Summary of the Q&A meeting with Professor Ian Hayes on 8th April 2016

Q: What is an ileo anal pouch/ J Pouch

A : An ileoanal pouch or a J pouch is a surgical technique that has been around since the 1980's for patients who have had the whole colon and rectum removed for familial polyposis or ulcerative colitis. In this technique the small bowel is joined to the anal sphincter zone and a reservoir or pouch is created as part of it is to perform a similar function to the rectum. If the technique works well, the patient would use their bowels 4-6 times a day. However sometimes the functional outcome is less good.

Q: Why isn't J Pouch surgery performed for Crohn's disease?

A: The problem with Crohn's is that the disease can recur in the pouch which can be a very complex situation.

Q: What causes IBD/ Inflammatory Bowel Disease?

A: The cause is unknown at this stage The disease is an auto-immune disease where the body mounts an immune response against itself**.**

Q: Where does Ulcerative occur?

A: UC is usually confined to just the colon as distinct from Crohn's disease which occurs anywhere from the mouth to the anus.

Q: Drugs versus surgery for UC

A: The medical or drug based treatments for ulcerative colitis have improved greatly and now the mainstay of treatment for ulcerative colitis is drug treatment. Surgery comes into play when a severe emergency happens or if the drugs fail to control the long term symptoms of the disease or if the lining of the bowel develops pre-cancerous or malignant changes.

Q: Risk of bowel cancer in UC ?

A: When UC involves the whole colon for more than 10 years there is a slightly increased risk of abnormal cells or even cancer. That is why we do ongoing colonoscopy screening for patients with long term UC.

Q: Can you have a temporary ileostomy permanently?

A: Yes occasionally circumstances arise where it was hoped that a loop ileostomy would be temporary but it ends up remaining long term.

Q: What is a fistula?

A:A fistula is an abnormal track between two parts of the body. A common example would be anal fistula which can occur with Crohn's where there is a track between the anal canal and the surrounding skin that leaks pus and mucous. A much more complex example would be an enterocutaneous fistula where there is an abnormal unplanned track between the gut and the skin of the abdominal wall.

Q: If a person who had an ileostomy for many years for UC develops a fistula around the stoma, why?

A: This feature would suggest that the condition may actually be Crohn's. This is a rare circumstance and there could be other explanations.

Q: When diseased small bowel is operated on, can TPN help?
A: Sometimes if a person has very low stores of nutrition it may be necessary to use TPN to build up their strength prior to surgery. However this is a rare scenario and would only apply to very sick patients who are unable to absorb enough nutrition through their gut.

Q: How much small bowel is required to absorb nutrition?
A: Generally it is said that a patient can just about manage with as little as 1 cm of small bowel per KG body weight. Thus an 80 KG person would need at least 80 cm small bowel remaining. Most people in the normal state have 2 or 3 metres of small bowel.

Q: Is there an increase in bowel cancer?
A: With long standing extensive colitis there is a slight increased risk of bowel cancer.

Q: How much surgery is being performed for IBD?
A: There is less surgery performed than previously because of improved drug treatments. Fewer ileoanal pouches are being done. There is still a role for surgery in treating anal problems such as abscess and fistula. Abdominal surgery is still required for perforation, obstruction, fistula and inflammatory bowel disease not responding to drug treatment.

Q: What types of supports are offered to patients with IBD and when they need to make a decision about having a stoma?
A: Beside the normal doctor, nurse and stomal therapy services in our public hospital, most of our surgical units do not have any other specific counselling services dedicated to IBD patients Groups such as YOU have an important role in filling these gaps.

Q: Why is a colostomy given rather than an ileostomy for a Slow Transit bowel?
A: It is relatively rare for patients to have surgery for slow transit. More often an ileostomy would be used but there are circumstances where a colostomy could be used.

Q: Prior to having surgery for UC / J Pouch what does a young girl need to do to ensure she can become pregnant & will she need a caesarean section?
A: It is important to consult with an obstetrician on these matters prior to surgery. Often a caesarean would be preferable to avoid injury to the anal sphincters. Often the colorectal surgeon will be asked to be present at the caesarian section to help deal with any bowel adhesions that might be discovered.

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