Clinical Practice Guidelines: Surgical Tx of Ulcerative Colitis (1/3)

Severe, medically refractory or fulminant UC should undergo total abdominal colectomy with end-ileostomy 1C

A **staged approach** for an IPAA is considered with high-dose corticosteroids or anti-monoclonal antibodies 1C

A **2 or 3-stage** approach to IPAA is preferred for most patients 1B

Pts undergoing proctectomy should be counseled regarding possible effects on fertility, pregnancy, sexual function, and urinary function 1B

Extended post-op VTE prophylaxis considered if exposed to tofacitinib 2C

*black box warning related to rheumatoid arthritis pts*

Holubar SD, Lightner AL et al. *Dis Colon Rectum* 2021;64(7):783-804
Clinical Practice Guidelines: Surgical Tx of Ulcerative Colitis (2/3)

UC of >8 years duration should undergo endoscopic surveillance for dysplasia / cancer by an expert 1B.

Dysplasia **not amenable** to endoscopic excision, invisible dysplasia, or colorectal CA should undergo surgery (total proctocolectomy with or without ileal pouch-anal anastomosis) 1B.

Indefinite dysplasia patients should undergo:
1) **medical Tx** to achieve mucosal healing
2) **repeat colonoscopy** using high-definition / chromoendoscopy with targeted and repeat random biopsies within 3 to 12 months 1C.

Patients with visible dysplasia that is completely excised endoscopically should undergo surveillance 1B.

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Total proctocolectomy with IPAA, end ileostomy, or continent ileostomy are acceptable options for patients with UC undergoing elective surgery. TAC+IRA may be considered in selected UC patients with relative rectal sparing.

Endoscopic surveillance should be performed after IPAA at 1 year and then every 3-5 years thereafter (every 1-3 years if prior neoplasia).

Pouchitis after IPAA is classified according to its responsiveness to antibiotics.

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