IX IGIBD the Italian Group for the study of Inflammatory Bowel Disease

Where tradition meets innovation

FACE TO FACE

Optimal timing for surgery: a multidisciplinary approach!!!

Gastroenterological point of view

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Look at the Time and not at the clock

Statement 4

Patients with severe active UC of any extent should be admitted to hospital for intensive treatment [LE: 5; GR: D]. Patients are best cared for jointly by a gastroenterologist and a surgeon, who should assess the possibility of surgery at admission and daily thereafter [LE: 5; GR: D].

2.1.2.1. ECCO statement 1B

Patients are best cared for jointly by a gastroenterologist and colorectal surgeon from admission (EL5) Symptoms, physical examination and signs of systemic toxicity should be closely monitored. Any clinical deterioration should prompt consideration of an emergent colectomy

Gionchetti P et al, Dig Liver Dis. 2017;49:604-617; Oresland T et al, JCC 2015;9:4-25.

Surgery in UC

- Emergency surgery
- Elective surgery

Emergency surgery in ulcerative colitis

Indications

Refractory severe acute ulcerative colitis (75%)

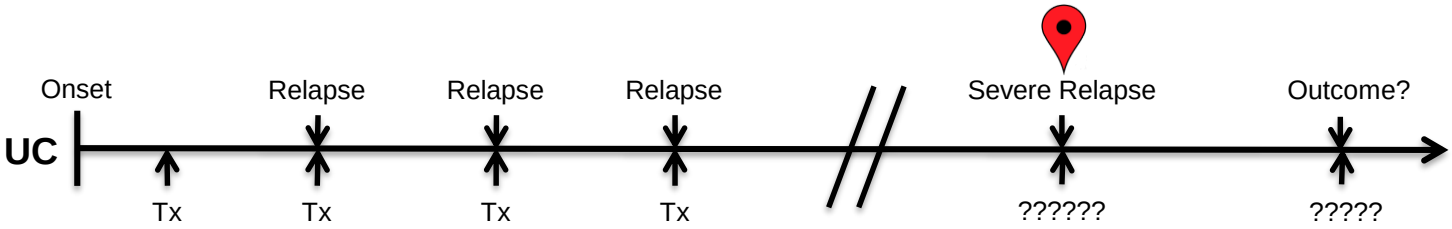
Toxic megacolon (15%)

Perforation (<10%)

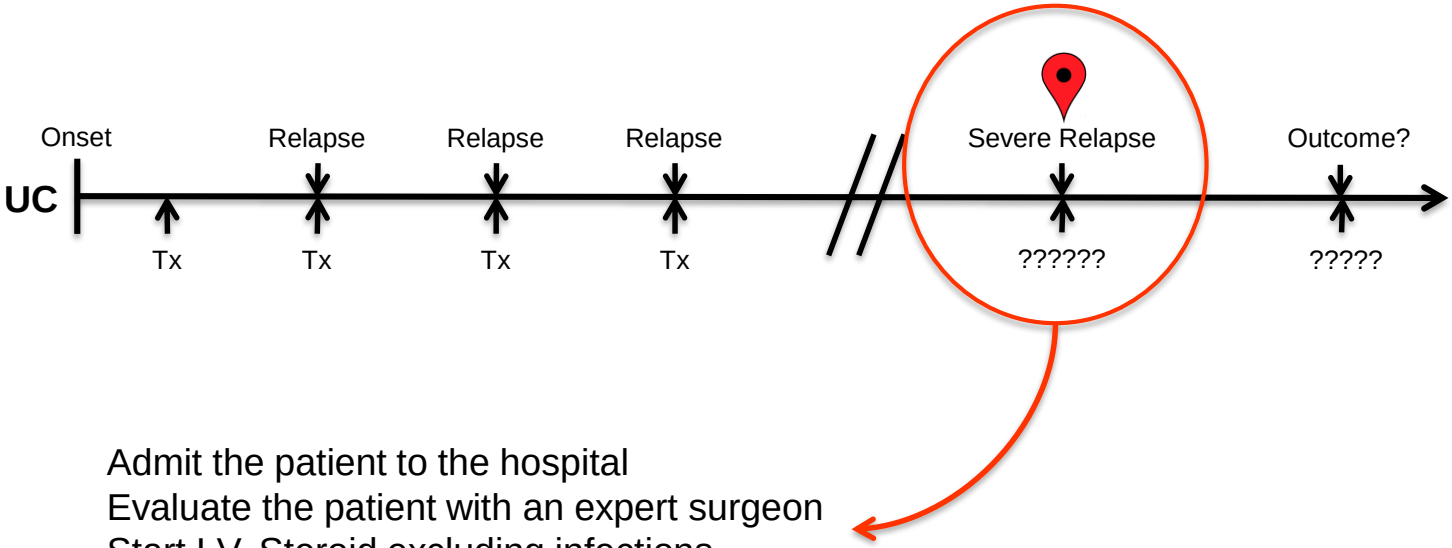
- spontaneous
- iatrogenic

Massive lower GI bleeding (<5%)

Correct time of Surgery in Acute Severe Ulcerative Colitis



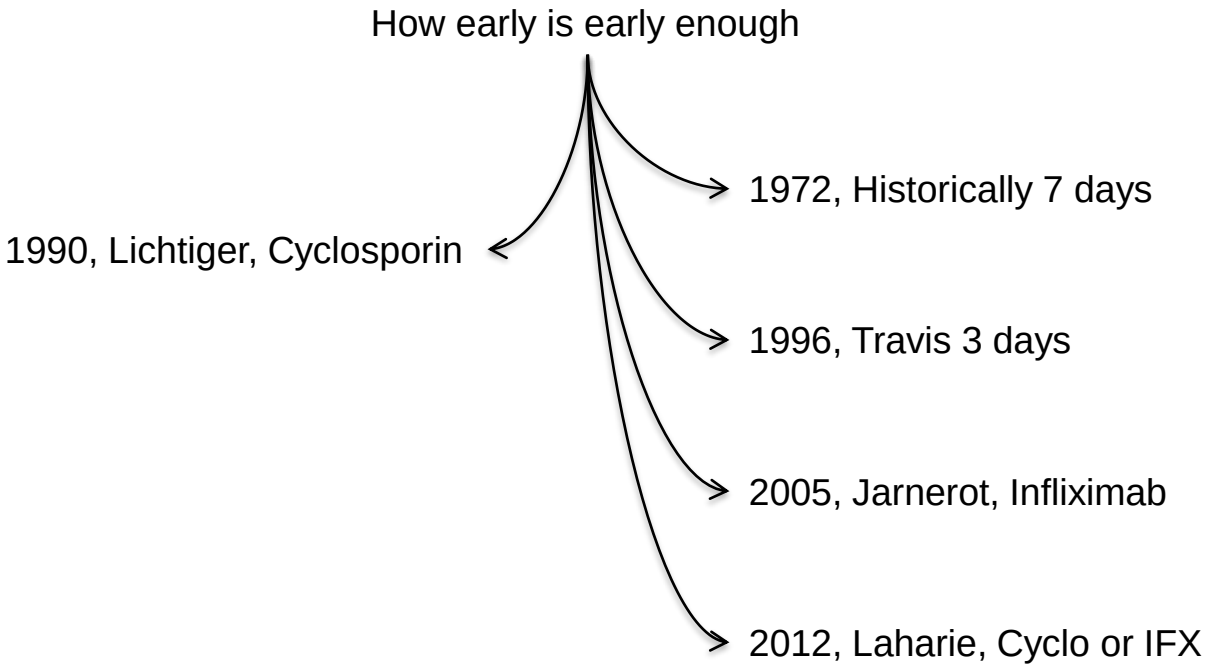
Correct time of Surgery in Acute Severe Ulcerative Colitis



Admit the patient to the hospital
Evaluate the patient with an expert surgeon
Start I.V. Steroid excluding infections
Careful follow-up for 3 days

Gionchetti P et al, Dig Liver Dis. 2017;49:604-617; Oresland T et al, JCC 2015;9:4-25.

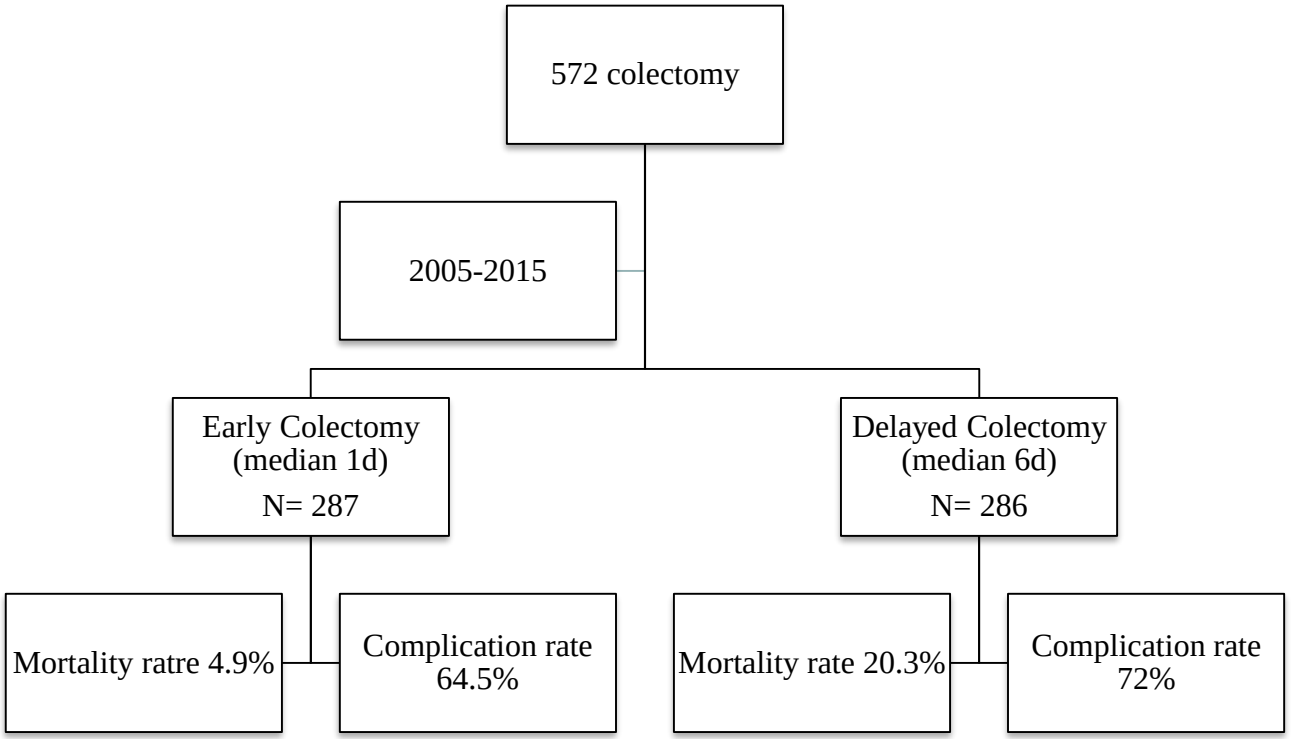
Correct Time of Surgery in Acute Severe Ulcerative Colitis



Third-line rescue therapy only in selected patients and in tertiary centers

Patel SS, Am J Surg 2013;205:333-337 – Coakley BA, Surgery 2013;153:242-248 – Randall J, Br J Surg 2010;97:404-409 – Leeds IL, J Gastrointest Surg 2017;21:1675-1682

Correct time of Surgery in Acute Severe Ulcerative Colitis



Multivariable logistic regression with propensity weighting of mortality: 82% decrease of odds of death in the early group

Leeds IL et al, Dis Colon Rectum. 2018 Nov 15. doi: 10.1097/DCR.0000000000001276. [Epub ahead of print]

Factors that influence my decision:

- Age
- Comorbidity
- Disease behaviour
- Previous treatment failures
- Ongoing treatment
- Thrombosis or heparin use in massive bleeding
- Sofa criteria for sepsis
- Malnutrition

Surgery in UC

- Not so Urgent
- Not Elective

Correct time of Surgery in Acute Severe Ulcerative Colitis

Pseudo-refractory patients:

- Chronically active despite:
- Over-optimized treatment
- Refractory steroid-dependency

Risks:

- Malnutrition and anemia
- Thrombosis or embolism
- Infections (mainly in steroid-abuse)

Surgery in UC

- Emergency surgery

- Elective surgery

Correct time of elective Surgery in Ulcerative Colitis

Patients at cancer-risk:

Long-term and chronically mild active

with Sclerosing Cholangitis
Impossibile to made an adeguate screening

Dysplasia

When surgery in CD?

Failure of medical treatment

… is hard to define

- Persistence or worsening of symptoms despite correct treatment
- Onset of unacceptable drug-related complications without other efficacious medical alternative
- Steroid-dependence
- Onset of complications associated to the disease that compromise pt's QoL

GOAL OF PHARMACOLOGICAL TREATMENT IS NOT TO AVOID SURGERY BUT RATHER TO IMPROVE QOL. IF THE LATTER CANNOT BE ACHIEVED THEN SURGERY WILL HAVE TO BE CONSIDERED AS THE NEXT STEP IN TREATMENT

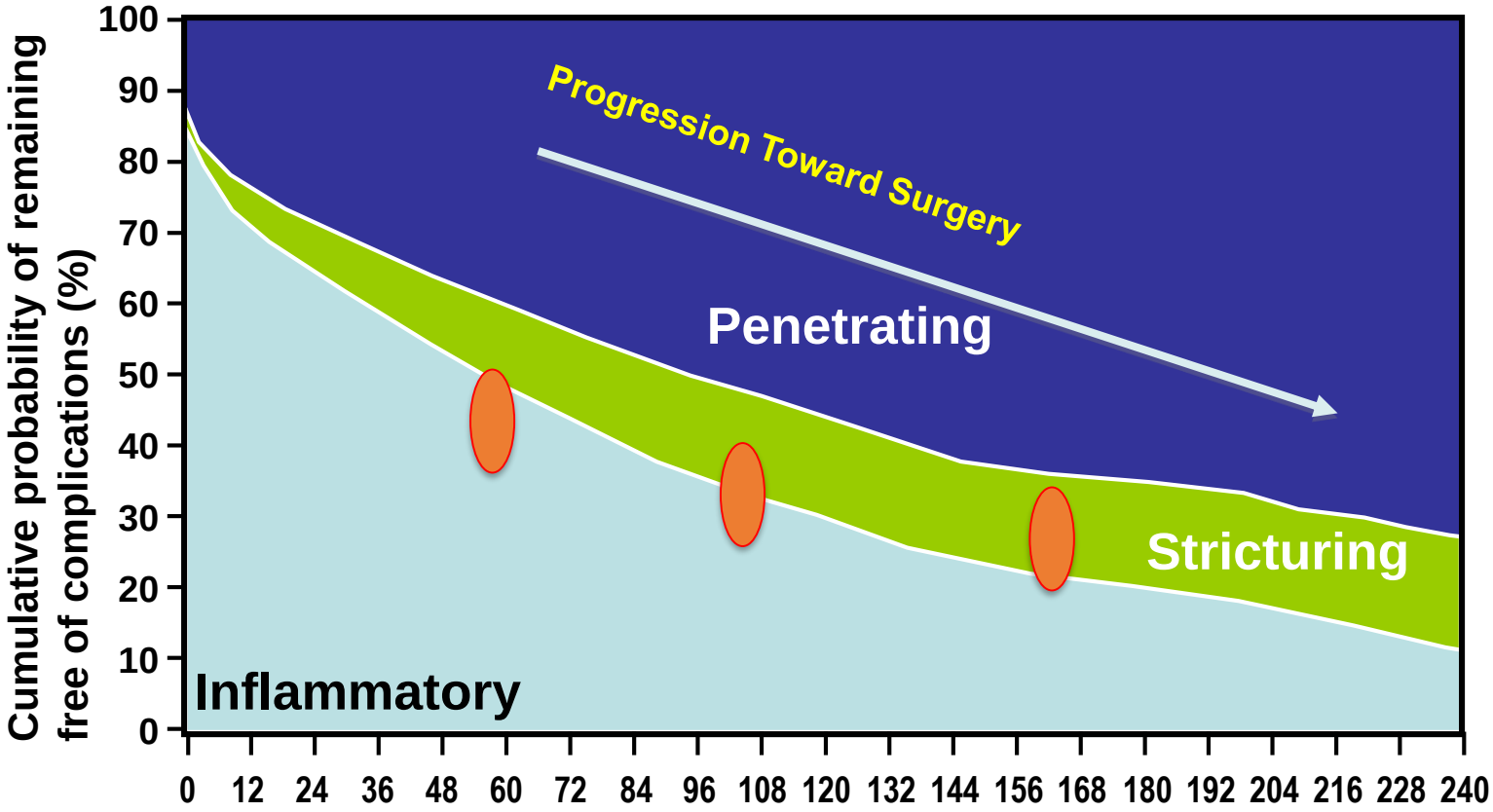
When surgery in CD?

Specific complications related to disease

Intestinal obstruction

Most frequent indications for surgery (25% of pts operated)

Symptomatic stenosis ad evolution of Crohn's disease behaviour



Cosnes J, et al. Inflamm Bowel Dis 2002;8:244–50

Small bowel obstruction

Factors that influence my decision:

Age

Comorbidity

Previous treatment failures

Ongoing treatment

Diet with fiber and nutritional status

CRP (be careful)
- Mild elevation > fibrosis
- Moderate elevation > OK
- Severe elevation > sepsis

Sepsis

PAIN
- No pain
- Chronic mild pain
- Moderate to severe pain

Physical examination
- Mass
- Tenderness

Imaging
- abscesses/phlegmon
- dilatation

Response to antibiotic
Response to iv steroids

The second European evidence-based consensus on the diagnosis and management of Crohn's disease: Current management

A. Dignass*,[1], G. Van Assche*,[1], J.O. Lindsay, M. Lémann, J. Söderholm, J.F. Colombel, S. Danese, A. D'Hoore, M. Gassull, F. Gomollón, D.W. Hommes, P. Michetti, C. O'Morain, T. Öresland, A. Windsor, E.F. Stange, S.P.L. Travis for the European Crohn's and Colitis Organisation (ECCO)

ECCO

JCC 2010

ECCO Statement 7A

Localised ileocaecal Crohn's disease with obstructive symptoms, but no significant evidence of active inflammation, should be treated by surgery [EL2b, RG C].

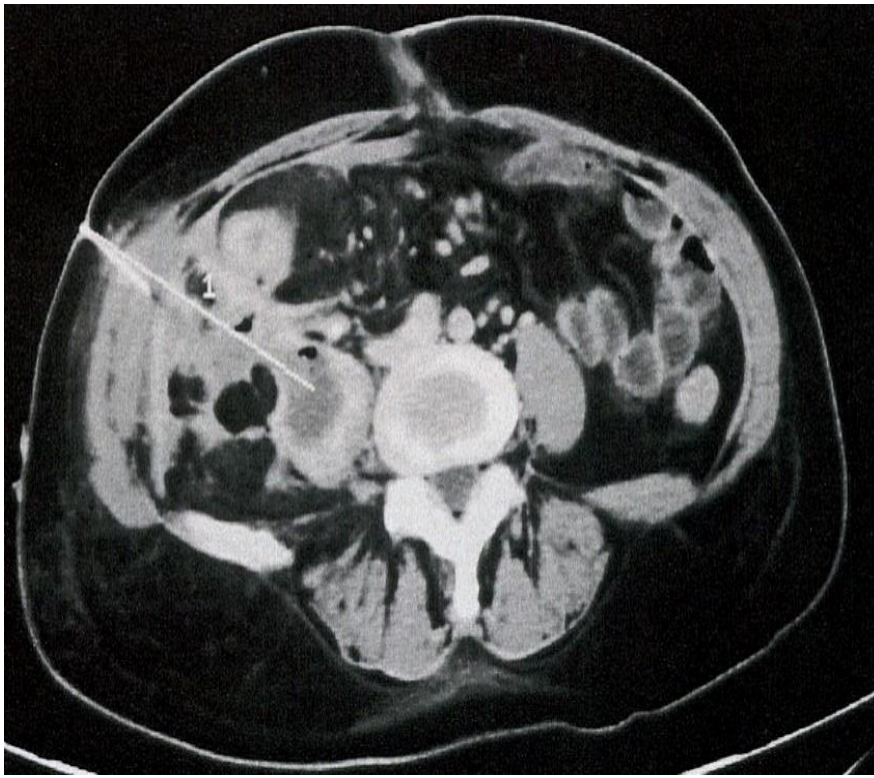
Risk of evolution into more complicated disease !!!

When surgery?

Specific complications related to disease

Abdominal Sepsis

- Treat sepsis (SOFA criteria) (remember heparin)
- **CT percutaneous drainage in case of abscess and if possibile**
- If even despite drainage, septic status shows no improvement, urgent surgery should be performed
- Then SURGERY SURGERY SURGERY



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ECCO

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ECCO Statement 7B

Active small bowel Crohn's disease with a concomitant abdominal abscess should preferably be managed with antibiotics, percutaneous or surgical drainage followed by delayed resection if necessary [EL3, RG C].

When surgery?

Specific complications related to disease

Abdominal fistulae

Internal fistulae *per se* are not an indication for surgery. (except in case of “by-pass like “effect)

Fistulae with target organ: vagina, bladder, ureter ➡ surgery

External fistula ➡ surgery (no spontaneous closure)

External fistula after surgery is not disease-related!

Take Home Messages

Look at the Time and not at the clock