Clinical Practice Guidelines: Surgical Tx of Crohn’s Disease (1/4)

Procedure of choice for acute colitis requiring emergency surgery (for failure of medical Tx, perforation) is **total colectomy and end ileostomy**

**Diverting ileostomy** should be considered after ileocolectomy with multiple risk factors for leak

**Enteric fistulas** that persist despite medical therapy should be considered for surgery

Restorative proctocolectomy with **IPAA may be offered** to select Crohn’s disease patients (without small bowel or perianal disease), recognizing that failure rates are increased

Clinical Practice Guidelines: Surgical Tx of Crohn’s Disease (2/4)

Crohn’s disease of >8 years and >1/3 of the colon (or >1 segment) should undergo endoscopic surveillance for cancer 1B

Invisible low or high grade dysplasia should have chromoendoscopy by expert endoscopist. Persistent, invisible dysplasia should prompt referral for colectomy 1B

Visual dysplasia can be removed endoscopically and have ongoing surveillance. 1B

Surgery recommended when dysplasia: cannot be endoscopically removed, is found in surrounding flat mucosa, is multifocal, or if adenocarcinoma is present 1B

Endoscopic dilation can be considered in short-segment non-inflammatory symptomatic bowel or anastomotic strictures 1C

Clinical Practice Guidelines: Surgical Tx of Crohn’s Disease (3/4)

Crohn’s intra-abdominal abscess can be treated with antibiotics. Consider surgery (based on clinical situation and patient preference) afterwards.

- Any suspicious ulcer or mass (especially when undergoing strictureplasty) should have biopsy performed to exclude cancer.

- Refractory disease (without short bowel syndrome) should undergo escalated medical tx vs. surgery based on multidisciplinary evaluation. Consider strictureplasty for multifocal disease.

- Preop high dose steroids increase risk of postop infectious complications.

- Smoking cessation may reduce postop morbidity with Crohn’s.

- It remains controversial if monoclonal antibodies influence postop outcomes. Delaying surgical intervention based on use of these medications alone is not recommended.

Clinical Practice Guidelines: Surgical Tx of Crohn’s Disease (4/4)

Extent of mesenteric resection remains controversial. 2C

Preop nutritional support for patients with malnutrition may decrease postop morbidity 2C

Postop, medical treatment should be considered to treat residual active disease or to maintain disease remission in higher risk scenarios 1B

Anastomosis can be technically created (side to side, side to end, or end to end) based on surgeon preference and experience. 1C