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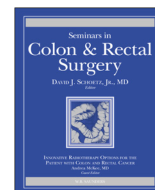

Reoperative transabdominal surgery for ileoanal pouch salvage

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A B S T R A C T

Restorative proctocolectomy with ileal pouch-anal anastomosis (RP/IPAA) is performed for surgical management of ulcerative colitis (UC) familial adenomatous polyposis (FAP), indeterminate colitis, and an extremely selected subset of patients with Crohn's disease (CD). Around one-tenth of ileoanal pouches fail in long term due to septic, mechanic, functional, or biologic complications. Transanal, transabdominal, or combined approaches are safe and feasible to salvage ileoanal pouch. This article focuses on reoperative transabdominal surgery for ileoanal pouch salvage. Transabdominal redo IPAA surgery is technically complex and a patient-driven procedure. The success of transabdominal redo IPAA surgery is highly correlated with patient's motivation, physician's experience, institutional infrastructure, and caseload.
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Introduction

Restorative proctocolectomy with ileal pouch-anal anastomosis (RP/IPAA) is performed for surgical management of ulcerative colitis (UC) familial adenomatous polyposis (FAP), indeterminate colitis, and an extremely selected subset of patients with Crohn's disease (CD). While a J-pouch with stapled IPAA is preferred technique in general (Fig. 1), a S-pouch can be created to achieve a tension free anastomosis in difficult cases (Fig. 2). Hand-sewn anastomosis is only preferred when a low-lying rectal dysplasia or cancer is present, unless there is a technical necessity at the time of index ileoanal pouch surgery. Patients undergoing a stapled IPAA have better outcomes and quality of life (QOL) compared to those undergoing a hand-sewn IPAA.[1] Ileoanal pouch failure was defined as a condition where the pouch was permanently diverted, revised, or excised.[2] Around one-tenth of ileoanal pouches fail in long term due to septic, mechanic, functional, or biologic complications. [3–7] Primary diagnosis (i.e., Crohn's disease), development of anal pathology, anal sphincter dysfunction, patient comorbidities (i.e. weight gain), pelvic sepsis, anastomotic stricture, and separation were found as predictors of pouch failure.[8,9]

Pouch failure is a big tragedy for some patients and they want to push the limits to salvage ileoanal pouch to avoid a permanent ileostomy. Surgical revision of the failed ileoanal pouch is the only option to salvage IPAA and maintain intestinal continuity. Salvage of the ileoanal pouch is a complex and technically demanding operation. All over the world, limited number of institutions have adequate experience, infrastructure, and case volume on redo IPAA surgery.[5,10]

Current status of redo IPAA surgery

Ileoanal J-pouch with stapled anastomosis is the gold standard technique to restore intestinal continuity and one of the most important improvements in the field of colorectal surgery in last three decades. RP/IPAA has prevented many patients to have a permanent ileostomy by providing acceptable functional and QOL outcomes, minimizing medication requirement, and reducing risk of neoplasia associated with chronic colitis and polyposis syndromes. There are certain factors causing failure and malfunction of IPAA after index ileoanal pouch creation. Leak/fistula (Fig. 3), pouch vaginal fistula, obstruction (Figs. 4 and 5), dysfunction, pelvic/perianal abscess, pouchitis, prolapsed, and neoplasia are the common operative indications for redo IPAA surgery. Our group recently published the largest series on transabdominal redo IPAA and showed that failed ileoanal pouches can be repaired or reconstructed with acceptable outcomes.[11] Since the initial applications of RP/IPAA represented good outcomes at specialized centers,[3,10] use of the technique spread quickly and number of patients having an ileoanal pouch surgery increased

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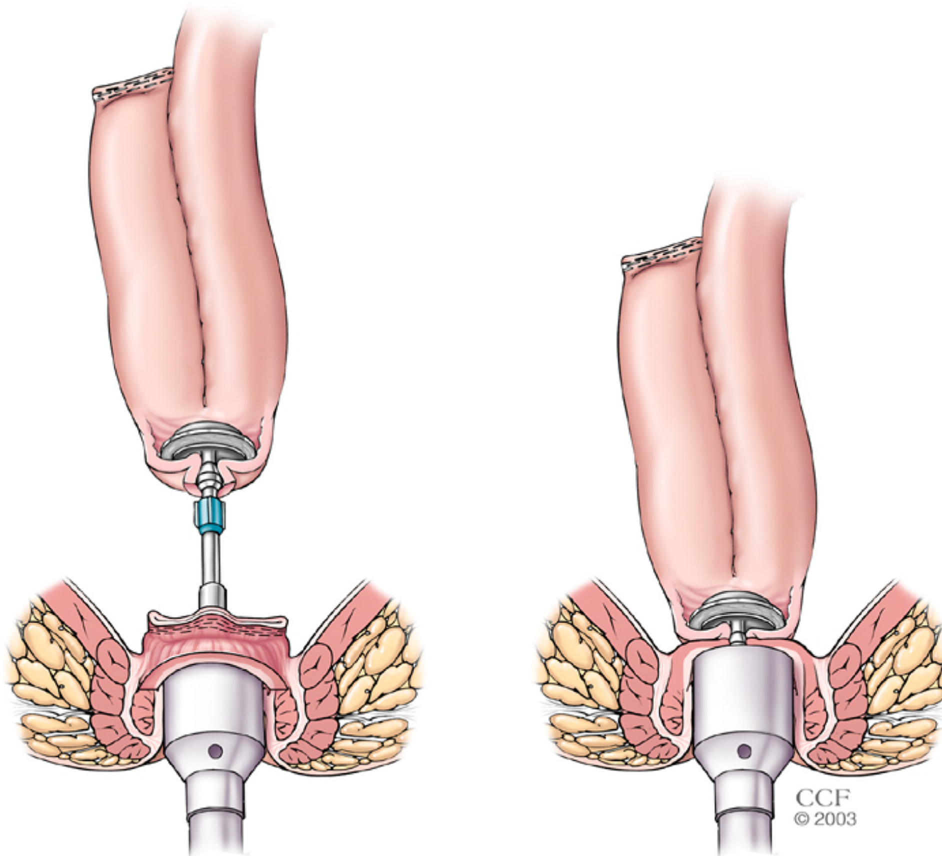

Fig. 1. J-pouch with a stapled ileal pouch-anal anastomosis. Reprinted with permission, Cleveland Clinic Center for Medical Art & Photography © 2015. All Rights Reserved.

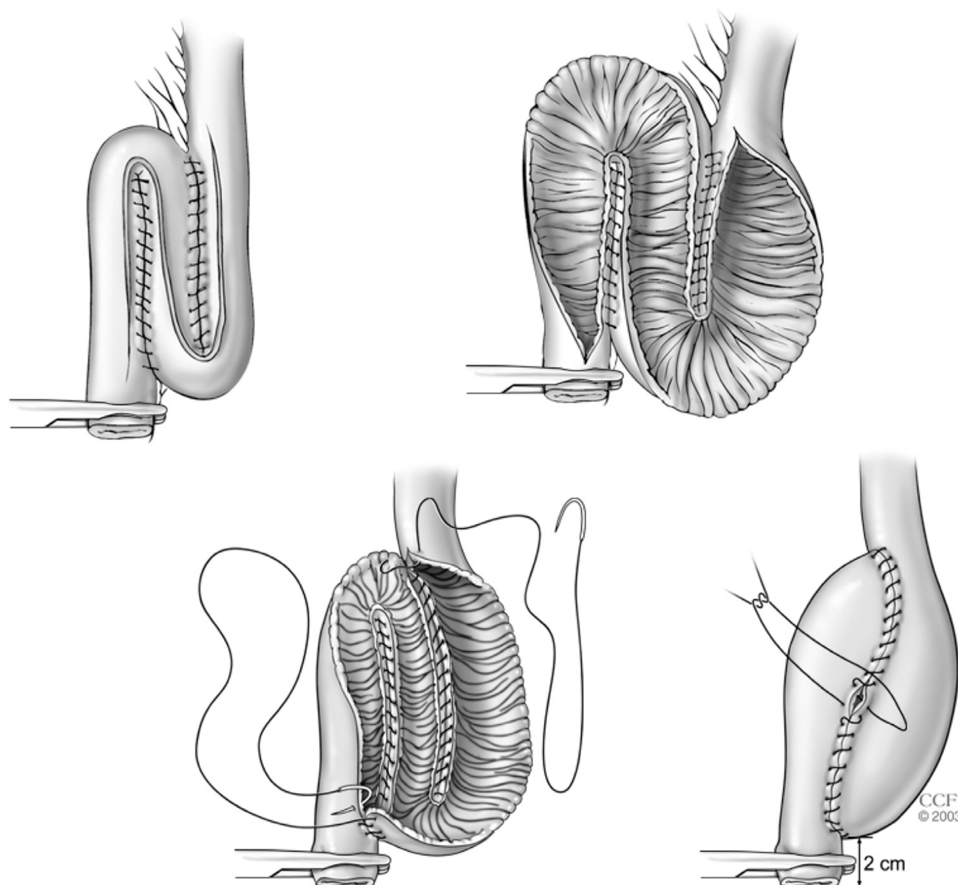

Fig. 2. Construction of an S-pouch. Reprinted with permission, Cleveland Clinic Center for Medical Art & Photography © 2015. All Rights Reserved.

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