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Navigating Ostomy Decisions in Ulcerative Colitis and Crohn's Disease

Dr. Buch:
This is *GI Insights* on ReachMD. I'm Dr. Peter Buch, and today I'm joined by Dr. Stefan Holubar to discuss ostomies in inflammatory bowel disease, also known as IBD. Dr. Holubar is Director of Research at the IBD Surgery Section at the Cleveland Clinic and is passionate about IBD research, having published over 400 articles to date.

Welcome back to the program, Dr. Holubar.

Dr. Holubar:
Thank you so much, Peter. It's a pleasure to be back. Thank you for having me.

Dr. Buch:
My pleasure. So, Dr. Holubar, let's start out with some background. When should ostomies be utilized in IBD surgery?

Dr. Holubar:
It's a great question. We know that the majority of patients with Crohn's disease—upwards of 90 percent—and at least 30 percent of patients with ulcerative colitis will require colon and rectal surgery at some point during their lifetime, but not all of them will require an ostomy. The role of the ostomy is really to get patients out of sticky situations where they're already behind the eight ball with risk factors such as malnutrition, anemia, and dependence on high-dose corticosteroids.

Dr. Buch:
Thank you. So now let's move on to some specific scenarios. How long should a patient have an ileostomy after an ileal pouch anal anastomosis?

Dr. Holubar:
So, typically, for ulcerative colitis and rarely Crohn's colitis patients who undergo an ileal pouch anal anastomosis, it's most commonly done these days in three stages. So, usually, patients will have the end ileostomy for a minimum of three months, sometimes six months if they're very debilitated and need more time to regain their health. So then three to six months later, we go in, we take out the rectum, we make the pouch, and then we almost always protect that pouch with a temporary loop ileostomy. And then patients have the third stage, which is a loop ileostomy closure, and that's typically done no sooner than three months after the pouch is formed.

Now, importantly, if they have a complication from the pouch, they may have that loop ileostomy for longer. And the questions that really get asked are two. One is, for that third stage, can it be done early? And the SLIRPS study—which is a pretty funny title for the study, but it was short versus long loop ileostomy reversal after pouch—was a multicenter randomized trial in surgery, which is very, very difficult to do, and it was closed early due to an interim analysis that showed that the major complication rate in their early ileostomy enclosure, meaning two weeks after the pouch was made, was unacceptably high, and so, this pretty much put that embargo on very early ileostomy closure after a pouch.

Dr. Buch:
So a follow-up question, Dr. Holubar, which I'm sure a lot of community physicians are concerned about, is what is the leakage rate under these circumstances when we perform in a community setting ileal pouch anal anastomosis?

Dr. Holubar:
Anastomotic leak is really the Achilles heel of this operation. Patients who have an uncomplicated pouch expect to move their bowels on

average seven times per 24 hours without any urgency, bleeding and pain, and when they're having deviations from that expected normal postoperative course, especially within the first year or two after surgery, we often have to think that this might be an occult leak. The pouch is pretty complicated. There's four different staple lines or suture lines, and that's why we almost always protect it with a loop ileostomy. The leak rate is pretty variable in the literature, but in general, it should be somewhere under 10 percent, roughly between five and 10 percent.

Dr. Buch:
And as a follow-up question for me, how can you have a leak without peritoneal findings? What do you have in mind?

Dr. Holubar:
So instead of having to take someone back to the operating room and make an ileostomy to divert the fecal stream so it's not leaking into the peritoneal cavity or the pelvis if you have a leak, it often is occult, and we may not pick it up unless the patient comes back with some subtle fevers or pelvic pain. And sometimes we see leaks after pouches very, very late, like years later, but sometimes this is why we get a Gastrografin water-soluble enema study before we close the loop ileostomy for a pouch patient to make sure there's not an occult leak. And if there's any suspicion of occult leak, we typically get an MRI of the pelvis often with the contrast. In these days I'm doing them using 3D pouchography, which is a manual three-dimensional segmentation that I do myself in-house at Cleveland Clinic.

Dr. Buch:
And moving on, when do patients with ulcerative colitis need a permanent end ileostomy rather than an ileal pouch anal anastomosis?

Dr. Holubar:
That's another really important question, Peter, and I'm going to take it in two parts because there's *When do they need it?* and *When do they want it?* Or *When do they choose it?* And when do they need it, that's really getting to what are the contraindications to having a J pouch. And for some of them age itself is not a contradiction to a pouch. We pouch patients into the 80s. They have to be healthy 80 but with advanced age severe comorbidities, fecal incontinence that we can't otherwise surgically address or improve—these are just some of the many. We came up with a whole table in some of our publications that goes over about 20-plus different relative contraindications to a pouch. Sometimes patients are morbidly obese. They're just too big. They have too much visceral adiposity for us to be able to get in there and make a pouch so sometimes we'll have to start with the subtotal colectomy.

But aside from patient conditions and comorbidity, it's really about what does the patient want? And what we're finding is that patients are so happy after the first step, after they get their sick colon out, because a good ileostomy is better than a bad colon, rectum, anus, or pouch for that matter, and so often patients will be so traumatized from having ulcerative colitis with 20 or 30 bloody, painful, urgent bowel movements a day that they're just so happy to be free of that.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Stefan Holubar about considerations for ostomies in inflammatory bowel disease.

So, Dr. Holubar, let's zero in on patients with Crohn's disease. When do these individuals require an ileostomy rather than an anastomosis?

Dr. Holubar:
Yeah, that's a good question. So the most common operation that we do for intestinal Crohn's disease is an ileocolic resection. We used to call it an ileocecectomy. I technically don't like to use that term because sometimes we have to take a little bit more of the colon for technical reasons. Most of the time, those patients don't need an ileostomy, but very similar to ulcerate colitis, if they're in bad shape clinically with anemia malnutrition, with low albuminemia or they have an acute small bowel obstruction or they have fistulas and abscesses and anemia and smoking, these are the risk factors.

On the other extreme is patients are just way too sick to even have an anastomosis. There's an adage that we say, "The anastomosis that is not made will not leak." Right? So if the patient's albumin is 2.0, they're acutely obstructed and in extremis, and it's emergency and we don't have any room for optimization with things like intravenous iron and exclusive enteral nutrition—which we can often get a patient off parenteral steroids by switching them to exclusive enteral nutrition. And having that mono diet seems to have an anti-inflammatory effect equivalent to steroids, so often they'll come in on steroids, having lost 10 or 15 pounds, and we wean the steroids, switch them to EEN, and then operate a month later without an ileostomy. But if we don't have room to optimize them or time to give them intravenous iron and they have severe anemia, then if they have these really severe risk factors and they're going to have a calculated leak rate over 10 percent, then that's just not safe. And then so we can do a resection and bring out the proximal bowels and end ileostomy, often bringing out the colon stump either as a mucus fistula or implanted in the ostomy site and then they can have an anastomosis once they've regained their health.

There's two other categories of Crohn's. Crohn's obviously is a lot more diverse and complicated than ulcerative colitis. Patients with Crohn's proctocolitis, they may require a total abdominal colectomy, kind of like we spoke about already. And sometimes when we do an ileorectal, we'll want to divert them if there's any risk factors because you really get one good shot to make that anastomosis. And sometimes with Crohn's proctocolitis, there won't be any opportunity to do something like an ileorectal or a pouch, which is very rarely done in Crohn's anyway, and they really need a total proctocolectomy with endo ileostomy.

Finally, the third category is patients with severe perianal Crohn's disease, and the TopCLASS consortium is a worldwide effort that we're part of, and they redesigned the classification of perianal Crohn's disease based on the goals of treatment and what you can reasonably expect to achieve with Class A suffix—meaning you can get rid of the fistula—and Class B—meaning you can just hope to improve their symptoms and improve their quality of life. And so Class C, TopCLASS class 3 is patients who really need an ileostomy, typically loop ileostomy, to improve their quality of life because their bottom is so bad with fistulas and watering-can perineum-type situation. The unfortunate thing for those patients is that although we tell them that it's a temporary loop ileostomy, the literature is very clear. In the multiple studies and systematic review with meta-analysis, the likelihood that the "temporary loop ileostomy" is going to be permanent is going to really be around 80 percent, so only about 20 percent of those get reversed and stay reversed in the long term.

Dr. Buch:
Thank you for that. I want to thank my guest, Dr. Holubar, for answering commonly asked questions on ostomies in patients with inflammatory bowel disease.

Dr. Holubar, it was a pleasure speaking with you today.

Dr. Holubar:
Thank you so much, Peter. It's always a pleasure to share talking about IBD. We could talk about it all night.

Dr. Buch:
We certainly could. For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in our series, visit *GI Insights* on ReachMD.com, where you could Be Part of the Knowledge. Thanks for listening and looking forward to learning with you again very soon.