like to make here is that now we have a lot of medications. But I also want to point out that if a stricture is purely fibrotic and we don't see inflammation, then pushing of medications might not be the right thing to do as well, meaning if somebody's already on one medication and now we have a fibrotic anastomotic stricture, changing their therapy might not help because that fibrotic tissue will not respond to a newer medication.

Dr. Nandi:
For those just tuning in, you're listening to *GI Insights* IBD Crosstalk on ReachMD. I'm Dr. Neil Nandi, and I have the great pleasure with speaking with Dr. Gursimran Kochhar about endoscopic stricture dilation in our Crohn's patients.

So, Gursimran, let me ask you, when we're counseling our patients about prepping for the surgery in terms of what we have with other endoscopic procedures, they ask about antibiotics, they ask about, radiation, how common is it to need antibiotics? And do you guys ever use intralesional steroids for these patients? And what's the efficacy there? A lot of questions I'm throwing at you there.

Dr. Kochhar:
So let's start with the use of the fluoroscopy. We have left the use of fluoroscopy to individual endoscopists. It just depends. There are some individuals who have been doing dilation for years now. They feel very comfortable. However, if you're early in career, just out of fellowship, and you're starting to deal with the strictures and you feel more comfortable, sure, you know, use the fluoroscopy.

And, you know, I also want to point out that we describe dilations mainly in two types, like the antegrade dilation and retrograde dilation. What we mean by that is in antegrade dilation we are not able to pass the scope through the stricture. In retrograde dilations, which are defined as that you are able to pass the scope through the stricture and on your, you know, pull back, you can dilate. In those instances you don't have to use fluoroscopy, again, if you feel very comfortable in your skill set.

In regards to steroids, so we in the guideline paper recommended against injecting intralesional steroids because the data on use of intralesional steroids in IBD patients is not very convincing. There was one paper that said there might be some benefit, and one paper said there is actually harm. Now, there is a reasonable amount of data in non-IBD patients in peptic strictures of injecting a steroid, but in IBD patients, we don't see any added benefit. So we have recommended against using intralesional steroids.

In regards with the antibiotics, now this is very interesting. There is no routine indication to use antibiotics during dilation. And I don't use antibiotics as well. But there have been times once or twice where patient had to call back with pain post procedure. This was no frank perforation, and we did treat them with antibiotics just like we treat the post polypectomy syndrome.

Dr. Nandi:
I think you have to use your best judgment, as to when to recognize a complication, when not to mask it and when to give empiric antibiotics.

So, listen, this was very high yield so far Let me ask you though. When you're characterizing or thinking about a patient referred to you for a balloon dilation, who are the patients you kind of outright know just are not going to be candidates?

Dr. Kochhar:

I think depends various, various factors. If the length of the stricture is 10 to 12 centimeters, I know endotherapy will not help them. I probably will be putting them through a risk of a procedure, you know, putting them through a risk of perforation and bleeding without much added benefit, so those patients I always have a very frank discussion saying, 'You probably need surgery up front.' There have been certain other instances, and there was actually a study by Cleveland Clinic group that showed that patients with primary strictures tend to do better with upfront surgery compared to patients, you know, let's say with anastomotic or secondary strictures. So I think there is always that case if you have a healthy patient, with a relatively new onset of disease and a stricture and you pushed your medications, you can do endoscopic therapy. You can do balloon dilation, but we also know that, you know, 60 percent of our patients would require surgery next one to three years, so that's again a discussion you want to have with the patient saying, 'Should we do the surgery when your inflammation is under control, or should we keep trying balloon dilation for rest of your life?' I think those are kind of discussions you sometimes have to have with the patients.

Fistula by the stricture again for me is a contraindication, and I think those patients are better served with surgery up front versus us trying a balloon dilation and, you know, trying to make things worse.

So I think these are some of the indications which will from the outset I know that endotherapy would not be of benefit to these patients, and that's a discussion you sometimes have to have with them.

Dr. Nandi:
I think your skill set, and the guidelines reflect to me, that we have a great asset in partnering with advanced endoscopists who specialize in IBD therapeutic interventional endoscopy like yourself, and that's a potentially underutilized talent pool in lieu of surgery that I'd like to have our GI colleagues consider reaching out to their local advanced endoscopists, reaching out to experts like yourself. Before we close, are there any last highlights or last points you want to have people take home?

Dr. Kochhar:
Yes. I think anytime you approach a patient with stricture, my recommendation is please obtain a preprocedure imaging, and if the stricture is less than 3 to 5 centimeters in length, those are your patients that you should consider for endotherapy. If there are anastomotic strictures, if there are secondary strictures, they have a high success or high likelihood of responding to endotherapy, but if the strictures are longer in length, you have a fistula, in those cases I think upfront surgery will help patients much better than us trying the endotherapy. And this is the kind of algorithm that I follow.

The second thing I would like to say here is that please get familiar if you are not already with balloon dilation. It's not a difficult skill set. We are training a lot of people that a lot of programs and courses across the country that, help people with the balloon dilation, because it's very important for IBD physicians to start doing endotherapy on their patients, because the way they understand the disease, the way they understand pathophysiology, sometimes non-IBD physicians cannot, and they have limited understanding of the disease process, and hence I think it'll be much nicer if IBD physicians start routinely doing dilations, routinely doing stricturotomies. I think the endoscopic field and management of IBD is, ripe now for us to help our patients.

Dr. Nandi:
Hundred percent. Couldn't agree with you more.

That's all the time we have today, folks. I want to thank my guest, Dr. Gursimran Kochhar, for sharing his insights.

It was really great speaking with you. Thank you for being on the program.

Dr. Kochhar:
Well, thank you for having me. It was a pleasure and an honor. Thank you so much.

Dr. Nandi:
For ReachMD's IBD Crosstalk, I'm Dr. Neil Nandi. To access this and other episodes in this series, please visit ReachMD.com/GIInsights where you can be Part of the Knowledge. Thanks for listening.