The Aging Ileoanal Pouch: Long Term Complications

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Pouch is the best, right?

- Goal: Improve QOL, reduce cancer risk

- Complications are common
  - Pouch failure 8.5% @ 60 months
    - Huelsing et al, Dig Surg, 2005

- Range of etiologies

No disclosures
Delayed presentation of technical complication

- Pouch sinus
- Perianal pain
- Pelvic pressure
- Tailbone pain/osteomyelitis
- P-V or P-C fistula
- Fever
- Weight loss
- Anemia

Pouch sinus: Diagnosis

- Ileo-anal or tip of the "J"
- Pouch-anal/pouch-vagina
  - 5.5%
- Evaluation (Tang, Inflamm Ed)
  - Pouchoscopy
  - Pouchogram
  - EUA
  - MRI

Pouch sinus: Treatment

- Periodic I&D of superficial sinus
- Fibrin glue/plug (Swain et al, DCR, 2004)
  - 5 diverted patients, 2 non diverted; 11 mo f/u

Pouch sinus: Treatment

- Novel approaches: endoscopic knife
Pouch sinus: Treatment

- Usual fistula treatments
- End of the line: re-do or excision
  - Salvage rates 50-100%
  - Function v primary IPAA (Remzi et al. DCR, 2009)
  - More seepage
    - 55% v 34% day
    - 69% v 52% night
  - More pads
    - 49% v 35% day
    - 56% v 43% night
  - Trend towards more urgency

Stricture

- Pre stoma closure = web-like, easily fractured/dilated
- Common locations
  - Anastomosis 5-38%
  - Pouch inlet
  - Ileostomy closure site
- Etiology
  - Ischemia
  - Abscess/fistula
  - Hand sewn
  - NSAID
  - CD

Stricture: Treatment

- Dilation: endoscopic or bougie (non-fibrotic)
- Strictureplasty
- Surgical revision
- Diversion
- Excision

Afferent limb syndrome

Ogawa et al, J Gastrointest Surg, 2012
Afferent limb syndrome

Ogawa et al, J Gastrointest Surg, 2012

Efferent limb syndrome

Wu et al, J Crohns Colitis, 2013

Pouchitis

- 10 year cumulative frequency: 23-46%
- Incidence 40% in 1st year
- CUC, not FAP
- Clinical presentation
  - Frequency, urgency, incontinence, cramping, pelvic discomfort, arthralgia
  - DDx: infectious (Cdiff, candida, CMV, campylobacter), celiac, NSAID, ischemia
Pouchitis: other treatments

- Probiotics (VSL#3)
  - Prophylaxis: 10% treatment vs 40% placebo
  - Gianchetti et al, Gastroenterology, 2003
  - Remission: 15% treatment vs 100% placebo
  - Wischmeyer, Mayo Clin Proc, 1993
- Abx refractory
  - Bismuth carbomer enemas
  - Short-chain fatty acid enemas
  - Glutamine enemas
  - Oral budesonide
  - Mesalamine enemas
  - 6-mercaptopurine or azathioprine, and infliximab

Cuffitis

- Presentation similar to pouchitis + blood
- Mesalamine, steroid suppositories/endoscopic injection
- Topical lidocaine
- If refractory, consider eval for
  - Chronic leak/fistula
  - Crohns
- Can lead to stricture, pouch failure
Crohn's Disease

- 2.7-13% after IPAA
- RF: Fam hx CD, smoking
- Abdominal pain, nausea, weight loss, FTT, fever, fistula
- DDx:
  - pouchitis
  - cuffitis
  - late technical complication,
  - NSAID

Laschner B, Gastroenterol Hepatol, 2008

Laschner B, Gastroenterol Hepatol, 2008
Crohn’s Disease
- Endoscopy, histology, abdominal imaging
- Types
  - inflammatory
  - fibrostenotic
  - fistulizing
- Treatment
  - Smoking cessation, stop NSAID
  - Medical (inflammatory, fistulizing)
  - Surgical/endoscopic (fibrostenotic)

Irritable pouch syndrome
- “Expected” outcomes
  - Mean frequency: 5.2/24hr; 1 overnight
  - Mild FI: 17%
  - Soiling/spotting underwear
  - Urge FI: 7.3%
  - Inability to defer > 15 min
  - Severe FI: 3.7%
  - Regular fecal loss, passive FI
- Diagnosis of exclusion,
  - Visceral hypersensitivity
- Antidiarrheals, antispasmodics, TCA, pain meds

Pouch neoplasia
- Cuff or pouch
- Flat or polypoid
- Risk factors (Das et al, Colorectal Dis, 2007):
  - duration of disease,
  - prior dysplasia/cancer,
  - pancolitis with backwash ileitis
  - chronic pouchitis
  - villous atrophy of pouch/histologic type C mucosa
  - PSC

Risk ratios
- Pre-op cancer, AHR 13.43 (3.96-45.53)
- Pre-op dysplasia, AHR 3.62 (1.59-8.23)

Pouch neoplasia
- Cumulative incidences
  - 0.9% at 5 years
  - 1.3% at 10 years
  - 1.9% at 15 years
  - 2.1% at 20 years
  - 2.7% at 25 years
- Risk ratios
  - Pre-op cancer, AHR 13.43 (3.96-45.53)
  - Pre-op dysplasia, AHR 3.62 (1.59-8.23)

Kariv, Gastroenterology, 2010
Conclusions

- Adverse long term outcomes are common
- Management is challenging
- Full informed consent before surgery is essential...and probably rare!