

Surgery for Ulcerative Colitis



Medical treatment, generally with medications taken orally or rectally, is the first therapeutic option for people with ulcerative colitis. However, about 25 to 40 percent of patients with ulcerative colitis will eventually require surgery. Some people elect to have surgery if they experience chronic severe symptoms or if medical therapy fails to adequately control symptoms.

Surgery may also become necessary if complications arise. Complications of ulcerative colitis which can require emergency surgical intervention include:

- Perforation of the colon
- Massive bleeding in the colon
- Sudden, severe ulcerative colitis
- Toxic megacolon (in which the muscle wall of the colon dilates and bacteria and gases build up inside the colon)

The standard surgical procedure for ulcerative colitis is proctocolectomy (removal of the colon and rectum). Unlike Crohn's disease, which can recur after surgery, ulcerative colitis is "cured" once the colon is removed.

Surgical Procedures

Proctocolectomy with Ileostomy: For many years, proctocolectomy has been performed along with a procedure called ileostomy. The ileum is the lowest part of the small intestine, and the word stoma means opening. An ileostomy—performed after the colon, rectum and anus have been removed—involves bringing the end of the small intestine (ileum) through a hole (stoma) in the abdominal wall, allowing drainage of intestinal waste out of the body.

After the procedure, an external bag must be worn over the opening at all times to collect waste. The bag is emptied several times a day. The usual site for an ileostomy is the right lower abdomen just below the belt line, to the right of the navel. People often worry that there will be odor and everyone will know. Actually, odor isn't a problem, and you can continue to wear your clothing with minimal adjustments. No one will know you have an ostomy unless you tell them.

This procedure is still widely performed. However, about 20 years ago, a modification was made to eliminate the need for an external waste collection (ostomy) bag.

Restorative Proctocolectomy: The newer procedure, called an ileoanal pouch anal anastomosis (IPAA) or restorative proctocolectomy, allows the patient to continue to pass stool through the anus. This procedure has become the most commonly performed surgical procedure for ulcerative colitis and is an attractive option for many people.

A restorative proctocolectomy is usually performed in two stages:

- In the first operation, the colon and rectum are removed, but the anus and anal sphincter muscles are preserved. The ileum (the end of the small intestine) is then fashioned into a pouch and pulled down and connected to the anus. Because the newly formed pouch needs time to heal, a temporary ileostomy is also performed.
- Ten to twelve weeks after the initial surgery (once the pouch has healed), the temporary ileostomy is closed. An external ostomy bag is no longer required. From this point on, the internal pouch serves as a reservoir for waste. Stool is passed through the anus in a bowel movement.

After the surgery, most people have on average six bowel movements per day. The consistency of the stool varies but is mostly soft, almost putty-like.

Possible Complications of Restorative Proctocolectomy: Most people do very well following the surgery, and after a period of recovery are able to return to work and normal activity. As with any surgery, however, there is the potential for complications. The two most common complications of restorative proctocolectomy are pouchitis and small bowel obstruction.

- *Pouchitis*, which is an inflammation of the pouch, occurs in about 30 percent of patients. Symptoms are diarrhea, crampy abdominal pain, increased frequency of stool, fever, dehydration, and joint pain. The condition is treated with an antibiotic – either metronidazole (Flagyl) or ciprofloxacin (Cipro®).
- Less common is *bowel obstruction*, which may develop due to adhesions or scar tissue from the surgery. Bowel obstruction causes crampy abdominal pain with nausea and vomiting. In about two-thirds of people who have this complication, it can be managed with bowel rest (not eating for a few days) and intravenous fluids. The other one-third of people will require surgery to remove the blockage.
- About eight to ten percent of patients will have pouch failure, which requires removal of the pouch and conversion to a permanent ileostomy.

Other Procedures: The use of the continent ileostomy (the Kock pouch), which was an operation with some promise before IPAA was developed, is *not* a good primary operation for patients with ulcerative colitis. Clinical studies on continent ileostomy are conflicting. The operation may be an alternative for people who already have an established ileostomy, but it is a highly technical operation and the surgeon must have great experience with the technique to decrease the high reoperation rate and overall poor outcomes of the procedure. Limited colonic resection in individuals with ulcerative colitis is not recommended because of the high recurrence rate.

Special Considerations

- It's important for people about to undergo any surgery for ulcerative colitis to go into the operation well nourished. Make sure you work with your doctor to bring up your nutritional status.
- People can live long, active, and productive lives with an ileostomy. The psychological implications of a change in body image, however, may be a problem at first. Support groups are available so you can meet others who are living with ileostomies and learn from those who have gone through the surgery.

- Making the decision to have surgery can be difficult. If medical therapy is not working, use all available resources to arrive at a decision. Speak with your gastroenterologist, surgeon, and, perhaps most importantly, other people who've undergone the procedure.
- Women who have undergone the IPAA procedure may have difficulty getting pregnant. If the ability to get pregnant is of major concern to you, be sure to discuss it with your gastroenterologist *and* your gynecologist to weigh your options and explore the risks and benefits of surgery before making a decision.

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