Transcript Details
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Pouchitis vs. Cuffitis: How Symptoms & Treatment Differ

Dr. Nandi:
You're listening to *GI Insights* on ReachMD. On our last segment, we spoke about the new endoscopic consensus guidelines on pouchitis published by a working group in *The Lancet* this past June of 2021. We featured one of the authors, Dr. Jason Schairer, who is a faculty member at the Henry Ford in the Division of Gastroenterology and Hepatology. He is the co-director of the Inflammatory Bowel Disease Program. Jason, welcome back to the program.

Dr. Schairer:
Thanks, Neil. Again, I'm excited to keep talking about pouches.

Dr. Nandi:
We can't talk enough about it. One of the things that we highlighted or alluded to in the last segment was how to differentiate between cuffitis and pouchitis. It's very challenging for some patients and doctors. How do we make the differentiation, and how does the treatment differ as well?

Dr. Schairer:
That's the problem with cuffitis is really trying to differentiate what is cuffitis, what is pouchitis, and when do patients have both?

If cuffitis is usually just untreated ulcerative colitis, then it's going to have typical ulcerative colitis symptoms. And the defining one is blood in the stool. It's not the only reason a person can have blood in the stool, but it is towards the top, and then urgency tends to be the other issue. So if you've ruled out infections, they're having these symptoms, you do a pouchoscopy, and you see that that last 2 or 3 centimeters is inflamed with relative sparing of the pouch body, cuffitis goes to the top of the list. If the cuff is inflamed, but also the pouch body is inflamed, then it becomes really difficult to decide is this only pouchitis present, is it cuffitis and pouchitis? And when you get to that part, it really does matter, because the treatments vary so differently. You know, bacterial pouchitis relies on antibiotics; cuffitis, we've really come a long way. When I started off, we just said, 'Well give them some topical 5-ASAs, give them a suppository or an enema.' And that was okay. But now that we've understood that this is just ulcerative colitis left behind, I've had patients where I've had to resort to biologics to get this under control.

And so just acknowledging that even though it's a super short distribution that can be you know, 1, 2, or 3 centimeters long, they may require more –effective therapies to attain remission, we have to make sure we offer that appropriately to those patients.

Dr. Nandi:
Absolutely. And that can be all the difference between the frustration of ongoing mesalamine and other suppositories versus starting them on a biological other immunosuppressant to treat cuffitis. Absolutely.

So Jason, there are other complications that can occur directly from the main disease or surgical complications, such as abscess or fistula or stricture. And it's not uncommon to have stricture. How do we treat stricture associated with a pouch? What can we possibly do?

Dr. Schairer:
So this has really changed a lot recently with the invention of interventional IBD. Traditionally, our options included, A, patients can just deal with the stricture. Again, we don't make the options we're just telling you, 'Well, your symptoms aren't that bad, just try to avoid vegetables and things like that.' B, the surgeon can go in and resect the area, but when we're talking about pouches, that's problematic because the pouch usually takes about 40 centimeters of ileum to make. So to resect the whole pouch for a stricture is a huge loss of the bowel. And then the third option was to go in and balloon dilate.

Now recently, we've started doing something where we can do a stricturotomy. And this involves using some of the tools from our advanced friends. And we'll use basically a needle knife or an insulated tip needle knife, and we can go and cut back the stricture. And this is really cool because first off, I can show you pictures, not in this format, but we can show you pictures about how much larger we can make the opening for these patients. It reduces your risk of getting a perforation because again, we're not causing a tear, we're doing a very controlled cut. And then the third benefit is it's more durable that, with the tear, over time right where we cause the trauma to the stricture, it starts to scar down again. Well, that can come back, you know, months later in some patients. But with a stricturotomy, where we resect the stricture itself, I have not had to go back very often. I think I've gone back once or twice in the past couple years to treat something that I had already treated endoscopically.

Dr. Nandi:
Jason, thank you so much. It's really nice to know that apart from serial dilations or just putting up with it or resorting to another proctectomy and diverting ostomy, that we have other options for pouchitis-associated stricture to offer our patients. Your paper is “Endoscopic Evaluation of Surgically-Altered Bowel and Inflammatory Bowel Disease, A Consensus Guideline from the Global Interventional Inflammatory Bowel Disease Group,” and we're going to include a show note link on our website. And I appreciate all the work that you and your colleagues have done to get this good information out.

Dr. Schairer:
Thank you, Neil. This has been a lot of fun and it was great to be here.

Dr. Nandi:
Thanks, Jason. To access the highlighted article and more on Dr. Schairer’s IBD work, please visit the podcast link for show notes. For ReachMD, I'm Dr. Neil Nandi. Please visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening.