International Journal of Surgery 12 (2014) S56–S59

Contents lists available at ScienceDirect

International Journal of Surgery

journal homepage: www.journal-surgery.net

Original research

Restorative proctocolectomy with ileal pouch-anal anastomosis is safe and effective in selected very elderly patients suffering from ulcerative colitis

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ARTICLE INFO

Article history:
Received 15 May 2014
Accepted 15 June 2014
Available online 23 August 2014

Keywords:
Restorative proctocolectomy
Elderly
Pouch
Ulcerative colitis
Function

ABSTRACT

Restorative proctocolectomy (RP) with ileal pouch-anal anastomosis is the mainstay treatment for intractable or refractory ulcerative colitis (UC). Safety and effectiveness of RP in elderly patients are debated. Our aim was to compare surgical outcomes and function of patients undergoing RP over 80-year-of-age with those of younger controls.

We retrospectively gathered data of patients receiving RP for UC aged >80 years between January 1990 and December 2012. A control group of younger patients was established for comparison (1:3 ratio). Functional outcomes and satisfaction with surgery 6 and 12 months after ileostomy closure were collected.

Ten patients >80-year-old were included (median age 87.5, range 84–90 years). All patients had at least one comorbidity (mean 2.1 ± 1) and were receiving medications for concomitant diseases. Half of them received a 3-stage procedure. Neither death nor major perioperative complications were observed. One patient (10%) required readmission for dehydration 2 weeks after RP with loop-ileostomy. Thirty younger patients (median age 34.3, range 25–52 years) served as controls. All patients had their ileostomy closed within 3 months from RP. At 6 month follow-up, elderly patients had more nocturnal seepage, antidiarrhoeals intake, and a trend toward more frequent day-time incontinence. At 12-month follow-up differences were less apparent. Only nocturnal seepage was higher in elderly. All patients retained their pouch and would have undergone surgery again. RP is feasible in selected advanced age patients, and functional results are comparable to younger patients.

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1. Introduction

Complicated or refractory ulcerative colitis (UC) is best treated by restorative proctocolectomy (RP) [1–4]. The procedure entails removal of the entire colon and rectum, fashioning of an ileal pouch and ileal pouch-anal anastomosis. Surgery can be performed in several stages or as a single procedure [1–4], it is effective in abolishing the risk of cancer [5], and confers optimal bowel control and quality of life [1–3,6,7]. Since inflammatory bowel diseases (IBD) can affect people at any age, researchers have sought for differences in the outcomes of RP at different ages, and found that the procedure is feasible in very young patients as well as in older subjects [2,3]. However, little is known about the results of RP in the very elderly UC population, despite the recent surgical advancements have shown that age is not a limit for major surgery [8–19].

The aim of our study was to compare safety, surgical outcomes and function of patients undergoing RP over 80-year-of-age compared with younger controls.

2. Material and methods

We interrogated our prospectively maintained database for data of patients receiving RP for UC over 80-year-of-age between January 1990 and December 2012 at our Unit. A control group of

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http://dx.doi.org/10.1016/j.ijsu.2014.08.380
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List of abbreviations

ASA	American Society of Anaesthesiologists score
BMI	body mass index
IBD	inflammatory bowel diseases
RP	restorative proctocolectomy
SD	standard deviation
UC	ulcerative colitis

matched younger patients was established for comparison, with 1:3 ratio.

2.1. Surgery

It is our practice to avoid RP with stoma omission in the very elderly [4], and to perform surgery with open approach to reduce operative time. Hence, control group only included patients receiving open RP with temporary faecal diversion.

Surgery was performed in 2 or 3 stages according to patient health status. Patients aged over 80 years were not routinely investigated with anorectal manometry, but they were evaluated for RP only provided no clinical disturbance of continence was observed. Patients had to be well motivated and able to understand the procedure.

At the time of loop-ileostomy closure, patients were evaluated clinically and with flexible pouchoscopy, while a pouchography was advocated in selected cases [20], as well as further imaging modalities [21].

2.2. Data of interest and follow-up

The following variables were considered: demographic, American Society of Anaesthesiologists (ASA) score, body mass index (BMI), concomitant medical treatment, perioperative complications, rate of pouch retention, functional outcomes and satisfaction with surgery.

All patients are followed-up periodically after RP at our Centre. We gathered data on function at 6 and 12-month follow-up after loop-ileostomy takedown. At the latter follow-up we are used to assess patient satisfaction with surgery. Pouch retention was assessed at last available follow-up.

2.3. Statistical analysis

Results are expressed as median with range or mean $\pm$ standard deviation (SD). Categorical data were compared using 2-tailed Fisher's exact test or Chi-squared test; continuous variables were compared using Mann–Whitney test. $P < 0.05$ was considered statistically significant.

3. Results

Data of ten patients >80-year-old were available, and allowed patient inclusion. Median age was 87.5 (range 84–90) years. Patients had at least one comorbidity (mean 2.1 ± 1), which required all patients to receiving medications for concomitant diseases.

Concerning the type of surgery performed, five patients received a 3-stage procedure (50%). Neither death nor major perioperative complications were observed. One patient (10%) required readmission for dehydration 2 weeks after RP with loop-ileostomy.

Thirty younger patients, median age 34.3 (range 25–52) years served as controls for complication comparison and functional evaluation. Fifteen patients received a subtotal colectomy before RP (3-stage procedure). Patients over 80-years-of-age received significantly more medications and had more comorbidities at the time of RP (10/10 vs 2/30, $p < 0.001$).

All patients had their ileostomy closed within 3 months from RP. Major perioperative complications did not significantly differ between groups (0/10 vs 1/30, >80 vs <80, $p > 0.99$).

At 6-month follow-up, elderly patients had more nocturnal seepage (5/10 vs 4/30, >80 vs <80, $p = 0.03$), used more frequently antidiarrheal medications (7/10 vs 7/30, $p = 0.02$), and showed a trend toward more frequent day-time incontinence (3/10 vs 4/30, $p = 0.33$).

One year after RP, differences were less apparent. Only nocturnal seepage was higher in the elderly (6/10 vs 5/30, $p = 0.02$). No cases of urgency were observed.

All patients retained their pouch at a median follow-up of 7 (range 2–13) years.

All patients would have undergone surgery again and would have recommended RP to other patients.

4. Discussion

Our data show that RP is feasible in selected very elderly UC patients. The rate of complications and pouch failure are similar. In the long-term, functional results are comparable to younger patients, with high satisfaction with surgery, provided that the procedure is performed by experienced surgical teams and by carefully selecting suitable patients.

RP is the treatment of choice for refractory UC or when cancer or dysplasia occur [1–5]. RP removes the entire diseased mucosa, eliminating the disease. A facet to consider is that IBD pathogenesis relies on complex etiopathogenetic mechanisms [21–24], not fully understood, posing IBD patients at increased risk of developing malignancies, via the inflammation–dysplasia–carcinoma sequence [5,25–28]. When a stapled ileal pouch anal anastomosis is performed, a strip of anal or anorectal mucosa is left behind. This does not seem to cause oncological concerns, unless the patients has dysplasia or cancer on the colectomy specimen, in which case a mucosectomy with manual ileal pouch-anal anastomosis is preferable [4,5]. This option should also be considered in long-standing disease and in young patients [3,5], as data suggest that follow-up may be delayed after RP with mucosectomy in patients without evidence of prior neoplasia [5].

Functional results of RP are optimal, and in the long-term no differences are to be expected in patients receiving a W- or a J-shaped pouch, provided that keen surgery is performed [1,6]. After an initial adaptation phase, continence is good with RP, even if a little decrease is observed over time [29], which is not reflected on quality of life [1–3,29]. Continence disturbances are a major concern in very elderly patients. It is known that a physiological decrease of continence is observed in the elderly. However, we would not recommend routine functional investigation in patients aged over 80 years, suggesting that clinical assessment alone may be used effectively to select suitable patients. It is important not overestimate symptomatic disturbances [30], and to differentiate contingent stool loss due to active disease from actual continence impairment, likely to be restored after removal of the diseased colon.

Our results show that functional outcomes of selected very elderly people are comparable to those of younger patients, provided no major perioperative complications occur. In fact, early septic complications may affect the outcome of surgery in the long-term. Pelvic sepsis is the *bête noire* of RP [31], and brings about

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