Colorectal surgeons at Penn Medicine are performing total proctocolectomy with J-pouch reconstruction/ intestinal pouch anal anastomosis (IPAA) for patients with ulcerative colitis (UC).

Since its introduction in the US in the 1980s, this procedure has undergone technical changes that make it much better tolerated, with improved outcomes and faster recovery. In selected individuals, it replaces total proctocolectomy with end ileostomy, and allows for the retention of gastrointestinal continuity—a major concern for all patients.

Emergent indications for surgery in UC include acute flares refractory to medical control, sudden, severe disease manifesting as uncontrolled bleeding in the colon, toxic megacolon, and perforation of the bowel. By contrast to Crohn’s disease, UC is cured by removal of the diseased colon and rectum.

At Penn Medicine, elective total proctocolectomy with J-pouch for UC is offered to patients who have pre-cancerous or dysplastic colonic mucosal changes and to those patients refractory to medical management with intolerable symptoms such as frequency, pain and urgency leading to a progressive decline in quality of life. Because the rate of synchronous or subsequent adenocarcinoma ranges from 10%-50% in this population, both high- and low-grade dysplasia constitute indications for proctocolectomy.

Total proctocolectomy with J-pouch reconstruction is most commonly performed in either two or three stages depending on the condition of the patient. Three-stage procedures are performed for acutely or chronically ill malnourished individuals, patients on high doses of immunosuppressive medications, or those who present emergently with the indications for surgery listed above.

The first part of the operation is a laparoscopic total colectomy with preservation of the rectum and end ileostomy in the right lower quadrant of the abdomen (Figure 1). Sparing the rectum in these circumstances is important. Proctectomy is often the most technically challenging part of the procedure. Performing this part of the operation in a well-nourished, healthy, immunocompetent individual reduces morbidity and makes J-pouch creation safer by improving outcomes and reducing septic complications.

The second part of the procedure occurs about 3-4 months later depending on the patient’s performance status. This step involves removal of the rectum, creation of the J-pouch from the terminal ileum (about 20 cm) and temporary loop ileostomy to divert the fecal stream proximal to the J-pouch (Figure 2).

About two months after J-pouch creation (after the pouch is checked via gastrograffin enema for leaks, sinus tracts or defects) the loop ileostomy is closed through a small peristomal incision.

Two stage procedures are done frequently in well-nourished patients who present electively for proctocolectomy for indications such as dysplasia or failure of medical management. Patients are screened for malnutrition, and are asked to stop anti-TNF therapy about one month in advance of the procedure. Prednisone doses higher than 20mg/day have been associated with J-pouch leaks/complications; thus consideration for a three stage procedure is warranted if higher doses of steroids are required.

Case Study
Mr. V, a 37-year-old with medically refractory ulcerative colitis, was referred to Penn Medicine for evaluation. A review of his medical history revealed that Mr. V’s disease began in his late teens. At this time, his symptoms included bloody diarrhea, bloating, acute pain and cramping. In the decades since, his UC had responded for varying periods of time to mesalazine, azathioprine, prednisone and finally, infliximab. Each medication brought about a remission followed by a gradual return of symptoms and flare-ups, the most recent of which was attended by 20 to 30 bowel movements a day, dramatic weight loss and hospitalization.

At the time of admission, Mr. V was taking infliximab every two weeks, and was on 30 mg prednisone daily. After a consultation to discuss further medical therapy with other anti-TNF-alpha alternatives,
it was discovered that Mr. V had considered surgery, but was reluctant because he felt he was too young for an ileostomy. After counseling, and in consultation with the Division of Gastroenterology, there was agreement that Mr. V would have a total proctocolectomy with J-pouch reconstruction, and that his acute presentation, relative malnutrition and immunosuppression mandated that the surgery proceed in three stages.

Mr. V returned home two days after the initial step (laparoscopic subtotal colectomy with temporary end ileostomy) in the three-step procedure. In the next four months, he gained almost twenty pounds while gradually weaning himself from prednisone. His sleep improved and for the first time in several years, he was able to begin moderate exercise. Returning for the proctectomy and creation of the J-pouch and temporary loop ileostomy, Mr. V spent another three days in the hospital, then returned home. Two months later his ileostomy was reversed.

Today, at a year post-surgery, he has between four and six bowel movements a day, with perfect control. He is exercising regularly, eating previously forbidden foods and has no activity restrictions or limitations.

Faculty Team

The Colon and Rectal Surgery Program at Penn Medicine provides the highest quality diagnostic and surgical options for patients with colon, rectal and anal cancer, inflammatory bowel disease (Crohn’s disease and ulcerative colitis), diverticular disease and many other diseases of the colon, rectum and anus. The division offers sphincter-preserving colon and rectal surgery for cancer and benign diseases, laparoscopic and robotic colorectal surgery, treatment for fecal incontinence and rectal prolapse and both operative and medical therapies for anal diseases.

Performing Total Proctocolectomy and J-Pouch Reconstruction for Ulcerative Colitis at Penn Medicine

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