When first line fails referral to surgery:
Surgical options for Ulcerative Colitis:
Stage II vs Stage III

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Disclosure Information

I have no financial or contractual disclosures

Objectives

Provide a platform to discuss surgical options for patients with Ulcerative Colitis

Discuss advantages and disadvantages seen in stage 2 vs. stage 3 repair

Guide a discussion about educational needs of patients and families when considering a colectomy
Indications for surgical consideration

Consult surgery:
- Failed medical therapies
- Steroid dependent disease despite treatment with medicinal interventions
- Colonic dysplasia

Emergency sx:
- Hemorrhage or perforation due to mucosal ulceration
- Severe colitis not responding after 3-5 days initial treatment of IV steroids or cyclosporines
- Various scales in the literature may be useful to classify disease activity which can assist patients and care teams when making decisions about surgery (factors like stools per day/labs like CRP, Hgb, plt, steroid use)
  e.g. PUCAI (pediatric ulcerative colitis activity index) ECCO/ESPGHAN

Two stage approach

Stage 1: Colectomy with ileostomy creation and pouch formation
Stage 2: Stoma closure
- 8-12 weeks between stage 1 & 2
  Preoperative considerations: cuff length, preserving the anal mucosa and transition zone, preservation of internal sphincters, anastomotic stenosis
  Postoperative complications: hemorrhagic fistula, pouchitis, (40-50%), abscesses, infection/ulceration, SBO, anastomotic leak, thrombosis (mesenteric type 3 weeks out: severe pain, NV) (Ryan, 2017)
  Long-term complications: pouch dysplasia, adenocarcinoma pouch prolapse (rare), pouch failure (10-14%) (Ryan, 2017)
  Scope w bx 1 year after pouch and every 3 yrs after
  If risk factors such as FMH, chronic pouchitis, dysplasia may need closer surveillance

Three stage approach

Stage 1: Colectomy with ileostomy creation
Stage 2: Pouch formation
Stage 3: Stoma closure
  Preoperative considerations: cuff length, preserving the anal mucosa and transition zone, preservation of internal sphincters, anastomotic stenosis
  Postoperative complications: hemorrhagic fistula, pouchitis, (40-50%), abscesses, infection/ulceration, SBO, anastomotic leak, thrombosis (mesenteric type 3 weeks out: severe pain, NV) (Ryan, 2017)
  Long-term complications: pouch dysplasia, adenocarcinoma pouch prolapse (rare), pouch failure (10-14%)
  Scope w bx 1 year after pouch and every 3 yrs after
  If risk factors such as FMH, chronic pouchitis, dysplasia may need closer surveillance
Comparing 2 stage vs. 3 stage

To pouch or not to pouch
Consider: steroid use, nutritional status, inflammation, health of the bowel, infection/abscess

Stage 3:
Pros: optimize nutrition, allow for time off of steroid to improve overall healing, decreased length of hospital stay, decreased complications (pouchitis, dehiscense, wound infection)
Cons: an additional surgery

*Stage 2 surgery carries slightly more risk due to inflammation, nutritional deficiencies, anemia, immunocompromised state, DVT risk (5-8%) (Ryan, 2017)

Stage 2:
Pros: one less surgery
Cons: longer hospital stay postoperatively, increased risk of pouchitis, dehiscence, infection, delayed wound healing

Education for the patients and families when making decision for surgery
- Q & A session to discuss surgery/shared decision making
  - Discuss 2 vs 3 stage repair
  - Provide information about stoma care in a format that is age appropriate
  - Consider quality of life, functional outcomes, side effects of prolonged medications, self-image, fertility, sexual function, impact to schooling/education
  - Provide information about who to contact for postoperative concerns (e.g. wound care, stoma care, nutrition, pouchitis)
  - Discuss counseling and/or support group resources on coping with physical, social, and psychological well being

Education for the patients and families when making decision for surgery
- Discuss long term plan
  - Explain need for future scopes and risk of dysplasia
  - Provide info about follow up appts
  - Discuss who will be assisting them with ostomy care
  - Discuss increase in frequency of stooling with ostomy takedown
  - Provide information about dietary changes
  - (Baker et. al, 2018)
References


