How to optimise an IBD pt for surgery

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Indications for surgery in IBD

• Acute severe/fulminant UC
• Steroid refractory/intolerant
• Failure of medical therapy
• Complicated IBD
• Malignant risk/Malignancy
• Inability to survey

• ECCO keeps changing the goalposts
Surgical heresy

ECCO Statement 71

Patients with a (unsuspected) diagnosis of Crohn’s disease after IPAA present markedly higher complication and failure rates. An IPAA may be discussed in highly selected and motivated patients with Crohn’s colitis, pending proof of absent small bowel disease and no existing or previous evidence of perineal involvement. Intensive combined management by IBD physicians is mandatory to maintain an acceptable pouch function in those patients [EL4].

Gionchetti et al 2017
Acute severe UC

• Involve the surgeon early
Top ten idiots with chainsaws!
Acute severe UC

- Involve the surgeon early
  - High dose steroids/anti-TNF
  - Toxic megacolon
  - Perforation and peritonitis
Acute severe UC: pre-op prep

• ICU
• MDT
• Not a lot of space for pre-op optimisation
• Settle for pre op resuscitation
• Don’t beat a dead horse
NO, REALLY.
You can stop now.
Acute severe UC: pre-op prep

• Don’t panic
• Not failure: bad disease
Consent

- Emergency: expect worst
- UC: IPAA 20% leak
  - 10% take down
  - Permanent stoma
- Crohn’s: 50% reoperation at 2 years
- Fertility
- Lapscope
ERAS

• Pre-operative optimisation is so much more than just pre-op...
ERAS

**Intraoperative**
1. Epidural anesthesia/analgesia
2. Fissureless surgical techniques
3. Protective lung ventilation
4. Single chest tube placement
5. Prevention of hypothermia

**Preoperative**
1. Preadmission education/counseling
2. Shortened fasting
3. Prophylactic antibiotics
4. Respiratory drug intervention
5. Intensive pulmonary physiologic therapy
6. Physical exercise training
7. Cardiopulmonary exercise testing
8. Optimized diets

**Postoperative**
1. Epidural analgesia/nonsteroidal analgesic painkillers
2. Measures to promote bowel movements
3. Standardized chest tube management
4. Intravenous fluid restriction
5. Early removal of epidural catheter
6. Early removal of urinary catheter
7. Early oral feeding
8. Early ambulation
ERAS

• Pre-op
• Intra-op
• Post-op
ERAS: goals

• Improved patient outcome
• Early return bowel function
• Early return social function
• Without compromising surgical results
ERAS: how to do it

• Hard work
• Systems
• Practice nurses
• Pre-op education
• Prehabilitation
Prehabilitation

• Exercise
• Nutrition
• Anxiety
Exercise

• Lower ECOG score
• No difference in surgical complication rate
• Improved anaesthetic outcomes
Nutrition

• IBD usually nutritionally deficient
• Worse outcome alb <30
• Set realistic goals
• Fe deficiency
  • Oral
  • lvi
Nutrition

• Carbohydrate drink up to 2 hours before surgery
Anxiety
Anxiety

• Involve MDT early
  • Psychologist is often forgotten member
Bowel prep

• Controversial
The great Trans Atlantic divide
Bowel prep

• Left sided colonic surgery
• Oral antibiotic with MBP
  • NSQIP: Reduce anastomotic leaks and infection
  • SELECT: Reduce infection but not leak
• Effect on microbiome
Sepsis

• Manage sepsis before surgery
  • Antibiotics
  • Percutaneous drainage
  • Endoscopic

• Surgery for sepsis before definitive management
  • Drainage
  • Diversion
  • Resection
Sepsis

• Prophylactic ivi antibiotics
Immune compromise

• Steroids
BE AFRAID...

BE VERY AFRAID
Immune compromise

• Steroids

• Azathioprine/6MP
DON'T BE AFRAID
IT'LL BE FUN
Immune compromise

• Steroids
• Azathioprine/6MP
• MTX
Meh.
Immune compromise

- Steroids
- Azathioprine/6MP
- MTX
- Anti-TNF
My boss said he wanted "2 weeks notice". I figure, in two weeks he'll NOTICE I'm not there.
Immune compromise

- Steroids
- Azathioprine/6MP
- MTX
- Anti-TNF
- Newer biologics
Immune compromise

• Steroids
• Azathioprine/6MP
• MTX
• Anti-TNF

• Newer biologics *mostly same*
Thromboprophylaxis

• 3x increase DVT
• LMW heparin
• Hold on day of surgery
Smoking

• Double edged sword
  • Drive to get out of bed
  • Anastomosis/wound healing/sepsis worse
Smoking

• Elective:
  • Stop min 2 weeks pre surgery
  • 6-8 weeks recommended

• Urgent:
  • Don’t stop
Take home messages

• Involve surgeon early
• Don’t flog a dead horse
• MDT
• Preoperative workup includes
  • Preop
  • Consent
  • Intraop
  • Postop
Department of Gastroenterology

Let's call it a day, I'm pooped.


