



Pouchitis: Diagnóstico y Tratamiento en 2018

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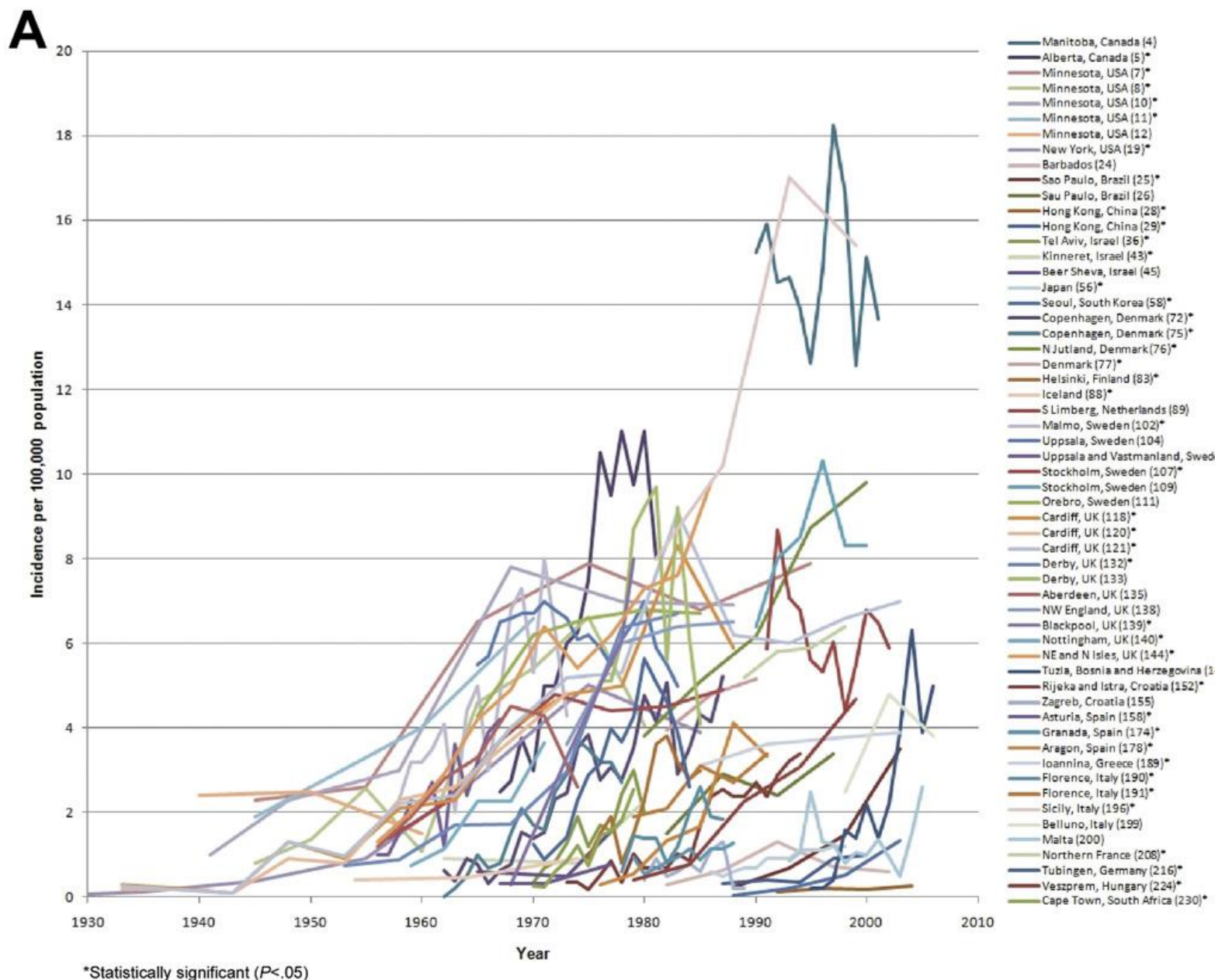
Hospital Universitario Nacional de Colombia

Expresidente Asociación Colombiana de Gastroenterología

Expresidente Asociación Colombiana de Endoscopia Digestiva

Ex Presidente Asociación Colombiana de Medicina Interna, Capítulo central

Colitis ulcerativa Aumento de la incidencia



CU, Leve a Moderada

30%
Intratabilidad
Curso fulminante
Displasia/Cáncer

7.5-10% a 5 años
10-13% a 10 años

Paso a paso
“Step UP”

Trasplante de
Materia fecal ?

Vedolizumab

Anti TNF 8-12 semanas
31-35% al año

Budesonide MMX

Inmunomoduladores, mantenimiento
Esteroides 2 Semanas

Moderada

Budesonide
MMX

5 ASA oral + tópico
4-8 semanas

64-75%

Leve

Proctocolectomy without ileostomy for ulcerative colitis

A G PARKS, R J NICHOLLS

British Medical Journal, 1978, 2, 85-88

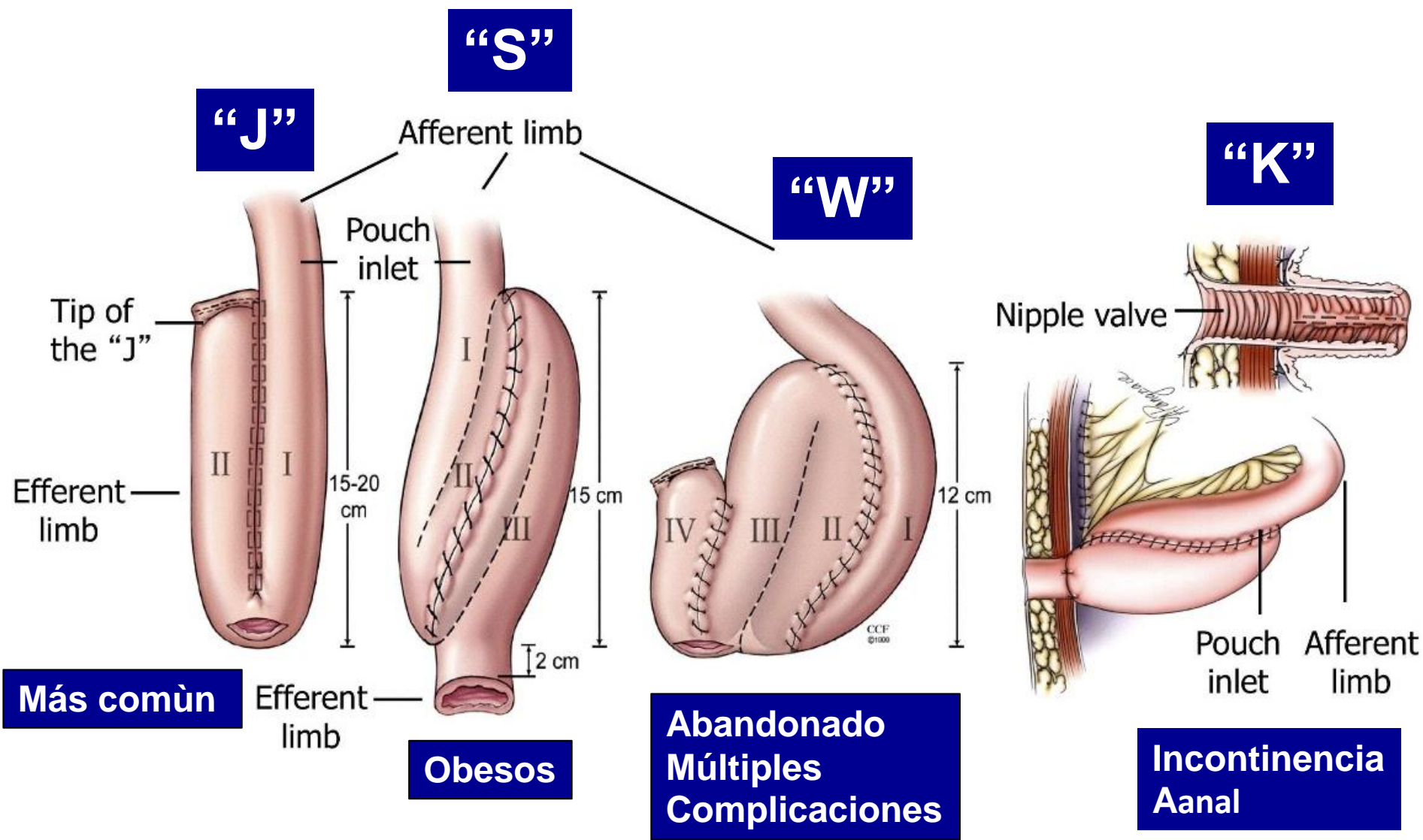
Summary and conclusions

An operation has been developed that permits total removal of all disease-prone mucosa in ulcerative colitis but avoids the need for a permanent ileostomy. The colon and upper half of the rectum are excised and the remaining inflamed mucosa is stripped from the rectal stump down to the dentate line of the anal canal. A pouch is fashioned from a triplicated loop of terminal ileum.

This is drawn down through the denuded rectum and an anastomosis created, via the per-anal approach, between the ileum just distal to the pouch and the mid-anal canal. A temporary ileostomy is made.

Out of eight patients so treated, five were available for assessment, and four of them were highly satisfied with the result in improved health and function. The remaining three were awaiting closure of their ileostomies.

Introduction



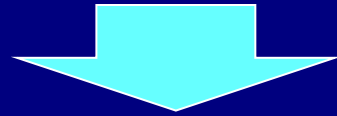
Shen B, Clin Gastroenter Hepatol 2013;11:1538-49

Pouchitis

Definición

No està estandarizada

Pouchitis



**Inflamación inespecífica idiopática
Dentro del reservorio ileal (*“pouch”*)**

Cheifetz A, Aliment Pharmacol Ther 1996;10:449-57

Int J Colorect Dis (1986) 1:167–174

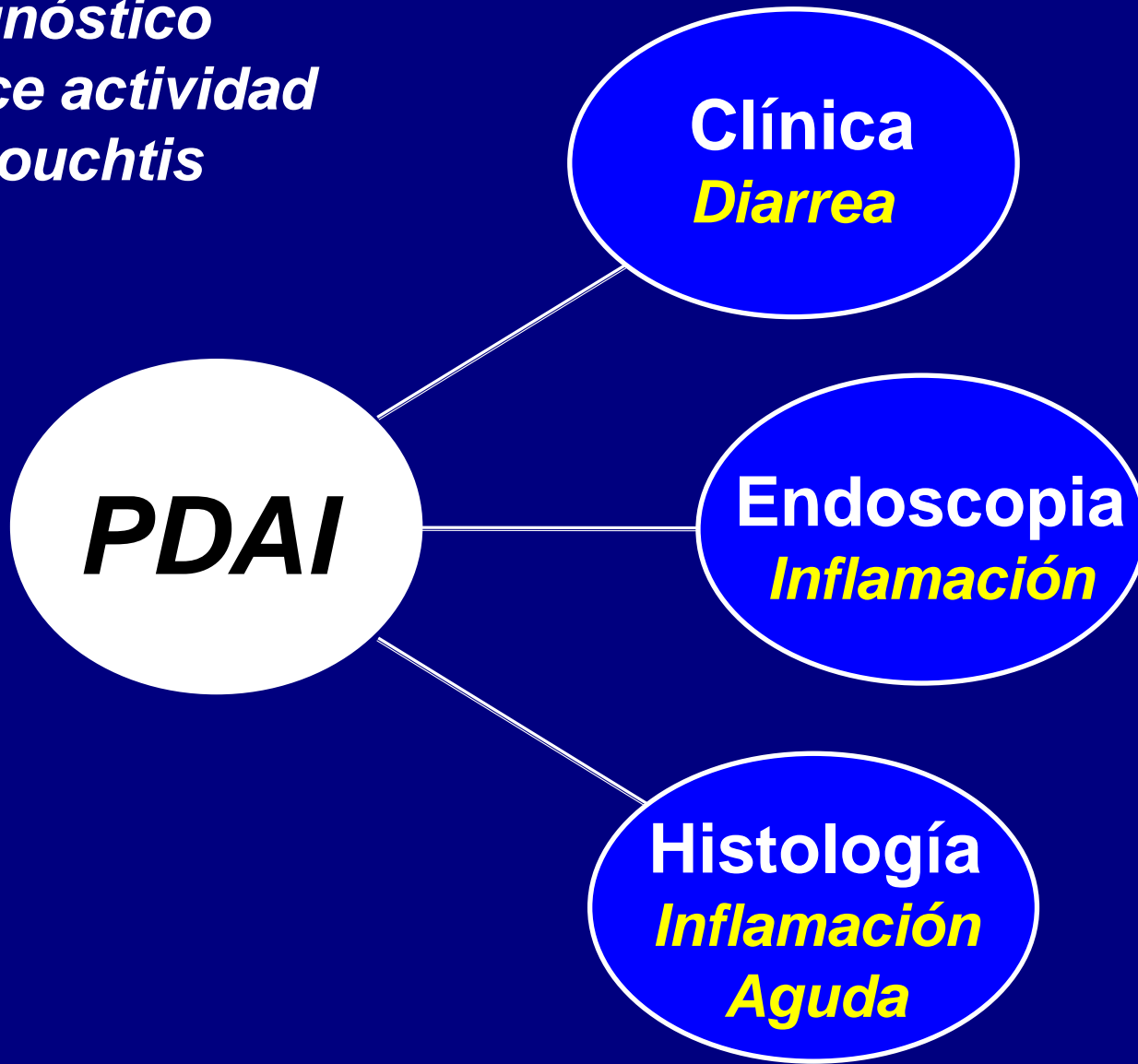
International
Journal of
**Colorectal
Disease**
© Springer-Verlag 1986

An assessment of inflammation in the reservoir after restorative proctocolectomy with ileoanal ileal reservoir

R. L. Moskowitz, N. A. Shepherd and R. J. Nicholls

St. Mark's Hospital, London, UK

*Diagnóstico
Índice actividad
de pouchitis*



**Sandborn WJ, Mayo Clin Proc 1994;69:409-15*

**Índice de
Actividad
“Pouchitis”**

**Diagnóstico
7 o mas**

**< 7:
No Pouchitis**

I. Clinical	
1. Stool frequency	(0, 1, 2)
2. Fecal urgency/Abdominal cramps	(0, 1, 2)
3. Rectal bleeding	(0, 1)
4. Fever > 37.8°C	(0, 1)
Maximal clinical subscore: 6	
II. Endoscopic finding	
1. Oedema	(0, 1)
2. Granularity	(0, 1)
3. Friability	(0, 1)
4. Loss of vascular pattern	(0, 1)
5. Mucous exudates	(0, 1)
6. Ulcerations	(0, 1)
Maximal endoscopic subscore: 6	
III. Histology—acute histological inflammation	
1. Polymorphonuclear infiltration	(0, 1, 2, 3)
2. Ulceration per low power field (mean)	(0, 1, 2, 3)
Maximal histological subscore: 6	
Maximal total PDAI: 18	

**Puntaje de
Actividad de
la “pouchitis”**

Severidad
Leve
Moderada
Severa

I. Clinical	
1. Stool frequency	(0, 2, 4, 6)
2. Fecal urgency	(0, 3)
3. Rectal bleeding	(0, 3)
Maximal clinical subscore: 12	
II. Endoscopic findings	
1. Oedema	(0, 1)
2. Granularity	(0, 1)
3. Friability	(0, 1, 2)
4. Erythema	(0, 2, 3)
5. Mucosal flattening	(0, 2)
6. Ulcerations/erosions	(0, 2, 3)
Maximal endoscopic subscore: 12	
III. Histological	
Acute inflammation	
1. Polymorphonuclear infiltration	(0, 1, 2, 3)
2. Ulcerations/erosions	(0, 1, 2, 3)
Chronic inflammation	
1. Mononuclear infiltration	(0, 1, 2, 3)
2. Villous atrophy	(0, 1, 2, 3)
Maximal (total) histological subscore: 12	
Maximal total PAS: 36	

Pouchitis, patogènesis



Schieffer KM, Aliment Pharmacol Ther 2016;44:817-35
Hata K, Dig Dis 2017;29:26-34
Dalal RL, Inflamm Bowel Dis 2018;24:989-96

Pouchitis

**Deposiciones
Frecuentes
>6**

**Urgencia
Tenosmo
Incontinencia**

**Hematoquezia
Dolor abdominal
Fiebre**

**Manifestaciones
Extraintestinales**

***Afecta la vida
de 50% de los
Pacientes***

Hata K, Dig Endosc 2017;29:26-34

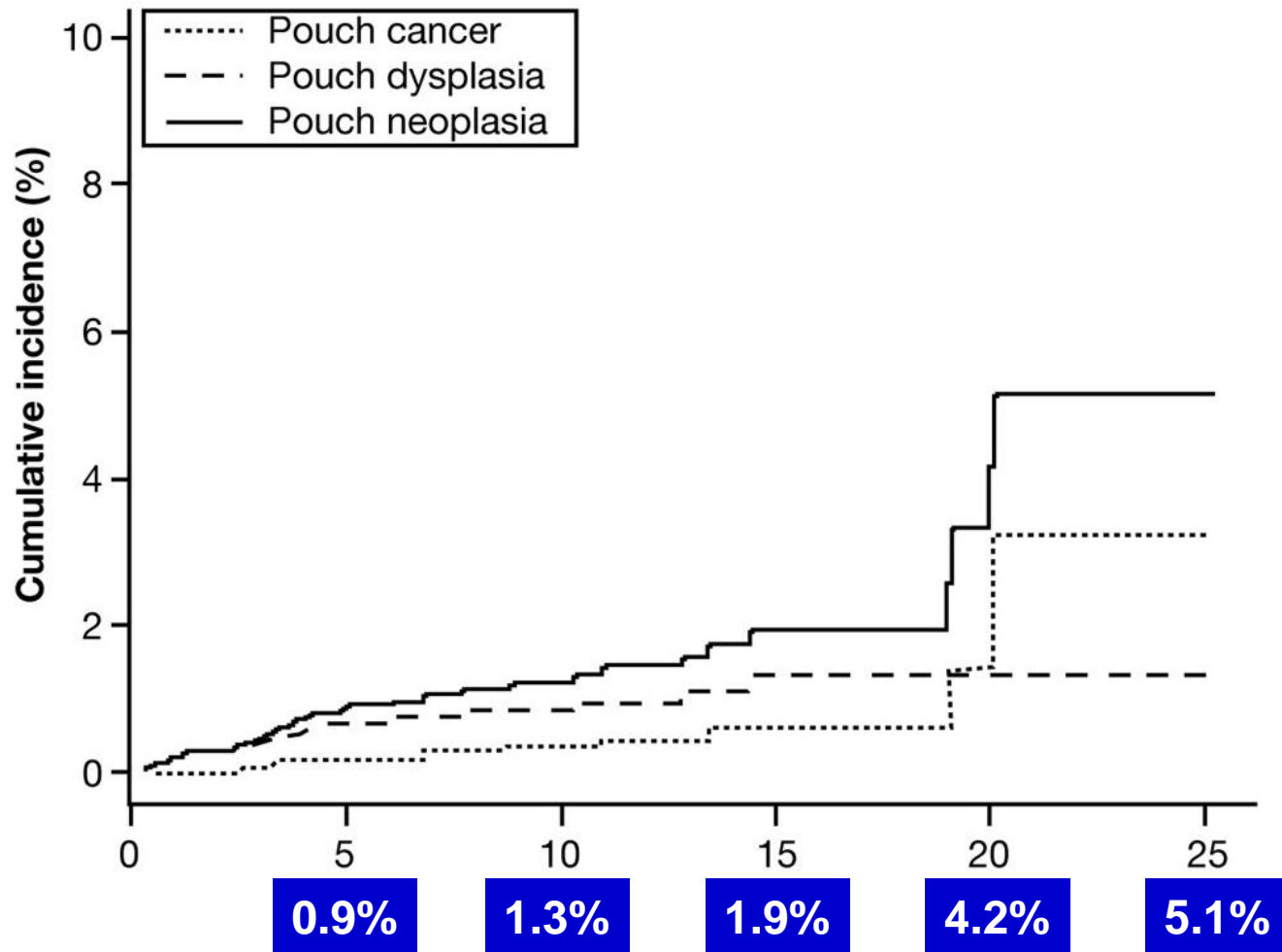
Sandborn WJ, Trends Inflamm Bowel Dis 1996;;51-63

Preoperative Colorectal Neoplasia Increases Risk for Pouch Neoplasia in Patients With Restorative Proctocolectomy

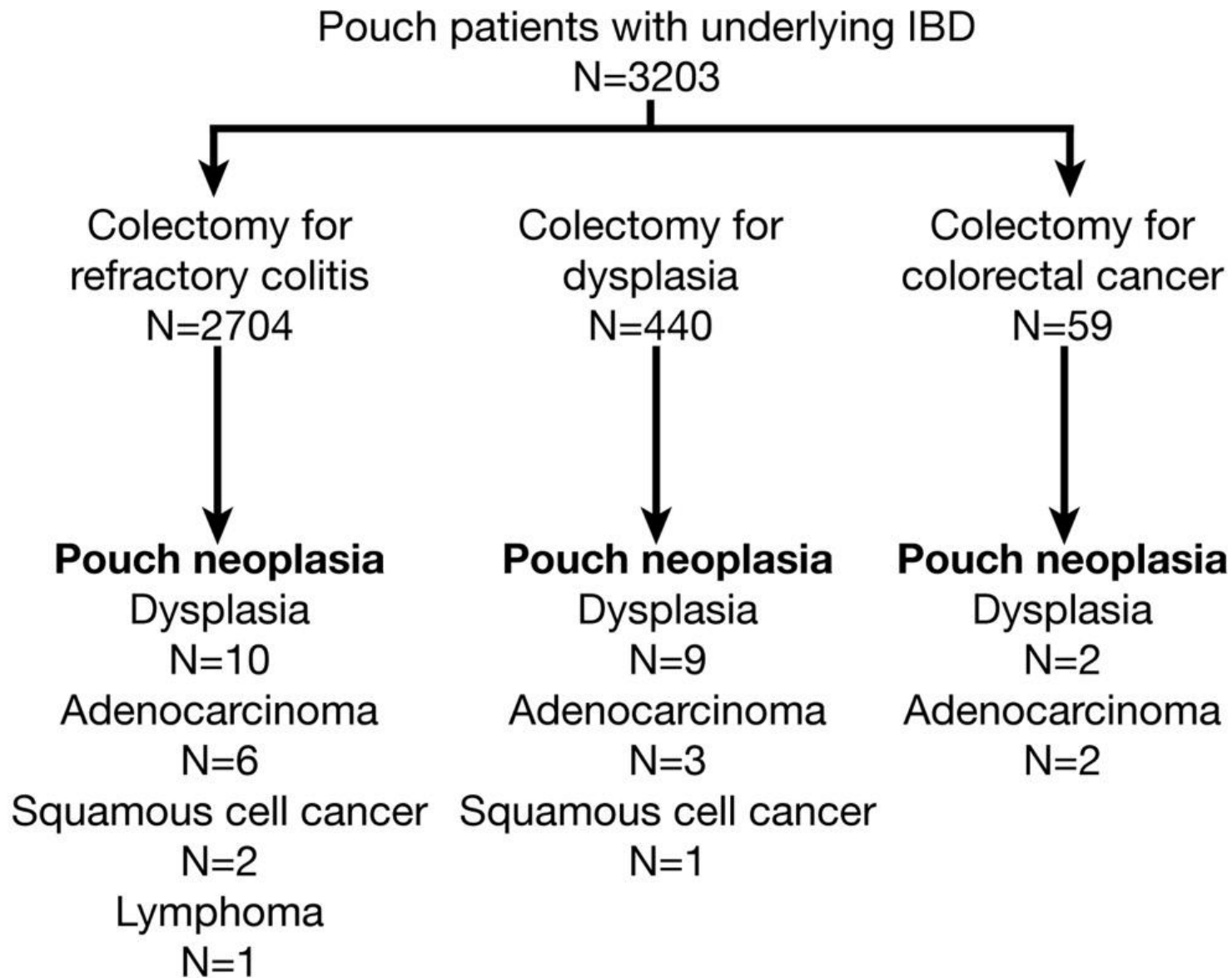
REVITAL KARIV,^{*,‡} FEZA H. REMZI,^{*} LEI LIAN,^{*} ANA E. BENNETT,^{*} RAVI P. KIRAN,^{*} YEHUDA KARIV,^{*,‡}
VICTOR W. FAZIO,^{*} IAN C. LAVERY,^{*} and BO SHEN^{*}

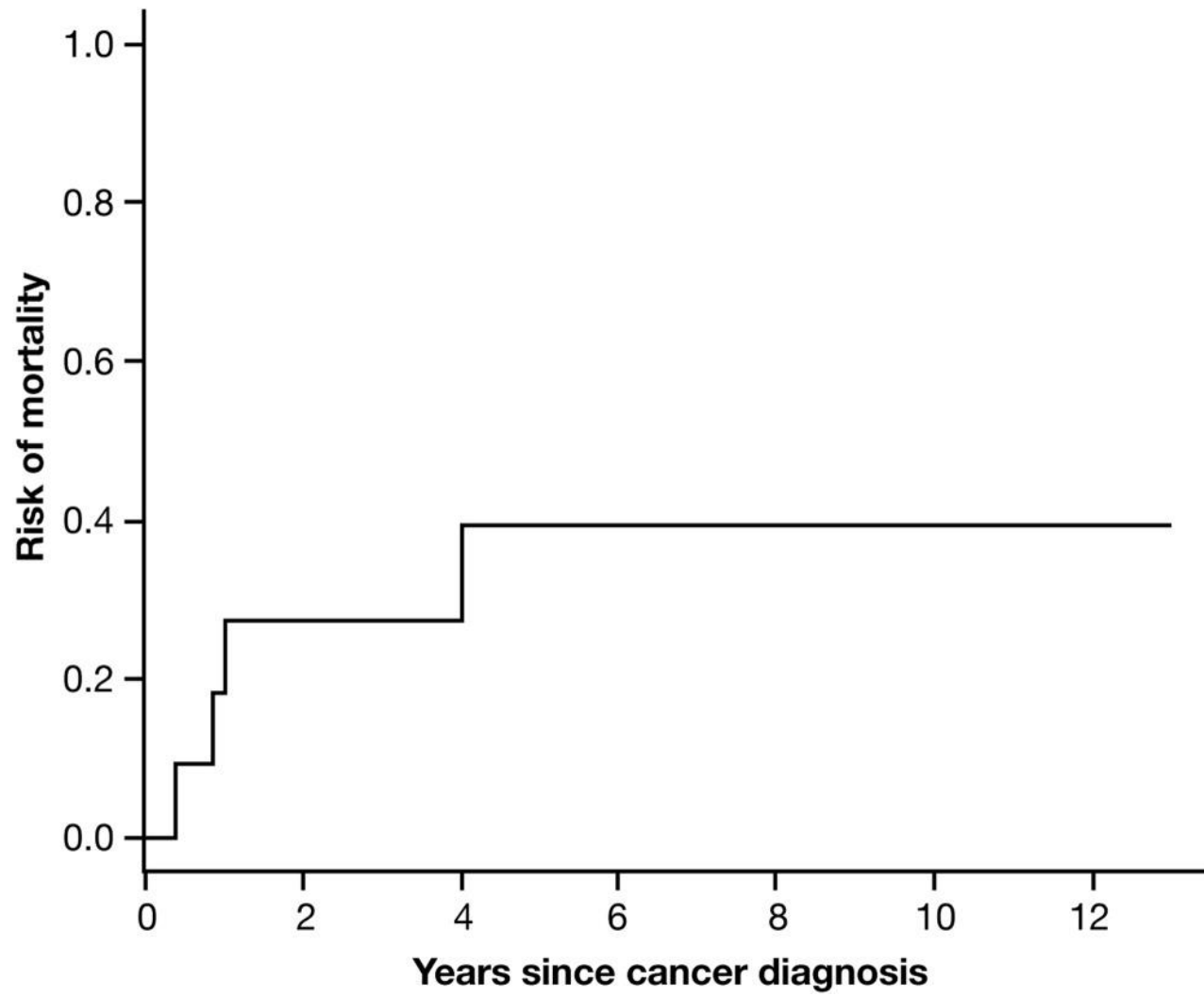
Gastroenterology 2010;139:806-12

Neoplasia después de Pouch ileoanal



Neoplasia después de Pouch ileoanal





Pouchitis

Clasificación

Pouchitis

Complicación más frecuente “*pouch*” ileoanal

20% 1 año, 40% 5 años, 50% 10 años



Aguda
< 4 S

Respondedor
antibióticos

3 episodios
Al año

Idiopática

Crónica
>4 S
10-15%

No
Respondedor
antibióticos

Más de
3 episodios
Al año

Dependiente de
Antibióticos

Secundaria
CMV
Autoinmune
Ig G4, CEP
Intraluminal
AINES, isquemia
Desviación
Inflamación
Crohn, cuffitis
Fístula

Segal JP, Aliment Pharmacol Ther. 2017;45:581-592

Shen B, Up To Date 2018

Pouchitis, Diagnóstico diferencial

Inflamación del cuff rectal

Síndrome de “*pouch*” irritable

Isquemia

Estenosis

Alteración del vaciamiento

Infección: citomegalovirus, *Cd*

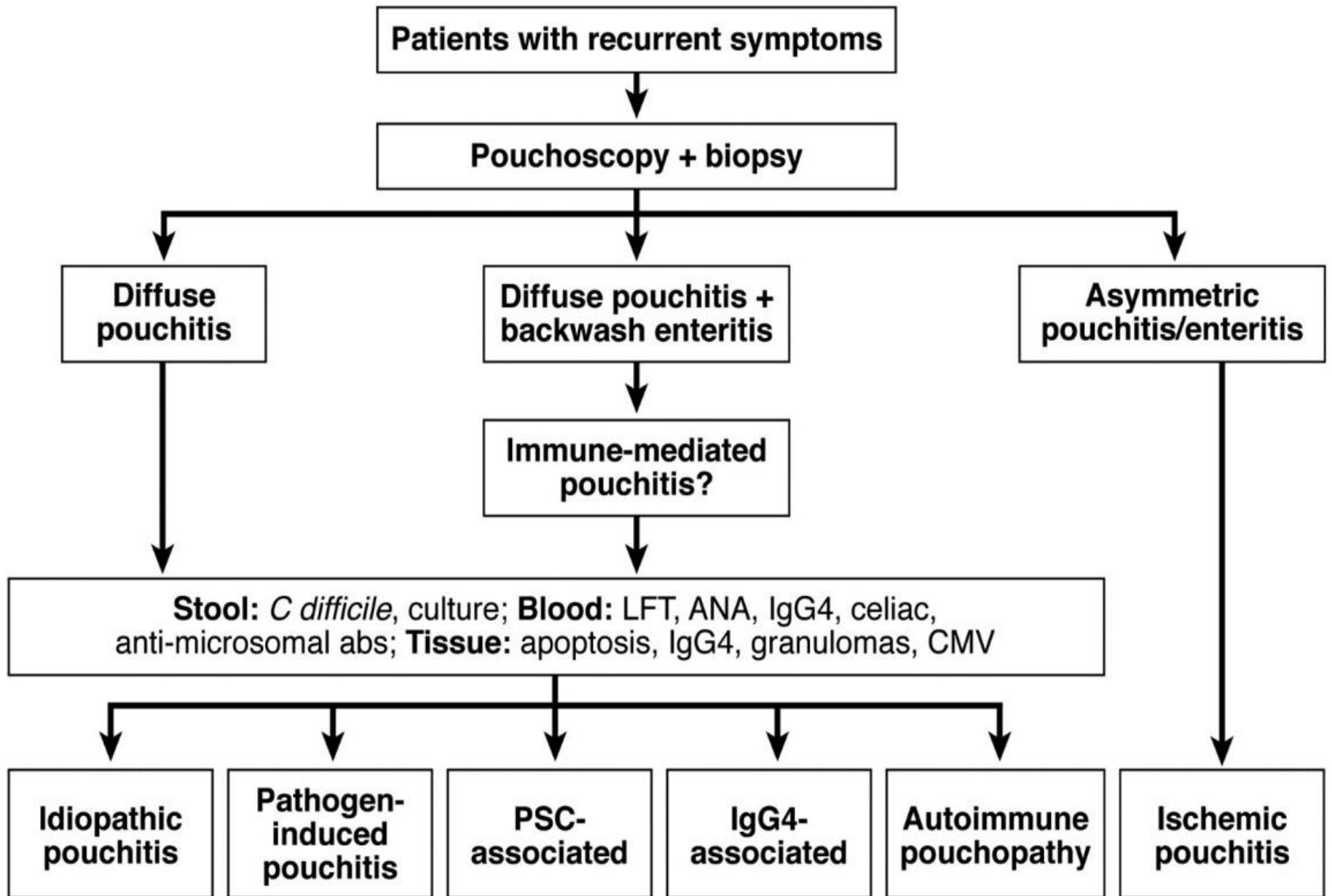
Mala-absorción de sales biliares

Crohn del *pouch*

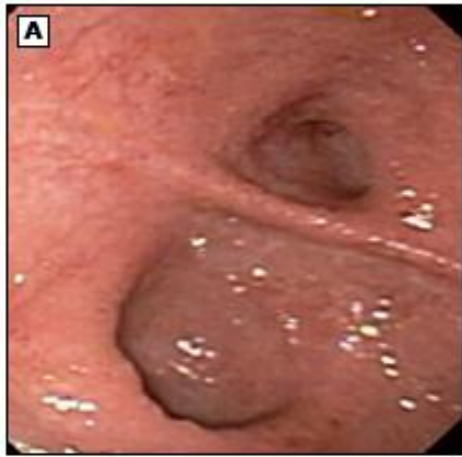
Disfunción del piso pélvico

Estenosis del “*pouch*”

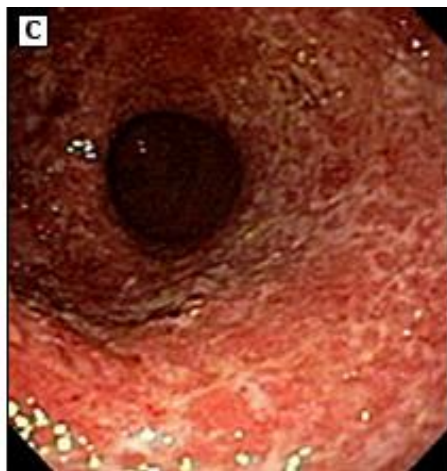
Adherencias



Pouch en "J"



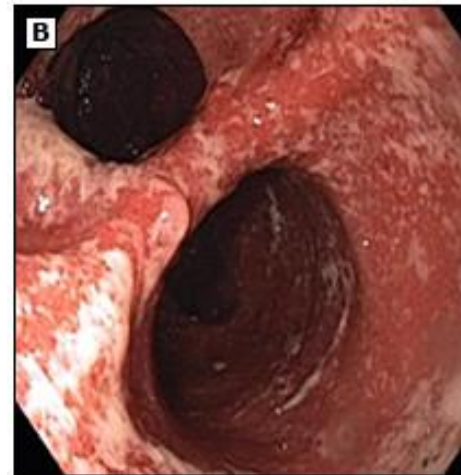
Pouchitis clásica
Inflación difusa



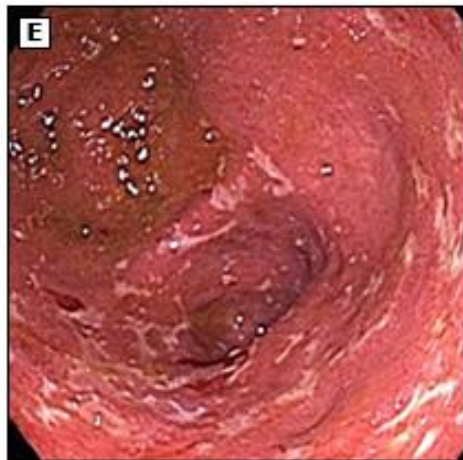
Pouchitis por
Clostridium difficile



Pouchitis
por desviación



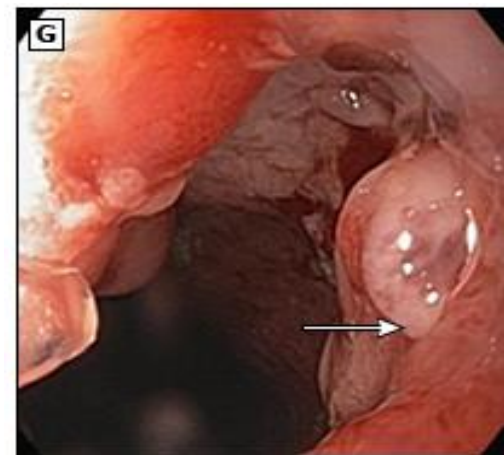
Pouchitis isquémica
Distribución asimétrica



"Cuffitis"



Crohn con
Fístula vaginal



Pouchitis

Tratamiento

Pouchitis

Tratamiento

**Medicamentos anti-inflamatorios
Convencionales para EII**

No tienen igual eficacia

**Antibióticos
Piedra angular**

Pouchitis, manejo

Profilaxis primaria

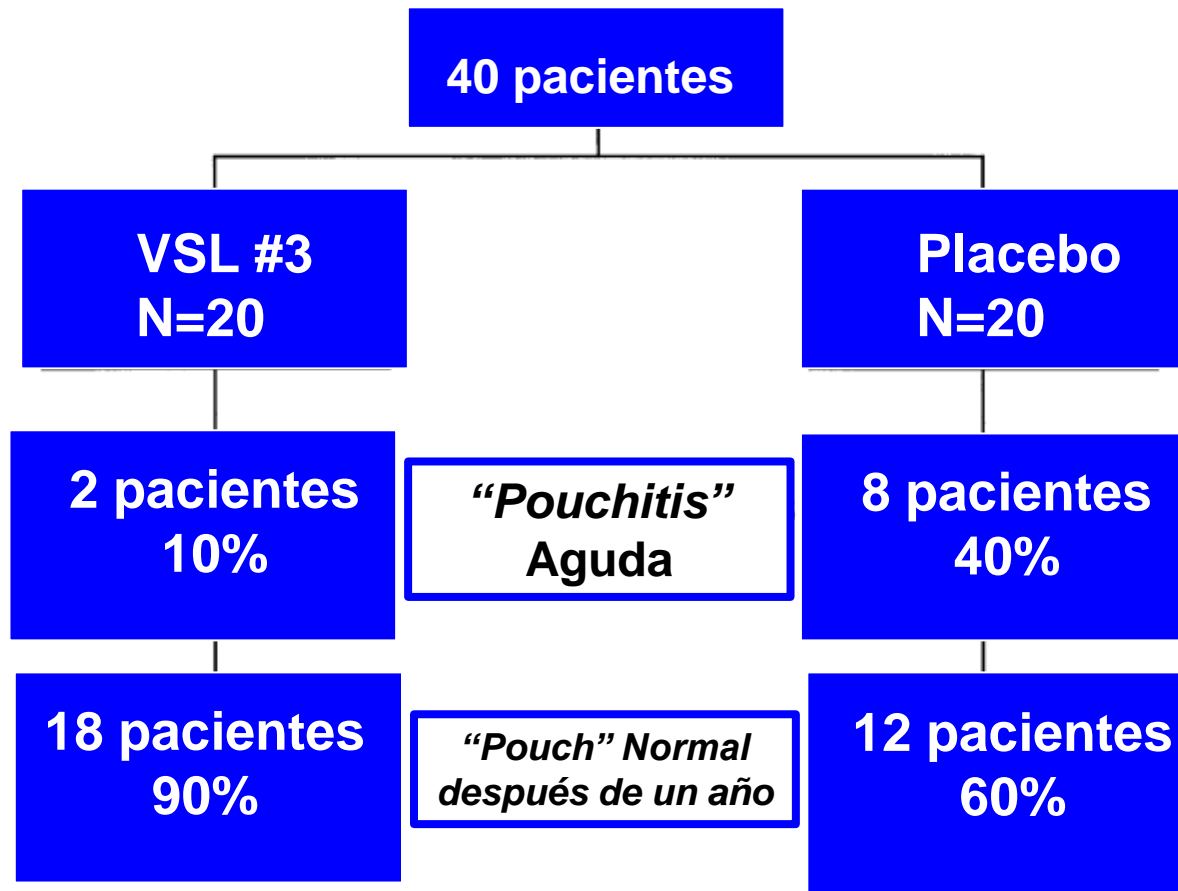
Tratamiento de Pouchitis Aguda

Mantenimiento de la Remisión

Tratamiento de Enfermedad Crónica

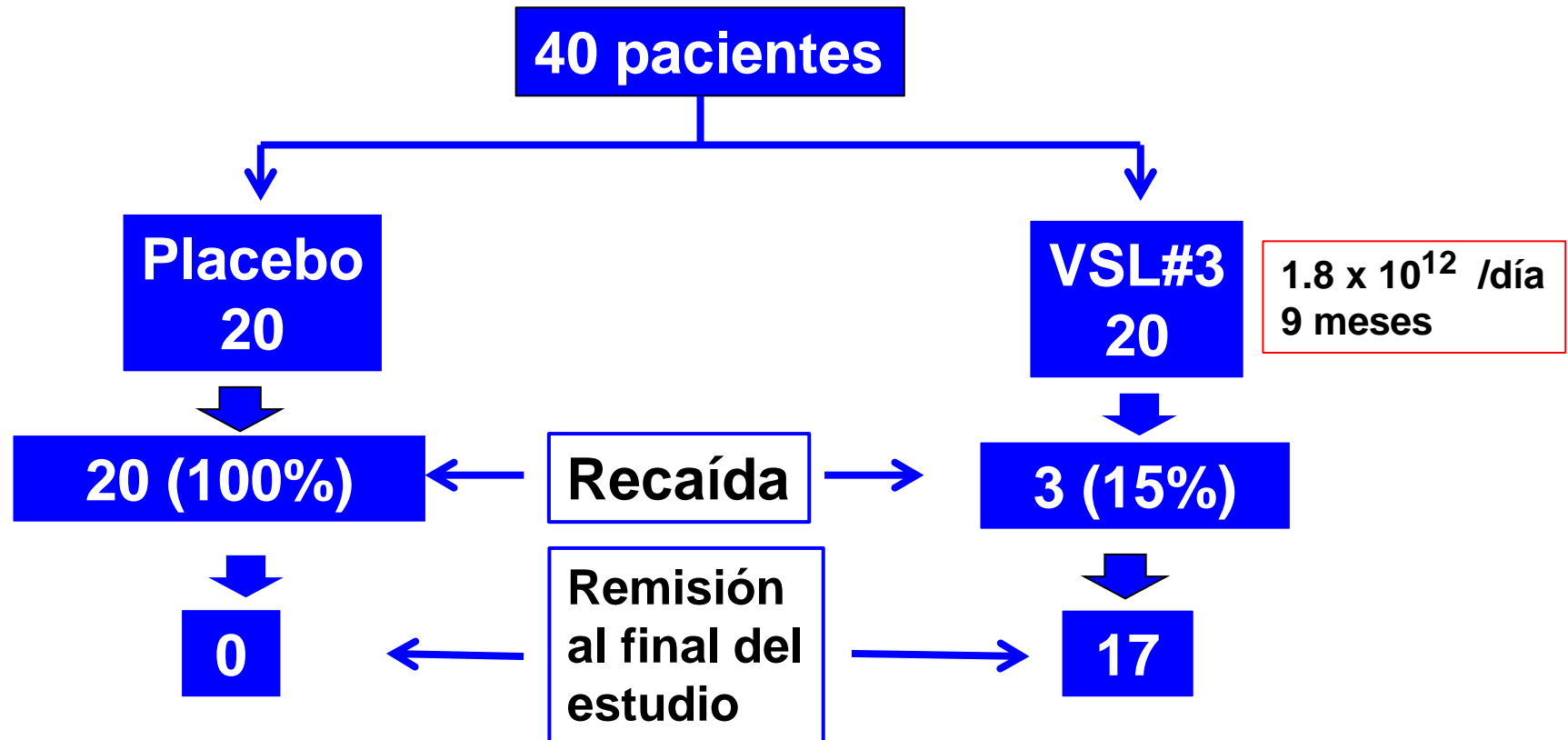
Prophylaxis of Pouchitis Onset With Probiotic Therapy: A Double-Blind, Placebo-Controlled Trial

PAOLO GIONCHETTI,* FERNANDO RIZZELLO,* ULF HELWIG,* ALESSANDRO VENTURI,*



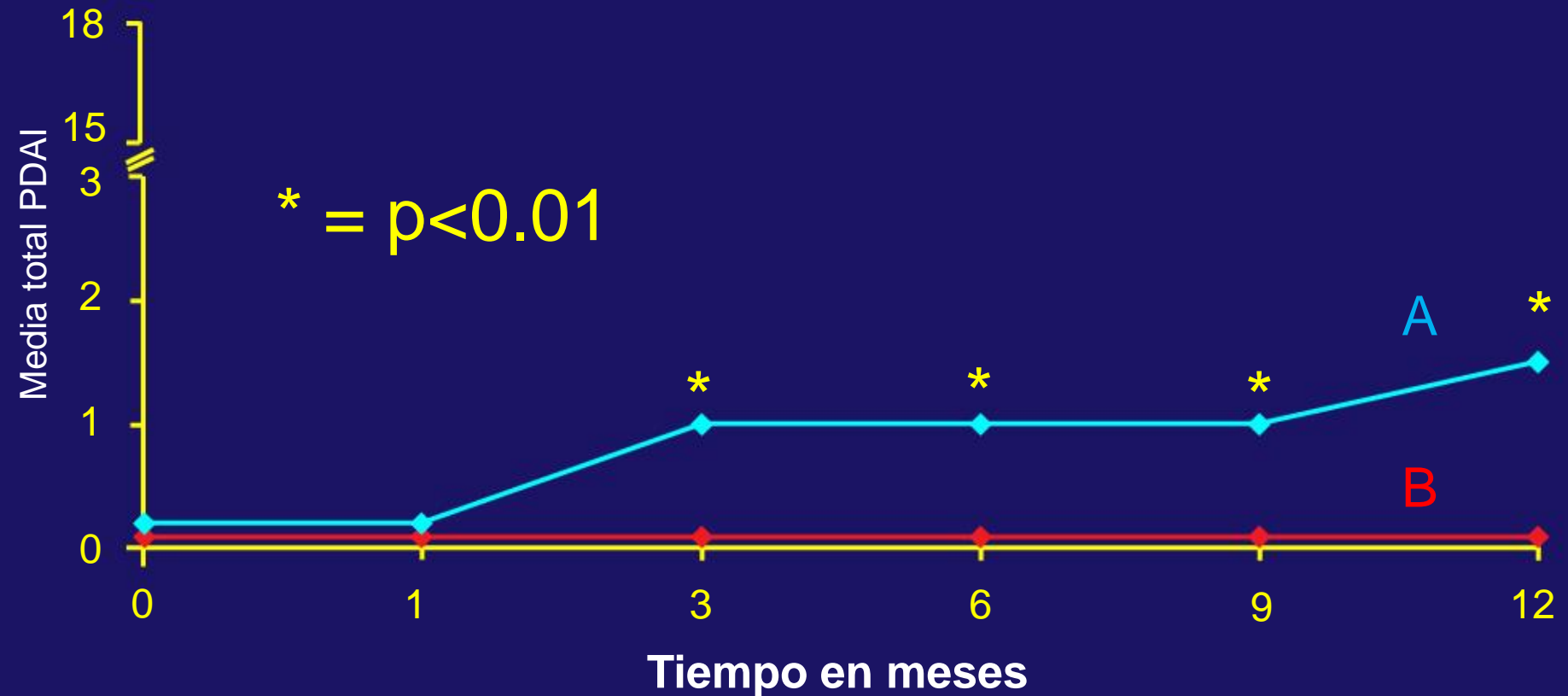
Oral Bacteriotherapy as Maintenance Treatment in Patients With Chronic Pouchitis: A Double-Blind, Placebo-Controlled Trial

PAOLO GIONCHETTI,* FERNANDO RIZZELLO,* ALESSANDRO VENTURI,* PATRIZIA BRIGIDI,†



Prophylaxis of Pouchitis Onset With Probiotic Therapy: A Double-Blind, Placebo-Controlled Trial

PAOLO GIONCHETTI,* FERNANDO RIZZELLO,* ULF HELWIG,* ALESSANDRO VENTURI,*



VSL #3

```
graph LR; VSL[VSL #3] -.-> Lactobacillus; VSL -.-> Bifidocateria; VSL -.-> Streptococcus;
```

Lactobacillus

casei

plantarum

acidophilus

delbruekii (bulgaricus)

Bifidocateria

longim

breve

infantis

Streptococcus salivari

(thermophilu)

Sospecha de pouchitis

“Pouchoscopia”, biopsias, *C. difficile*

Pouchitis activa

Ciprofloxacina 500 mg 2v/d/ Metronidazol 500 mg 2v/d por 14 días/TND

Respuesta

Recurrencia

**3 o más, Crónica
Dependiente AB**

**Pouchitis
Responde AB**

No Respuesta

Pouchitis refractaria a AB Dificil de manejar

Exclusión de causas secundarias

**AB según cultivo O Ciprofloxacina +
MTND o Rifaxmina O TNDZ 4 semanas**

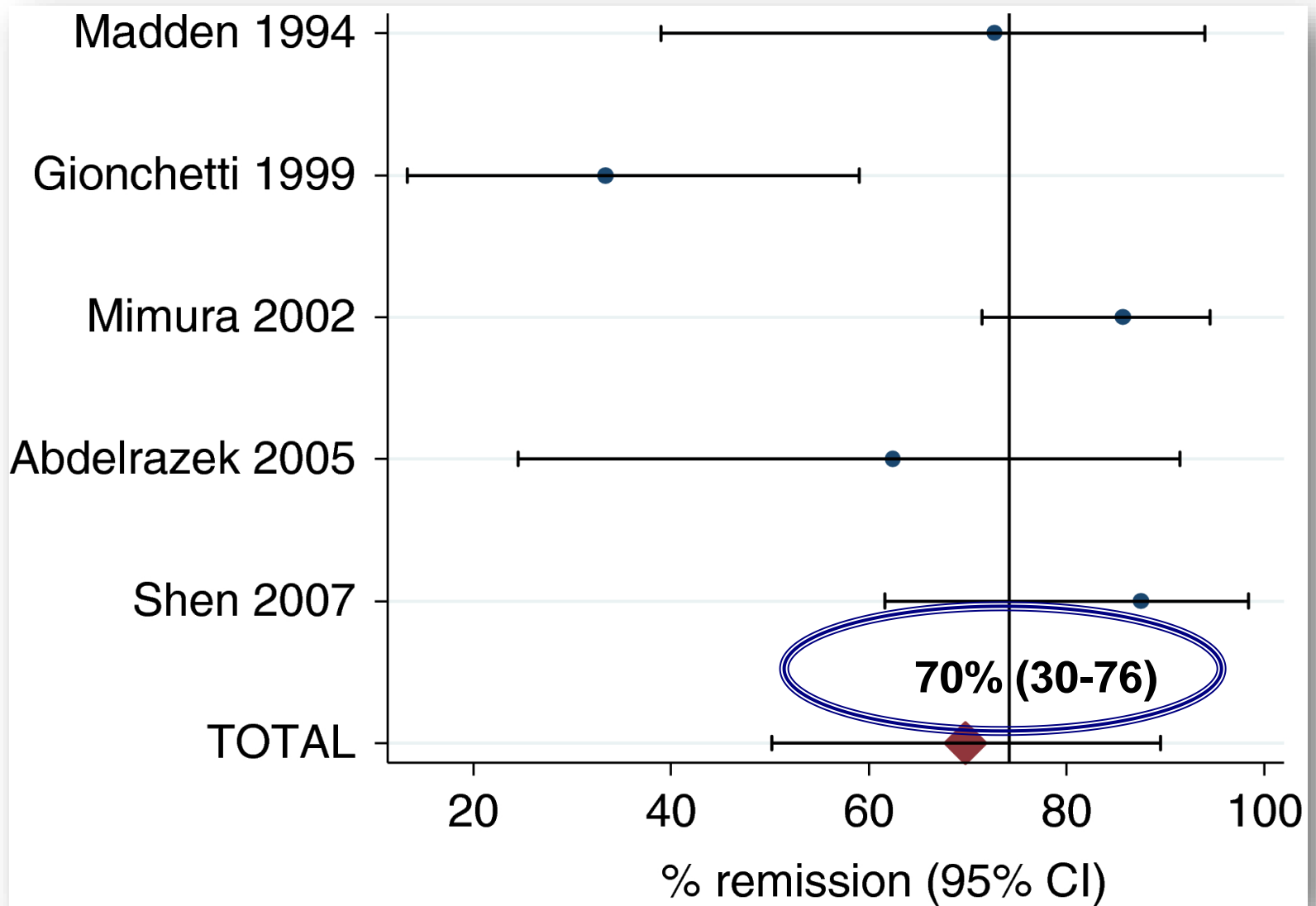
5 asa Oral/Tópico, Budesonida, *Biológicos*

*Segal JP, Aliment Pharmacol Ther 2016;
Shen B, Up To date 2018
Dalal RL, Inflamm Bowel Dis 2018;24:898-96
Hata K, Dig Endosc 2017;29:26-34*

Antibióticos de mantenimiento

Pouchitis crónica

Pouchitis crónica, Antibióticos



Long-term follow-up of the use of maintenance antibiotic therapy for chronic antibiotic-dependent pouchitis



Jonathan P Segal,^{1,2} Stephanie X Poo,³ Simon D McLaughlin,⁴
Omar D Faiz,^{1,2} Susan K Clark,^{1,2} Ailsa L Hart^{1,2}

39 pacientes, seguimiento 102 meses (9-125)

Remisión
21%

Falla “*Pouch*”
18%

EA Antibióticos
28%

Resistencia AB
78%

Pouchitis Terapia Biológica

Anti TNF

Vedolizumab

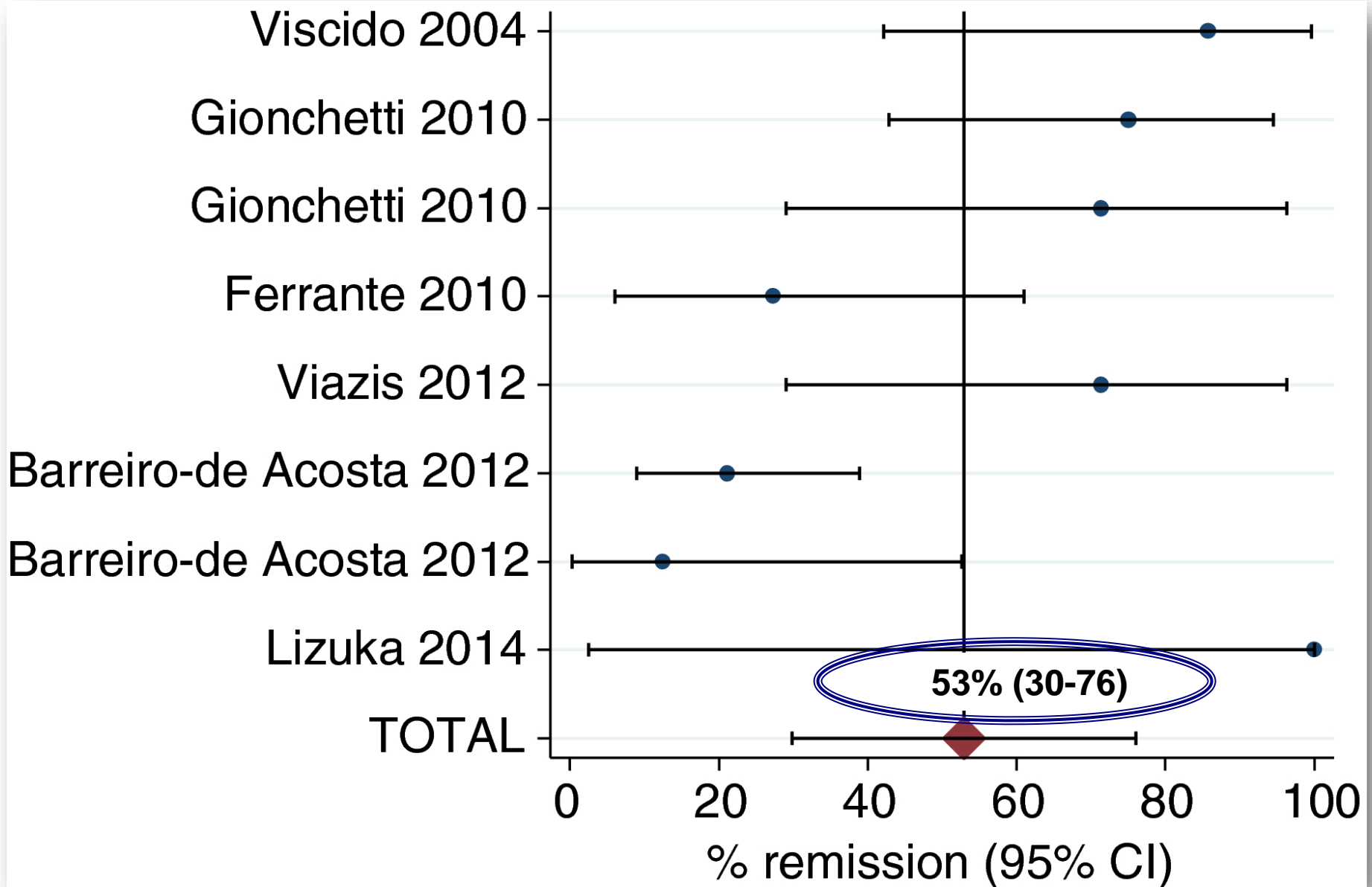
Ustekinumab

Huguet ; Inflamm Bowel dis 2018;24:261-8

Bär F, Aliment Pharmacol Ther 2017:

Peter J, JCC 2018, early Rel

Pouchitis crónica, Biológicos

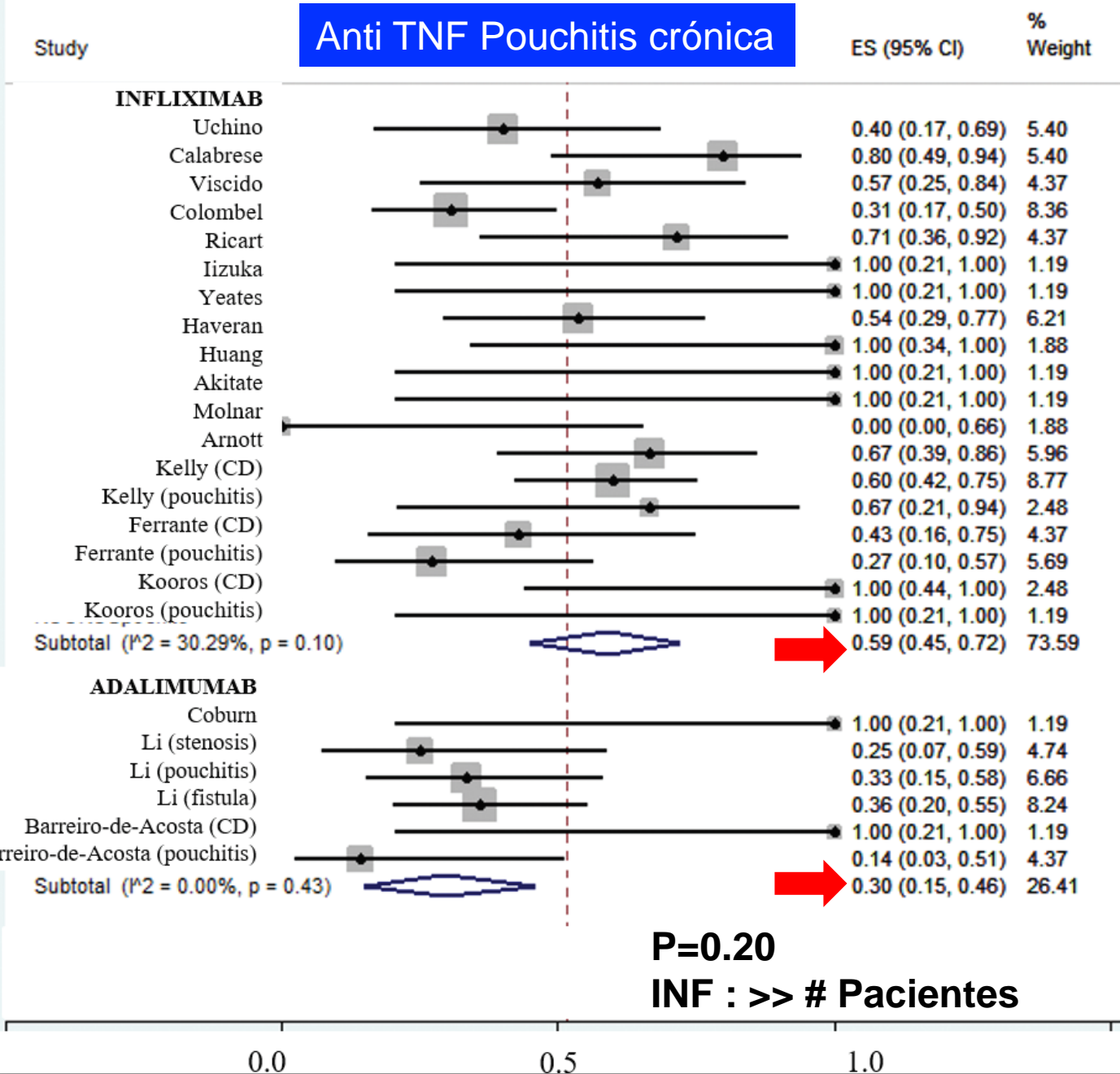


Systematic Review With Meta-Analysis: Anti-TNF Therapy in Refractory Pouchitis and Crohn's Disease-Like Complications of the Pouch After Ileal Pouch-Anal Anastomosis Following Colectomy for Ulcerative Colitis

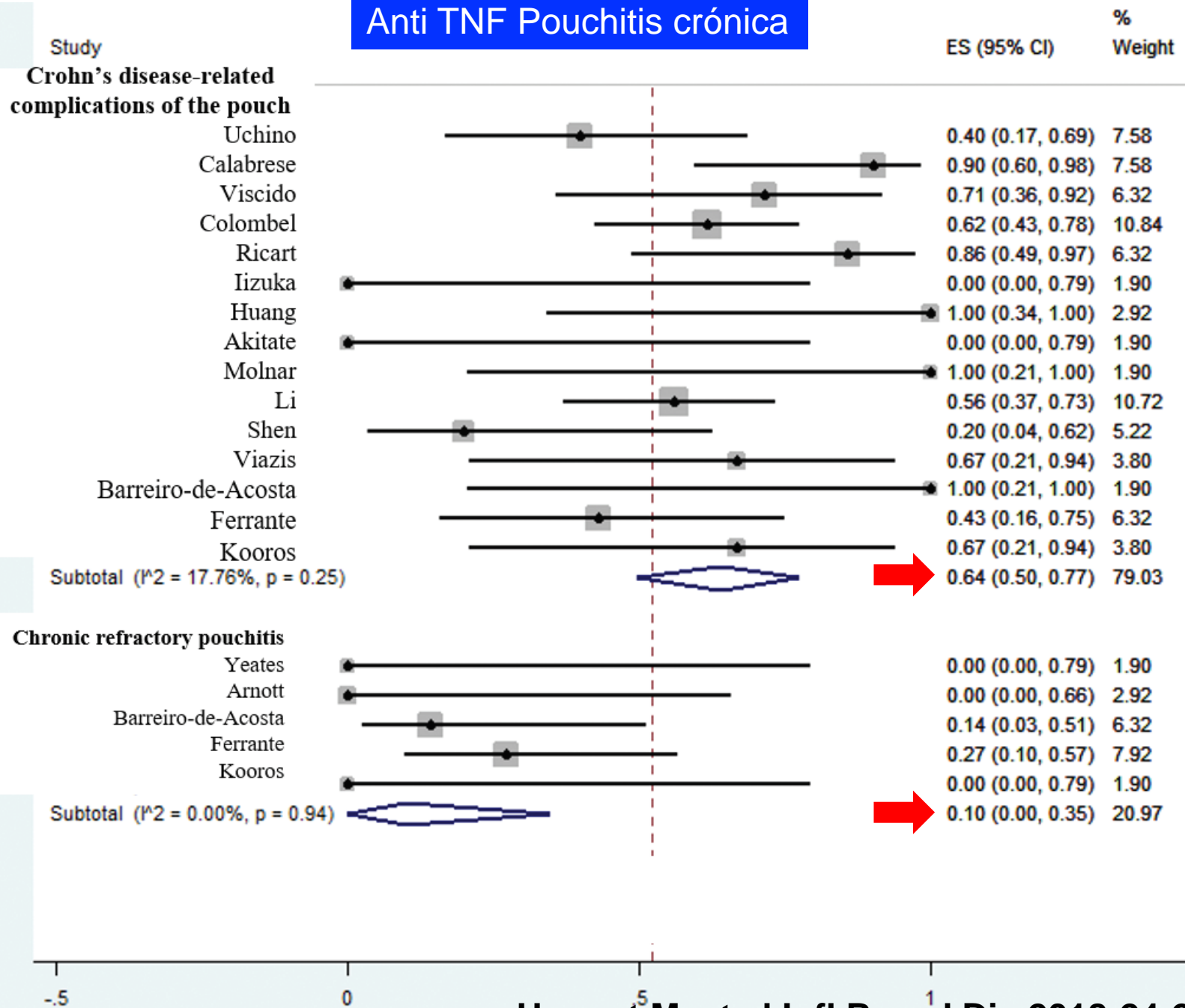
Mathilde Huguet, MD, Bruno Pereira, PhD,[†] Marion Goutte, MSc,^{*,‡} Félix Goutorbe, MD,* Anne Dubois, MD,[§] Gilles Bommelaer, MD, PhD,^{*,‡} and Anthony Buisson, MD, PhD^{*,‡,*}*

Infl Bowel Dis 2018;24:261-8





Anti TNF Pouchitis crónica



Anti TNF Pouchitis crónica

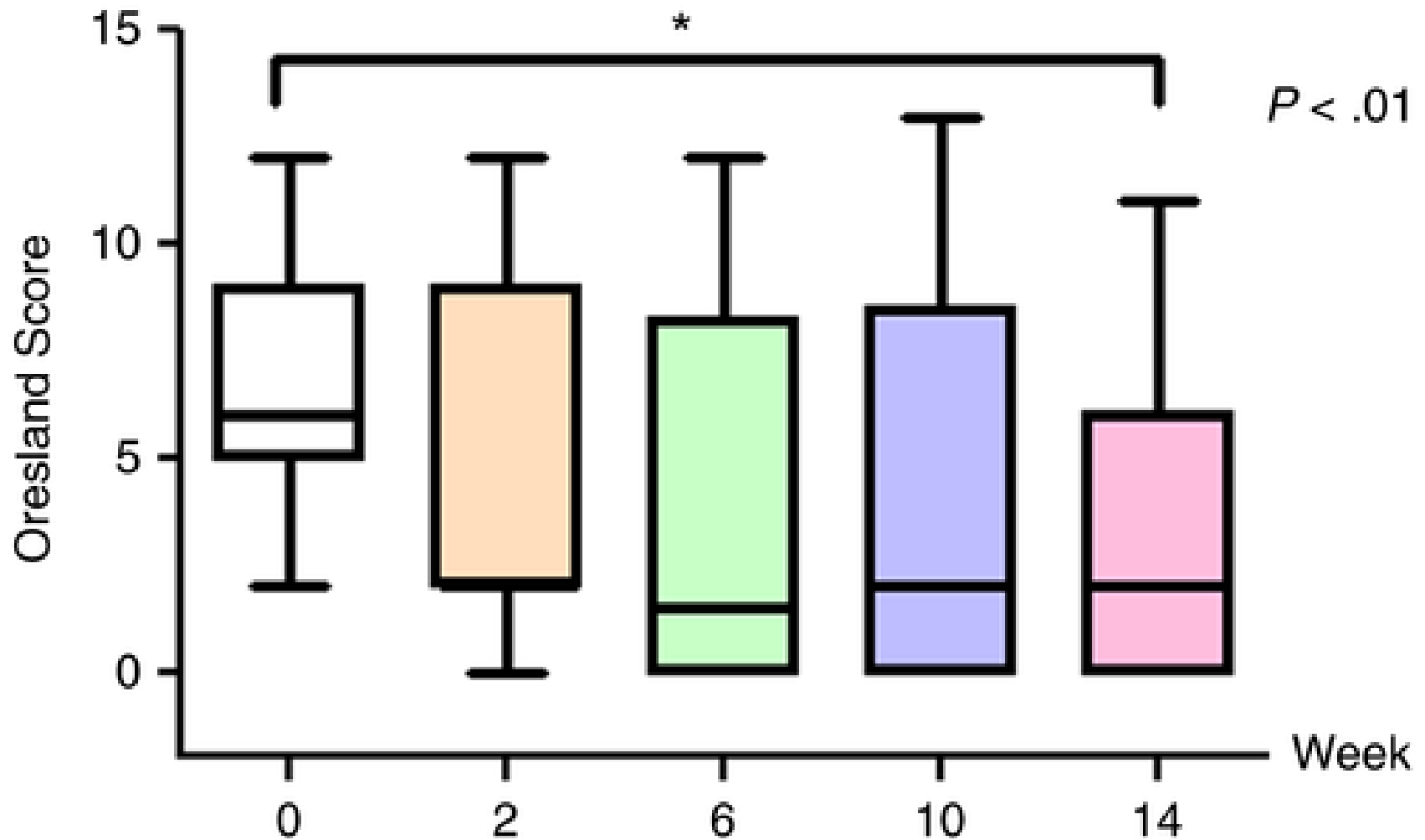


Vedolizumab in the treatment of chronic, antibiotic-dependent or refractory pouchitis

F. Bär¹  | T. Kühbacher² | N. A. Dietrich¹ | T. Krause³ | A. Stallmach⁴  |
N. Teich⁵ | S. Schreiber⁶  | J. Walldorf⁷  | R. Schmelz⁸ | C. Büning⁹ |
K. Fellermann¹ | J. Büning¹ | U. Helwig¹⁰ | on behalf of the German IBD Study Group

Aliment Pharmacol Ther 2018; 47: 581-7

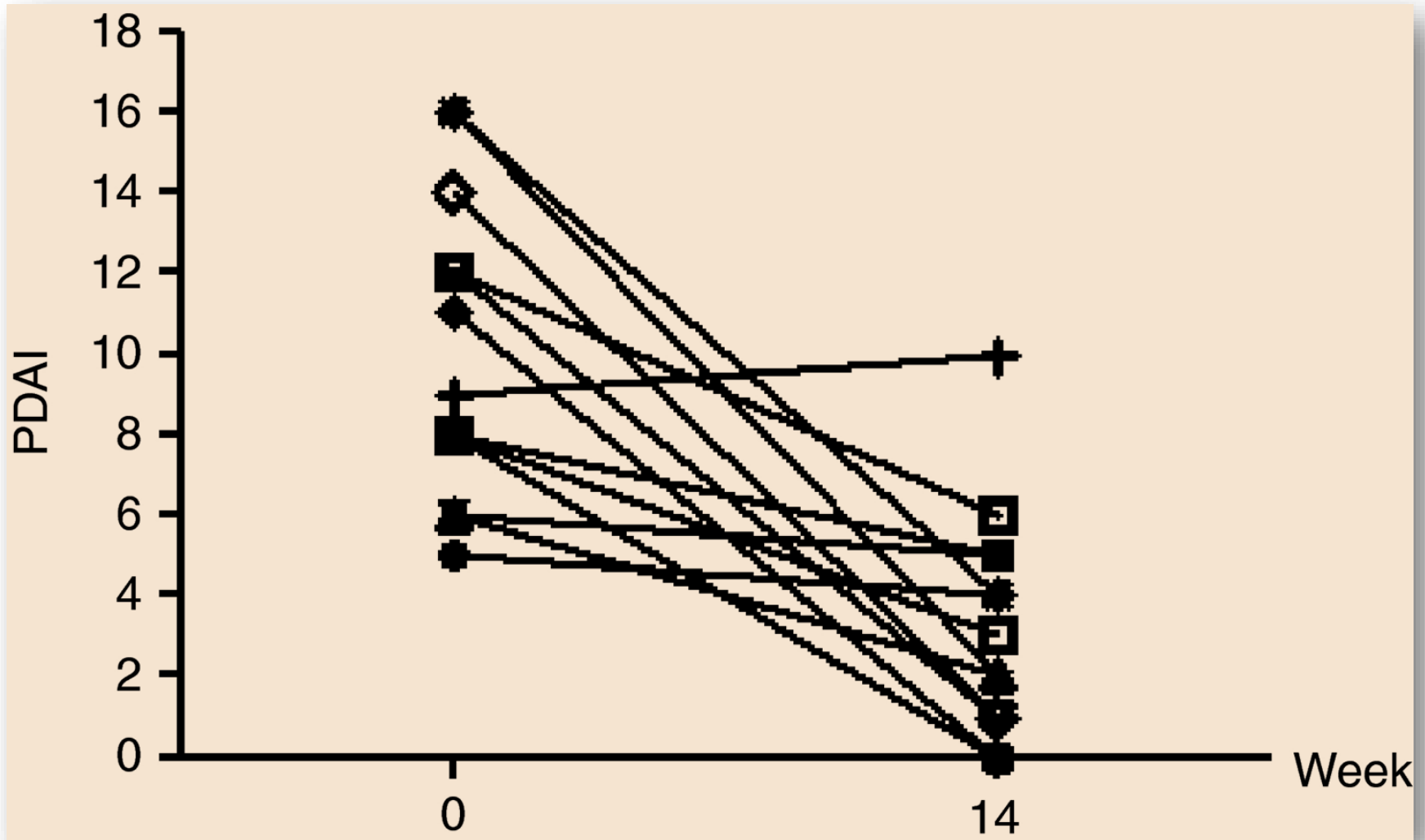
Vedolizumab en pouchitis crónica dependiente de AB



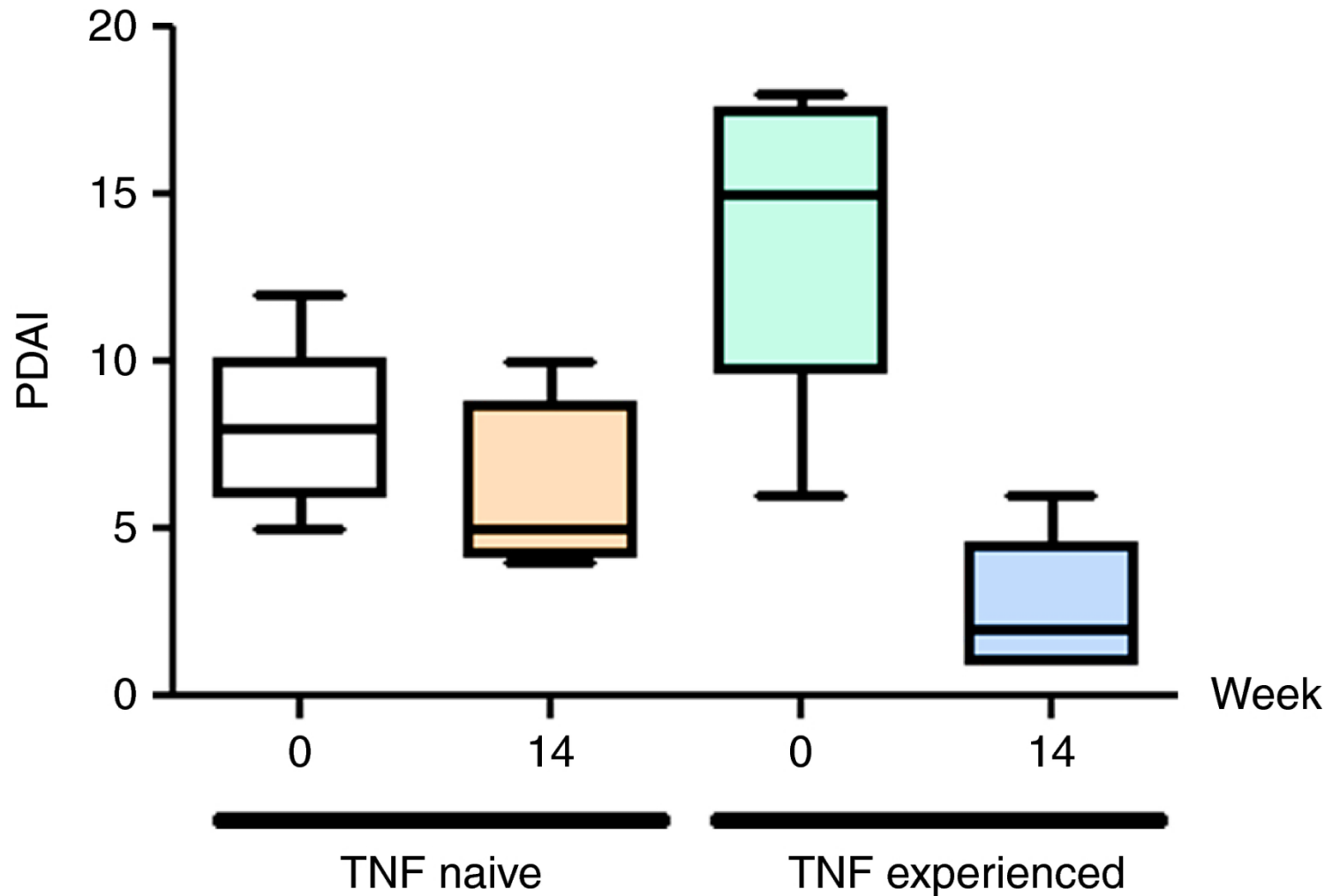
Actividad clínica
"Oresland"

Bär F, et al. Aliment Pharmacol Ther 2018; 47: 581-7

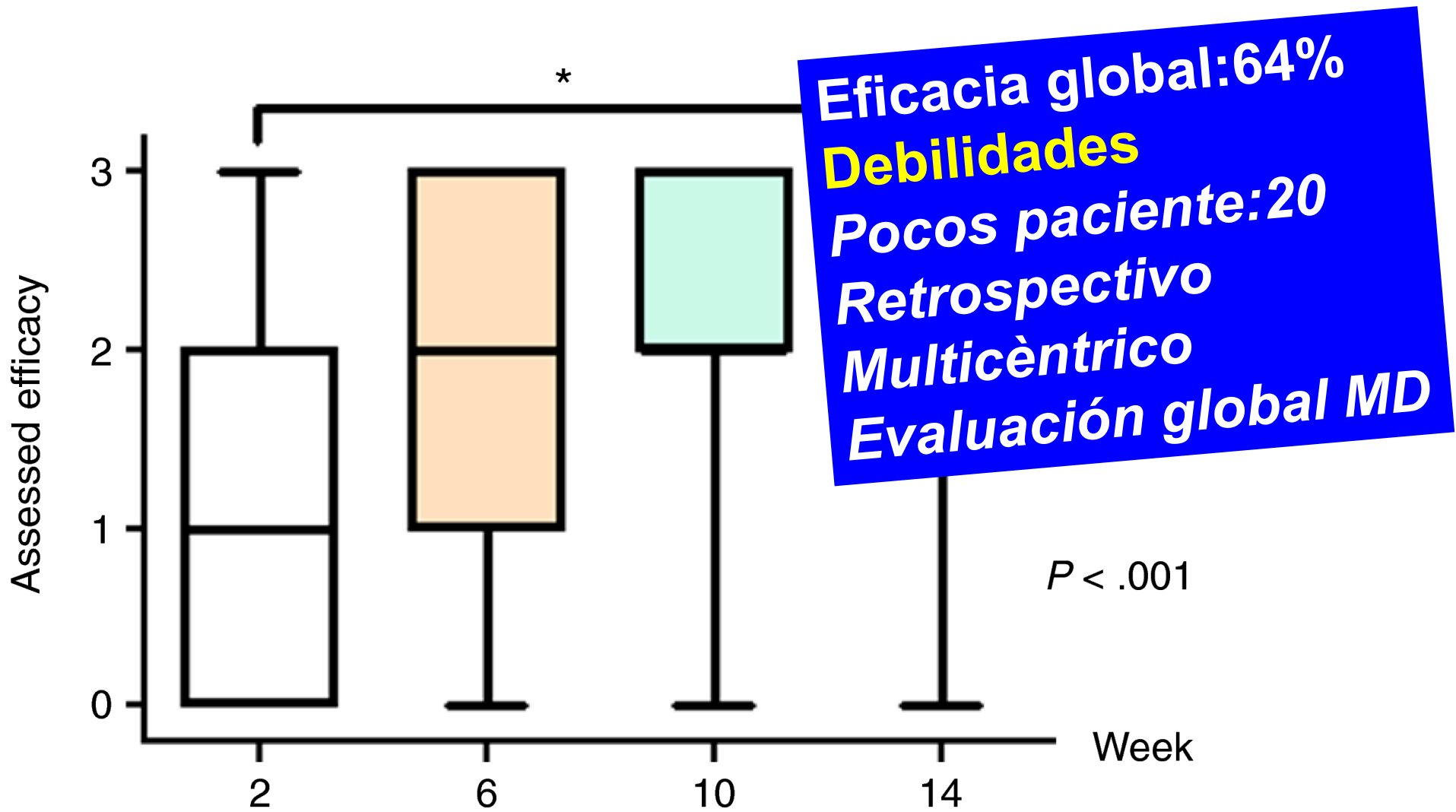
Vedolizumab en pouchitis crónica dependiente de AB



Vedolizumab en pouchitis crónica dependiente de AB



Vedolizumab en pouchitis crónica dependiente de AB



Pouchitis crónica Ustekinumab

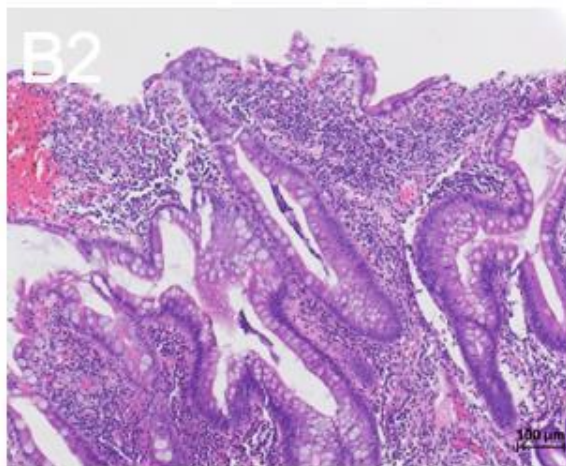
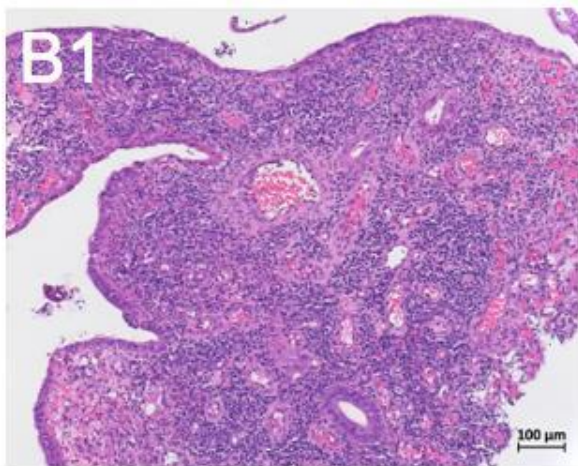
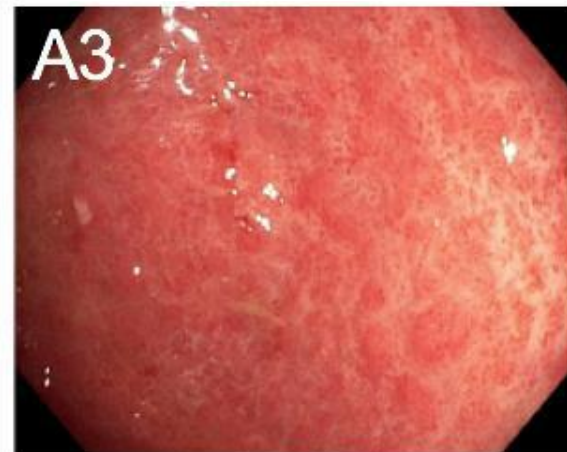
Semana 0, PDAI 12



Semana 0, PDAI 6



Semana 12, PDAI 6



“Crohn like”

Peter J, JCC 2018, early rel April 6

Revisión sistemática y meta-análisis

1ª Línea: antibióticos

Ciprofloxacina 500 2vd x 14d
+ Metronidazol 500-1000mg 2vd x 14d
Ciprofloxacina + Rifaximina o Tinidazol

2ª Línea: esteroides

Beclometasona o budesonide

3ª Línea: Biológicos

Infliximab, Adalimumab

Dilatación con balón

Fumery M, Inflamm Bowel Dis 2018; Early Rel

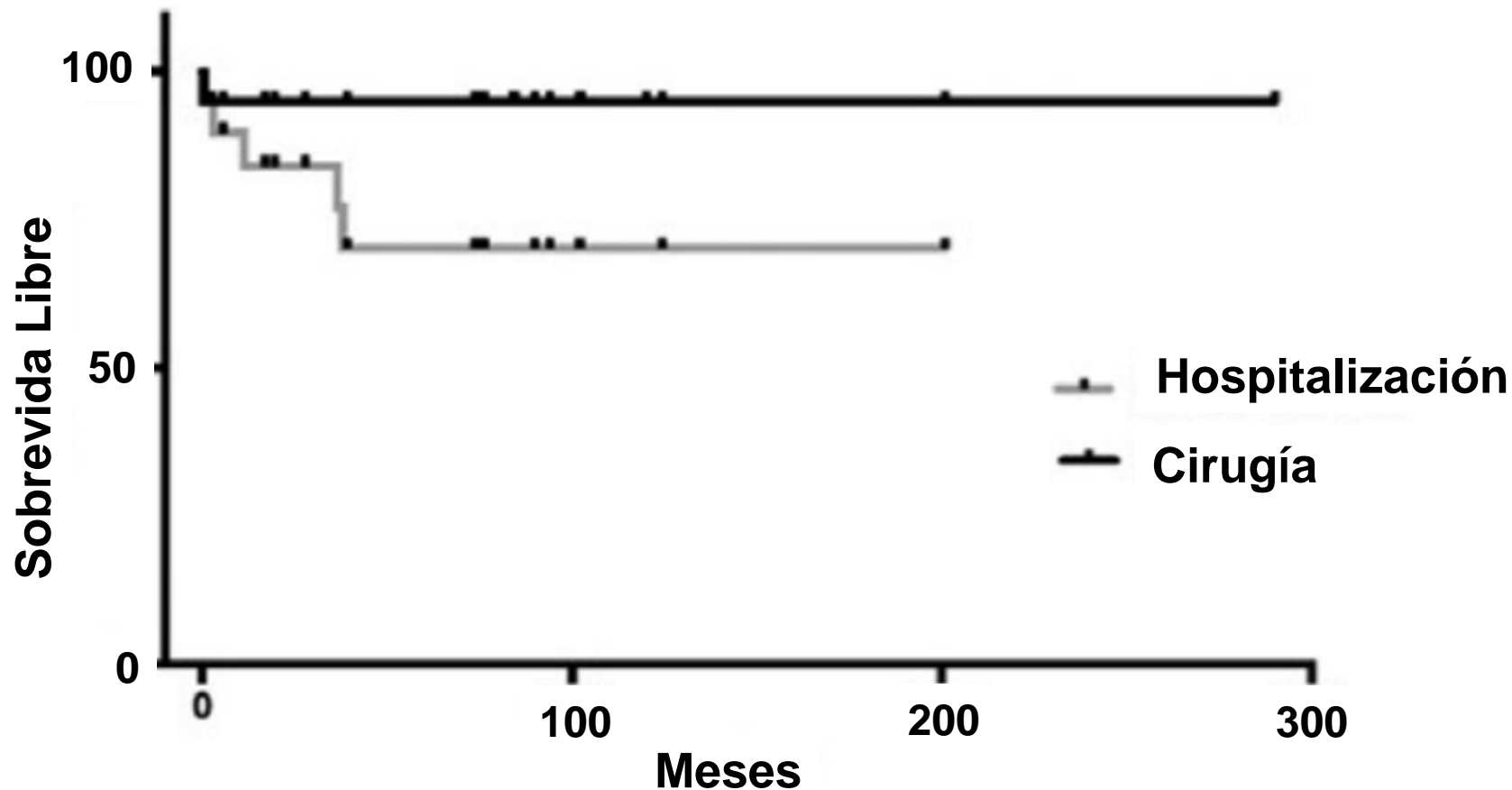
Efficacy and Safety of Endoscopic Balloon Dilatation of Ileoanal Pouch Strictures

Mathurin Fumery, MD,^{,†} Niraj S. Patel, MD,^{*} Brigid S. Boland, MD,^{*} Parambir S. Dulai, MBBS,^{*} Siddharth Singh, MD, MS,^{*} and William J. Sandborn, MD^{*}*

Dilatación de Estenosis Con Balón

Median no. of dilatation (n, IQR)	3.5 (2.0–7.0)
Median size of smallest balloon (mm, IQR)	12 (12–15)
Median size of largest balloon (mm, IQR)	18 (15–20)
Associated finger dilatation (n, %)	12 (13.6%)
Modifications of IBD related treatment at dilatation	18 (20.5%)
Antibiotics initiation	4 (4.5%)
Budesonide initiation	4 (4.5%)
Antibiotics and budesonide initiation	1 (1.1%)
Anti-TNF optimization	2 (2.3%)
Anti-TNF with immunosuppressants initiation	3 (3.4%)
Anti-TNF with immunosuppressants and budesonide initiation	1 (1.1%)
Anti-TNF with immunosuppressants and oral steroids initiation	1 (1.1%)
Ustekinumab with immunosuppressants, oral steroids and antibiotics initiation	1 (1.1%)
Hydrocortisone suppository	1 (1.1%)
Technical efficacy (n, %)	87 (98%)
Clinical improvement of obstructive symptoms (n, %)	21 (95%)
Pouch surgery related to stricture (n,%)	1 (5%)
Hospitalizations after 1st dilatation related to stricture (n,%)	5 (25%)
Complications (n,%)	0
Final outcomes	
Complete disappearance of the pouch stricture	9 (45%)
Persistent passable strictures without related symptoms	7 (35%)
Diverting stoma because of resistant Crohn of the pouch	3 (15%)
Death (not related to IBD)	1 (5%)

Dilatación de estenosis del “pouch” con balón



Fumery M, et al. Inflamm Bowel Dis 2018;24:1316–20,

Mensajes para la casa

Diagnóstico: Clínica+Endoscopia+Histología

Afectará 20-50% de pouch ileoanal

La profilaxis con VSL # 3 es eficaz

El tratamiento convencional de EII no funciona

Antibióticos piedra angular

Pouchitis crónica: 10-15%

En pouchitis crónica:

Antibióticos combinados, Bismuto, 5 Asa

Terapia biológica: resultados alentadores

Se necesitan más estudios

Muchas gracias!