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COLOPROCTOLOGY



31 August - 2 September

INTERCONTINENTAL CITY STARS CAIRO **2022**
EGYPT

Innovation in pouch surgery, preventing failing pouch, and strategies for pouch failures

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St. Mark's Hospital
and Academic Institute

Why does this matter?

Sarah – 22 year old student, no family as yet

Fails medical management



Needs emergency subtotal colectomy



Ileoanal pouch surgery



Pouch failure

Pouch failure

Pouch failure

This is defined as absence of anal function owing to removal of the pouch or formation of a diverting ileostomy with no intention to close it.

Pouch failure: type of RPC and pouch failure

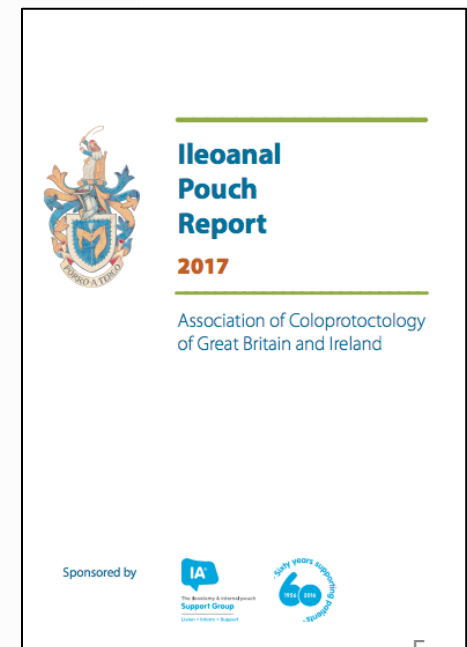
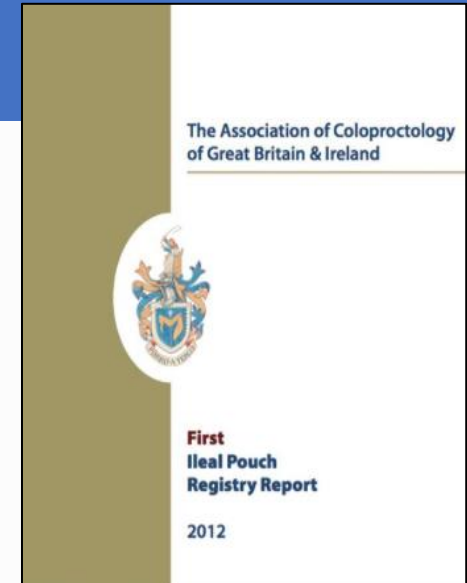
		Pouch failure (complication)			
		No	Yes	Unspecified	Rate (95% CI)
RPC type	Primary	2,095	114	0	5.2% (4.3-6.2%)
	Redo	137	25	0	15.4% (10.4-22.1%)
	Unspecified	12	0	0	0.0% (0.0-34.8%)
	All	2,244	139	0	5.8% (4.9-6.9%)

Pouch - morbidity

Patients having primary RPC: complications

		Count	Rate (95% CI)
Post-operative complications	None recorded	1,608	72.8% (70.9-74.6%)
	Any complication	601	27.2% (25.4-29.1%)
	Pelvic sepsis ¹	280	12.7% (11.3-14.2%)
	Anastomotic leak	81	3.7% (2.9-4.6%)
	Fistula	130	5.9% (5.0-7.0%)
	Abscess	125	5.7% (4.7-6.7%)
	Wound infection	63	2.9% (2.2-3.7%)
	Obstruction	217	9.8% (8.6-11.2%)
	Haemorrhage	25	1.1% (0.7-1.7%)
	Other	242	11.0% (9.7-12.3%)
	Unspecified	0	
	Patient denominator	2,209	

1. Includes any one or more of: anastomotic leak, fistula or abscess.



Strategies to reduce Pouch failure

Innovate to 'perfect' pouch surgery

Manage complications well acutely

Manage pouch dysfunction well

Innovation

Innovation

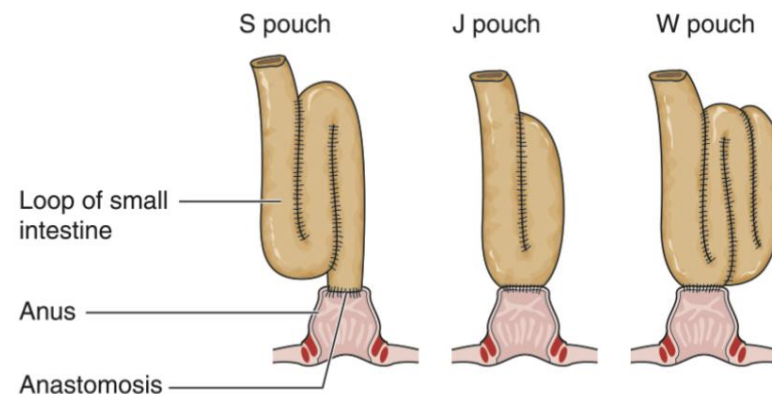
DISSECTION

- Open pouch surgery
- Multiport laparoscopic surgery
- Single port laparoscopic surgery
- Transanal approaches (TAMIS)
- Robotic pouch surgery



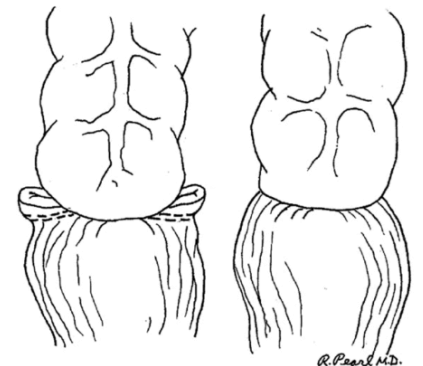
POUCH CONFIGURATION

- S-, W-, or J-
- Close rectal versus TME



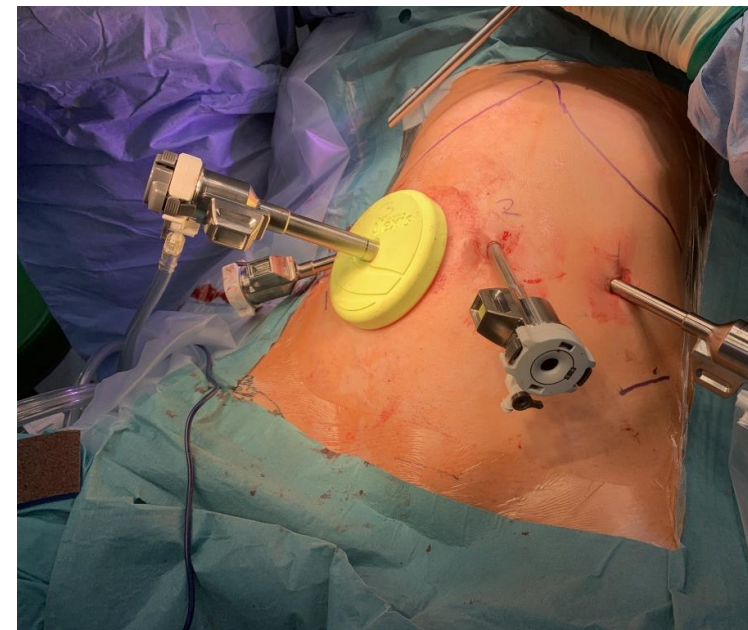
ANASTOMOSIS

- Handsewn
- Stapled
- Double purse string
- Robotic double purse



Key aspects of successful technique

- Bloodless pelvic dissection
- Short cuff (so that pouch sits on the pelvic floor)
- (Nearly) **faultless** anastomosis
- Salvage is feasible when a leak occurs



panproctocolectomy and ileoanal pouch with RiSSA for FAP

Mr Fletcher

ROBOTIC PANPROCTOCOLECTOMY AND ILEOANAL POUCH WITH RISSA FOR FAP

OPERATING COLORECTAL SURGEONS

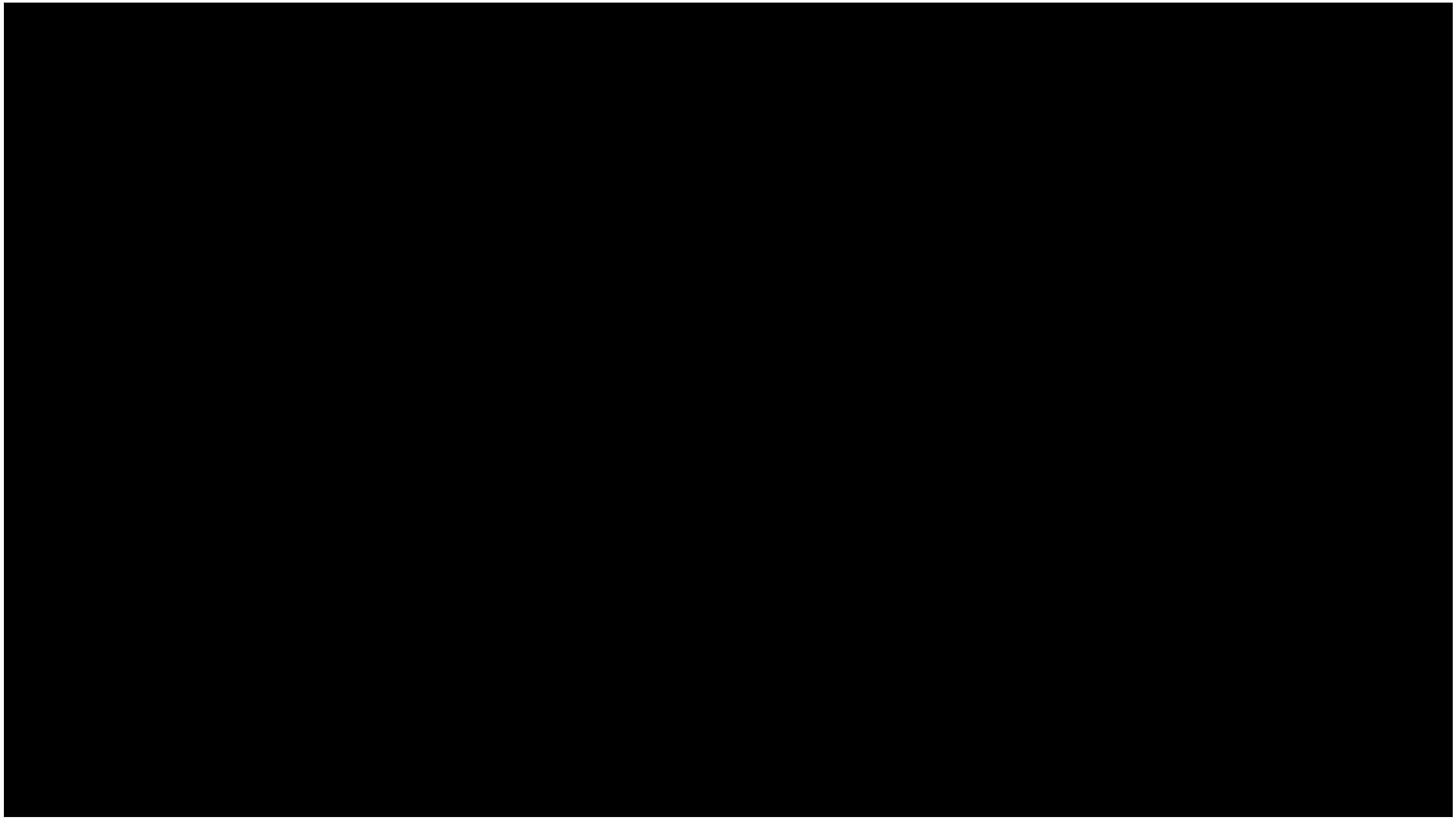
MR DANILO MISKOVIC AND PROFESSOR OMAR FAIZ

VIDEO/SOUND EDITING & PRODUCTION, ILLUSTRATION AND MOTION GRAPHICS

MR JORDAN FLETCHER,

DR CORINA BEHRENBRUCH, MR MOHAMMED DEPUTY

Robotic pouch surgery



Does the robot fulfil what is required?

- Bloodless pelvic dissection
- Short cuff (so that pouch sits on the pelvic floor)
- (Nearly) **faultless** anastomosis
- Salvage is feasible when a leak occurs



Preventing complications – the management of acute pelvic sepsis

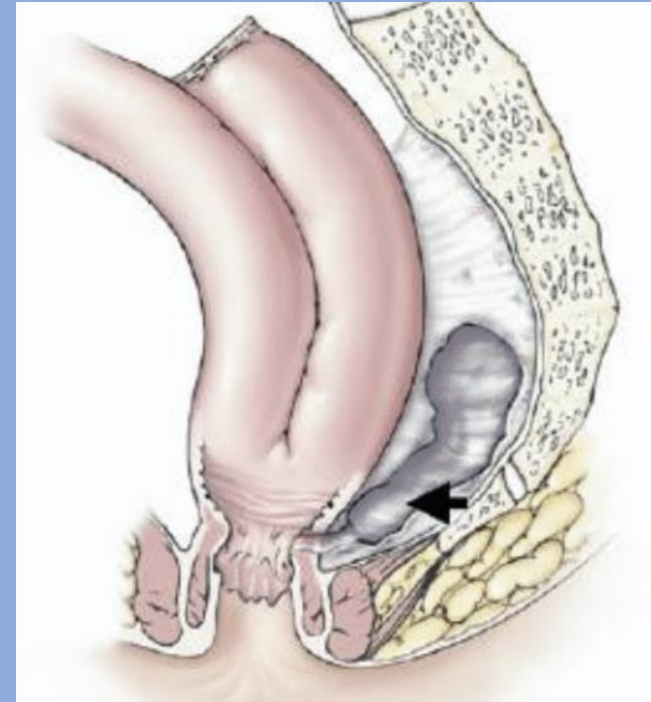
The complication to avoid – pelvic sepsis

- The causes of pouch failure:

- Pouch sepsis - 50%

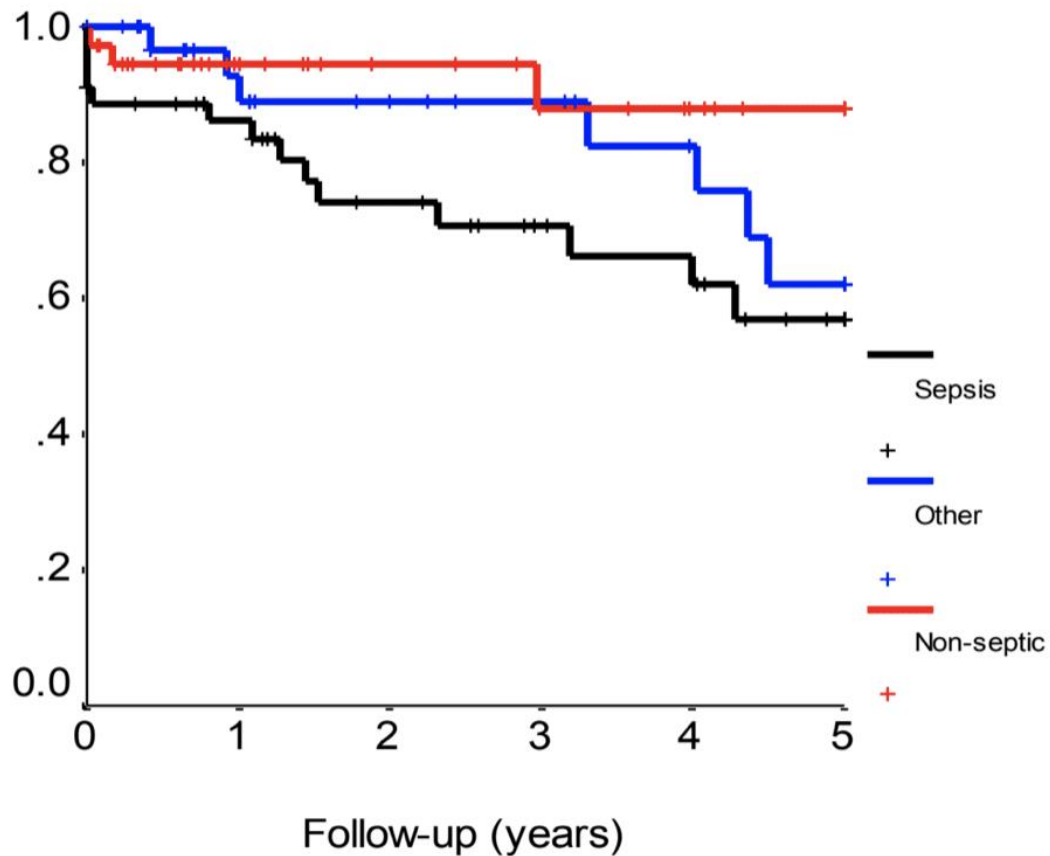
- Poor function – 30%

- Pouchitis – 10%



Tulchinsky et al, 2003

Pelvic sepsis – the implication on pouch survival



5-year pouch survival

Sepsis 56%
Non-sepsis 87%

Acute salvage following leak

Endosponge therapy

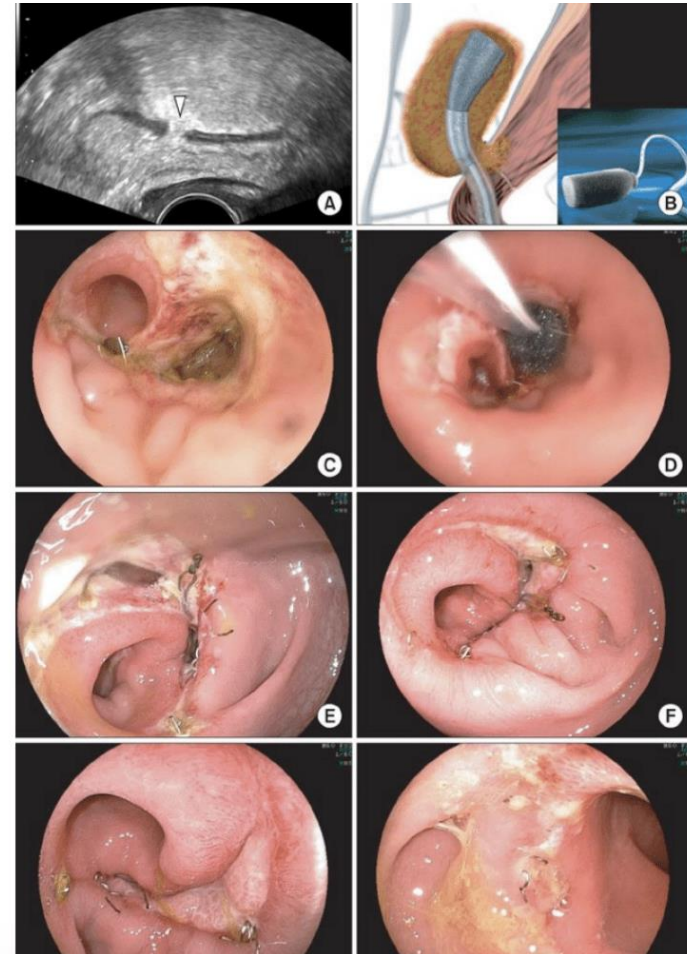
If no primary ileostomy then the first Endosponge placement was under GA with creation of stoma

Cavity cleaned and diminished (3-6 endosponge changes)

Surgical closure transanally with PDS 3-0 over Reydron
Vacum drain

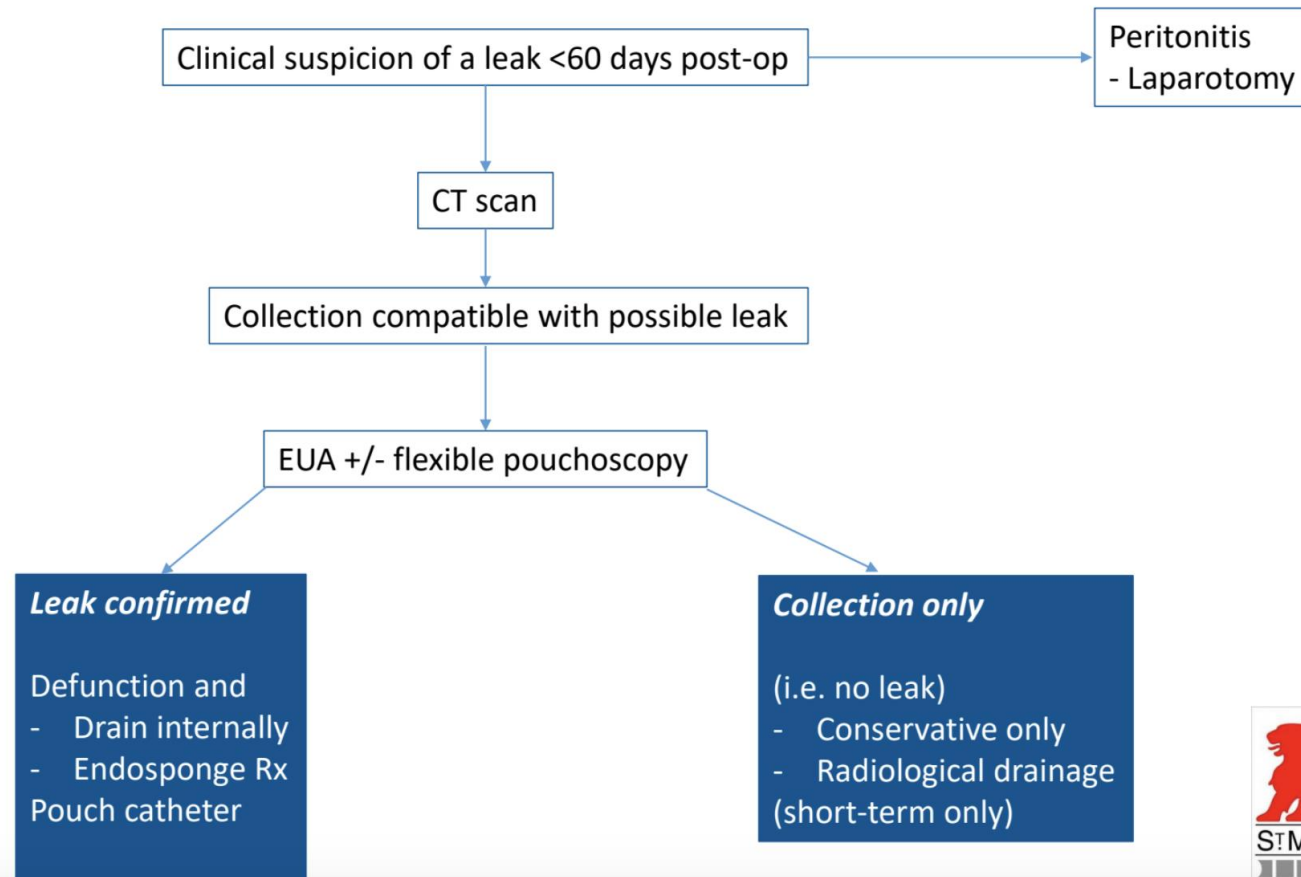
Transanastomotic drain removed after 3 days and
Antibiotics for 14 days

Endoscopic and CT inspection at 2 weeks



Management of pelvic sepsis

Algorithm for acute pouch sepsis



How to approach pouch dysfunction

Causes of dysfunction/failure

septic

inflammatory

diagnostic

Mechanical/
functional

septic

Early anastomotic leak
Late anastomotic failure

inflammatory

Pouchitis
Cuffitis

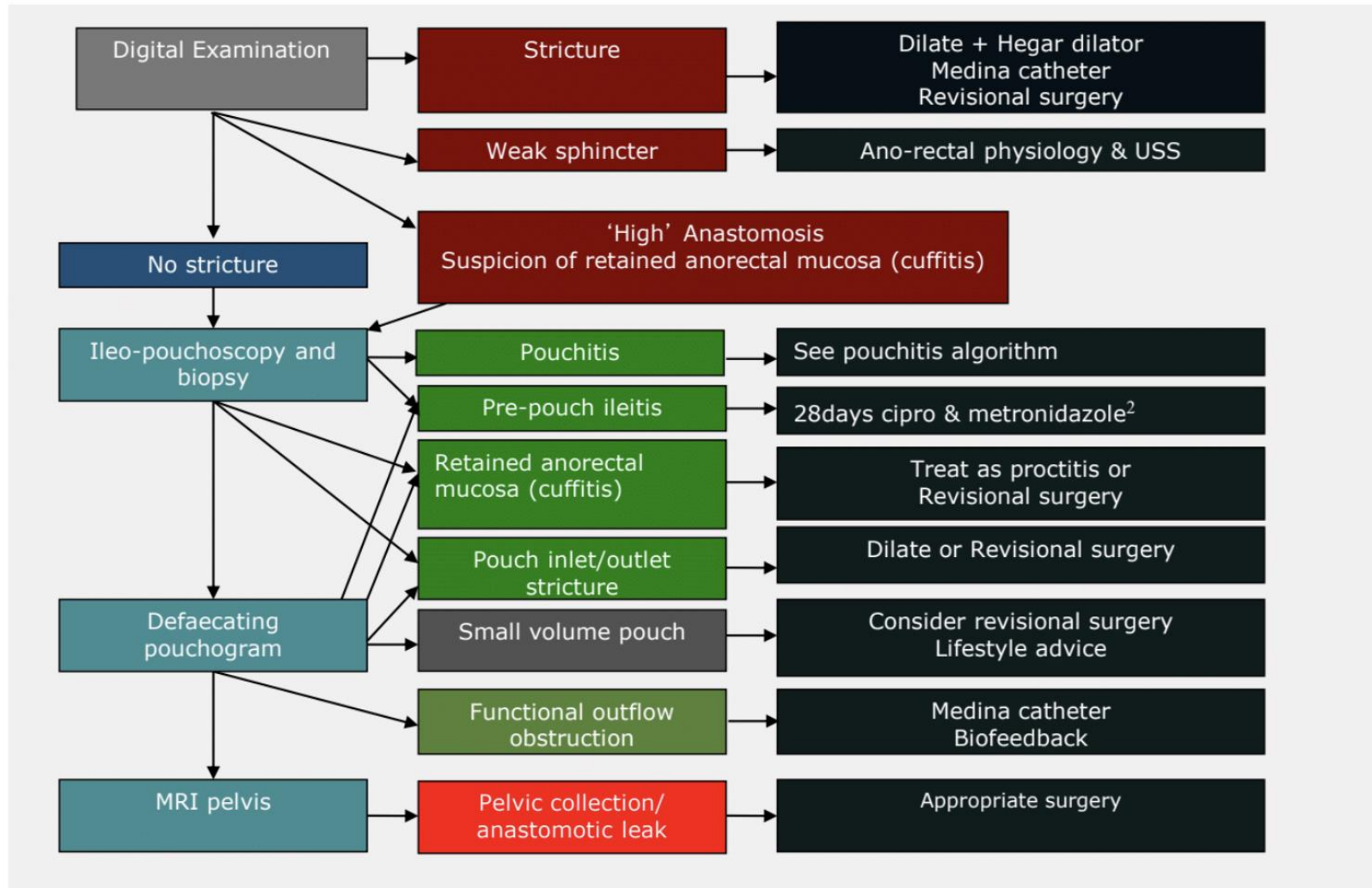
diagnostic

Undiagnosed Crohn's disease

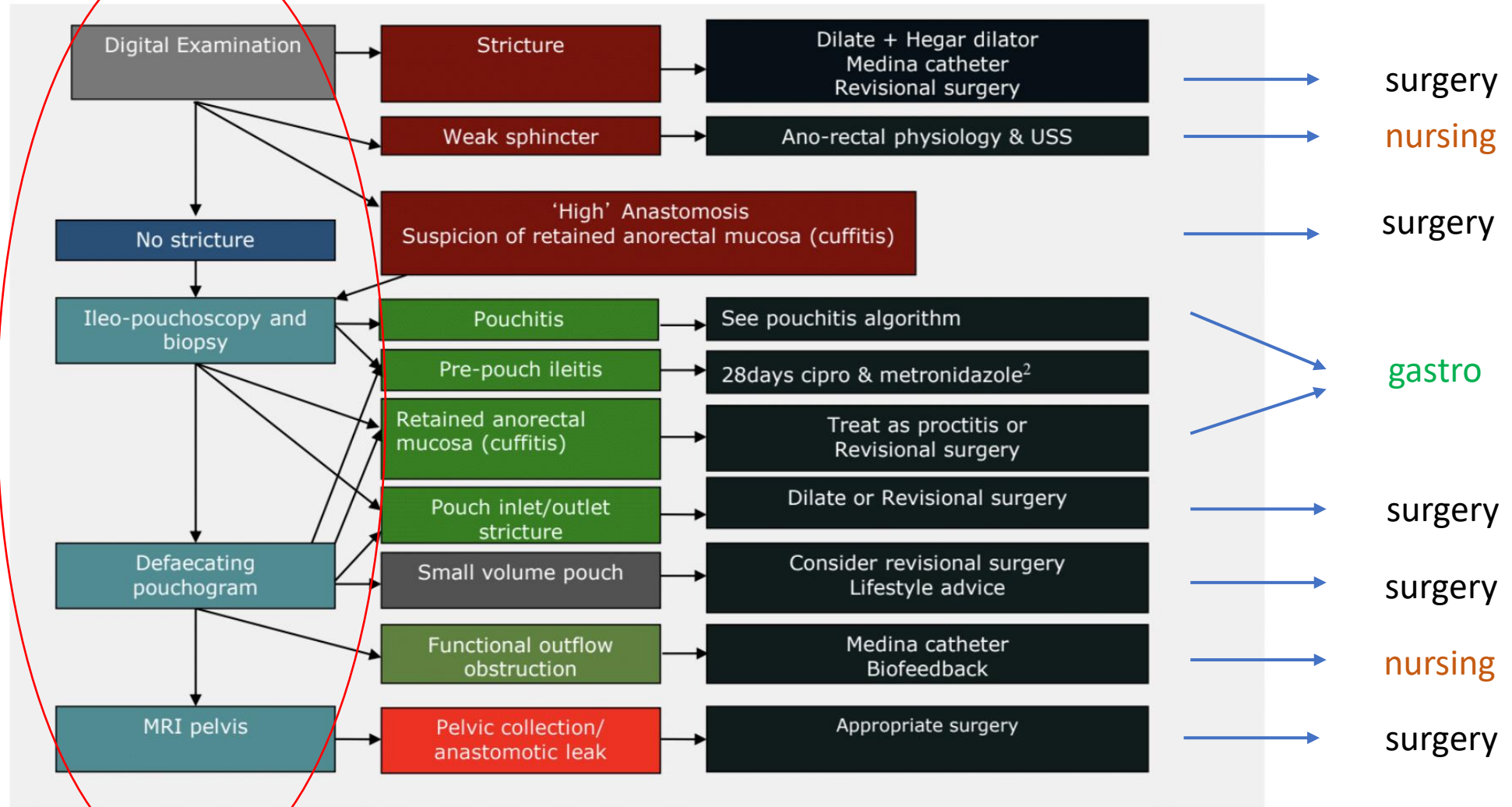
Mechanical /functional

High frequency, incontinence, inflow and outflow problems, evacuatory disorders

Algorithm for the investigation of pouch dysfunction

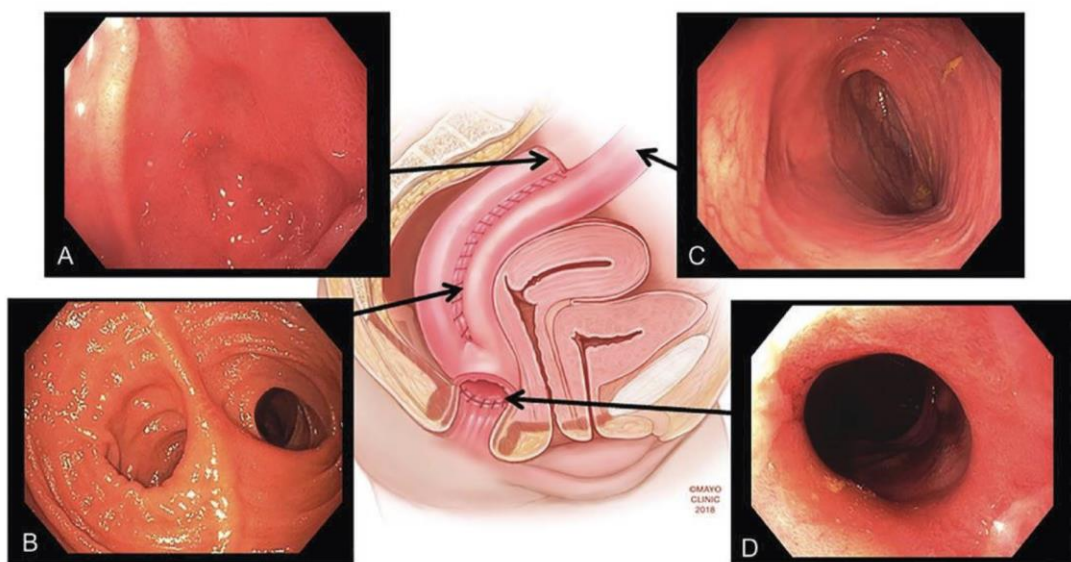


Algorithm for the investigation of pouch dysfunction



Managing inflammatory disorders

The anatomy of a pouch



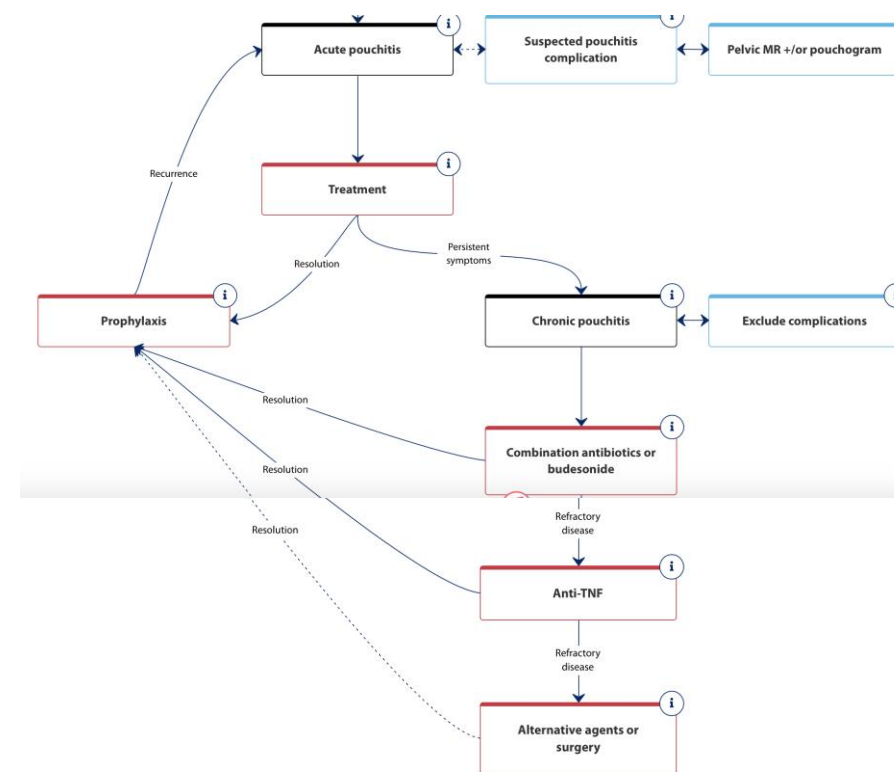
A = efferent limb

B= pouch

C = afferent limb

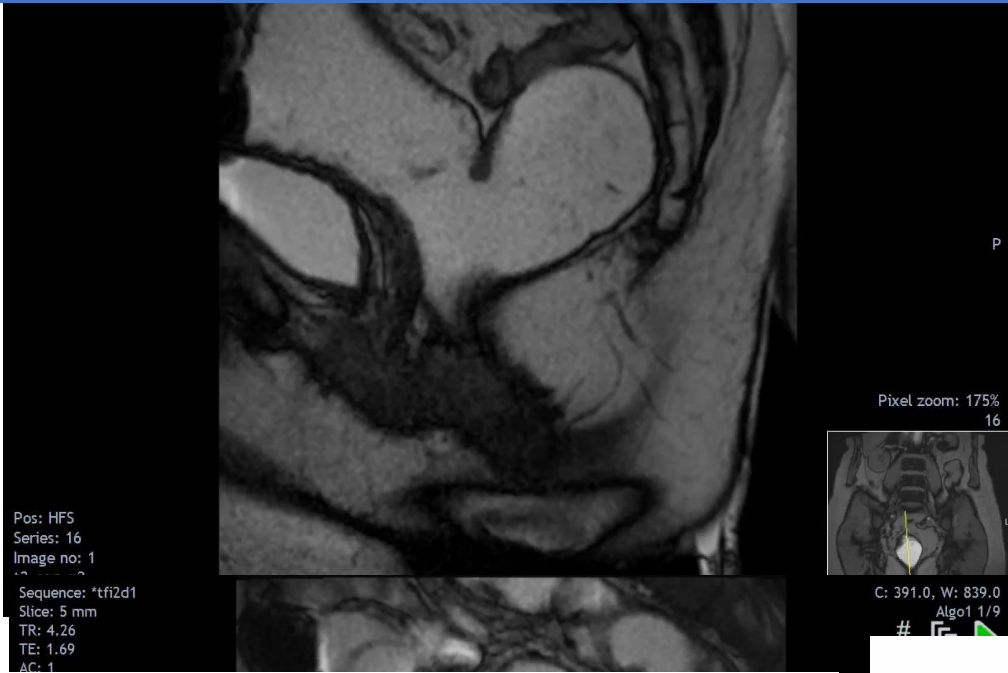
D= anastomosis

Inflamm Bowel Dis • Volume 00, Number 00, Month 2018, *British Journal of Surgery* 1998, **85**, 1517–1521



Pouchitis - ECCO guidance

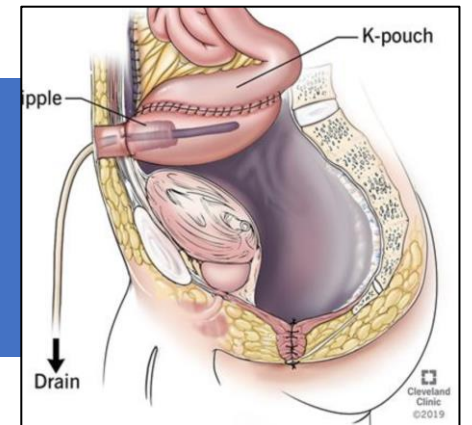
Managing evauatory disorders



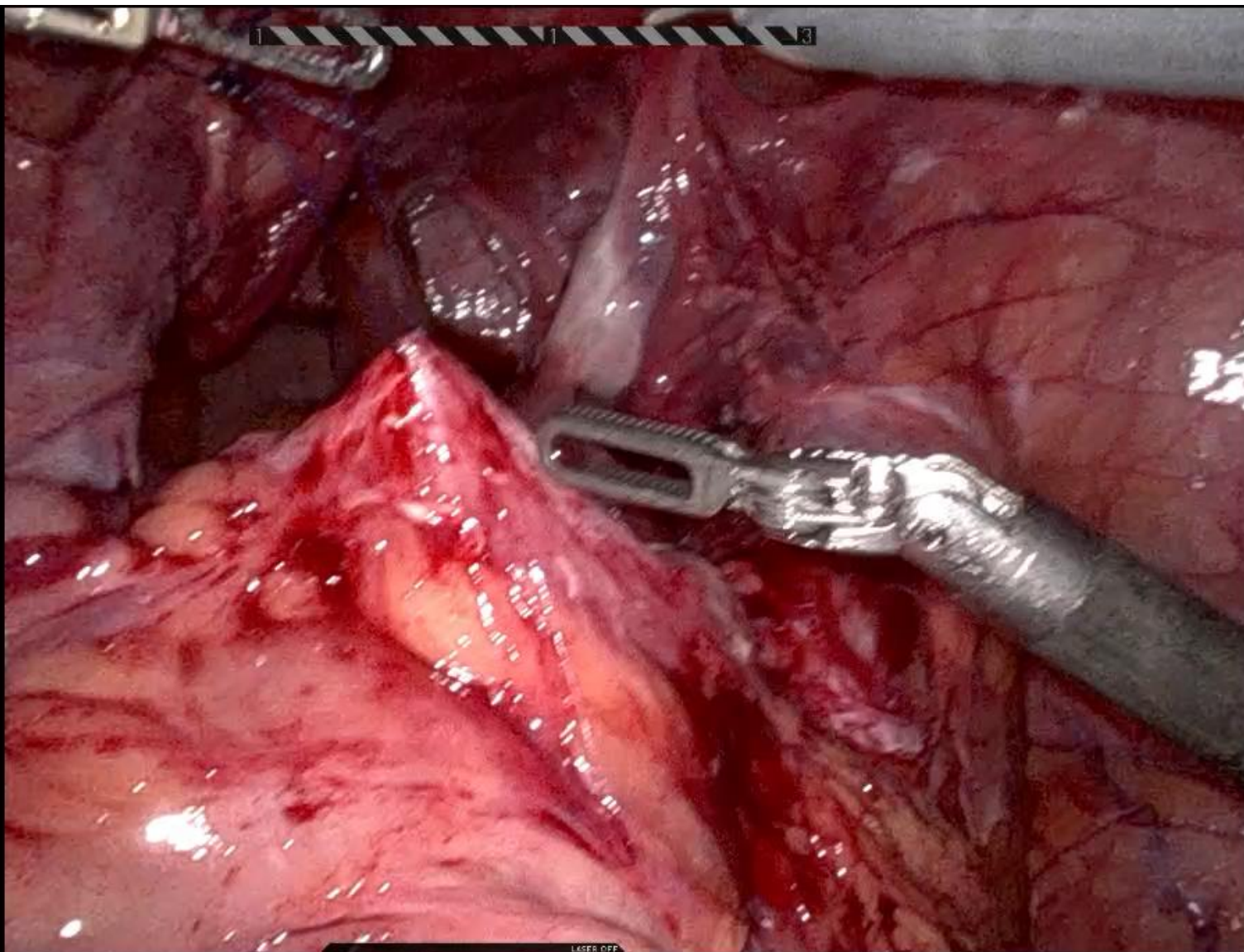
Pouch dysfunction

Defunctioning stoma (preferably end)

Pouch revision/excision *rare conversion to*







1 FENESTRATED BIPOLAR FORCEPS COAG

2 LASER OFF 21° 9° 1x 30°

3 MONOPOLAR CURVED SCISSORS CUT COAG

4 CADIERE FORCEPS

Conclusions

- The bar is high in pouch surgery – we need to keep innovating to make the procedure safer and more reliable
- Major complications following pouch surgery can take a persons QoL to a lower state
- **Avoid** complications where possible and **manage** them well when they occur – both require experience & try to centralise experience as much as possible

Thank you



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