Honesty Equality Accountability Respect Teamwork

Putting **patients** at the **HEART** of everything we do

NHS
London North West Healthcare
NHS Trust

The Ileo Anal Pouch

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Aims of the session

- Patient suitability
- Patient expectations of having a pouch
- What is ‘normal’ pouch function?
- When to start investigating
- Types of complications
- Investigations
- Treatment and management
- Recommended follow up for pouch patients

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Patient suitability

- Disease progression in ulcerative colitis (UC)
- Indeterminate UC
- Familial Adenomatous Polyposis (FAP)

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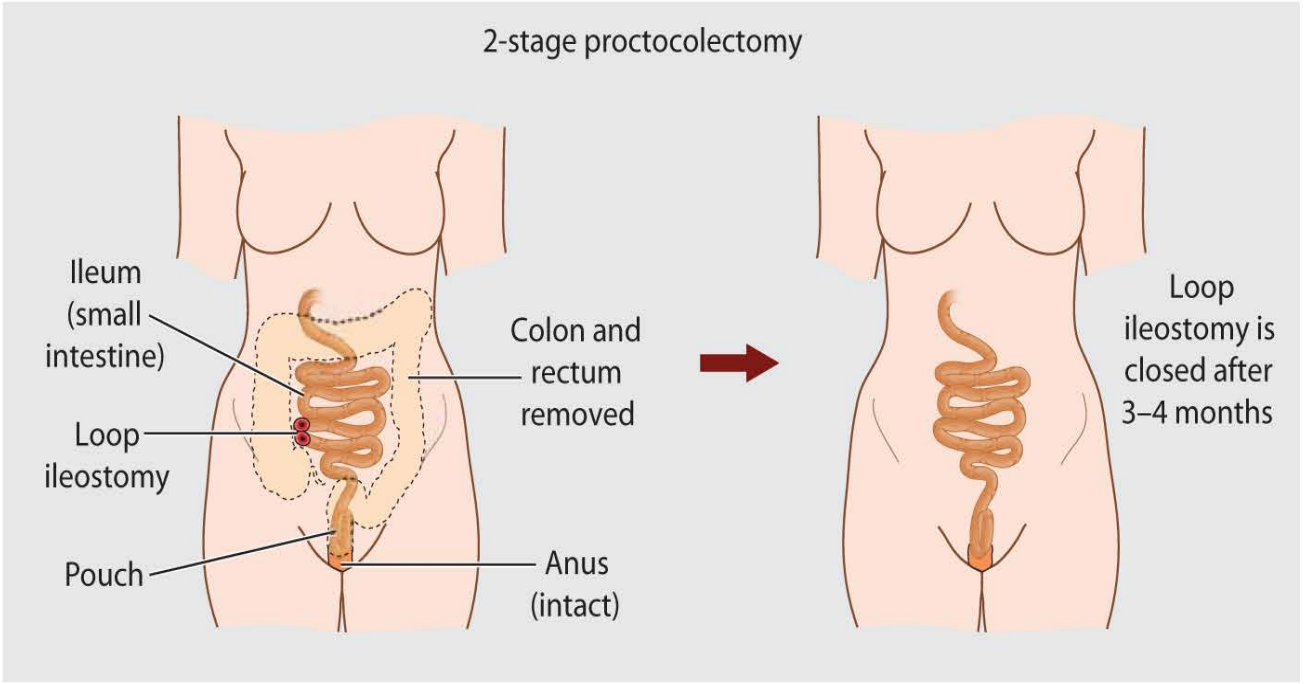
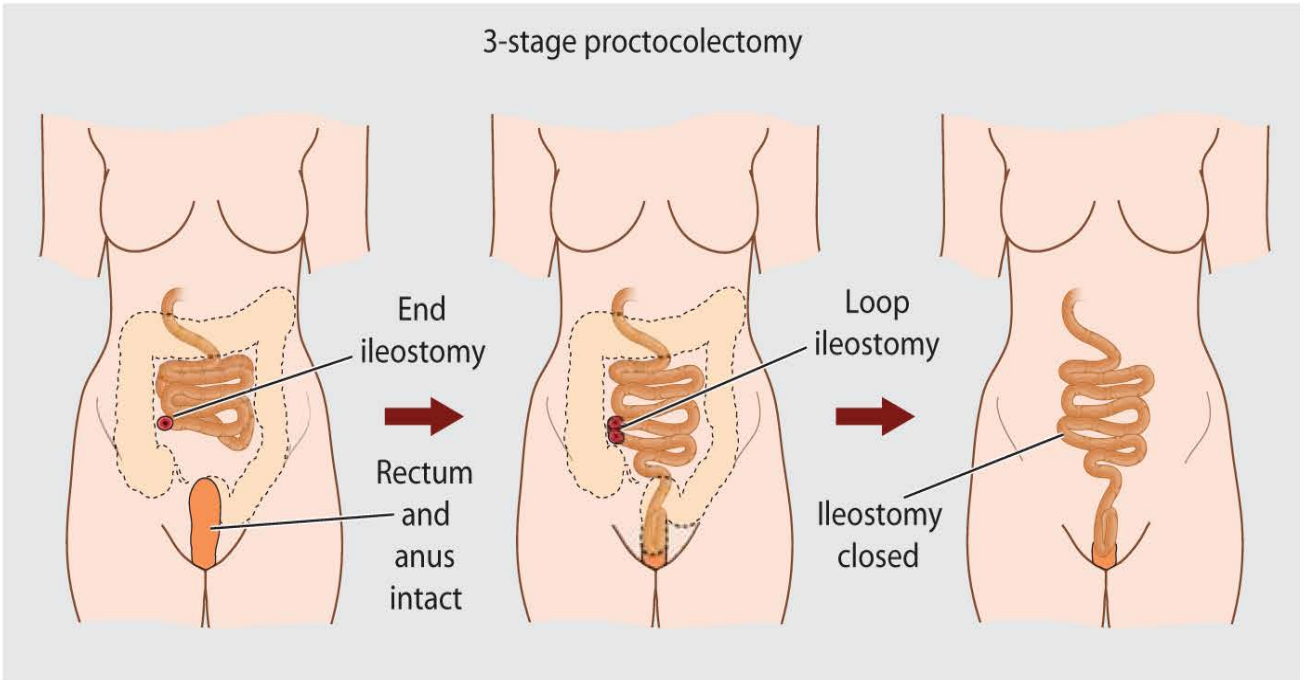
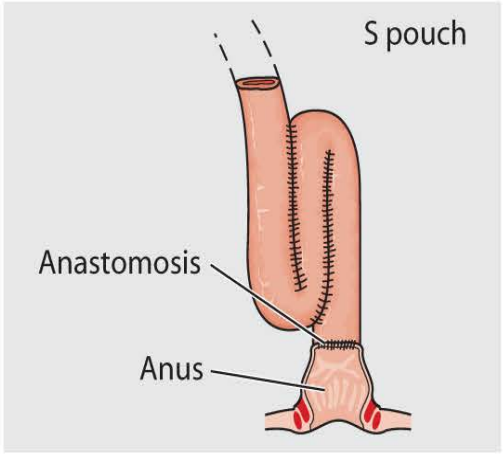
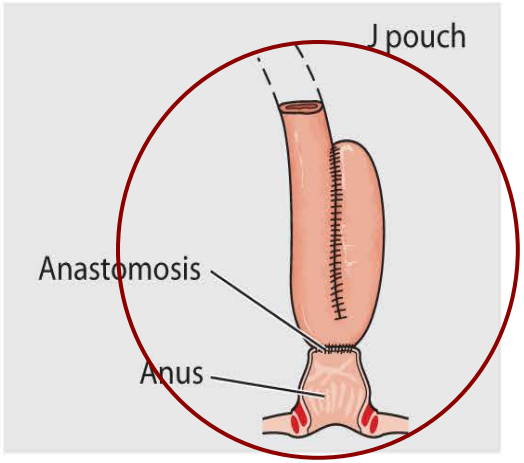
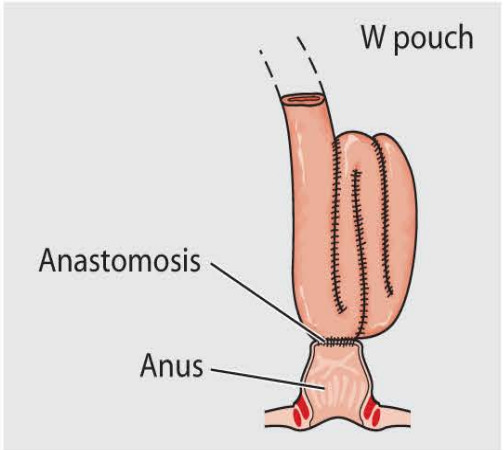

2-stage proctocolectomy
Ileum (small intestine)
Loop ileostomy
Pouch
Colon and rectum removed
Anus (intact)
Loop ileostomy is closed after 3–4 months

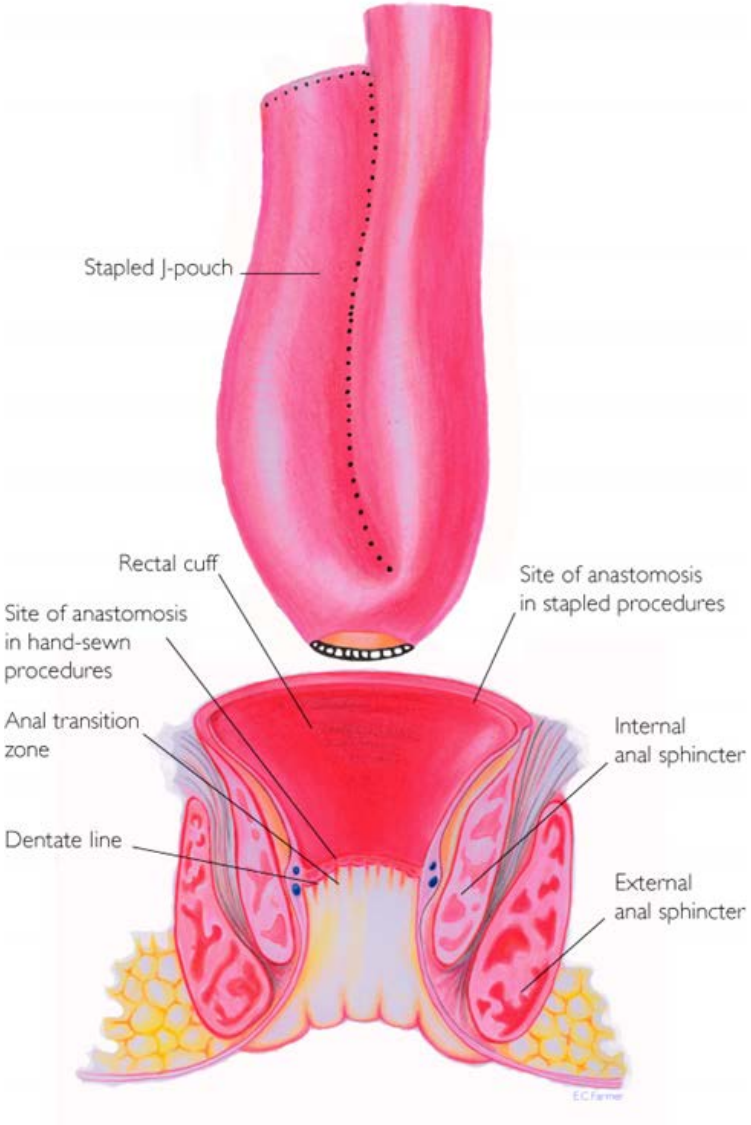

3-stage proctocolectomy
End ileostomy
Rectum and anus intact
Loop ileostomy
Ileostomy closed


S pouch
Anastomosis
Anus


J pouch
Anastomosis
Anus


W pouch
Anastomosis
Anus

The Ileo-anal pouch



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What to expect with a pouch

- Pouch function
- Lifestyle/routine
- Diet
- Work
- Sport
- Sexual function
- Fertility/fecundity
- Pregnancy
- Travel

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Team effort

Patient
Consultant surgeon
Consultant gastroenterologist
Research fellow
Stoma nurses
Pouch nurse
Polyposis nurses
Endoscopists

IBD nurses
Macmillan nurses
IBD dietician
Family and friends of patient
Dietician
Psychologist/Psychiatrist

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Normal pouch function

- Normal pouch function : 4-6 times in 24hrs, occasionally one nocturnal motion
- Loose stool (porridge consistency)
- Ability to defer defaecation for up to 1 hour
- No faecal leakage in the day, may occur at night
- Very individual

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When to start investigating

- Increased pouch frequency
- Urgency
- Bleeding
- Abdominal pain
- Bloating
- Fever/night sweats
- Lethargy
- Ineffective emptying of pouch
- Nausea/vomiting
- Incontinence
- Leakage
- Symptoms of fistulae (sepsis, vaginal/perianal discharge

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Initial investigations

- Abdominal examination
- Digital exam- check for narrowing
- Rigid pouchoscopy- limited views
- Flexible pouchoscopy with biopsies - can exclude or confirm pouchitis, cuffitis, dysplasia, pre-pouch ileitis, strictures, Crohn's. Can also balloon dilate strictures in mid pouch
- Bloods: FBC, U&Es, LFTs, Vitamin B12, Vitamin D, ferritin, folate, Coeliac screen

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Types of complications

Inflammatory

Non-inflammatory

- Mechanical
- Functional

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Inflammatory pouch problems

Most common:

- Pouchitis
- Cuffitis (retained rectum)

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What is pouchitis?

- Pouchitis is an inflammatory response to changes within the pouch, aetiology is unknown
- It is thought to be triggered by changes in the intra-luminal bacteria within the pouch
- 20-50% of patients will suffer from pouchitis at some time Moskowitz et al 1986; Nassar et al 2006

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Possible causes/theories of pouchitis

- Multi-factorial
- Imbalance of bacteria in the pouch
- Immunological factors
- Excessive bile acid production
- ?Genetics – increased incidence in patients with Primary Sclerosing Cholangitis (PSC)

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Common symptoms

- Frequency
- Loose stool – no change with diet or Loperamide
- Abdominal pain/cramping
- Generally feeling under the weather
- Possibly fever
- Possibly bleeding
- Symptoms not getting any better, progressively getting worse

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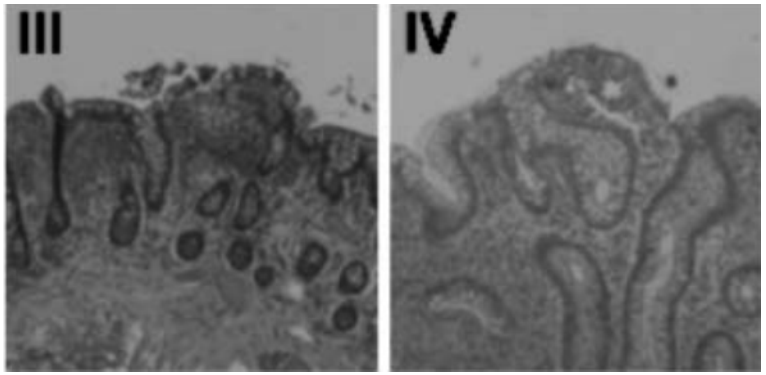
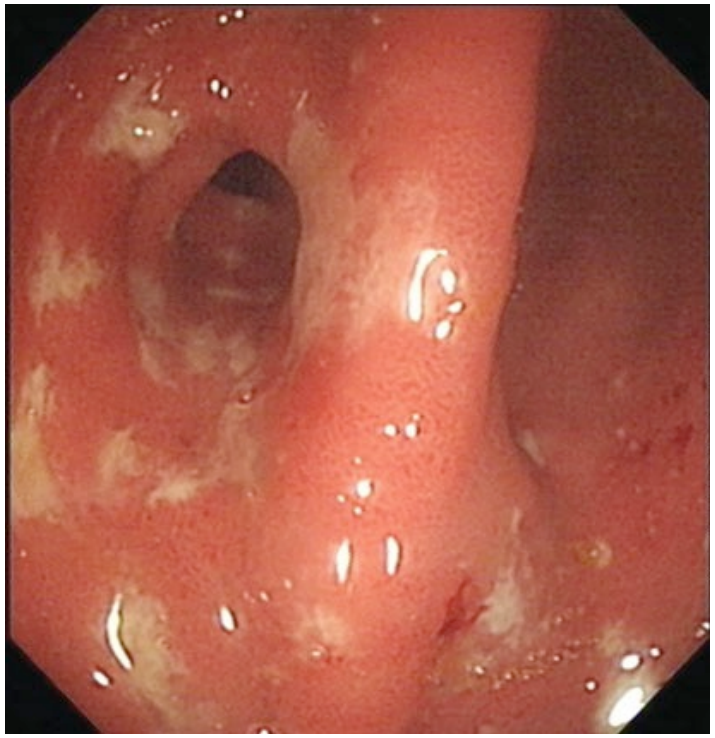
Pouchitis

Diagnosis based on:

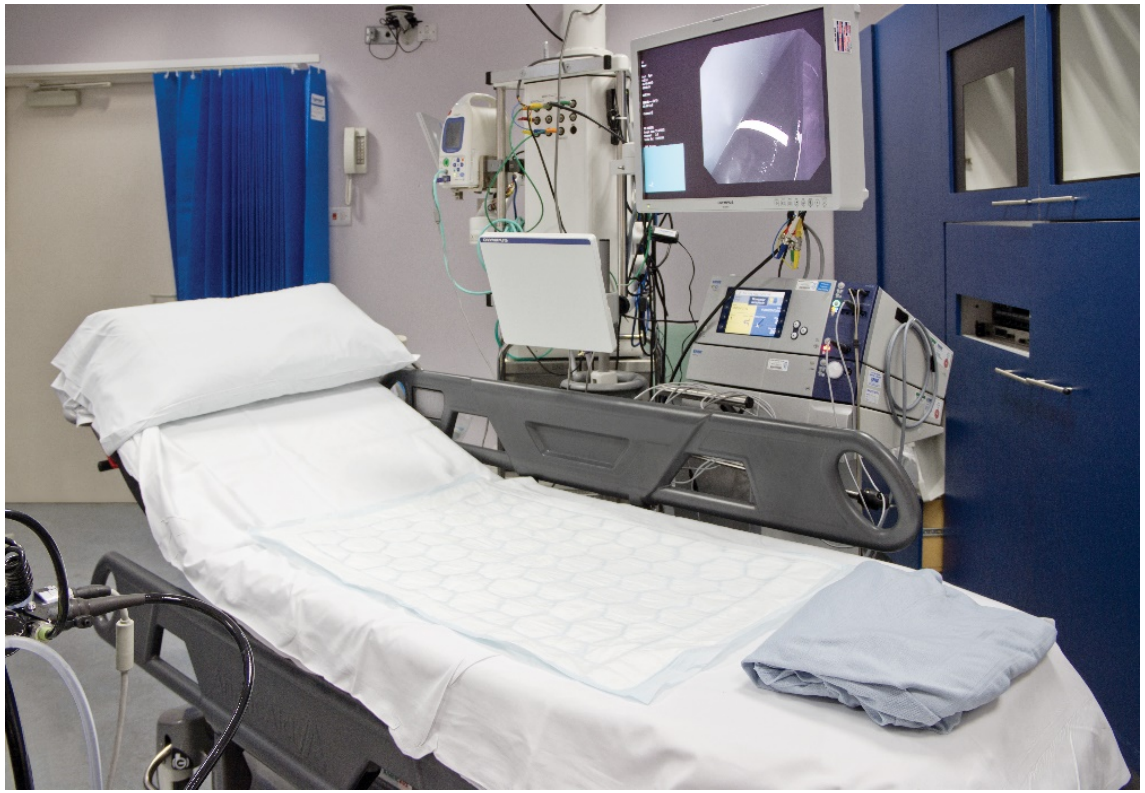
- Compatible symptoms
- Endoscopy
- Histology



Clinical
- Stool frequency
- Faecal urgency or abdominal cramps
- Rectal bleeding
- Fever



Pouchoscopy



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- Simple pouchitis (acute) one episode per year
  - antibiotic responsive

- Complex pouchitis (chronic) – more than 3 episodes per year
  - antibiotic responsive
  - antibiotic dependent
  - antibiotic resistant

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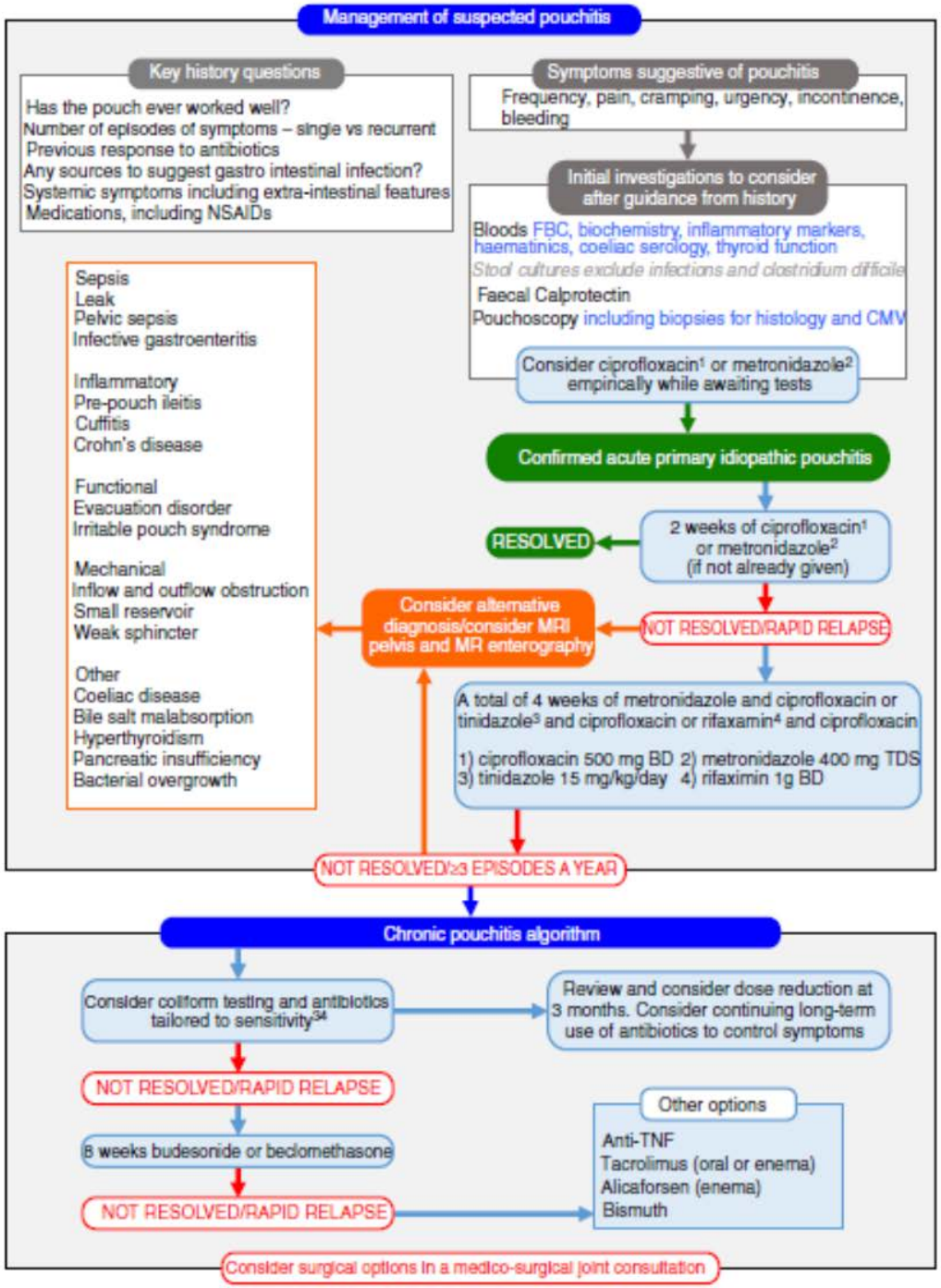
Treatment protocol



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Most common treatment

- 14 day course of Ciprofloxacin – 500mg twice a day

- If does not resolve or patient has a rapid relapse then needs a 28 day course of Ciprofloxacin 500mg twice a day alongside Metronizadole 400mg three times a day

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Cuffitis symptoms

- Frequency
- Urgency
- Bleeding
- Feeling of ‘something up there’
- Anal pain

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Treatment of cuffitis

- Mesalazine suppositories 500mg PR bd for 6 weeks
- Predsol suppositories 5mg bd for 6 weeks
- Pouch revision surgery if rectal cuff is long

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Non inflammatory pouch problems

Common:

- Ineffective emptying of pouch
- Pouch anal anastomotic narrowing

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Symptoms of ineffective emptying

- Multiple visits to the toilet in a short space of time
- Knowingly not emptying effectively
- Straining
- Struggling with loose stool and porridge like consistency
- Leakage
- ? Narrowing of the pouch anal anastomosis

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Strictures in pouches

- Develop above, in or below the pouch
- Most commonly at pouch anal anastomosis
- If there is a narrowing at the pouch anal anastomosis patient will require an EUA and dilatation
- Post theatre some patients will be taught how to use a Hegar dilator to help maintain anastomosis

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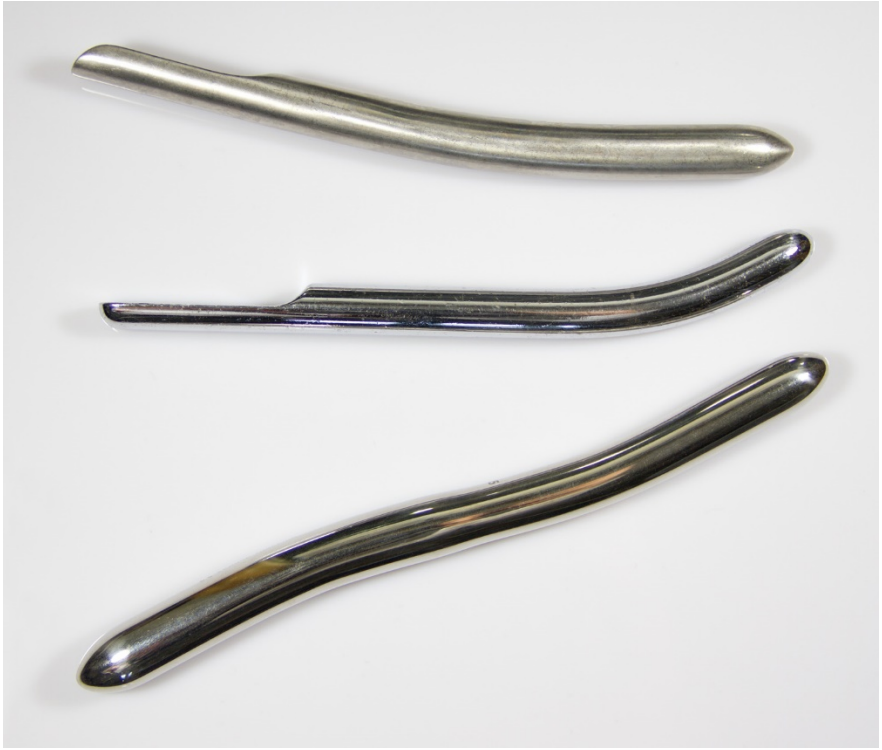
Hegar dilators



HOW TO USE A HEGAR DILATOR

(available on prescription)

EQUIPMENT NEEDED:

1. Hegar dilator or St Mark's dilator
2. Lubricating jelly (available from your GP), Lidocaine gel 2% (St Mark's formula), or instilligel (available from your GP)

INSTRUCTIONS FOR USE:

1. Empty the pouch before using the dilator
2. Lubricate the end of the dilator with the jelly
3. Lie on your left side with your knees drawn up to your chest.
4. Gently insert dilator into the anus about 3-6cm.
5. Your doctor or pouch nurse can show you how far you need to insert the dilator by gently inserting a finger into the anus and feeling the anastamosis (or the join which may have narrowed)
6. Rotate the dilator 360 degrees and then gently remove
7. Your doctor or pouch nurse will advise you on how frequently this needs to be done. Usually this only needs to be done once a day.
8. After use, the dilator should be cleaned in hot soapy water, dried and stored in a safe place

IT IS IMPORTANT TO DILATE REGULARLY EVEN IF YOU FEEL SLIGHTLY UNCOMFORTABLE DURING THE PROCESS. EFFECTIVE DILATION MAY PREVENT THE NARROWING IN YOUR ANASTAMOSIS REOCCURING.

Reference: Williams (2002) The Essentials of Pouch Care Nursing

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- If no narrowing of the pouch anal anastomosis found then go through pouch emptying techniques
- Correct positioning on the toilet
- Standing up, sitting down
- Wiggling hips

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Defaecating pouchogram

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Medena/ileostomy catheters

HOW TO USE A MEDINA CATHETER

Dispensed by Wellspect Healthcare Tel: 01453 791763 (Code 68735)

EQUIPMENT NEEDED:

1. Medina catheter
2. Lubricating jelly (available from your GP), Lidocaine gel 2% (St Mark's formula), or instillagel (available from your GP)
3. Syringe

INSTRUCTIONS FOR USE:

1. Fill the syringe with 20-30mls of warm tap water
2. Lubricate the 'eyelet' (end) of the medina with the lubricating jelly
3. Hold the medina catheter between the thumb and forefinger about 3-4" from the eyelet end
4. Gently insert the catheter into the anus until your fingers touch your buttocks
5. Ensure the other end of the catheter is aimed towards the toilet
6. Once the catheter has been inserted into the anus the pouch should drain faecal fluid or flatus
7. Ensure the pouch is empty by wiggling your hips, gently massaging your abdomen, coughing or standing slightly from the toilet
8. If the consistency of the faecal matter is too thick, then attach the syringe to the end of the catheter and insert a little water, to aid drainage.
9. After the pouch has been emptied remove the catheter slowly. Try to relax as this will assist removal. If the catheter becomes stuck, **do not panic**. Gently rotate catheter if possible or insert a little water as you pull downwards.
10. After use, wash in hot, soapy water, dry and store in a safe place.

Reference: Williams (2002) The Essentials of Pouch Care Nursing pg 162

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Biofeedback

- Non surgical and non invasive
- Behavioural /holistic approach
- Learning through reinforcement
- Involves advanced assessment, patient education, bowel and muscle retraining
- Practical techniques are taught to control and improve bowel symptoms and function
- Dietary advice

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- Loperamide and/or Fybogel usage
- Anal skin care
- Pouch training
- Improving anal sphincter tone and pelvic floor muscles
- Renew Inserts
- Irrigation
- Psychological support
- Follow ups every 4-6 weeks for 5 appointments

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Qufora and Renew Insert

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Follow up at St Mark's

- All patients who have had a pouch for ulcerative colitis
- Information about what to expect with the pouch is reiterated in detail when patient is on the ward following closure
- A date is made before discharge for the patient to come to clinic in 6 weeks

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- Assess how patient is managing their pouch at 6 weeks, 3 months, 6 months and 12 months
- Cleveland Global Quality of Life score is used
- Can use to judge against previous visit/review
- Pouch functional score – symptoms
- Pouch functional score - restrictions

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- Diet, lifestyle, routine, discuss any concerns
- Check stoma closure site for healing
- Digital examination of pouch anal anastomosis if deemed necessary
- Pouch nurses can liase with surgical/medical teams if needed
- Point of contact between clinic appointments

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Patients who can be discharged

- If patients with a history of UC are well at 1 year following closure then discharged
- Can continue to make contact with pouch nurses via phone and email if needed

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Patients who are not discharged

- Patients with FAP are followed up by the Polyposis team but can contact us at anytime
- Pouchoscopy annually for patients with a history with dysplasia or cancer when they underwent colectomy
- Annual clinic review for patients with a history of chronic pouchitis and possible pouchoscopy depending on circumstances
- Patients with Primary Sclerosing Cholangitis (PSC) need to remain under gastroenterologist

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Routine follow up

Blood tests required annually:

- Full blood count
- Urea and electrolytes
- Liver function tests
- Calcium
- Vitamin D

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- Vitamin B12
- Patients who are deficient will require 3 monthly vitamin B12 injections
- Folate
- Ferritin

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Conclusion

- Patients need to be fully informed before proceeding with pouch surgery
- Pouches can have complications – the majority can be investigated and treated
- Supporting the patient needs to be a multidisciplinary effort
- Some patients with pouches will never be discharged
- All patients with a pouch require annual blood tests

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