Proctocolectomy and ileal J-pouch anal anastomosis on the surgical treatment of familial adenomatous polyposis and ulcerative colitis: analysis of 49 cases

http://www.producao.usp.br/handle/BDPI/40793

Downloaded from: Biblioteca Digital da Produção Intelectual - BDPI, Universidade de São Paulo
Proctocolectomy and ileal J-pouch anal anastomosis on the surgical treatment of familial adenomatous polyposis and ulcerative colitis: analysis of 49 cases

Bruno Amaral Medeiros1, Leonardo Estenio Iezzi1, Marley Ribeiro Feitosa1, Rogério Serafim Parra2, Ana Luiza Normanha Ribeiro de Almeida1, Raphael Gurgel de Carvalho1, Jose Joaquim Ribeiro da Rocha3, Omar Feres4

1MD; Resident of the Division of Coloproctology of the Department of Surgery and Anatomy of the Ribeirão Preto Medical School at Universidade de São Paulo (USP) – Ribeirão Preto (SP), Brazil. 2MD; Research fellow of the Division of Coloproctology of the Department of Surgery and Anatomy of the Faculdade de Medicina de Ribeirão Preto da USP – Ribeirão Preto (SP), Brazil. 3MD; PhD; Head of the Division of Coloproctology of the Department of Surgery and Anatomy of the Faculdade de Medicina de Ribeirão Preto da USP – Ribeirão Preto (SP), Brazil. 4MD; PhD; Professor of Division of Coloproctology of the Department of Surgery and Anatomy of the Faculdade de Medicina de Ribeirão Preto da USP – Ribeirão Preto (SP), Brazil.

ABSTRACT: Objective: To evaluate the results of ileal J-pouch anal anastomosis in ulcerative colitis and familial adenomatous polyposis. Method: Retrospective analysis of medical records of 49 patients submitted to ileal J-pouch anal anastomosis. Results: Ulcerative colitis was diagnosed in 65% and familial adenomatous polyposis in 34%. Mean age was 39.5 years. 43% were male. Among familial adenomatous polyposis, 61% had colorectal cancer. Thirty-one percent of patients with ulcerative colitis had previous surgical approach and 21% of these had toxic megacolon. Average hospital stay was 10 days. Post-operative complications occurred in 50% of patients with ulcerative colitis and 29.4% of familial adenomatous polyposis. Intestinal diversion was performed in 100% of ulcerative colitis and 88% of familial adenomatous polyposis. Pouchitis occurred in eight cases (seven ulcerative colitis and one FAP), requiring excision of the pouch in three ulcerative colitis. Mortality rate was 7.6%: two cases of carcinoma on the pouch and two post-operative complications. Late post-operative complications occurred in 22.4%: six familial adenomatous polyposis and five ulcerative colitis). Two patients had erectile dysfunction, and one retrograde ejaculation. One patient with severe perineal dermatitis was submitted to excision of the pouch. Incontinence occurred in four patients and two reported soil. Mean bowel movement was five times a day. Conclusion: Ileal J-pouch anal anastomosis is a safe surgery with acceptable morbidity and good functional results, if well indicated and performed in referral centers.

Keywords: adenomatous polyposis coli; colonic pouches; intestinal polyposis; proctocolitis.


Study carried out at the Division of Coloproctology of the Department of Surgery and Anatomy of the Ribeirão Preto Medical School at Universidade de São Paulo (USP) – Ribeirão Preto (SP), Brazil.
Financing source: none.
Conflicts of interest: nothing to declare.

Submitted on: 04/04/2012
Approved on: 11/05/2012
INTRODUCTION

Proctocolectomy and ileal pouch-anal anastomosis (IPAA) was first idealized by Nissen in 1933 to pediatric patients with familial adenomatous polyposis (FAP). Ravitch and Sabiston and Ravitch associated rectal mucosectomy and suturing of ileal mucosa to dentate line, with poor results.

Later technique modifications improved partially the results, but without large acceptance. Only in 1980 Utsunomiya, a J ileal pouch was devised, with satisfactory post-operative results, including good quality of life.

With these technical modifications, and confirmed relationship between capacity of “neorectum” and functional outcome, proctectomy with IPAA became the ideal surgical treatment for most patients with refractory ulcerative colitis (UC) and selected cases of FAP.

The complications severity depends on the patient previous diagnoses, usually worst on UC. Nutritional status, previous surgery, size of pouch and even presence of intestinal diversion are involved on prognosis.

Although stapler adoption, improved pre and post-operative cares and antibiotics, early and late postoperative complications (anastomotic leakage, fistula, pouchitis, dysplasia and even pouch carcinoma) may occur.

We decided to assess the results of IPAA in 49 patients with UC or FAP.

RESULTS

Thirty-two patients (65%) were diagnosed with UC and 17 (34%) with FAP. Average age was 39.5 years. Forty-three percent were male. Among FAP, 61% were diagnosed with colorectal carcinoma by colonoscopy.

Twenty-one percent of the patients with UC had toxic megacolon, 31% had undergone a surgical approach before the IPAA (usually subtotal colectomy) and half of the patients presented other complications (bleeding requiring transfusion or surgery, peritonitis or severe dysplasia on endoscopic examination).

Mean operative time was 4 hours and 30 minutes (4 hours and 36 minutes FAP versus 4 hours and 27 minutes UC). This time included patients from the beginning of the surgical experience on our hospital and some cases performed manual anastomosis (2 hours and 30 minutes, with mechanic anastomosis).

Average hospital stay was 10 days (5 to 57 days): 10.1 FAP and 10.7 UC. Fifty percent of patients with UC had surgical complications in the early postopera-
Proctocolectomy and ileal J-pouch anal anastomosis on the surgical treatment of familial adenomatous polyposis and ulcerative colitis: analysis of 49 cases
Bruno Amaral Medeiros et al.

Early surgical complications occurred in 29.4% of FAP: three cases of stenosis of the anastomosis, one pouch-anal anastomotic leakage and one anastomotic leak to incision fistula.

Intestinal diversion was performed in 100% of UC and 88% FAP. The closure of the ileostomy was performed in 87.5% UC and 76.4% FAP.

Pouchitis occurred in eight cases: 16.3% (seven UC and one FAP), requiring the excision of pouch in three UC.

Late post-operative complications (intestinal obstruction, erectile dysfunction, pelvic abscess and liver) occurred in 22.4% of cases, six cases in patients with PAF and five in patients with UC). Two patients had erectile dysfunction, and one retrograde ejaculation. Incontinence was observed in 6.1% of cases. One patient (1.9%) with a severe case associated to severe perineal dermatitis was submitted to performed excision of pouch. Two (3.8%) reported soil. Mean bowel movement was five times a day (3 to 20).

One patient was evaluated with urinary tract infection and mortality rate was 7.6%: two cases of carcinoma on J pouch and two postoperative complications.

DISCUSSION

Most patients had UC (65%; 32 patients); 34% (17) had FAP.

The majority of patients with FAP (61%) were admitted with colorectal carcinoma (from in situ to ‘T4’ stage tumors). We attribute this data to delay since symptoms onset until search for medical treatment.

Figure 2. Creation of J-pouch. (A) First linear stapling. (B) Ileal J-pouch. (C) Preparing to anastomosis. (D) Ileal pouch-anal anastomosis.
Twenty-one percent of the patients with UC had previously toxic megacolon and 31% undergone a surgical approach before the IPAA (usually subtotal colectomy and terminal ileostomy or ileorectal anastomosis).

Half of the patients presented other complications (bleeding, peritonitis or severe dysplasia on endoscopic examination), similar to Langenbeck's Fazio and Pemberton.13-15

Average operative time – 4 hours and 30 minutes – improved with stapler anastomosis (2 hours and 30 minutes) and the diagnoses do not affect average hospital stay (10.1 days for FAP versus 10.7 days for UC) or procedure length (4 hours and 36 minutes for FAP versus 4 hours and 27 minutes for UC).

Early postoperative complications were more common on UC (51%: 18% had anastomatic stenosis and 15.6%, pouch-anal anastomotic leakage) than FAP (29.4%: three cases of stenosis of the anastomosis, one pouch-anal anastomotic leakage and one IPAA fistula).

Our preference is to perform IPAA with a loop ileostomy (to prevent impact of an anastomotic leak, mainly on UC using steroids). 100% with UC and 88% with FAP) and closed in 87.5% with UC and 76.4% with FAP.16,17

Pouchitis occurred in eight cases (16.3%): seven of UC and one of FAP. The three excisions of IPAA, converted to terminal ileostomy, occurred on UC. Two patients had severe pouchitis (biopsy posteriorly suggested Crohn’s disease) and one patient had severe perineal dermatitis and extensive cellulitis.

Mortality rate (7.6%), late post-operative complications like intestinal obstruction, erectile dysfunction and pelvic abscess (22.4%, six cases in patients with PAF and five in patients with UC) are similar to other authors.18,19

Two patients had erectile dysfunction, and one of these, retrograde ejaculation. Incontinence was observed on four patients (8.1%). Two patients (3.8%) reported nocturne soil. Mean bowel movement was five times a day (3 to 20).

**CONCLUSION**

This study suggests IPAA is a safe surgery with acceptable morbidity, if well indicated and performed by a specialized team in referral centers. It provides satisfactory functional results and can avoid permanent ileostomy. The low post-operative morbidity and mortality and good functional results demonstrate the effectiveness of the IPAA surgery.

**Table 1. Operative complications of ileal pouch-anal anastomosis on familial adenomatous polyposis and ulcerative colitis patients.**

<table>
<thead>
<tr>
<th>Operative complications and adverse outcomes in each group</th>
<th>PAF (n=17)</th>
<th>UC (n=32)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Anastomotic stenosis</td>
<td>3</td>
<td>17.65</td>
<td>7</td>
</tr>
<tr>
<td>Anastomotic leakage</td>
<td>1</td>
<td>5.88</td>
<td>4</td>
</tr>
<tr>
<td>Anastomotic fistula</td>
<td>1</td>
<td>5.88</td>
<td>1</td>
</tr>
<tr>
<td>Intestinal obstruction</td>
<td>3</td>
<td>17.65</td>
<td>1</td>
</tr>
<tr>
<td>Liver abscess</td>
<td>1</td>
<td>5.88</td>
<td>0</td>
</tr>
<tr>
<td>Erectile dysfunction</td>
<td>1</td>
<td>5.88</td>
<td>1</td>
</tr>
<tr>
<td>Incontinence</td>
<td>1</td>
<td>5.88</td>
<td>3</td>
</tr>
<tr>
<td>Pouchitis</td>
<td>1</td>
<td>5.88</td>
<td>7</td>
</tr>
<tr>
<td>Mortality</td>
<td>2</td>
<td>11.76</td>
<td>2</td>
</tr>
<tr>
<td>Deep-vein thrombosis</td>
<td>0</td>
<td>0.00</td>
<td>1</td>
</tr>
<tr>
<td>Excision of pouch</td>
<td>0</td>
<td>0.00</td>
<td>3</td>
</tr>
<tr>
<td>Post-operative Pneumonia</td>
<td>0</td>
<td>0.00</td>
<td>1</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>1</td>
<td>5.88</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100</td>
<td>33</td>
</tr>
</tbody>
</table>
REFERENCES


Correspondence to:
Omar Feres
Divisão de Coloproctologia do Departamento de Cirurgia e Anatomia da Faculdade de Medicina de Ribeirão Preto da Universidade de São Paulo
Avenida Bandeirantes, 3.900 – Campus da USP
14048-900 – Ribeirão Preto (SP), Brazil
E-mails: omar.feres@hsuslp.com.br e brunoamedeiros@yahoo.com.br