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The American Society of Colon and Rectal Surgeons Clinical Practice Guidelines for the Surgical Management of Crohn's Disease

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The American Society of Colon and Rectal Surgeons (ASCRS) is dedicated to ensuring high-quality patient care by advancing the science, prevention, and management of disorders and diseases of the colon, rectum, and anus. The Clinical Practice Guidelines Committee is composed of Society members who are chosen because they have demonstrated expertise in the specialty of colon and rectal surgery. This committee was created to lead international efforts in defining quality care for conditions related to the colon, rectum, and anus and develop clinical practice guidelines based on the best available evidence. While not

proscriptive, these guidelines provide information on which decisions can be made and do not dictate a specific form of treatment. These guidelines are intended for the use of all practitioners, health care workers, and patients who desire information about the management of the conditions addressed by the topics covered in these guidelines.

These guidelines should not be deemed inclusive of all proper methods of care nor exclusive of methods of care reasonably directed toward obtaining the same results. The ultimate judgment regarding the propriety of any specific procedure must be made by the physician in light of all of the circumstances presented by the individual patient.

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STATEMENT OF THE PROBLEM

Crohn's disease (CD) is an idiopathic, incurable chronic inflammatory disease of the GI tract, which affects over one million people in the United States and continues to increase in incidence for unknown reasons.¹ The characteristic transmural inflammation of CD can occur anywhere along the GI tract, resulting in an inflammatory, fibrostenotic, or penetrating phenotype. Although the degree of symptoms is variable and may wax and wane throughout the disease course, patients can require chronic immunosuppression and operations to *treat* the disease symptoms, but both are unable to *cure* the disease.

Monoclonal antibodies have become the cornerstone of medical therapy for moderate-to-severe disease; however, their utility is limited by primary and secondary loss

of response and the risk of serious opportunistic infection with anti-tumor necrosis factor (TNF) medication.²⁻⁹ Although the rate of surgical intervention for medically refractory disease has decreased over the past 6 decades and less emergent surgery is being performed, a meta-analysis of population-based studies reported that rates of surgical intervention for medically refractory disease remain high at 16%, 33%, and 47% at 1, 3, and 5 years from diagnosis.^{10,11} After resection, because surgery is not curative, 70% to 90% of patients will have endoscopic recurrence by 1 year and up to 35% of patients will have a repeat intestinal resection within 10 years.¹²⁻¹⁴ Given the typical complexity of patients with CD requiring surgical intervention, multidisciplinary care with gastroenterologists, surgeons, radiologists, pathologists, and other ancillary team members is critical for optimizing patient care. Because the management of patients with CD involves different medical disciplines working in conjunction with one another, these guidelines must be viewed in that context and represent only a portion of the treatment necessary for the optimal care of these patients. This clinical practice guideline will focus on the surgical management of patients with CD.

METHODOLOGY

This clinical practice guideline is based on the previous ASCRS *Clinical Practice Guideline for the Surgical Management of Crohn's Disease* that was published in 2015.¹⁵ Bowel preparation, enhanced recovery pathways, prevention of thromboembolic disease, and the management of perianal disease, although relevant to the management of patients with CD, are beyond the scope of this guideline and are addressed in other ASCRS clinical practice guidelines.¹⁶⁻¹⁹ An organized search of MEDLINE, PubMed, EMBASE, Scopus, and the Cochrane Database of Collected Reviews limited to the English language was performed from January 1, 2014 through December 1, 2019. The complete search strategy is listed in **Supplemental Digital Content**, <http://links.lww.com/DCR/B243>. Keyword combinations included “Crohn's disease”; “colitis”; “ileitis”; “fibrostenotic”; “stricture”; “abscess”; “phlegmon”; “fistula”; “megacolon”; “fulminant”; “complications”; “infliximab”; “steroids”; “TNF”; “tumor necrosis factor”; “immunomodulators”; “Crohn abscess”; “Crohn anastomosis”; “Crohn cancer”; “Crohn colitis”; “Crohn dilation”; “Crohn dysplasia”; “Crohn endoscopy”; “Crohn laparoscopy”; “Crohn laparotomy”; “Crohn operation”; “Crohn resection”; “Crohn stricture”; “Crohn strictuoplasty”; and “Crohn surgery” or “laparoscopic approach*” or “laparoscopic resection*” or “minimally invasive approach*” or “minimally invasive surgery*” or “pouch*” or “pouch failure*” or “pouch outcome*” or “robotic platform*” or “robotic resection*” or “robotics*” or “stoma*” or “stomas*” or “use of diversion.*”

In brief, a total of 15,643 unique journal titles were identified including 142 articles from a directed search of

references embedded in candidate publications including references from the 2015 guideline. The initial review of the search results titles led to the exclusion of 14,562 articles. After a review of the remaining 1081 articles, a total of 312 articles were chosen for grading of the recommendations (Fig. 1). Emphasis was placed on prospective trials, meta-analyses, systematic reviews, and practice guidelines. Peer-reviewed observational studies and retrospective studies were included when higher-quality evidence was insufficient. The final source material used was evaluated for the methodologic quality, the evidence base was examined, and a treatment guideline was formulated by the subcommittee for this guideline. The final grade of recommendation and level of evidence for each statement were determined using the Grades of Recommendation, Assessment, Development, and Evaluation system (Table 1).^{20,21} When agreement was incomplete regarding the evidence base or treatment guideline, consensus from the committee chair, vice chair, and 2 assigned reviewers determined the outcome. Members of the ASCRS Clinical Practice Guidelines Committee worked in joint production of these guidelines from inception to final publication. Recommendations formulated by the subcommittee were reviewed by the entire Clinical Practice Guidelines Committee, selected members of the ASCRS Inflammatory Bowel Disease committee, and selected practicing gastroenterologists. The guideline was peer reviewed by *Diseases of the Colon & Rectum* and the final guideline was approved by the ASCRS Executive Council. In general, each ASCRS Clinical Practice Guideline is updated every 5 years. No funding was received for preparing this guideline and the authors have declared no competing interests related to this material. This guideline conforms to the Appraisal of Guidelines Research and Evaluation (AGREE) checklist.

OPERATIVE INDICATIONS

Medically Refractory Disease

1. **Patients who demonstrate an inadequate response to, develop complications from, or are nonadherent with medical therapy should typically be considered for surgery. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.**

The goals of medical treatment of CD are to achieve remission with endoscopic mucosal healing in patients with active disease and avoid relapse in those with quiescent disease. When glucocorticoids are used, clinical improvement is usually evident within days of initiating intravenous therapy and within 2 to 4 weeks of treatment with oral glucocorticoids. When immunomodulators (eg, 6-mercaptopurine, methotrexate, azathioprine) are used as a monotherapy, a plateau in improvement of clinical symptoms is often demonstrated within 12 to 16 weeks.¹⁴ On the initiation of monoclonal antibody therapy with

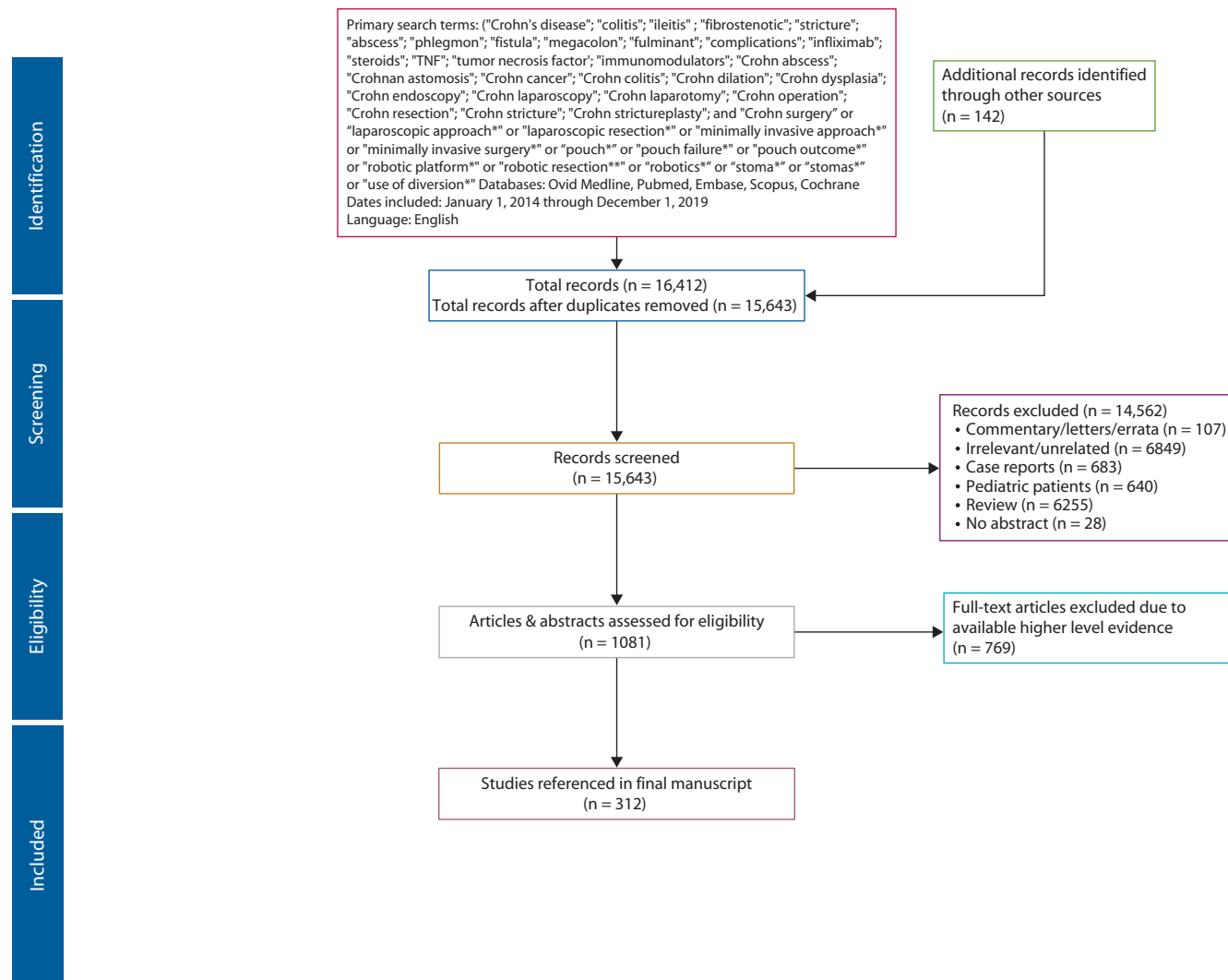


FIGURE 1. PRISMA literature search flow sheet.

an anti-TNF (eg, infliximab, adalimumab, certolizumab pegol), anti-integrin (eg, vedolizumab), or anti-interleukin (eg, ustekinumab) a 6- to 12-week course of therapy is usually recommended to assess efficacy.²² An exception to these timelines is in the setting of severe, acute colitis, when infliximab is given as a loading dose in an attempt to control the acute presentation; in this situation, a more limited period of about 5 to 7 days is usually recommended to determine the initial response justifying continuation of therapy.^{23–25}

Surgical intervention may be warranted in patients who are unable to tolerate medical therapy because of side effects, are nonadherent to medical therapy, or have medically refractory disease activity due to primary or secondary loss of response.^{26–29} Surgery may also be considered in patients who are steroid dependent regardless of disease severity because of the deleterious effects of chronic glucocorticoid use.³⁰ A recent randomized, controlled trial also proposed laparoscopic resection as a reasonable

option rather than initiating monoclonal antibody therapy in the setting of otherwise refractory, relatively limited disease (eg, short-length <40 cm, inflammatory, nonstricturing, ileocolic disease).³¹

Inflammation

1. Patients with severe acute colitis who do not adequately respond to medical therapy or who have signs or symptoms of impending or actual perforation should undergo surgery. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Because of the limited evidence specific to CD, the management of severe, acute colitis in patients with CD is based almost entirely on our understanding of this condition in patients with ulcerative colitis (UC).^{32,33} A recent prospective cohort comparative analysis showed that the severe forms of UC and Crohn's colitis respond similarly to medical therapy with a response to steroids in 73% and

TABLE 1. The GRADE System: grading recommendations

Grade	Description	Benefit versus risk and burdens	Methodologic quality of supporting evidence	Implications
1A	Strong recommendation, High-quality evidence	Benefits clearly outweigh risk and burdens or vice versa	RCTs without important limitations or overwhelming evidence from observational studies	Strong recommendation, can apply to most patients in most circumstances without reservation
1B	Strong recommendation, Moderate-quality evidence	Benefits clearly outweigh risk and burdens or vice versa	RCTs with important limitations (inconsistent results, methodologic flaws, indirect or imprecise) or exceptionally strong evidence from observational studies	Strong recommendation, can apply to most patients in most circumstances without reservation
1C	Strong recommendation, Low- or very-low quality evidence	Benefits clearly outweigh risk and burdens or vice versa	Observational studies or case series	Strong recommendation but may change when higher-quality evidence becomes available
2A	Weak recommendation, High-quality evidence	Benefits closely balanced with risks and burdens	RCTs without important limitations or overwhelming evidence from observational studies	Weak recommendation, best action may differ depending on circumstances or patients' or societal values
2B	Weak recommendations, Moderate-quality evidence	Benefits closely balanced with risks and burdens	RCTs with important limitations (inconsistent results, methodologic flaws, indirect or imprecise) or exceptionally strong evidence from observational studies	Weak recommendation, best action may differ depending on circumstances or patients' or societal values
2C	Weak recommendation, Low- or very-low quality evidence	Uncertainty in the estimates of benefits, risks and burden; benefits, risk and burden may be closely balanced	Observational studies or case series	Very weak recommendations; other alternatives may be equally reasonable

GRADE = Grades of Recommendation, Assessment, Development, and Evaluation; RCT = randomized controlled trial.

Adapted from Guyatt G, Guterman D, Baumann MH, et al. Grading strength of recommendations and quality of evidence in clinical guidelines: report from an American College of Chest Physicians Task Force. *Chest*. 2006;129:174–181.²⁰ Used with permission.

68% of patients and to anti-TNF drugs in 89% and 86% of patients.³³

“Severe acute colitis” and “fulminant colitis” are terms that apply to patients with colitis, frequent stools (≥ 6 /day), and systemic inflammatory response syndrome (SIRS).^{32,34} The degree of severity can be classified as mild, moderate, or severe using the modified Truelove and Witts criteria, with severe colitis defined as ≥ 6 bowel movements per day and at least one of the following: temperature $>37.8^{\circ}\text{C}$, pulse >90 beats per minute, erythrocyte sedimentation rate >30 mm/h, C-reactive protein >30 mg/L, or a hemoglobin <10.5 g/dL.³⁴ “Megacolon” is often defined as transverse colon diameter ≥ 5.5 cm and, in the setting of SIRS, is termed “toxic megacolon.”^{35,36} When severe Crohn's colitis is suspected, alternative causes of colitis (eg, *Clostridium difficile*, cytomegalovirus) should typically be excluded with stool studies and endoscopic mucosal biopsy via careful flexible sigmoidoscopy, and therapeutic drug monitoring may be helpful to guide monoclonal antibody therapy.^{37–40} Laboratory testing including serum C-reactive protein, hemoglobin, creatinine, and albumin levels, fecal calprotectin and monoclonal antibody drug levels

for therapeutic drug monitoring can help measure the response to therapeutic interventions.^{40,41} Given the potentially masking effects of high-dose steroids, patients are usually followed with plain abdominal x-rays to determine the presence of megacolon or bowel perforation, and these may need to be repeated often, if not daily, until patients' overall clinical condition improves.

Initial treatment of severe colitis includes supportive care, intravenous fluid resuscitation, avoidance of antidiarrheal medication, limited use of opiates and anticholinergics, and prompt initiation of intravenous glucocorticoids (eg, methylprednisolone 60 mg/day). Venous thromboembolism prophylaxis beginning on hospital admission is recommended because active colitis is a risk factor for this potentially life-threatening condition, whereas bowel rest and prophylactic antibiotics are usually not necessary.^{40,42,43}

In general, a response to steroid therapy includes improvement or resolution of the SIRS, a decrease in stool frequency (eg, <6 /day), and overall clinical improvement. When patients do not respond adequately within about 72 hours, using a second-line therapy such as an

anti-TNF drug or cyclosporine should typically be considered.^{24,25,44,45} A response to anti-TNF or cyclosporine in this setting should occur typically within about 5 to 7 days.^{46–48} For medical treatment failures or colitis-related emergencies (eg, colon perforation), subtotal colectomy with end ileostomy is generally recommended.⁴⁹

Stricture

1. Endoscopic dilation may be considered for patients with short-segment, noninflammatory, symptomatic small-bowel or anastomotic strictures. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Strictures complicating CD can arise anywhere along the intestinal tract and are often classified as either inflammatory or fibrostenotic in nature. The degree of inflammation surrounding the bowel wall can be suggestive of an inflammatory stricture, and chronic upstream bowel dilation is more typical of a fibrostenotic stricture. However, these categories are not mutually exclusive because intestinal fibrosis is a dynamic process and inflammation and fibrosis can coexist within the same stricture or region.^{50,51} Ultrasound, computed tomography enterography (CTE) and magnetic resonance enterography (MRE) can diagnose small-bowel strictures with a high level of accuracy, and recent guidelines report algorithms for trying to distinguish between fibrotic and inflammatory strictures.^{52–54} Magnetic resonance imaging avoids the radiation exposure from CT imaging that may be a particularly relevant consideration in younger patients who potentially face an increased lifetime cumulative radiation exposure.⁵⁵ In addition, MRE may be better than CTE in distinguishing inflammatory, fibrotic, and mixed inflammatory/fibrotic strictures.⁵³ However, obtaining an MRE after a CTE has been performed is not usually recommended because of the lack of additional diagnostic yield under these circumstances.⁵⁶

Medical therapy with steroids, immunomodulators, or anti-TNF drugs remains the first-line treatment for strictures with an inflammatory component, whereas endoscopic or surgical therapy is usually indicated for fibrostenotic strictures.^{51,57} The typical indication for endoscopic therapy is a limited, short-segment (<5 cm) stricture in the absence of associated penetrating disease (eg, abscess, fistula). Primary and anastomotic strictures may be successfully dilated with endoscopic techniques.^{58,59} The most commonly used dilation approach is a “through-the-scope” method using variable diameter dilating balloons, although a standardized methodology of sequential dilations has not been established.⁶⁰

The technical success of endoscopic stricture dilation is about 90%, and complications (eg, perforation, hemorrhage) occur in 2% to 4% of cases.^{53,58,59,61,62} After successful dilation of a nonanastomotic site (eg, primary stricture), repeat endoscopic dilation is required in 41% to

73% of patients followed for up to 5 years, and recurrence rates are higher at anastomotic sites in comparison to nonanastomotic sites.^{54,59,60,63} Dilation of strictures <5 cm in length in the setting of CD has been associated with the best long-term outcome.^{58,59} Steroid injection of the stricture during dilation is typically not helpful.^{59,63,64} Within 2 to 5 years after endoscopic dilation of primary or anastomotic strictures, surgical intervention is required in about one-third of patients.^{53,58,59,63}

2. Surgery is indicated for patients with symptomatic small-bowel or anastomotic strictures that are not amenable to medical therapy and/or endoscopic dilation. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Resection or strictureplasty is warranted for small-bowel and anastomotic strictures when medical and/or endoscopic treatments are unsuccessful or when a stricture is believed to be fixed and fibrotic in nature and not amenable to medical therapy.⁶⁵ When resection is performed, the extent of resection should typically include only about 2 cm of grossly uninflamed bowel proximal and distal to the diseased segment, because there is no benefit to obtaining microscopically negative margins or removing extended lengths of normal bowel.^{66–68} Although limited mesenteric excision remains the most common practice under these circumstances, the role of a more extensive mesenteric resection is being investigated and is reviewed later.⁶⁹ Sutured or stapled techniques, both suitable for bowel anastomosis in this setting, and the use of a defunctioning ileostomy are discussed elsewhere in this guideline.^{70–72}

Strictureplasty, an alternative to resection, is used in general to preserve bowel length and is often the preferred option for patients with multiple strictures separated by relatively longer segments of grossly normal small bowel, in particular, in patients who are at risk for short-bowel syndrome. Strictureplasty may also be particularly suitable for selected duodenal strictures where resection carries higher risk, but should typically be avoided in the setting of perforation, inflammatory mass, malignancy, dysplasia, or severe malnutrition.^{73–75} In 38% to 71% of cases, strictureplasty is combined with bowel resection to address multifocal disease while maximizing bowel preservation.^{76,77}

The type of strictureplasty performed is largely based on the length of the stricture and the pliability of the affected bowel. In general, Heineke-Mikulicz strictureplasty is used for strictures <10 cm, Finney strictureplasty can address strictures 10 to 25 cm in length, and isoperistaltic side-to-side strictureplasty is indicated for strictures longer than about 25 cm.^{75,78–80} Complications of strictureplasty have been reported in 4% to 18% of patients in large series and include surgical site infection, obstruction, stricture-site hemorrhage, sepsis, perforation, and, in 6% of patients, early reoperation.^{76,78,81–83} Low preoperative

albumin, weight loss, advanced age, preoperative steroid use, and abscess or fistula at the time of strictureplasty are risk factors for intra-abdominal septic complications.^{82,84}

Patients undergoing strictureplasty are at a risk for recurrence, which, in general, is comparable to patients undergoing resection.⁸⁵ Studies report a 5-year recurrence rate after strictureplasty in jejunoileal and ileocolic locations of 25% to 30% that includes a roughly 3% site-specific recurrence rate; the remaining majority of recurrences develop in intestinal segments remote from original strictureplasty sites.^{81,82} After strictureplasty, reoperation for recurrent disease has been reported in 29%, 34%, and 73% of patients after 5, 7.5, and 10 years.^{76,82}

3. Patients with strictures of the colon that cannot be adequately surveyed endoscopically should be considered for resection. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Colonic strictures occur in 9% to 13% of patients with CD and are most commonly found at a single site, although multiple strictures may be present.^{86–88} Endoscopic dilation can be used in colonic strictures to alleviate symptoms with success rates similar to those seen after dilating small-bowel strictures.⁶² It is important to appreciate that 2% to 6% of colonic CD strictures contain occult dysplasia or cancer, but it is often difficult to differentiate malignant from benign strictures by using clinical criteria alone. Factors more commonly associated with cancer include shorter segment strictures, advanced patient age, longer duration of disease, and absence of active colitis.^{87–89} Colorectal strictures should be assessed with multiple endoscopic biopsies and cytological brushings, if needed, to evaluate for malignancy.⁹⁰ If a stricture cannot be adequately surveyed to exclude a concomitant carcinoma, resection following standard oncologic principles should typically be performed. Although colonic strictureplasty has been reported, this is generally discouraged due to a lack of proven benefit as well as concerns about potential carcinoma being left in situ.⁹¹

Penetrating Disease

1. Patients with a free perforation should undergo surgical resection of the perforated segment. Grade of recommendation: Strong recommendation based on moderate-quality evidence, 1B.

Free perforation of the bowel in patients with CD is uncommon with a reported incidence of 1.5% to 16% with nearly all cases involving a solitary perforation of the small bowel.^{92–97} Resection of the perforated segment is preferred over simple suture closure because of the relatively high failure rate and increased risk of morbidity associated with primary repair.^{93,98}

2. Patients with penetrating Crohn's disease with abscess formation may be managed with antibiotics with or

without drainage followed by interval elective resection or medical therapy depending on the clinical situation and patient preferences. Grade of recommendation: Weak recommendation based on moderate-quality evidence, 2B.

Intra-abdominal abscesses in patients with CD typically result from a penetrating disease phenotype with an associated distal stricture and can have an associated inflammatory process that affects other segments of bowel walling off the abscess. Although smaller abscesses (<3 cm) can generally be treated with antibiotics alone, larger abscesses are typically treated with antibiotics and percutaneous drainage (PD) that has a low rate of enterocutaneous fistula formation.^{99–105} Comparative studies and meta-analyses comparing PD and initial surgery for spontaneous abdominal abscess in patients with CD indicate that successful PD, defined as abscess resolution and avoidance of subsequent surgery, occurs in 23% to 78% of patients; abscess recurrence is significantly higher after PD alone versus surgical intervention (OR, 2.16; 95% CI, 1.03–4.54; $p = 0.04$).^{106–111} Factors associated with PD failure include concomitant steroid use, colonic disease, and abscesses that are large, multiloculated, or multifocal.^{107,112,113}

Percutaneous drainage used as a bridge to bowel resection compared with bowel resection without prior PD results in decreased overall complications, need for diverting stoma, and overall cost, and no difference in rates of postoperative enterocutaneous fistula and anastomotic leak.^{107,109,114} Preoperative PD combined with antibiotics typically improves postoperative outcomes and shortens the overall length of stay.^{115–117} In a meta-analysis of 513 patients who have CD with spontaneous abscess, the postoperative complication rate was significantly lower in patients who underwent PD followed by surgical intervention versus surgical intervention at presentation (OR, 0.44; 95% CI, 0.23–0.83; $p = 0.03$).¹⁰⁹ Resection under these circumstances should emphasize bowel preservation and avoid overaggressive resection, because the removal of bowel can lead to immediate or future development of short-bowel syndrome.¹⁰³

Anti-TNF therapy in the setting of an inflammatory mass (ie, phlegmon) with a concomitant abscess typically carries a low risk when initiated after intravenous antibiotics and PD of the abscess, as needed.¹¹⁸ Although conflicting studies have been published, the treatment strategy of drainage followed by anti-TNF therapy may prevent bowel resection in up to 30% of patients.¹¹¹

3. Patients with enteric fistulas that persist despite appropriate medical therapy should be considered for surgery. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

In the setting of penetrating disease with enteric fistulas, concomitant abscesses should be identified and drained

when feasible.¹¹⁹ The inability to control intra-abdominal consequences of a penetrating phenotype (ie, abscess, phlegmon) usually warrants resection of the diseased bowel.¹²⁰ In a multicenter, retrospective study of 93 patients with intra-abdominal fistulizing CD (enteroenteric/colic 77%, enterovesicle 17%, enterovaginal 6%), 59% had a coexisting stricture, but none had a coexistent abscess; all patients were treated primarily with anti-TNF therapy with or without a concomitant immunomodulator, and surgery was eventually performed in 44% of patients.¹²¹ In this study, the cumulative surgery rate was 18%, 27%, 37%, and 47% at 1, 2, 3, and 5 years from the induction of anti-TNF agents, and did not differ by fistula location; thus, surgery was avoided in over 50% of patients. A lower Crohn's Disease Activity Index¹²² and shorter interval between the diagnosis of fistula and starting the monoclonal antibody were independently and significantly associated with lower risk of undergoing surgery. In other multicenter retrospective studies and systematic reviews of patients with enterovesicular fistulas, anti-TNF therapy has been shown to result in a complete and durable response in 45% to 57% of patients.^{123,124}

When operative treatment is required, management requires differentiating diseased bowel from other loops of bowel or organs that are secondarily involved that may or may not require resection. In general, diseased bowel is resected, whereas noninflamed bowel can be primarily repaired and other internal organs (eg, bladder, vagina) can be repaired or left to heal by secondary intention, depending on the circumstances.^{125–129} Of note, the mere presence of a fistula does not necessarily mandate surgery, especially in the absence of malabsorption, intractable diarrhea, or recurrent infection.¹¹⁶

Hemorrhage

1. Stable patients with gastrointestinal hemorrhage may be evaluated and treated by endoscopic and/or interventional radiologic techniques. Unstable patients, despite resuscitation efforts, should typically undergo operative exploration. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Acute lower GI hemorrhage is an unusual complication of CD, occurring in 0.9% to 10% of patients with an incidence that correlates with disease duration.^{130–135} Significant lower GI bleeding in patients with CD is more often secondary to severe inflammation and, unlike other more common sources of massive lower GI bleeding (eg, diverticula, arteriovenous malformation), rarely necessitates the diagnostic journey required in a bleed of unknown origin. Patients with significant bleeding should undergo concomitant resuscitation along with appropriate diagnostic measures, which, in stable patients, may include CT angiography, endoscopy, nuclear scintigraphy, and/or conventional mesenteric arteriography.¹³⁶ Although

not specific to CD, CT angiography in the setting of acute GI bleeding has sensitivity rates up to 89% and specificity rates up to 92%.^{136–138} The likelihood of identifying a precise bleeding source is somewhat limited, because spontaneous cessation of bleeding occurs in nearly one-half of all patients with lower GI bleeding; however, recurrent bleeding occurs in nearly 40% of cases.^{129,133} More specific to patients with CD, endoscopic clipping may be difficult in the presence of inflamed and friable mucosa and rebleeding in patients successfully managed with nonoperative measures may be reduced with anti-TNF therapy.^{130,133}

In general, surgical treatment is recommended in patients with CD with life-threatening bleeding, persistent hemodynamic instability, or recurrent, significant GI bleeding following nonoperative measures. Although mortality related to surgical management is high (up to 7%), rates of rebleeding are much lower compared with nonsurgical intervention (6% versus 39%).^{130,139} The primary challenges with surgical intervention are accurately identifying the bleeding site and effectively managing the risk of short-bowel syndrome with every additional segment of bowel removed, recognizing that two-thirds of patients with CD who bleed have otherwise quiescent disease.¹³⁰ Therefore, if the source of bleeding has been localized by using preoperative or intraoperative modalities, a targeted resection is typically recommended.¹³⁹ In cases of persistent hemodynamic instability or serious bleeding that cannot be localized to 1 segment of the colon, a total colectomy may be necessary.¹⁴⁰

Colorectal Dysplasia and Cancer

1. Patients with long-standing Crohn's colitis involving at least one-third of the colon or more than 1 segment, should typically undergo endoscopic surveillance at regular intervals. Grade of recommendation: Strong recommendation based on moderate-quality evidence, 1B.

In comparison with an age-matched general population, patients with Crohn's colitis have a 2- to 3-fold increased risk of colorectal cancer, similar to the risk of colorectal cancer developing in patients with UC.^{141,142} Risk factors for colorectal cancer in patients with CD include disease extent (usually defined as the most extensive disease documented at any time point in a patient's course) and duration, a family history of colorectal cancer, and concomitant primary sclerosing cholangitis (PSC).^{141,143–146} Although a diagnosis of dysplasia may precede or accompany the diagnosis of adenocarcinoma in patients with Crohn's colitis, cancer can also be the index neoplastic lesion.^{1,147–150}

Although surveillance colonoscopy for patients with CD is endorsed by multiple societies, controversy persists regarding timing and intervals.¹⁵¹ Patients, regardless of the extent of disease at initial diagnosis, should typically undergo screening colonoscopy within 8 years of the onset of symptoms. Exceptions are made for patients with

PSC who should typically begin screening at the time of diagnosis and then undergo surveillance annually. Patients with a strong family history of colorectal cancer (age <50, first-degree relative) should typically also undergo more frequent surveillance.^{141,151} The recommendation for dysplasia detection in patients with CD is based largely on the experience with patients with UC and typically involves high-definition, white-light colonoscopy with nontargeted (random) 4-quadrant biopsies (often recommended to be taken at 10-cm intervals with a total of ≥ 32 biopsies) or chromoendoscopy with targeted biopsies.^{141,151-154} The recommended interval for subsequent screening or surveillance endoscopic examination is determined by individualized risk assessment and varies according to different societies' guidelines; societies agree that surveillance is recommended for patients with involvement of at least one-third of the colon or more than one segment.^{141,152,155} The European Crohn's and Colitis Organization recommends that patients at highest risk, those with PSC or a history of dysplasia or stricture, undergo annual colonoscopy; intermediate-risk patients with extensive or long-standing colitis or a family history of colorectal cancer undergo colonoscopy every 2 to 3 years; and patients without high or intermediate risk use a 5-year interval. Surveillance colonoscopy should ideally be performed when the colonic disease is in remission.¹⁵⁶ Meanwhile, the American Society for Gastrointestinal Endoscopy recommends that patients with PSC, active inflammation, history of dysplasia or colorectal cancer in a first-degree relative, or an anatomic abnormality such as a stricture have annual screening, preferably with chromoendoscopy or high-definition, white-light endoscopy, whereas average-risk patients can undergo surveillance every 1 to 3 years.¹⁵⁷ Average-risk patients with endoscopically and histologically normal examinations on 2 consecutive colonoscopies can usually extend their intervals to beyond every 3 years.¹⁵⁸

2. Patients with visible dysplasia that is completely excised endoscopically should typically undergo endoscopic surveillance. If dysplasia is not amenable to endoscopic excision, is also found in the surrounding flat mucosa, or is multifocal, or if colorectal adenocarcinoma is diagnosed, total colectomy or total proctocolectomy is typically recommended. Grade of recommendation: Strong recommendation based on moderate-quality evidence, 1B.

In patients with colitis, endoscopic biopsies may be classified as negative for dysplasia, indefinite for dysplasia, low-grade dysplasia (LGD), or high-grade dysplasia (HGD) based on histopathology assessment by a gastroenterology-trained pathologist. The term "indefinite for dysplasia" usually applies to situations where the pathologist cannot distinguish between dysplastic and nondysplastic atypia or there are inflammatory-associated changes due to underlying inflammation that make histologic

interpretation difficult. Patients with indefinite dysplasia may benefit from optimizing medical management in an effort to promote mucosal healing and typically undergo repeat endoscopy in 3 to 12 months.¹⁵⁹ Low-grade dysplasia and HGD are differentiated based on the distribution of nuclei within the cells of the mucosa.^{141,155} Low-grade dysplasia is characterized by nuclei confined to the basal half of the cells, whereas HGD has nuclei located haphazardly throughout the mucosal cells. The terms "dysplasia-associated lesion or mass" and "adenoma-like mass" are no longer commonly used and have been replaced with more simplified descriptors of visible or invisible lesions.¹⁶⁰ Visible lesions are described morphologically as polypoid (pedunculated or sessile) or nonpolypoid (slightly elevated, flat, or depressed) with borders classified as distinct or indistinct.¹⁵⁴ Other noteworthy descriptors include the presence of overlying ulceration and features of submucosal invasion such as depression or failure to lift with submucosal injection, which can predict inability to endoscopically resect and raise the suspicion for cancer.¹⁵¹

The management of patients who have CD with dysplasia continues to evolve over time and currently depends on whether or not the dysplasia is invisible or visible, or is unifocal or multifocal, and if complete endoscopic excision of a visible lesion is achieved.^{141,154} The diagnosis of dysplasia on mucosal biopsy specimens is associated with a high level of interobserver variability, especially when diagnosing indefinite and low-grade dysplasia.^{161,162} Therefore, if possible, at least 2 pathologists with expertise in GI diseases should evaluate specimens with dysplasia before implementing a management plan.^{152,163}

Retrospective studies indicate that 64% to 92% of colorectal dysplasia in patients with IBD is visible.^{148,164,165} Visible dysplastic lesions with LGD or HGD, in colitic or noncolitic mucosa, that are amenable to complete endoscopic excision (eg, dysplasia-free margins), without dysplasia in the flat mucosa immediately adjacent to the polypectomy site or elsewhere in the colon, should be treated with endoscopic excision when appropriate expertise is available.^{29,141,150,166} En bloc excision is preferred over piecemeal removal to allow for histologic evaluation of the completeness of resection; this may require referral to a center experienced in advanced polypectomy techniques, including endoscopic mucosal resection and endoscopic submucosal dissection. Although the success with endoscopic mucosal resection and endoscopic submucosal dissection in the setting of CD has only been demonstrated in a limited number of small studies, and the long-term efficacy of these techniques with regard to preventing subsequent malignancy or surgery is unclear, these approaches may allow for a greater proportion of lesions to achieve complete endoscopic resection with negative margins.¹⁶⁷⁻¹⁶⁹ Regardless of the technique used, a tattoo should typically be placed adjacent to the polypectomy

site after removing a large polyp to facilitate future surveillance and biopsies of the flat mucosa surrounding the polypectomy site evaluating for adjacent dysplasia should typically be obtained.^{151,170}

Ongoing surveillance for patients with CD after having visible lesions endoscopically removed is based on the relatively low risk of developing cancer under careful surveillance in patients with UC. In studies reported after 2000, the incidence of HGD or cancer diagnosed at surveillance colonoscopy after removal of a visible dysplastic lesion in patients with UC was 3% to 18% with surveillance periods of 3 to 7 years.^{164,165,171–174} In addition, a study of 18 patients with Crohn's colitis and 30 patients with UC who underwent endoscopic excision of a visible dysplastic lesion reported that 48% had recurrent dysplasia, but none were found to have cancer with a mean 4.1 years of follow-up.¹⁶⁶ However, because of the 10-fold increased risk of developing recurrent dysplasia, close endoscopic surveillance is recommended with surveillance colonoscopy performed within 1 to 6 months and again at 12 months after index lesion removal and should typically include biopsies taken at the prior excision site.^{151,175}

For visible dysplastic lesions not amenable to endoscopic resection or with dysplasia in the surrounding flat mucosa, multifocal dysplasia, or cases of colorectal adenocarcinoma, total colectomy with ileorectal anastomosis or total proctocolectomy is typically recommended rather than segmental resection, because multifocal dysplasia is ultimately found in more than one-third of specimens from patients undergoing colectomy for LGD or HGD in the setting of Crohn's colitis.^{176,177} Further support for total colectomy or total proctocolectomy comes from the observation that 14% to 40% of patients with Crohn's colitis who undergo segmental colorectal cancer resection develop metachronous colorectal cancer.^{176,177} However, much of the supporting evidence regarding dysplasia and CD is based on research performed before the use of chromoendoscopy and high-definition, white-light colonoscopy. If adequate surveillance is possible, a total colectomy with ongoing endoscopic surveillance every 1 to 2 years is reasonable in patients with rectal-sparing disease; rectal cancer was reported in only 0.7% of patients with a preserved rectum following total colectomy with an ileorectal anastomosis.¹⁷⁸

3. Patients with invisible, indefinite dysplasia should typically be referred to an experienced endoscopist for repeat colonoscopy using enhanced imaging with repeat random biopsies within 3 to 12 months. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

When nontargeted (random) endoscopic biopsies are indefinite for dysplasia, subsequent surveillance colonoscopy in patients with UC identifies dysplasia in up to 28% of patients.¹⁴¹ In a retrospective study of 84 patients

with CD or UC with mucosal biopsies indefinite for dysplasia (92% invisible), 13% of patients had LGD and 2% had HGD or malignancy found over a median surveillance period of 28 months.¹⁷⁹ In patients with CD or UC with nontargeted biopsies indefinite for dysplasia, both the 2010 American Gastroenterological Association and 2015 SCENIC guidelines recommend, ideally, repeating surveillance using high-definition colonoscopy with chromoendoscopy within 3 to 12 months.^{141,154}

4. Patients with invisible, low- or high-grade dysplasia on routine surveillance colonoscopy should typically be referred to an experienced endoscopist for high-definition colonoscopy with chromoendoscopy with repeat random biopsies within 3 to 6 months. Patients found to have invisible, low- or high-grade dysplasia at the time of high-definition colonoscopy with chromoendoscopy should typically undergo total colectomy or proctocolectomy. Grade of recommendation: Strong recommendation based on moderate-quality evidence, 1B.

When nontargeted biopsies reveal dysplasia, patients with CD should ideally undergo high-definition colonoscopy with chromoendoscopy.^{158,180} If repeat nontargeted biopsies reveal unifocal LGD or multifocal LGD confirmed by 2 gastroenterology-trained pathologists, total colectomy in cases with rectal sparing or proctocolectomy is typically recommended, based on the rates of progression to cancer in UC studies, because supporting data specific to CD are lacking. This recommendation in the setting of unifocal LGD is controversial, and, given the available evidence, it may be appropriate to offer selected patients frequent endoscopic surveillance as an alternative to resection. A 2012 prospective study of 42 patients who have UC with LGD reported progression of LGD in 19% of patients (2 developed cancer and 6 developed HGD), whereas 17% had persistent LGD and the remaining 64% had indefinite or no dysplasia identified over a median interval of 18 months.¹⁸¹ Another meta-analysis of 671 patients who have UC with LGD found synchronous colorectal cancer in 17% of patients (11% of patients in studies published after 2000) and a 6.1% annual rate of dysplasia progression in patients with an initial diagnosis of invisible dysplasia.^{89,182} A 2019 multicenter analysis of patients with IBD across 7 tertiary referral centers found that, of the 287 patients with LGD, 21 (7%) developed more advanced lesions (HGD or cancer) at a median follow-up of 86 months, and risk factors for the development of more advanced lesions included metachronous lesions, nonpolypoid lesions, and colon strictures. A single-center, retrospective review of 2130 patients with UC who underwent abdominal colectomy or proctocolectomy supports this lower rate of progression. Although 141 patients had a pre-colectomy diagnosis of LGD and 33 had HGD on random biopsy, cancer was identified in only 3 (2%) and 1 (3%) patients at the time of colon resection. Of the 1801 patients without a

preoperative diagnosis of dysplasia, 62 (3%) were found to have dysplasia in their colectomy specimen.¹⁸³

Although the risk of colorectal cancer in Crohn's colitis and UC appears to be similar, specific data to guide the management of invisible LGD in Crohn's colitis are lacking.^{141,142,144,184} A reasonable approach to invisible LGD in Crohn's colitis mirrors the approach to invisible LGD in UC and recommends total colectomy in the setting of rectal-sparing disease and total proctocolectomy in cases of rectal involvement, while allowing for individualized decision making with input from both the patient and a multidisciplinary IBD team recognizing the controversy noted above.¹⁸⁵

As with invisible LGD, the management of invisible HGD in CD is similarly largely based on our knowledge of patients with UC. Although there are reports of synchronous cancer in 42% to 67% of patients with invisible HGD, a study of 59 patients who have UC with HGD diagnosed by endoscopic biopsy revealed LGD, HGD, or cancer in only 20 (34%), 3 (5%), and 1 (2%) patients.¹⁸³ Furthermore, a 2019 multicenter, retrospective study of 28 patients who have IBD with HGD across 7 IBD referral centers reported progression of HGD to cancer in only 4 patients (14%) who were surveyed over a median 180 months.¹⁴⁸ Although the rates of progression may be lower than previously thought, because of the possible progression to colorectal cancer or the presence of a synchronous unidentified lesion, if invisible HGD is confirmed, total colectomy or proctocolectomy is typically recommended.^{29,151,152,154}

5. Suspicious lesions (eg, mass, ulcer) identified in patients with Crohn's disease should be biopsied, especially when considering small-bowel or colonic strictureplasty. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Suspicious lesions along the GI tract in patients with CD warrant evaluation with a diagnosis confirmed by pathology, when possible. The incidence of small-bowel carcinoma in patients with CD is 0.3/1000 person-years duration and this represents an 18.75-fold increase compared with an age-matched general population.¹⁸⁶ Although uncommon, cases of adenocarcinoma arising at or near previous strictureplasty sites have been reported,¹⁸⁷⁻¹⁹⁰ and strictures of the colon are a significant risk factor for colonic adenocarcinoma.⁸⁷ Therefore, biopsy of strictures or suspicious ulcerations at the time of strictureplasty in long-standing disease can help guide therapy.

SITE-SPECIFIC OPERATIONS

1. Patients with symptomatic disease of the stomach or duodenum despite medical therapy should typically be considered for endoscopic dilation, bypass, or

strictureplasty. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Gastroduodenal disease occurs in 0.5% to 4% of patients with CD with the most common presenting phenotype being stricturing disease.¹⁹¹ Although obstructive symptoms can be managed endoscopically or surgically with bypass, strictureplasty, or resection, there are no trials comparing the efficacy of these approaches. Single, short, moderately thick strictures of the duodenum without associated penetrating disease can usually be successfully treated with endoscopic dilation as the initial procedure, but there is a risk of recurrent stenosis.¹⁹²⁻¹⁹⁴

When endoscopic intervention is not feasible or ineffective, surgical management can be performed with bypass (ie, gastrojejunostomy, duodenojejunostomy) or strictureplasty, both of which are typically preferred over resection because of decreased overall morbidity. Patients best suited for strictureplasty have nonperforated, nonphlegmonous stenotic lesions and/or lesions in the second or third portion of the duodenum.¹⁹⁵⁻¹⁹⁹ Retrospective reviews have conflicting results; one series favored bypass because of its decreased postoperative complications and need for reoperation and a longer interval to reoperation, whereas another series concluded that strictureplasty was the preferred approach because of the lower risks for major complications and reoperation.^{199,200} Procedure choice depends on the anatomy of the affected duodenum, number and length of strictures, and surgeon experience. If the affected portion of the duodenum is technically difficult to mobilize, it may be best to bypass; however, bypass can result in delayed gastric emptying or marginal ulcer formation; thus, a strictureplasty is usually preferred when technically feasible.²⁰¹

2. Patients with medically refractory disease isolated to the jejunum, ileum, or ileocolon without existing or anticipated short-bowel syndrome should typically undergo escalation of medical therapy or resection of the affected bowel, ideally, as determined by a multidisciplinary team. For patients undergoing an operation with multifocal disease, strictureplasty should be considered. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Ileocolic resection is the most commonly performed operation for CD.²⁰² Early resection rather than the initiation of monoclonal antibody therapy may be appropriate in patients with limited, nonstricturing ileocecal CD as supported by a randomized, controlled trial that compared early laparoscopic ileocecal resection (n = 73) and infliximab initiation (n = 70) and demonstrated improved quality-of-life scores and decreased overall cost in the operative group.^{31,203} At the time of resection, limited macroscopic disease-free resection margins of about 2 cm are usually adequate to conserve bowel length and have not

been associated with an increased risk of disease recurrence.⁶⁷ In the setting of multifocal stricturing disease, especially in situations with longer segments of uninvolved intervening small bowel, strictureplasty is the preferred strategy for bowel conservation and has low rates of disease recurrence at strictureplasty sites.^{81,204}

3. The procedure of choice for emergency surgery in Crohn's colitis is a total abdominal colectomy with end ileostomy. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Total (or, in appropriate circumstances, a subtotal) colectomy with construction of an end ileostomy and closure of the distal colon or construction of a mucous fistula is typically recommended in patients with severe or fulminant Crohn's colitis who require emergency surgery.²⁰⁵ This approach removes the involved colon while avoiding a pelvic dissection and the risks of an anastomosis. Extrafascial placement of the closed stump may be associated with fewer pelvic septic complications compared with leaving the stump intraperitoneally, although it may be technically challenging to position the stump above the fascia.^{206–209} Transanal drainage of the rectum may further decrease the risk of pelvic sepsis under these circumstances.²¹⁰

4. Patients with colonic disease and rectal sparing who proceed with elective surgery may undergo segmental colectomy for single-segment disease or total colectomy for more extensive disease. Grade of recommendation: Strong recommendation based on moderate-quality evidence, 1B.

Outside the aforementioned circumstances regarding dysplasia and malignancy, symptomatic disease of the colon with rectal sparing can be managed by removal of only the diseased segment or by total abdominal colectomy. A meta-analysis of 11 studies including 1010 patients who underwent segmental colectomy (n = 500) or total colectomy (n = 510) for CD reported no difference with respect to CD recurrence, but segmental colectomy was associated with a decreased risk of a permanent stoma compared with total colectomy (OR, 0.52; 95% CI, 0.35–0.77).²¹¹ Another meta-analysis of 6 studies including 488 patients reported no significant differences in complications or rates of permanent stoma creation between patients who underwent segmental colectomy versus total colectomy, but the segmental colectomy group had a shorter interval to surgical recurrence (defined as the need for reoperation as a result of a CD-related complication or failed medical therapy) compared with the total colectomy group (weighted mean difference 4.4 years).^{211,212} When 2 or more colonic segments are affected, total colectomy with ileoproctostomy is typically preferred because of earlier recurrence following segmental resection.²¹²

5. For patients undergoing elective surgery for rectal disease, total proctocolectomy with end ileostomy or

proctectomy with creation of a colostomy should typically be performed. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Refractory Crohn's proctitis, in general, warrants total proctocolectomy with a permanent ileostomy owing to its frequent association with concomitant colonic disease. Proctectomy alone with creation of a colostomy can be considered if the colon is spared, but a proctocolectomy is typically recommended in the presence of perianal disease because of the high rates of disease recurrence in the colon and/or at the colostomy following proctectomy with end colostomy creation under these circumstances.²¹³ When a proctectomy is performed, the entire rectum and anal canal should typically be resected because carcinoma has been described in patients left with even a short rectal remnant, and the resection should typically incorporate a total mesorectal excision because of potentially impaired perineal wound healing associated with a close rectal dissection.^{214,215} Furthermore, in cases that do not require an oncologic distal dissection, an intersphincteric approach with primary closure of the perineal wound is preferred, in general, because it is associated with fewer wound complications and decreased overall surgical morbidity compared with a traditional abdominoperineal resection.²¹⁶ In cases of proctitis with severe fistulizing perianal disease, patients may be approached in a staged manner starting with fecal diversion and drainage of any active perianal sepsis, because proctectomy under these circumstances may result in a large perineal defect requiring flap reconstruction. Patients undergoing staged operations who experience continued local sepsis despite diversion and medical therapy may still require a more extensive perianal excision rather than an intersphincteric approach.

6. Restorative proctocolectomy with IPAA may be offered to selected patients with Crohn's disease without perianal or small-bowel disease, recognizing that long-term pouch failure rates are increased in this population. Grade of recommendation: Weak recommendation based on low-quality evidence, 2C.

Creating an ileal pouch in patients specifically known to have CD (as opposed to patients diagnosed with CD after having pouch surgery) has remained controversial since the first reported series of 31 patients in 1996.²¹⁷ There are no randomized, controlled trials evaluating this issue and most case series are small and show pouch failure rates (pouch excision or proximal diversion) of 3% to 56%.^{217–224} In a series of 32 patients diagnosed with CD after undergoing IPAA, 93% experienced pouch-related complications (eg, fistula, stricture, sepsis) and the overall pouch failure rate was 29%.²²⁵ In a retrospective review including 204 patients who underwent IPAA for CD (10% of the patients were diagnosed with CD before pouch surgery, 47% were diagnosed by histopathology at the time of

the pouch surgery, and 43% were diagnosed in a delayed fashion at a median of 36 months after IPAA), pouch retention rates and functional outcomes were better when the diagnosis of CD was made before or at the time of ileal pouch formation. The pouch failure rate was 15% in patients diagnosed with CD before or at the time of IPAA and was 51% for patients diagnosed in a delayed fashion ($p < 0.001$).²²⁶

After IPAA, overall functional outcomes and quality of life have been shown to be similar in patients with CD who are able to keep their pouch compared with patients with UC who had a pouch.²²⁷ The 2018 clinical practice guideline from the European Crohn's and Colitis Organization and the European Society of Colo-Proctology supported IPAA in carefully selected patients who had CD without perianal or small-bowel disease, but noted that the long-term pouch failure rate is increased in these patients.²²⁸

PREOPERATIVE CONSIDERATIONS

1. Preoperative high-dose glucocorticoids increase the risk of postoperative infectious complications and attempts should typically be made to wean glucocorticoids before surgical intervention. Immunomodulators are not associated with increased risk of postoperative infectious complications and do not typically need to be held before surgery. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

The majority of patients with CD evaluated for surgical intervention have been exposed to immunosuppressive therapy in the attempt to control inflammation and achieve disease remission.²²⁹ Glucocorticoids are a known risk factor for increased 30-day postoperative infectious complications after bowel surgery, with some studies suggesting that this risk is increased with daily doses >20 mg.²³⁰ For risk reduction purposes, attempts should typically be made to wean patients' glucocorticoids at least to a daily dose <20 mg before surgical intervention, if possible. Conversely, immunomodulators are not associated with increased risk of postoperative complications and can typically be safely continued in the perioperative period.^{222,229–231}

2. Whether or not preoperative exposure to monoclonal antibody therapy influences outcomes remains controversial, but delaying surgical intervention based on monoclonal antibody therapy alone is not typically recommended. Grade of recommendation: Weak recommendation based on low-quality evidence, 2C.

Data regarding the association of preoperative exposure to monoclonal antibody therapy including anti-TNF agents and vedolizumab (a monoclonal integrin antagonist) in terms of postoperative complications remain controversial because of the heterogeneity in patient populations

and study designs.^{30,229,232–244} A multicenter, prospective, cohort study of 209 patients undergoing ileocecal resection for CD found no significant association between using anti-TNF agents or anti-TNF serum drug levels and postoperative complications.²³⁴ Preliminary data from the PUCCINI multicenter, prospective, observational analysis also revealed no association between preoperative anti-TNF agents or their serum levels and postoperative infectious complications in patients with IBD.²⁴⁵ Meanwhile, prospectively collected, risk-adjusted data from a French collaborative identified anti-TNF therapy within 3 months of an ileocecal resection for CD as an independent predictor of 30-day postoperative overall and intra-abdominal septic morbidity.²³³ Similarly, a 2019 systematic review and meta-analysis with risk adjustment identified preoperative anti-TNF therapy as a risk factor for postsurgical complications in patients with CD.²⁴⁶ Further confounding the issue, a single-center, retrospective study found that preoperative serum anti-TNF drug levels directly correlated with postoperative complications after CD surgery, but a large, prospective study in which serum drug levels were analyzed from the day of surgery found no association between serum drug levels and postoperative complications.^{233,238,247}

Whether or not preoperative exposure to vedolizumab increases postoperative morbidity also remains controversial because a variety of types of studies report conflicting results.^{242,244,248–250} When only patients with CD were analyzed, as compared with pooled data from patients with UC and CD, a single-center, retrospective review compared 100 vedolizumab-exposed patients, 107 patients treated with anti-TNF agents, and 105 monoclonal antibody-naïve patients, and found vedolizumab to be an independent predictor of postoperative surgical site infection but not intra-abdominal septic complications.²²⁹ This article recommended that, although vedolizumab-treated patients with CD may be a sicker cohort of patients, it is important to consider these findings with regard to preoperative counseling, operative timing, and primary closure of wounds.

Ustekinumab, a monoclonal interleukin-12 and -23 blocker approved by the Food and Drug Administration in 2016 for the treatment of moderate to severe CD, has very limited data regarding its use and potential effects on postoperative outcomes. A consortium of 6 IBD centers retrospectively compared 44 patients treated with ustekinumab with 169 patients treated with anti-TNF agents and found no difference in postoperative outcomes after CD surgery.²⁵¹ A single-center, retrospective review of patients with CD similarly found no difference in postoperative outcomes among 30 patients treated with ustekinumab compared with 73 patients treated with vedolizumab.²⁵²

Given the literature regarding monoclonal antibody therapy, in general, it is not recommended to delay

surgical intervention due to monoclonal antibody therapy alone, because the data do not consistently show any class of monoclonal antibody to be an independent risk factor for postoperative infectious complications.²⁵³ Rather, when possible, if a patient is on an every 8 weeks dosing regimen, the optimal time to perform surgery may be approximately 4 weeks after the last monoclonal antibody dose to allow for a washout period of about one half-life, with the plan to resume the monoclonal antibody about 4 weeks after surgery, if necessary, for postoperative treatment or prophylaxis.²⁵⁴

3. Preoperative nutritional support for patients with malnutrition may decrease postoperative morbidity. Grade of recommendation: Weak recommendation based on low-quality evidence, 2C.

Malnutrition may be variably defined as greater than 10% weight loss in the previous 3 months, BMI <18.5 kg/m² or serum albumin <3.0 mg/dL, although serum albumin is a relatively poor marker of malnutrition because levels can be affected by other processes like inflammation or sepsis.²⁵⁵ Malnutrition, found in up to 85% of patients with CD, significantly increases the risk of postoperative complications.^{256,257} A systematic review of 29 studies regarding preoperative nutritional support in patients with CD found malnutrition to be associated with increased postoperative morbidity and preoperative nutritional support to be associated with improved outcomes.²⁵⁸ According to the European Society for Clinical Nutrition and Metabolism 2017 guidelines, malnourished patients with CD who cannot meet their caloric needs by eating, should be given preoperative exclusive enteral nutrition (EEN), a preformulated liquid diet, to decrease the risk of postoperative morbidity.²⁵⁵ Several retrospective studies of patients with CD undergoing intestinal resection have shown that 4 weeks to 3 months of preoperative EEN significantly decreased postoperative complications, superficial surgical site infection, intra-abdominal septic complications, infectious complications, and the total comprehensive complication index.^{259–262} In a large study of 498 patients with CD undergoing surgery, preoperative EEN was associated with significantly decreased rates of intestinal diversion, anastomotic leak, and reoperation.²⁶³ Total parenteral nutrition can be used when patients are unable to tolerate oral intake.²⁵⁷

4. Smoking cessation may reduce postoperative morbidity in patients with Crohn's disease. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

Smoking has a known deleterious impact on the severity, exacerbations, and recurrence of CD and is associated with increased rates of hospitalization for disease flares and of postoperative disease recurrence.²⁶⁴ Retrospective data also indicate that active smoking is associated with

increased postoperative complications. A retrospective National Surgical Quality Improvement Program study of patients with CD who underwent resection found that active smokers (n = 2047) had significantly increased rates of postoperative infectious complications (OR, 1.30; *p* < 0.001), pulmonary complications (OR, 1.87; *p* < 0.001), and readmissions (OR, 1.58; *p* = 0.004) compared with nonsmokers (n = 5584).²⁶⁵ However, in another single-institution, retrospective review of 691 patients with CD, smoking was not significantly associated with postoperative complications.²⁶⁶

OPERATIVE CONSIDERATIONS

1. A minimally invasive approach to Crohn's disease surgery should typically be considered. Grade of recommendation: Strong recommendation based on moderate-quality evidence, 1B.

Randomized, controlled trials of patients with CD undergoing elective ileocelectomy have demonstrated shorter length of stay, fewer complications, decreased cost, and improved pulmonary function related to the laparoscopic approach in comparison with open surgery and comparable clinical recurrence rates.^{267–269} National Surgical Quality Improvement Program database studies regarding elective and emergency surgery for CD showed that laparoscopy (when possible) was associated with decreased morbidity and a shorter length of stay after emergency or elective ileocelectomy.^{270–273} In addition, a laparoscopic approach to colorectal resection is associated with lower risks of subsequent small-bowel obstruction and operation for small-bowel obstruction, which is particularly relevant to patients with CD who may ultimately require multiple operations.²⁷⁴

Another factor that may support using a laparoscopic platform over open surgery when operating on patients with CD deals with the incidence of incisional hernia. In a single-institution, retrospective review of patients with CD, the incisional hernia rates of laparoscopic and open surgery were similar (8.4% versus 10.8%) when a midline incision was used. In the 37 patients who had an intracorporeal anastomosis and an extraction site that used a transverse incision, the incisional hernia rate was zero.²⁷⁵ Single-institution, retrospective series have also shown that laparoscopic resection in patients who have CD with a penetrating phenotype or with obesity has morbidity equivalent to laparoscopic surgery in patients who have CD without these risk factors.^{276,277}

In terms of the potential utility of a robotic approach for operating on patients with CD, a national database was used to perform a propensity score-matched analysis with 108 patients in each cohort and found that, compared with open surgery, a robotic approach had a shorter length of stay by a median of 2 days (*p* < 0.001) and a lower 30-day

complication rate (24% versus 38%; $p = 0.03$).²⁷⁸ When robotic total colectomy was compared with multiport laparoscopy for all pathologic indications using data from the nationwide inpatient sample database, there was no improvement in morbidity related to the use of robotics.²⁷⁹ Although single-incision laparoscopy has been shown to be feasible in cases of complex CD, it has not demonstrated consistent advantages over multiport laparoscopy.^{280–285}

2. A diverting ileostomy should be considered when performing ileocelectomy in patients who have Crohn's disease with multiple risk factors. Grade of recommendation: Strong recommendation based on moderate-quality evidence, 1B.

Although the majority of patients with CD who undergo an ileocelectomy may have a primary anastomosis with an acceptable anastomotic leak rate, patients with multiple risk factors (eg, smoking, steroid use, weight loss) have an increased risk of anastomotic leak, and temporary diversion should typically be considered in these situations.²⁸⁶ Overall, the decision to divert or omit an anastomosis should depend on an individualized assessment of the risk factors for surgical complications and should consider that an ileostomy carries its own risk profile (eg, dehydration, acute renal insufficiency, need for subsequent reversal).²⁸⁷ A defunctioning ileostomy should typically be considered in patients with CD who are on high-dose glucocorticoids, in particular, in combination with other CD medications (eg, immunomodulators or monoclonal antibodies), are profoundly malnourished or anemic, have a chronic bowel obstruction, or, potentially, have had prior bowel resection.^{234,239,288–290}

An additional potential benefit of temporary ileostomy creation after ileocelectomy is that it is associated with reduced long-term risk of surgical recurrence in active smokers and patients with penetrating disease.²⁹¹ Another study, published in abstract form only, demonstrated a reduced risk of endoscopic recurrence at 3 years if an ileostomy was left in place an average of 3 months after ileocelectomy.²⁹²

3. The extent of mesenteric excision during resection for Crohn's disease remains controversial. Grade of recommendation: Weak recommendation based on low-quality evidence, 2C.

Basic science research suggests that the mesentery plays a role in IBD, but the exact mechanism remains unclear.²⁹³ In 2018, Coffey et al⁶⁹ published a retrospective review comparing a cohort of patients with CD who had undergone conventional ileocolic resection with mesenteric division close to the intestine ($n = 30$) with a group of patients who had undergone a more extended excision of the adjacent mesentery ($n = 34$). The cumulative reoperation rates for CD were 40% for the standard group versus 2.9% for the extended mesenteric excision group ($p = 0.003$)

with a mean duration of follow-up of 70 and 52 months. The authors also demonstrated that advanced mesenteric disease, as assessed grossly by the degree of fat wrapping, predicted increased surgical recurrence (HR, 4.7; 95% CI, 1.71–13.01; $p = 0.003$). Although these results seem compelling, others have pointed out several concerns with the study.²⁹⁴ For instance, the standard resection group had surgery many years before the extended mesenteric excision group at a time when surveillance was performed differently, medical management was less effective, and postoperative medical therapy to maintain patients in remission was not as commonly utilized. In addition, the standard resection group had longer follow-up potentially allowing for the detection of a higher recurrence rate. The underlying theory behind the Coffey study was also called into question by preliminary data from a trial involving the Kono-S anastomosis that involves a limited mesenteric excision that showed a decreased risk of endoscopic CD recurrence 6 months postoperatively.^{295,296}

4. Following ileocecal resection, reconstruction using side-to-side, side-to-end, or end-to-end handsewn or stapled anastomosis based on surgeon preference and experience is reasonable. Grade of recommendation: Strong recommendation based on low-quality evidence, 1C.

The data regarding anastomotic technique, leak, and recurrence after ileocolic anastomosis in CD are limited. A Cochrane database meta-analysis including 264 noncancer patients including patients with CD from 3 randomized, controlled trials compared stapled versus handsewn anastomoses in patients undergoing ileocelectomy and found no significant difference in leak rates.⁷⁰ This meta-analysis was largely based on data from 1 randomized trial that showed no difference in leak or CD recurrence rates related to anastomotic technique.⁷² Case series regarding patients with CD have favored stapled anastomosis and oversewing of the stapled anastomosis that may be associated with a decreased leak rate; however, the quality of these data is low.^{297,298} In addition, 1 larger retrospective review involving 233 patients with CD compared the results between side-to-side, side-to-end, and end-to-end stapled and handsewn anastomoses and identified no difference in the need for reoperation for recurrent disease over a median follow-up of 93 months.²⁹⁹ Another large retrospective review of 1437 patients from 200 centers in Europe compared cutting with noncutting staplers and oversewing the staple line versus not oversewing the staple line following ileocelectomy (14% of the patients had CD) and found no differences in leak rates with any of the techniques used.³⁰⁰ A single-institution review compared 60 patients with CD who underwent bowel resection with stapled side-to-side anastomosis to 68 patients who had a handsewn end-to-end anastomosis. In the 2 years after resection, patients in the stapled group had significantly more emergency department visits, hospitalizations, and

abdominal CT scans, and lower quality-of-life scores, but had comparable 30-day postoperative complications and 2-year clinical, endoscopic, and surgical recurrence.³⁰¹

POSTOPERATIVE CONSIDERATIONS

1. After surgery for Crohn's disease, patients should be considered for medical therapy to treat residual active disease or to maintain disease remission. Grade of recommendation: Strong recommendation based on moderate-quality evidence, 1B.

After an ileocectomy, 70% to 90% of patients have endoscopic recurrence in the neoterminal ileum at 1 year, and, by 3 years, endoscopic recurrence is ubiquitous.^{302,303} At 5 years, an estimated 50% of patients will have evidence of clinical recurrence and 25% will experience a surgical recurrence. At 10 years, the rate of surgical recurrence may reach as high as 35%.¹⁴ Perioperative risk factors for recurrence include age at diagnosis of CD <30 years, <10 years between diagnosis and surgery, presence of perianal disease, penetrating phenotype, 2 or more prior intestinal resections, and active tobacco use.^{302,304} According to the American Gastroenterological Association guidelines, patients can be grouped according to their risk of recurrence as low risk (patient age >50 years, nonsmoker, first surgery for short segment of fibrostenotic disease less than 10–20 cm, and disease duration >10 years) or high risk (patient age <30 years, active smoking, 2 or more prior surgeries for penetrating disease with or without perianal disease).³⁰⁵

In low-risk patients without ongoing, active CD, pharmacologic prophylaxis is not typically recommended.³⁰⁵ However, metronidazole or ornidazole can be considered for prevention of clinical postoperative recurrence, although, even with this prophylaxis, endoscopic recurrence remains problematic and patients risk having side effects from the long-term use of these agents.^{306–308} In general, metronidazole use should be limited to about 3 months under these circumstances. At 6 months postoperatively, low-risk patients should typically undergo ileocolonoscopy with Rutgeerts scoring, a scoring system developed in the early 1990s to predict postoperative recurrence based on the extent and severity of lesions detected at the ileocecal anastomosis and neoterminal ileum, with scores ranging from i,0 (no lesions) to i,4 (diffuse inflammation with larger ulcers, nodules, and/or narrowing).¹³ Asymptomatic patients with a Rutgeerts score <i>2 should typically repeat an ileocolonoscopy in 1 to 3 years. If the Rutgeerts score is \geq i,2, an anti-TNF (or other monoclonal antibody agent if the patient had previously lost response or had no response, per gastroenterology management) should typically be started with or without a thiopurine. The PREVENT trial randomly assigned 297 patients with CD after ileocectomy to infliximab or placebo and found that the

treatment group had lower endoscopic recurrence (22.4% versus 51.3%; $p < 0.001$), but the clinical recurrence rates were similar between the 2 groups. A meta-analysis of 10 randomized, controlled trials evaluated CD recurrence and found that anti-TNF therapy was associated with the greatest reduction in clinical and endoscopic recurrence.^{309,310} When comparing types of anti-TNF monotherapy for postoperative prophylaxis, a retrospective, multicenter, observational study found that infliximab and adalimumab were equivalent; meanwhile, anti-integrins (vedolizumab), anti-interleukins (ustekinumab), and small molecules have not yet been adequately studied in the setting of prophylaxis.³¹¹

In patients with residual disease after surgery or in patients who are otherwise high risk for recurrence, postoperative treatment or prophylaxis, depending on the circumstances, can typically start within 2 to 4 weeks after surgery, with input from gastroenterology and barring postoperative infectious complications. As with low-risk patients, an anti-TNF agent with or without a thiopurine is typically recommended. Patients receiving postoperative pharmacologic prophylaxis should typically undergo standardized ileocolonoscopy after 6 months to evaluate disease status and allow for further escalation of medical therapy, as needed. With this treatment approach, 18-month clinical and endoscopic recurrence are reduced compared with ongoing pharmacologic prophylaxis alone.^{304,312}

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