Poster
No.PE244

International Surgical Week
The World's Congress of Surgery
isw2024.org
Kuala Lumpur, Malaysia
25-29 August 2024

Refractory IBD – a treatment challenge: evaluating the types and outcomes of surgical management.

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INTRODUCTION:

Refractory IBD refers to persistent acute symptomatic disease despite anti-inflammatory therapy or as chronically active disease requiring continuous treatment for relief of symptoms

Challenges pertaining to refractory IBD:

- Prolonged symptomatic period contributing to morbidity of the patients
- Cost of therapy is a challenge in a centre catering to a lower socioeconomic background population
- Decreased quality of life.
- Higher risk of complications and death

AIM: To evaluate surgical outcomes in patients presenting with refractory IBD.

METHODS:

This original article is a retrospective analysis over a span of 10 years of data from a tertiary centre in North India catering to a large number of patients presenting with the disease a large number as refractory or severe fulminant forms of IBD. Diagnosis of Ulcerative colitis and Crohn's disease made on lower GI endoscopy by using Olympus Evis Exera III CD-190 HD and Histopathological correlation.

Presenting symptoms of patients:

- Decreased stool consistency
- Bowel urgency
- Tenesmus
- Crampy abdominal pain
- Weight loss or fatigue
- Extraintestinal manifestations- joint pains

All patients were initially started in medical therapy – 5 ASA and corticosteroids , immunomodulators

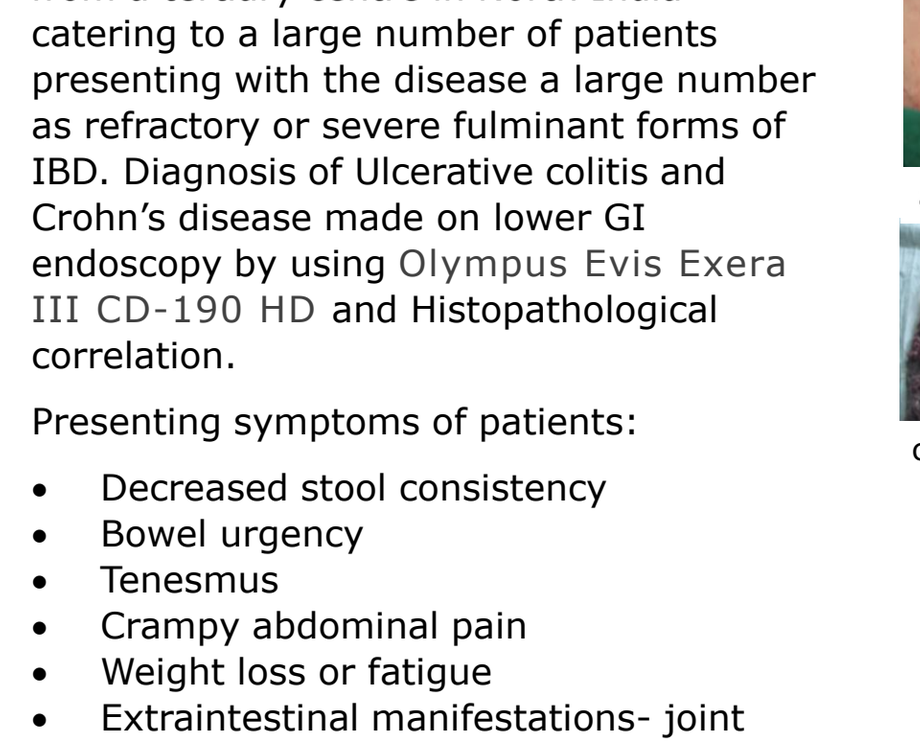

Table 1: demographic details

Variable	Characteristics
Sex (Male:Female)	1.2 :1
Mean Age	31
Duration of symptoms	6 months
Hb (mean Hb)	8.7 gm/dl
ULCERATIVE COLITIS (UC)	
Proctitis	87
Left sided colitis	217
Pancolitis	91
CROHN COLITIS (CD)	
Segmental disease	31
Sigmoidal disease	13
Rt colonic disease	35
TREATMENT	
MEDICAL	374 in UC ; 79 in CD
SURGICAL	84 in UC ; 3 in CD

Among these the indication for surgery were:

- Severe colitis not responding to treatment
- Requiring prolonged therapy
- Developed dysplastic changes which were detected on screening colonoscopy
- Developed complications

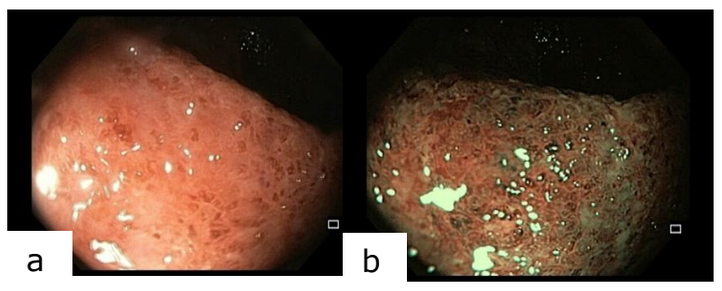

Image I: a) White light endoscopy and b) narrow band imaging of a patient presenting with severe ulcerative colitis

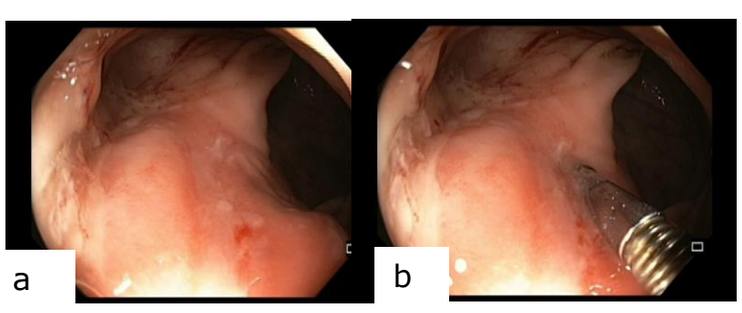

Image II: a) White light endoscopy showing a patient presenting with crohn's colitis

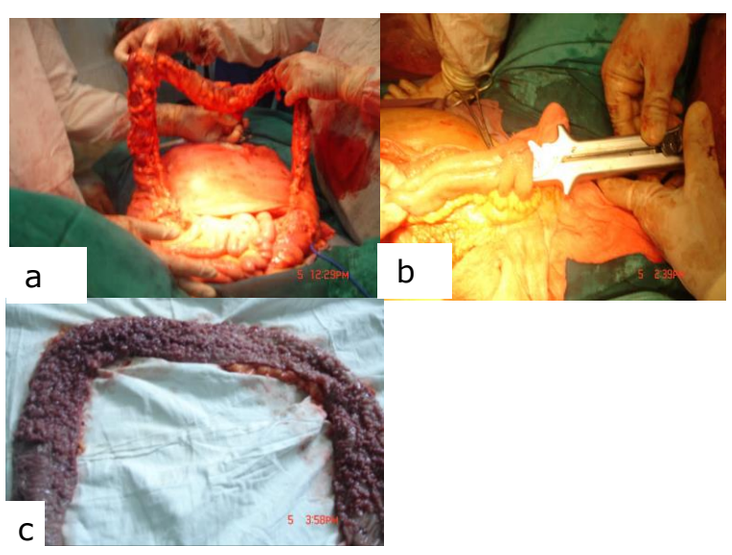

Image III: a) total proctocolectomy b)creation of J pouch c) cut open specimen showing severe ulcerative colitis

RESULTS:

First line medical therapy started in all diagnosed cases of ulcerative colitis, 82.35% (308) responders with medical therapy and 22.4 % (84) were non responders who underwent surgical intervention. Treatment duration for Medical therapy was 8 weeks to 2 years with follow up period of every month in newly diagnosed and moderate disease. And biweekly in cases of severe disease on treatment with 37 patients requiring in hospital stay. For patients on maintenance therapy it was 6 monthly to those with complete remission yearly.

Second line therapy (Infliximab) was given in 15 patients due to cost limitation and complete remission observed in 3 cases

Table 3: Response in ulcerative colitis

	Medical therapy	Surgical therapy
Remission rate	82.3%	92.8 %
Relapse rate	22.4	7.1%

Table 4: Surgical options offered with complication rates in ulcerative colitis

Surgical options	Complications	Incidence of complications	Advantages
IPAA with J pouch creation	Pouchitis and frequent bowel movements	42.8%	Removal of disease with total remission
Distal colectomy	Recurrence of symptoms	10.5%	Preservation of bowel function
Subtotal colectomy	Recurrence of symptoms	4%	Preservation of bowel function
Hemicolectomy	Altered bowel movements	10.7%	Preservation of bowel function
Total colectomy with ileorectal anastomosis	Increased frequency of bowel movements	5%	Preservation of rectum

Table 5 :Patients presenting with complicated disease

Indication of surgery	No of patients
Pateints on long term steroids 2-5 years; recurrent remission relapse	19
Bleeding and pain	56
Perforation	3
Dysplasia	1
Toxic megacolon	5

- Patients undergoing Total proctocolectomy with Ileal pouch anal anastomosis with J pouch creation developed pouchitis 6 in 14 patients with incidence of 42.8 % which was managed with local steroid application and keeping on prebiotics for a minimum of 4 weeks.
- Those prolonged bleeding episodes and repeated transfusions reported that frequency of mucus and blood in stools was more detrimental to QoL (quality to life) than having a temporary ileostomy.
- Patients with segmental colectomies reported better bowel function, urinary function and sexual function post surgery.
- Those with segmental resections either subtotal colectomy, distal colectomy or hemicolectomy developed recurrence of similar symptoms usually 2 years after the surgery who had to be restarted on medical therapy.

CONCLUSION:

Treatment goals in refractory IBD:

- Having patient centred discussions
- Early identification of nonresponders and complicated IBD
- Early management of relapse and complications
- Nutritional goals to be achieved since most of these patients are malnourished
- Close psychological support and tolerance in case of non-compliance to medications
- Preference to continent preservation surgeries
- Segmental resections and preservation of bowel function can serve as a long-term benefit in handling morbidity associated with the procedure.

Medical therapy has been the standard of care in treatment of IBD with introduction of new biologics and immunomodulators happening with research. With the term "refractory IBD "shifting every year considering the availability of these newer drugs ,there are still various limiting factors to the use of immunomodulators and biologics . In a developing nation cost of treatment becomes a challenge to handle also number of patients having loss to follow-up and later presenting with complicated disease is quite high. Surgical treatment is an answer to these challenges in patients who present with decreased quality of life and those who have been having remission and relapse episode in the long run, those in elderly age group and those with advanced disease presenting in younger age. Surgical interventions can be offered to patients at any stage of disease but preference should be given in choosing the type of surgery , the length of remaining functioning bowel , need for a stoma , avoiding enterocutaneous fistulas also minimizing and handling postoperative complications.

References:

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