

Management of Crohn's Disease After Surgical Resection



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KEYWORDS

• Crohn's disease • Surgery • Prevention • Recurrence

KEY POINTS

- Approximately 25% to 35% of patients require repeat surgery after initial resection for Crohn's disease.
- Smoking, multiple prior surgeries, and penetrating or perianal disease are risk factors associated with disease recurrence.
- Early initiation of anti-tumor necrosis factor agents and immunomodulators within 4 to 8 weeks of surgery is consistently effective in decreasing risk of recurrence of Crohn's disease, whereas the benefit of mesalamine is uncertain.
- Regardless of initial approach to prevention of recurrence of Crohn's disease, active colonoscopic surveillance for early detection of endoscopic recurrence within 6 to 12 months of surgery is recommended.
- In the absence of endoscopic recurrence, noninflammatory causes should be sought for gastrointestinal symptoms such as bile acid malabsorption and small intestinal bacterial overgrowth.

INTRODUCTION

Crohn's disease (CD) is a chronically relapsing inflammatory condition of the gut that leads to complications requiring intestinal resection. Even though surgery often leads to resolution of symptoms, a meta-analysis of population-based cohorts of patients with CD who had undergone initial surgery showed that nearly a quarter of patients

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required a subsequent surgery within 5 years of their first surgery and 35% within a decade.¹ Surgical recurrence is often preceded by clinical recurrence, defined as the presence of inflammatory bowel disease (IBD)-related symptoms, and is observed in 28% to 50% of patients within 5 years.² Even before the onset of symptoms, there is endoscopic recurrence just proximal to anastomosis, which serves as a harbinger of need for subsequent surgery, and is observed in 50% to 90% of patients within 5 years of surgery. Significant advances in medical therapy have led to a steady decline in rates of first surgery for CD over the last several decades.^{3,4} Although cumulative rates of second intestinal surgery initially decreased between 1970 and the late 1980s, they have not continued to decrease since then.^{1,4,5} Thus, there is an opportunity to optimize postoperative management of CD through risk stratification, postoperative surveillance of endoscopic recurrence, and prophylactic medical therapy.

RISK STRATIFICATION OF POSTOPERATIVE RECURRENCE

Risk stratification for disease recurrence following resective surgery is the first critical step in optimizing postoperative outcomes. The identification of high-risk individuals could prompt early medical prophylaxis, whereas low-risk individuals may adopt a more conservative wait-and-monitor approach. Several phenotypic characteristics are associated with increased risk of recurrence. Individuals who underwent initial bowel surgery for fistulizing disease have been shown across multiple observational studies and meta-analyses to have increased risk of endoscopic and surgical recurrence.^{6,7} Similarly, the presence of perianal fistula has been linked with increased recurrent surgery.⁸ A prior history of 2 or more resective surgeries has also been consistently shown to be associated with higher rates of postoperative endoscopic and surgical recurrence.⁹ Numerous studies have also shown that active tobacco smokers have a greater than 2-fold risk of clinical and surgical recurrence compared with nonsmokers and ex-smokers.¹⁰ Other clinical factors that may predispose to disease recurrence include shorter disease duration (<10 years), isolated small bowel or continuous ileocolonic involvement, and young age at diagnosis (<30 years).^{2,8}

Although clinicians have an understanding of the clinical factors that are associated with postoperative disease recurrence, there are currently no risk models that quantify such risk based on the number and relative weighting of predisposing factors.¹¹ In general, postoperative patients with CD should be considered at higher risk for recurrence if they have had 2 or more prior resective surgeries, have fistulizing or perianal disease, or are active smokers.¹²

ASSESSING FOR ENDOSCOPIC RECURRENCE

Endoscopic recurrence frequently precedes clinical recurrence and occurs in as many as 80% to 90% of postoperative patients within 5 years.^{2,13-15} Ileocolonoscopy is usually used to assess for recurrent endoscopic lesions in the neoterminal ileum and is classified using the Rutgeerts score (Fig. 1). Endoscopic recurrence is defined as a Rutgeerts score of i2 or greater (at least 5 aphthous lesions with normal intervening mucosa), which predicts clinical recurrence.¹⁶ Only 5% of postoperative patients with a Rutgeerts score of i0 or i1 go on to develop recurrent IBD-related symptoms at 3 years. In contrast, the 3-year rate of clinical recurrence is 15%, 40%, and 90% for those with i2, i3, and i4 recurrence, respectively. Note that, although the Rutgeerts score has been used to guide medical treatment, it has never been formally validated in postoperative treatment trials. Moreover, the interrater reliability of the Rutgeerts

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