The Evaluation of Postoperative Patients with Ulcerative Colitis

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KEYWORDS

• Crohn's disease • Endoscopy • Ileal pouch • Pouchitis • Pouchoscopy
• Restorative proctocolectomy • Ulcerative colitis • Ileoscopy

KEY POINTS

- Restorative proctocolectomy with ileal pouch-anal anastomosis has become the standard surgical treatment modality for patients with ulcerative colitis or familial adenomatous polyposis who require colectomy.
- Normally staged pouch surgery is performed. The classic 2-stage restorative proctocolectomy involves (1) total proctocolectomy, the creation of a J or S pouch with anastomosis to a short rectal stump, and loop ileostomy and (2) closure of loop ileostomy.
- In patients with severe colitis and strong immunosuppression, a 3-stage surgery is advocated, which consists of (1) subtotal colectomy and end ileostomy; (2) ileal pouch construction and anastomosis, loop ileostomy; and (3) closure of the loop ileostomy.
- Endoscopy plays an important role in postoperative monitoring of disease status and delivery of therapy, if necessary.
- Ileal pouch surgery significantly alters bowel anatomy, with new organ structures being created.
- Endoscopy of the altered bowel includes the evaluation of end ileostomy, Hartmann pouch or diverted rectum, loop ileostomy, diverted pouch, and pouchoscopy.
- Each segment of the bowel has unique landmarks. It is important for endoscopists to be familiar with those landmarks and recognize the status of healthy and diseased.

INTRODUCTION

The last 2 decades have witnessed a great progress in medical therapy for inflammatory bowel disease (IBD), including Crohn's disease (CD) and ulcerative colitis (UC). The availability and wide use of anti–tumor necrosis factor (TNF) and anti-integrin biological agents have revolutionized the management of IBD. However,

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approximately 20% to 30% of patients with UC will eventually need colectomy for medically refractory disease or colitis-associated neoplasia. Restorative proctocolectomy (RTC) with ileal pouch-anal anastomosis (IPAA) is the surgical treatment of choice for patients with UC who require colectomy. RTC and IPAA are technically challenging procedures with a risk for the development of various forms of complications. In addition, inflammatory and even neoplastic conditions can develop after colectomy. In most patients, their underlying IBD is still not considered as being cured after RPC and IPAA.

One-stage RPC and IPAA are rarely offered to patients. The standard 2-stage RPC involves (1) total proctocolectomy (TPC), the creation of a J or S pouch with anastomosis to rectal stump, and loop ileostomy (LI) and (2) closure of LI. In patients with severe colitis and strong immunosuppression, a 3-stage surgery is advocated, which consists of (1) subtotal colectomy (STC) leaving a diverted rectum, also named Hartmann pouch, and end ileostomy (EI); (2) ileal pouch construction and anastomosis and LI; and (3) closure of LI. The staged procedures create de novo anatomic structures, including Hartmann pouch, EI, LI, diverted pouch, and connected pouch. Various disease conditions can occur in those segments of the bowel. Anatomic classification of surgery-altered bowel in UC is listed in **Table 1**.

Proctoscopy for Hartmann Pouch

In patients with severe or fulminant colitis, STC, rather than TPC, should be performed. With the extensive immunosuppressive agents, such as corticosteroids[1] and anti-TNF agents, there have been concerns for the increased risk for postoperative infectious complications.[2,3] The first of the 3-stage RPC and IPAA involves STC, EI, and Hartmann pouch reduce the risk for postoperative infectious complications. The length of a Hartmann pouch can be 10 to 25 cm, depending on the degree of the concern of stump leak. For patients with severe colitis and a significant concern of stump leak, surgeons temporarily leave a long rectal stump, which is connected to the abdominal fascia, to reduce the risk for intrapelvic abscess in case stump leaks.

Diversion proctitis can develop, largely because of the lack of nutrients from luminal bacteria to the rectal mucosa. Patients may present with pelvic discomfort and pain, urgency, and mucous or bloody discharge. On endoscopy, there can be extremely friable mucosa, even with minimum air insufflation, edema, erythema, ulcers,

Table 1
Bowel anatomy after colectomy for ulcerative colitis

Name	Configuration	Duration of Creation	Purpose of Creation
Ileostomy	End ileostomy	Temporary	Primary (for setting stage for subsequent pouch surgery)
		Permanent	Primary (for those with colectomy without intention for having an ileal pouch)
			Secondary (due to failed pouch)
	Loop ileostomy	Temporary	Setup for subsequent initial pouch construction or pouch revision surgery
Pouch	Hartmann pouch	Temporary	Equivalent to diverted rectum
	Diverted pouch		Primary (set-up stage for initial construction or pouch revision)
		Permanent	Secondary (due to pouch failure with permanent fecal diversion)
	Connected pouch	Permanent	Functioned pouch

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