

FAILING POUCHES



Poorly defined

most series this means a stoma (end)

AVOID

Restorative proctocolectomy is the first choice elective surgical treatment for ulcerative colitis

N. S. Williams 1989

Quality of life is markedly improved by surgery for UC

Q of L returns (more or less) to normal

No discernable difference in Q of L between procedures

McLeod RS, Gastroenterology 1991; 101:1307–1313.

Jimmo B Dis Colon Rectum. 1998 Jan;41(1):41-5

POUCH FAILURE

24 patients after excision of the pouch

Markedly reduced quality of life

Lepistö A Dis Colon Rectum. 2002 Oct;45(10):1289-94.

136 patients (31 left in situ)

Q of L better in patients that had pouch excised

Kiran RP Dis Colon Rectum. 2012 Jan;55(1):4-9

“ABSOLUTE” CONTRA-INDICATIONS

Acute colitis

Crohn's disease

Anal sphincter damage / incontinence

Anal fistula

Shape

Co-morbidities

RELATIVE CONTRA-INDICATIONS

Extra-intestinal manifestations

Drugs

Previous small bowel resection

Family planning

Age

Minor anal ailments

SPHINCTER FUNCTION



HISTORY

EXAMINATION

MANOMETRY

Age



REVERSIBLE RISK FACTORS

Smoking

Drugs

Weight

Diabetes

"BAWDY, BLISTERING... THIS IS *CATCH-22* WITH STETHOSCOPES."
—*COSMOPOLITAN*

*The Classic Novel of Life and Death
in an American Hospital*

The House of God



"Fascinating."
—*THE WALL STREET JOURNAL*

"Brilliant."
—*CHICAGO TRIBUNE*

With an Introduction by
JOHN UPDIKE

S A M U E L S H E M

Best possible



Specialist nurses

Family

Support groups

Other patients

Worst imaginable



FAILING POUCHES

IMMEDIATE CALAMITOUS FAILURE

Major anastomotic breakdown

Sepsis

Bleeding



PREVENTION, DIAGNOSIS AND
MANAGEMENT OF COLORECTAL
ANASTOMOTIC LEAKAGE

March 2016

ISSUES IN PROFESSIONAL PRACTICE
PREVENTION, DIAGNOSIS AND MANAGEMENT OF COLORECTAL ANASTOMOTIC LEAKAGE

DOING BADLY

“POUCHITIS”

↑ frequency

Urgency

Blood

incontinence

Bloating

Pain

Sepsis

Parameters	
Diagnosis	FAP
Patient comorbidity	No comorbid conditions
Prior anal pathology	No prior anal pathology
Anal sphincter manometry	Normal manometry (RP>40, SP>100)
Anastomotic separation	No anastomotic separation
Anastomotic Stricture	No stricture or asymptomatic stricture
Pelvic sepsis	No sepsis
Fistula formation	No fistula
Time (in years) from Ileal Pouch Surgery*	0

*Not required, but if entered will give an ileal pouch failure rate specific to the length of follow up (in years) following ileal pouch surgery.

<http://www.riskprediction.org.uk/index-ccfipf.php>

Symptom	N (%)
High frequency of defaecation	83 (69)
Abdominal pain	45 (37)
Incontinence	45 (37)
Perianal pain	44 (36)
Difficult evacuation	33 (27)
Bleeding from the anus	30 (25)
Urgency	24 (20)
Watery faeces	22 (18)
Mucous anal discharge	18 (15)
Faecal vaginal discharge	17 (14)
Purulent anal discharge	8 (7)
Vomiting	8 (7)
Enterocutaneous fistula	6 (5)
Purulent perianal discharge	5 (4)
Abdominal distension	5 (4)
Pouch prolapse	3 (3)
Weight loss	3 (3)
Pneumaturia/ faecaluria	2 (2)

Long term antibiotic therapy in 29 (25%)

Defunctioning ileostomy in 19 (16%),

Medena catheter to promote anal evacuation in 17 (15%)

Dilatation of a stenosis under anaesthetic in 12 (10%)

Six (5%) underwent major revision with a defunctioning
ileostomy

Pouch excised 6 (5%)

Long rectal stump
Small capacity pouch
Stenosis
Poor sphincter function
Twist

Cuffitis
Crohn's disease
NSAID enteritis

Infections CMV, C Diff

“Irritable pouch syndrome”

Objective pouchitis score

Pouchitis activity score

Pouchitis Disease Activity Index

Clinical symptoms 0-6

Endoscopic appearance 0-6

Pathology 0-6

Score ≥ 7 = Pouchitis Sensitivity 60% Specificity 96%

Incidence

25 – 50% at 10 year

(FAP 3 – 14%)

5 – 20% relapsing pouchitis

1% of patients lose their pouch

TREATMENT

ANTIBIOTICS

Metronidazole 750 – 1500 mg/day

Ciprofloxacin 500 mg

80 – 90% response rate in small RCTs /open label studies

Augmentin, Erythromycin, Tetracycline
Rifaximin

Probiotics

Treatment

23 patients treated with 2 sachets VSL 3 /day
for 4 weeks

70% achieved remission and were maintained

Gionchetti et al Dis Colon Rectum. 2007 Dec;50(12):2075-82

Combination therapy

Targeted Therapy

15 patients 13 relapsed after combination
 2 after ciprofloxacin

Coliform culture showed cipro resistance in all
+ varied other patterns of resistance

80% remission with tailored 4 week antibiotic
Maintained with rotating regime

Mclaughlin et al 2009

Infliximab

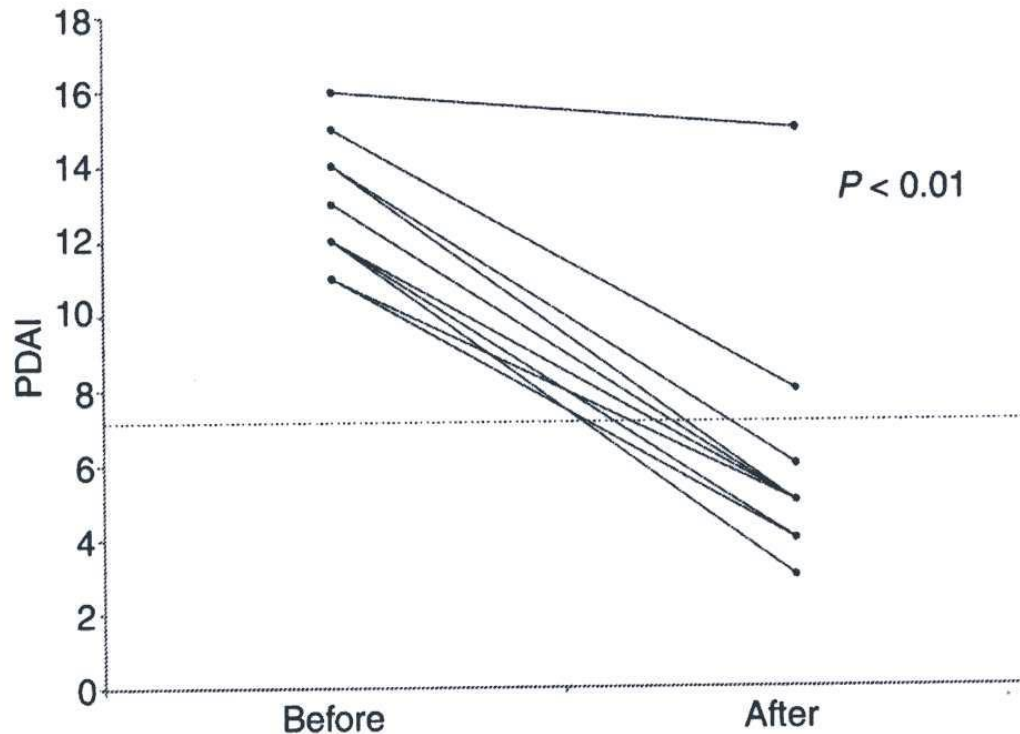
Calabrese et al Aliment Pharmacol Ther. 2008 May;27(9):759-64.

10 patients with chronic pouchitis

All had proximal lesions on capsule endoscopy

Infliximab 5 mg/kg at 0, 2 and 6 weeks

9/10 “clinical remission”



POUCH ANAL / VAGINAL FISTULA

True incidence is very hard to determine

Approx 10% in long term

???occult leaks???

Vaginal fistula

Several case series

Transvaginal repair

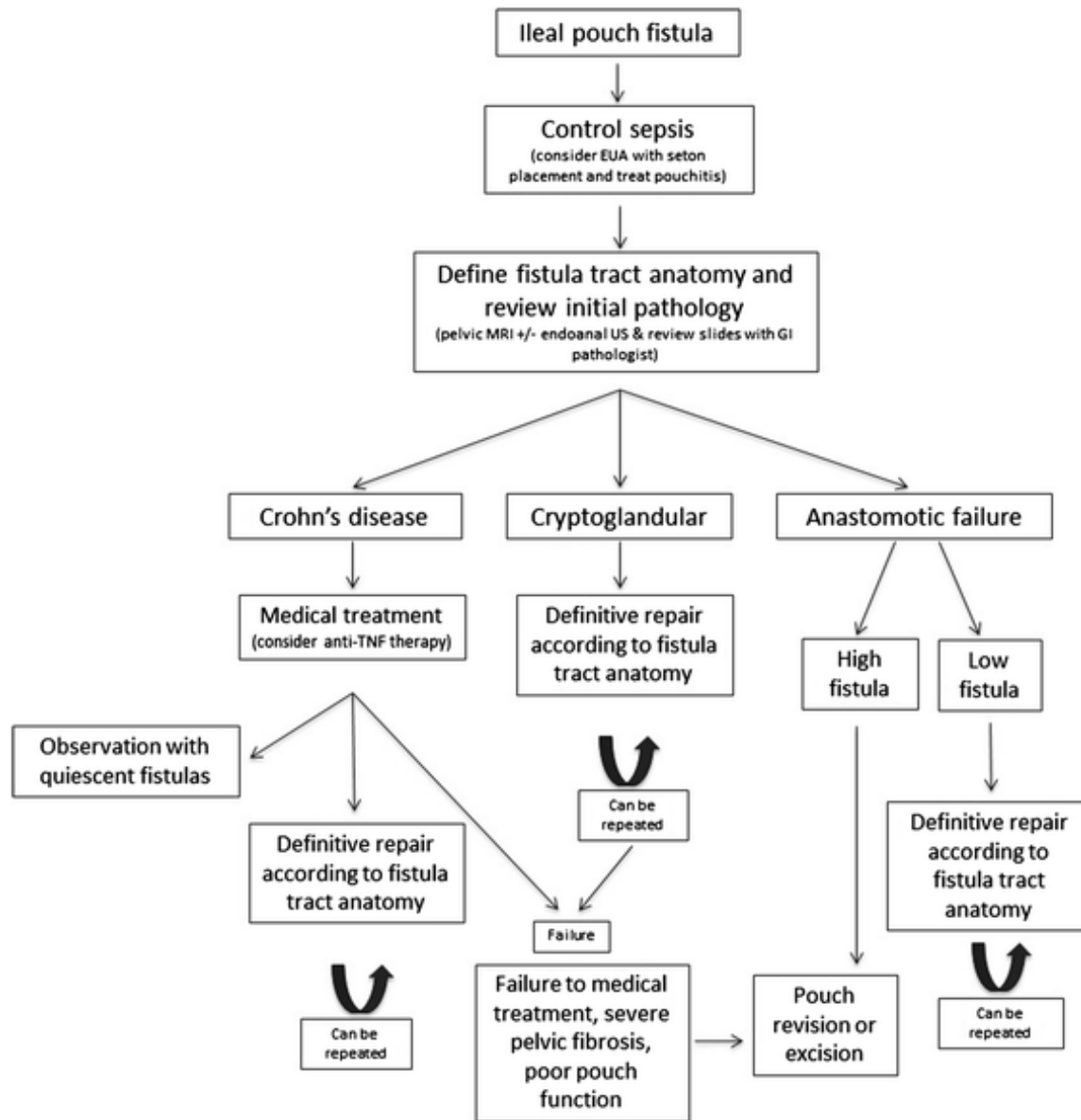
Interposition flap

Martius

Gracilis

Anal fistula

Manage as cryptoglandular



MALIGNANCY

Very rare

0.35% at 20 years

Selvaggi et al Inflammatory Bowel Diseases:
[July 2014 - Volume 20 - Issue 7 - p 1296–1308](#)

241 Redo pouches

Fistula 67, Leak 65, stricture 42, dysfunction 40,
Pelvic abscess 25

71 New pouch
170 pouch salvaged

29 failed reconstruction

Outcomes comparable to primary pouch apart from leakage
and pad usage

Remzi et al DCR 2009 Feb;52(2):198-204

Pouch excision

68 patients

1.4% mortality

62.3% morbidity

Multiple readmissions many needing surgery

Perineal wound problems common

2 impotence

1 Short bowel syndrome needing TPN

Karoui M et al DCR 2004 Jun;47(6):869-75

SUMMARY

Patient selection is key.

The highly motivated put up with less good function

Many poorly functioning pouches can be managed medically

Pouchitis rare cause of failure

Majority fail through poor function or fistula

Salvage surgery is highly morbid