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Surgical management of fibrostenosing or structuring Crohn's disease: an update based on our experience and data of the literature

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Introduction: Up to 70% of the patients affected by Crohn's disease (CD) will face one or more surgeries during the course of their life. Stenosis is a frequent complication and occlusion is the most common indication of surgical intervention. About 25% of these patients will have stenosis of the small bowel, while 10% will develop colonic stenosis.

Aim & Methods: The purpose of this review is to point out the appropriate therapeutic approach in the management of structuring CD. The Aa have conducted a review of the literature of the last ten years and have revised critically their experience.

Results: To establish the most appropriate therapeutic approach from the data reported in the literature emerges the importance of defining the location, length and type of stenosis, the disease activity and the clinical condition of the patient. Diagnosis is based on the clinic and the endoscopy, as well as ultrasound (US), entero-RM and entero-TC. Patients who are not responders to conservative therapy or with signs of vascular suffering or with perforation risk should be operated urgently. Elective surgery is justified in cases of persistent obstruction despite medical therapy, especially if it is a long-lasting stenosis with a major fibrotic component. Also, in cases of occlusion in the absence of important signs of flogosis (fecal calprotectin, vascularization, contrast enhancement), early surgery would be a valid alternative to medical therapy. In all cases it is important to evaluate the ongoing therapy: steroids increase the risk of postoperative complications; the biologicals, referred to as conservative therapy in non-immediate surgery patients, would lead to an increase in postoperative complications, but not infections. Endoscopic balloon dilation (EBD) is indicated in the stenosis of the large intestine and in the stenosis of ileo-colonic anastomoses that can be reached by the instrument. The choice of medical, endoscopic, surgical treatment and choice of type of intervention (resection or strictureplasty, open or laparoscopic surgery) is based on a variety of factors including the number, length and location of the stenosis, the length of residual intestine, the presence or absence of complications (perforation, abscesses). The intervention of choice is still resection and reconstruction of the transit can be protected by ileostomy if required. Concomitant abscess imposes surgical or TC-guided drainage during preoperative study. A wide side-to-side anastomosis would be the best, as it would have lower complication rates compared to the end-to-end anastomosis. The strictureplasty (Mikuliks, Finney, Michelassi, Taschieri, Fazio) is reserved for a few selected cases with stenosis of the small bowel.

Conclusions: Stenosis represents a common complication and occurs approximately in one third of patients affected by CD. Evaluation of patients with suspect of stenosis can be performed by endoscopy, US and imaging techniques such as CT- and MR-enterography. Optimization of medical treatment can prevent the recurrence of the disease and represents therefore the first step in the management of stenosis in patients with CD. Stenosis treatment may require EBD, strictureplasty or intestinal resection. The choice between EBD, strictureplasty and either laparoscopic or open surgery is based upon the occurrence of complications, the residual intestinal length and upon the number and length of each stenosis. Surgery should be performed when local and general conditions are such as to reduce as much as possible the risk of complications. At present, given the high complexity in reaching such a condition, the management of patients with stenosing CD requires a multidisciplinary approach.

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