OPINION

Pouch dysfunction: don't forget the surgeons!

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We read the article 'Pouchitis: a practical guide'¹ with great interest, and support the authors' efforts to simplify the management of patients with ileal pouch dysfunction. In particular, we agree that a diagnosis of pouchitis must not be presumptive, but should be made based on clinical, histological and endoscopic findings, and that pouch complications are best defined as a deviation from normal pouch function. Although their well considered algorithm is comprehensive from a gastroenterologist's perspective, Steinhart and Ben-Bassat¹ have rather skated over crucial elements that inform a surgeon's practice. Although pouchitis is the most common long-term complication of ileal pouch–anal anastomosis (IPAA), there are several 'surgical' entities that have similar presenting symptoms and signs, such as pelvic sepsis, fistulae, abscesses, strictures, sinuses and cuffitis. The timely diagnosis and treatment of these complications (including surgical intervention) ought to be seamlessly integrated to any pathway designed to manage pouch dysfunction.

Sepsis is the most significant post-operative complication leading to pouch failure.² From their prospective series at the Mayo Clinic, Farouk *et al*³ found that 4.8% of 1508 patients developed post-operative sepsis, of which 63% required further local or abdominal salvage surgery. From their series of over 200 patients in Oregon, USA, Hoda *et al*⁴ showed that patients who had already had anastomotic complications following surgery were more likely to develop chronic pouchitis in the future, and would probably benefit from earlier strategies to prevent this. Therefore an early, clear diagnosis and management plan following pelvic sepsis is crucial to prevent longer-term pouch failure. Cuffitis (inflammation of the residual cuff of rectal mucosa) may also be confused with pouchitis, and may require surgical intervention; however, in their recent study from Beijing,

Wu *et al*⁵ found that nearly one quarter of those patients with cuffitis unresponsive to medical therapy had surgical complications such as fistulae and sinuses. Pouch strictures may present with vague pouchitis-like symptoms such as abdominal cramps, watery stools, straining, urgency, and a sensation of incomplete evacuation,⁶ but it is unlikely that antibiotics would be of any therapeutic use. Instead, either self-dilatation or dilatation under general anaesthesia may be more appropriate.⁷ Small bowel obstruction may occur in up to 23% of patients undergoing IPAA.⁸ Although this can often be managed conservatively, up to 25% may require an operation.⁹ Re-operative surgery and conversion to permanent ileostomy after pouch failure may sometimes be necessary to improve quality of life.¹⁰

Radiological modalities and intervention are also of importance in managing the surgical complications that lead to pouch dysfunction. Some examples are CT-guided drainage of sepsis, pelvic MRI and water-soluble pouchograms to delineate the anatomical shape of a pouch in order to demonstrate structural abnormalities such as strictures, sinuses or fistulae.¹¹ We would favour a management algorithm incorporating such diagnostic tests. If re-operative management is to be planned, important decisions need to be made regarding the type and approach of surgery. For example, local repair for fistulae may be preferable to abdominal surgery when conditions are favourable.¹² There are also different options for surgery after pouch failure—re-do pouch surgery for salvage, complete pouch excision, or defunctioning loop ileostomy; this surgery should be concentrated in the hands of a few surgeons at specialist centres.¹³

Earlier this year, Francone and Champagne¹² neatly summarised the diagnosis and management of the early and

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late complications of IPAA from a surgical perspective, but did not integrate medical management of pouchitis in great detail. It is clear that there are specific surgical and medical pathways for the management of pouch dysfunction. However, rather than have one algorithm for surgeons and one for physicians, we support the development of joint speciality clinics working to facilitate a pan-speciality pathway for the management of pouch complications. This may enhance the care of patients following IPAA by using a multidisciplinary approach, a model well recognised as superior for patients whose care involves multiple specialists.

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REFERENCES

- 1 Steinhart AH, Ben-Bassat O. Pouchitis: a practical guide. *Frontline Gastroenterol* 2013;4:198–204.
- 2 Gorgun E, Remzi F. Complications of ileoanal pouches. *Colon Rectal Surg* 2004;17:43–55.
- 3 Farouk R, Dozois RR, Pemberton JH, *et al.* Incidence and subsequent impact of pelvic abscess after ileal pouch–anal anastomosis for chronic ulcerative colitis. *Dis Colon Rectum* 1998;41:1239–43.
- 4 Hoda KM, Collins JF, Knigge KL, *et al.* Predictors of pouchitis after ileal pouch–anal anastomosis: a retrospective review. *Dis Colon Rectum* 2008;51:554–60.
- 5 Wu B, Lian L, Li Y, *et al.* Clinical course of cuffitis in ulcerative colitis patients with restorative proctocolectomy and ileal pouch–anal anastomoses. *Inflamm Bowel Dis* 2013;19:404–10.
- 6 Fleshman JW, Cohen Z, McLeod RS, *et al.* The ileal reservoir and ileoanal anastomosis procedure. Factors affecting technical and functional outcome. *Dis Colon Rectum* 1998;31:10–16.
- 7 Prudhomme M, Dozois RR, Godlewski G, *et al.* Anal canal strictures after ileal pouch–anal anastomosis. *Dis Colon Rectum* 2003;46:20–3.
- 8 MacLean AR, Cohen Z, MacRae HM, *et al.* Risk of small bowel obstruction after the ileal pouch–anal anastomosis. *Ann Surg* 2002;235:200–6.
- 9 Fazio VW, Ziv Y, Church JM, *et al.* Ileal pouch–anal anastomosis complications and function in 1005 patients. *Ann Surg* 1995;222:120–7.
- 10 Lichtenstein GR, Cohen R, Yamashita B, *et al.* Quality of life after proctocolectomy with ileoanal anastomosis for patients with ulcerative colitis. *J Clin Gastroenterol* 2006;40:669–77.
- 11 Shen B. Pouchitis: what every gastroenterologist needs to know. *Clin Gastroenterol Hepatol*. Published Online First: 16 Apr 2013. doi:10.1016/j.cgh.2013.03.033
- 12 Francone TD, Champagne B. Considerations and complications in patients undergoing ileal pouch anal anastomosis. *Surg Clin North Am* 2013;93:107–43.
- 13 Shawki S, Belizon A, Person B, *et al.* What are the outcomes of reoperative restorative proctocolectomy and ileal pouch–anal anastomosis surgery? *Dis Colon Rectum* 2009;52:884–90.