LETTER TO THE EDITOR

Disappointing results following proctectomy with end-colostomy for anorectal Crohn’s disease

Dear Sir,

I read with interest the article by de Buck van Overstraeten et al., ‘Intersphincteric proctectomy with end-colostomy for anorectal Crohn’s disease (CD) results in early and severe proximal colonic recurrence’. In their case series, 10 consecutive patients underwent intersphincteric proctectomy with end-colostomy. Early symptomatic recurrence occurred in 9 of the 10 patients at a median follow-up of 9.5 months. Completion colectomy with end-ileostomy was performed in 5 patients. One patient, who underwent a second segmental colectomy with a new end-colostomy, showed again endoscopic recurrence requiring surgery despite anti-TNF-α treatment. Based on these results, the authors recommend a proctocolectomy with end-ileostomy for anorectal CD.

These results are quite impressive to me. I believe that following bowel resection for CD, recurrence in the proximal part of the stoma is not common, although recurrence in the proximal site of the anastomosis is common. Before the era of biologics, extensive active colitis was common in patients with anorectal CD probably because colonic disease was not under control with conventional medical treatment. Therefore, many patients underwent proctocolectomy with end-ileostomy for severe anorectal CD. In my research in Birmingham, 103 patients who underwent single-stage proctocolectomy with end-ileostomy for CD were reviewed. The reoperation rate for small bowel recurrence was quite low; 13% at 5 years, 17% at 10 years and 25% at 15 years after surgery. The most common site of recurrence was the distal ileum within 25 cm of the ileostomy.

In the present study, all patients except one were taking immunosuppressant or anti-TNF-α agents before surgery. Although only 2 patients showed mild colitis at ileocolonoscopy, all other patients had no signs of colitis. Under these conditions, all patients underwent proctectomy with end-colostomy for anorectal CD. In all but one patient, medications with anti-TNF-α agents or immunomodulators were restarted after surgery. We do not know why many patients developed severe colitis after proctectomy with end-colostomy despite these medications. However, I have recently had similar experiences. After defunctioning colostomy for severe anorectal CD, several patients developed severe colitis at the stoma and the proximal part of the stoma. These patients required completion proctocolectomy with end-ileostomy despite anti-TNF-α treatment. A single-center experience reported in this study gives us an important message. Further reports from other high-volume centers are awaited to confirm their experience.

Another concern after proctectomy is persistent perineal sinus; a discharging, unhealed perineal wound. This is the most common morbidity following proctectomy for CD. In patients receiving immunosuppressant or biologic agents, the incidence of persistent perineal sinus may be increased due to a compromised immune system. In this study, 5 patients had perineal wound dehiscence. However, wound problems were superficial in these patients, which may be due to intersphincteric resection.

Conflict of interest
None declared.

References
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