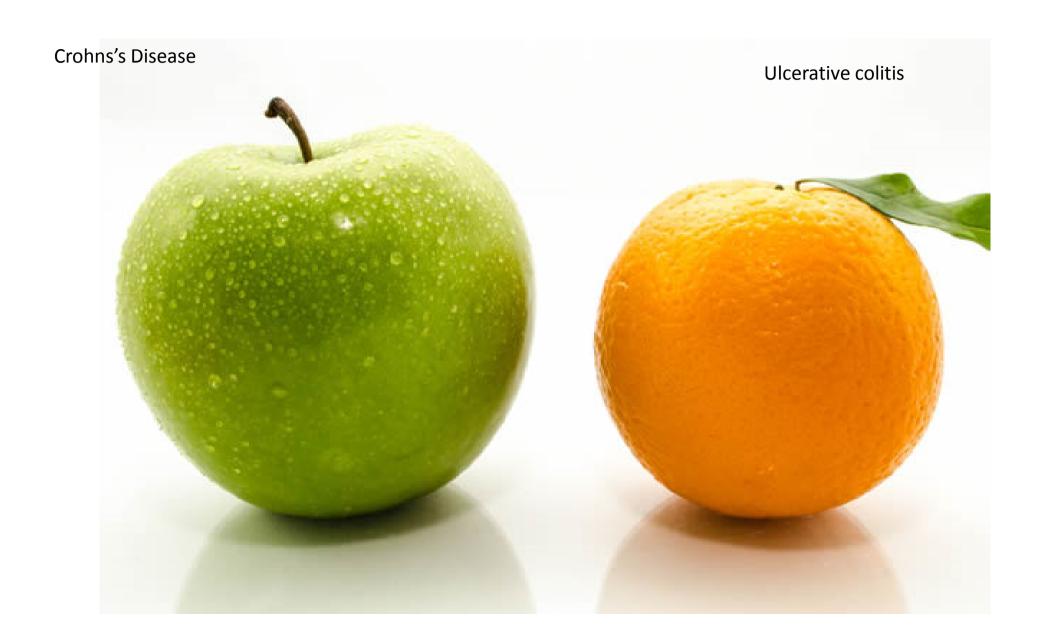
Surgery for IBD What you need to know...



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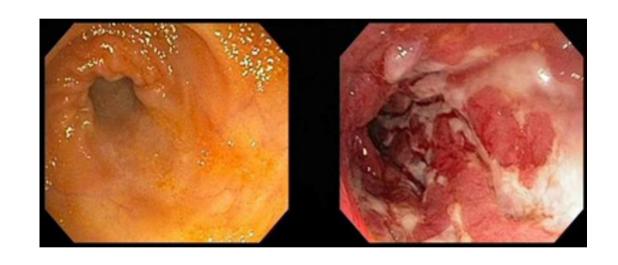
Surgery in Crohn's Disease

- "Top-Down" approach
- Peri-anal disease
- Complications
- Prevention of recurrence
- Preserve gut length at all costs



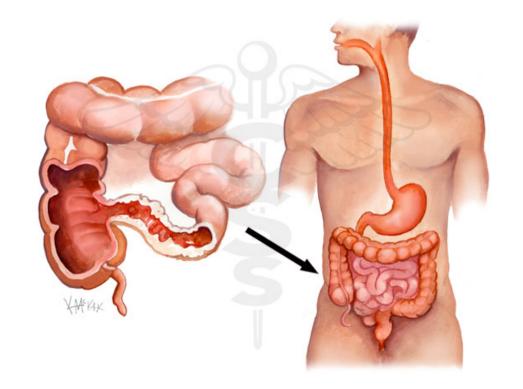
Surgery in Crohn's

- Entire GIT
- Cannot be cured
- 70% will require surgery
- 30%-70% will repeat surgery



"Top-Down" Approach

- Isolated Short Segment Disease
- Get it away, Keep it away
- 6 months colonoscopy



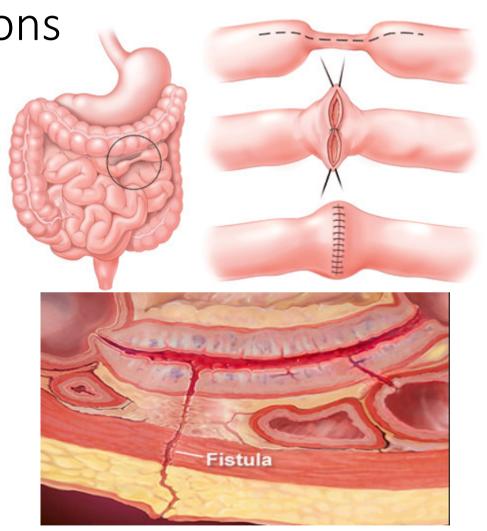
Peri-anal Crohn's

- 50% will develop anal disease
- NEVER have a hemorrhoid op!
- Treatment always include medicine
- Drainage and Setons



Surgery for Complications

- Late in disease
- Aim is to prevent complications
- Fistulae/Obstruction
- NB to optimise before surgery



Laparoscopic Surgery

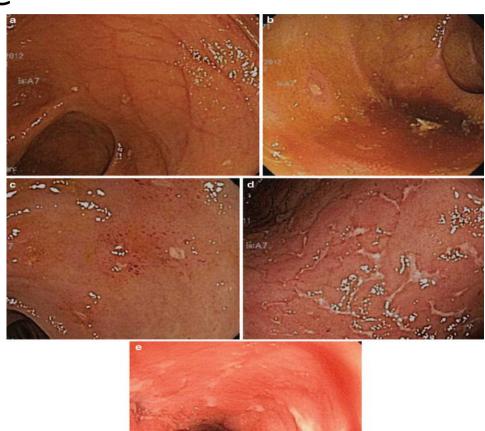
- Faster recovery
- Less pain
- Cosmesis
- Easier to re-operate



Prevent recurrence

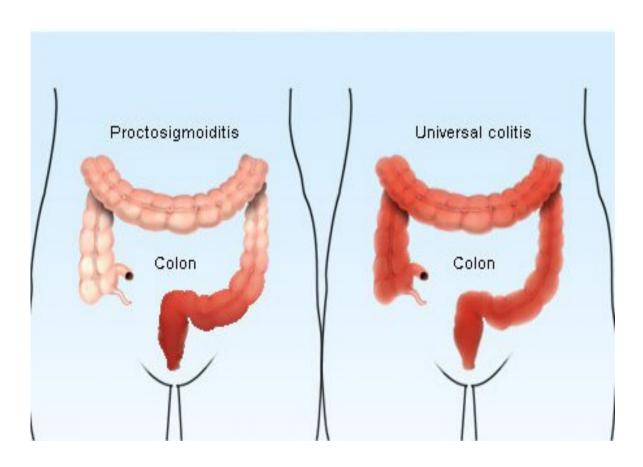
 STOP SMOKING STOP SMOKING STOP SMOKING Stop smoking stop smoking stop smoking

- Anastomotic technique
- Flagyl
- Colonoscopy 6 months
- Immune suppression



Ulcerative Colitis

- Involves only the colon
- "Always" involve the rectum
- No anal disease
- Can be cured with surgery



Ulcerative Colitis

- Emergency
- Treatment Failure
- Cancer

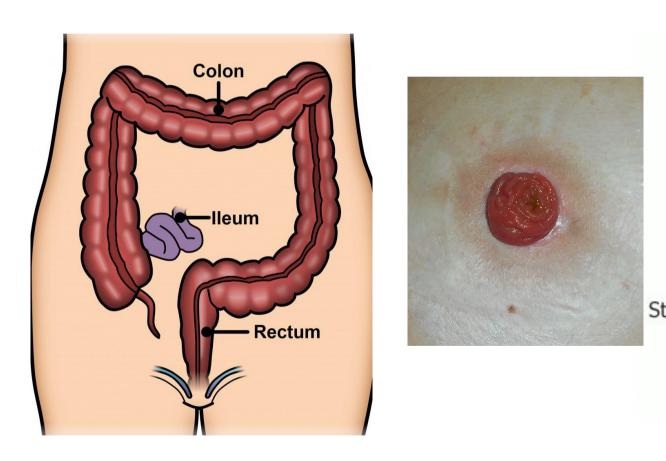


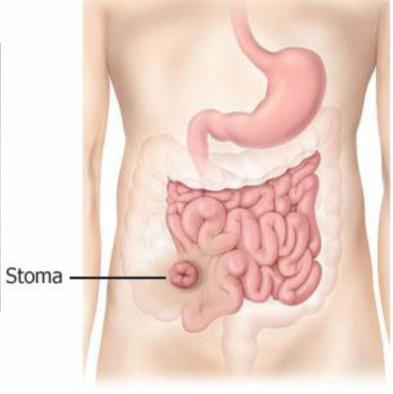
Ulcerative Colitis

- Removal of the colon and rectum
- Restore function
 - Ileostomy
 - Ileo-anal Pouch
 - 1,2,3 Stage

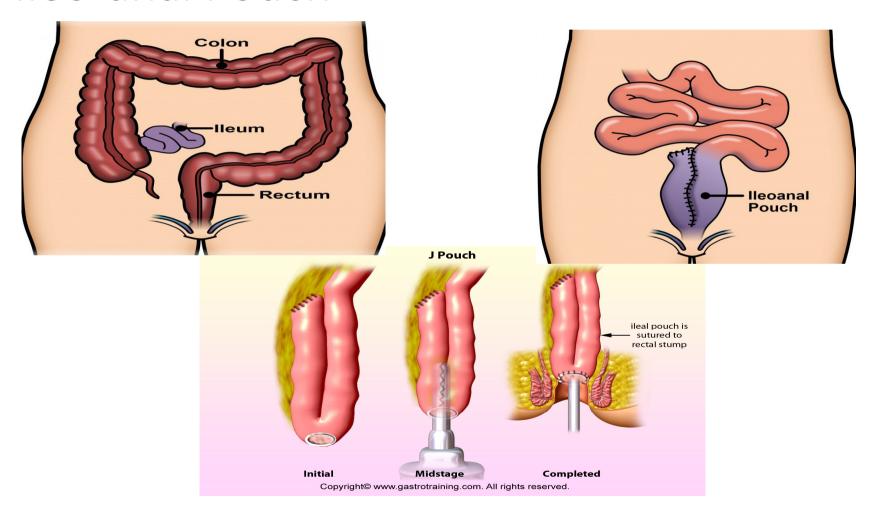


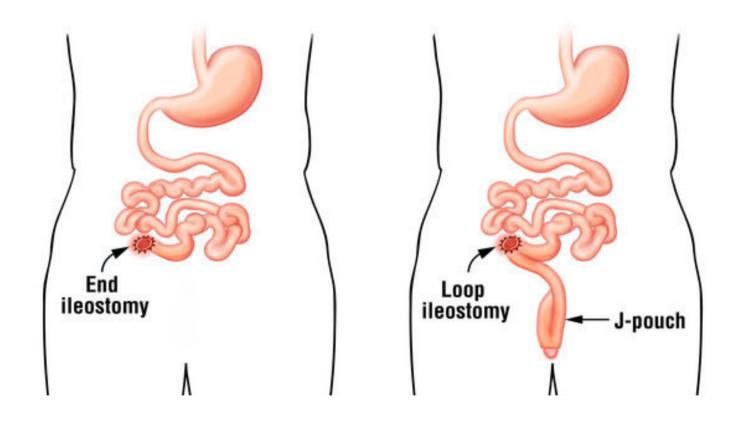
Colectomy and Ileostomy





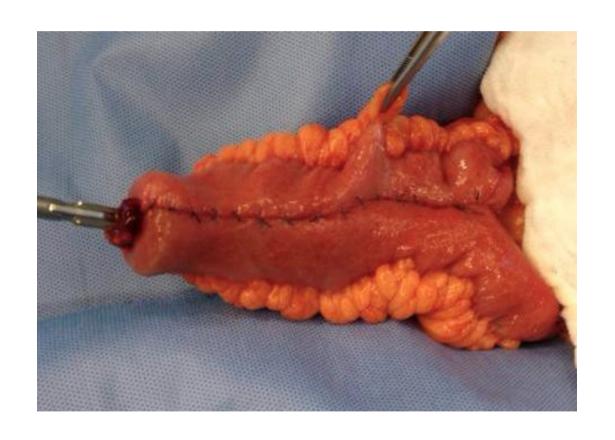
lleo-anal Pouch





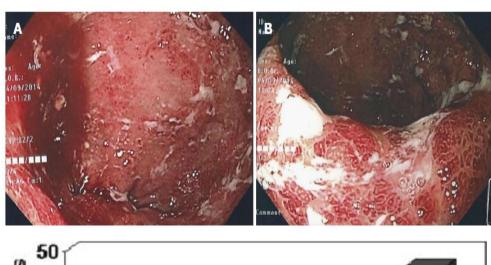
Expectations after pouch surgery

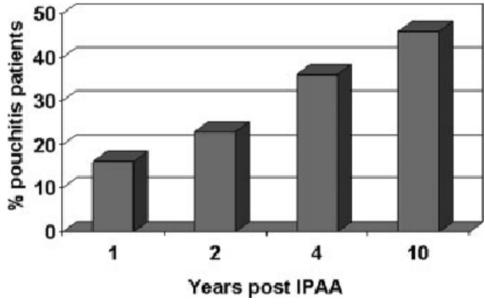
- Consistency
- Frequency
- Continence
- Fertility
- Pouchitis



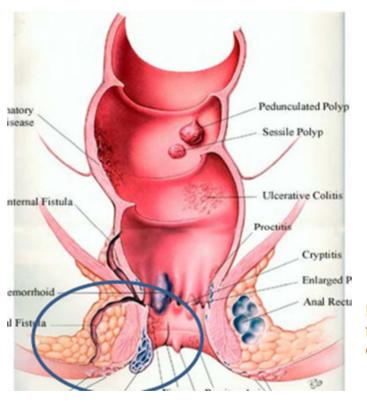
Pouchitis

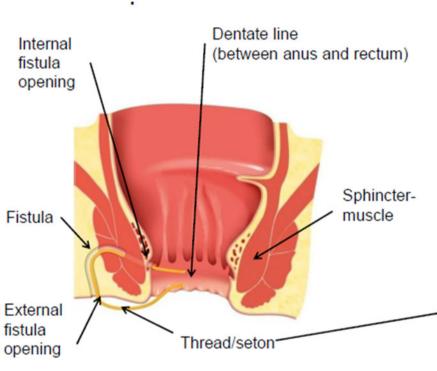
- Inflammation of the pouch
- Cause not clear
- Symptoms
 - Frequency
 - Pain, Cramps, Bloating
 - Incontinence
 - Bleeding
- Treatment
 - Medication
 - Surgically remove pouch



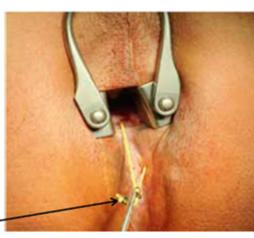


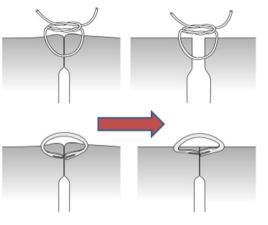
Fistula and surgery











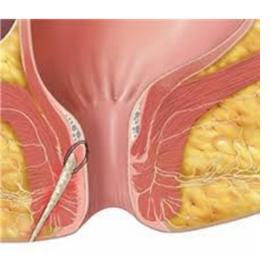


Other Surgeries......

Mucosal advancement flap

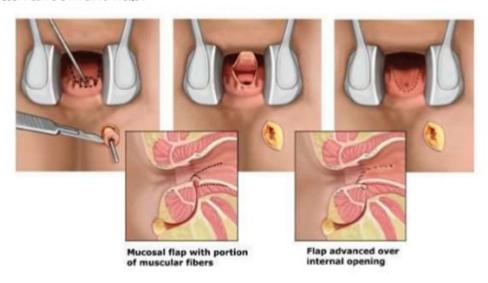


Collagen Fistula Plug





 High fistulas can be treated with an anorectal advancement flap.



What you need is an aggressive Gastroenterologist an a conservative Surgeon







