

crohn's colitis

Name of Clinical Care Pathway

Postoperative Management of Crohn's Disease

Objective

Provide direction for the management of patients with Crohn's disease after ileocecal or ileocolic resection bowel resection

Patient Population

Adult patients (18+ years) with Crohn's disease with a recent surgical

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These clinical decision support tools were developed by Canadian experts in IBD, based on their interpretation of current evidence and considerations specific to Canadian healthcare. International guidelines from Europe and the United States are available. However, these may reflect regional factors not directly applicable in Canada.

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Abbreviations

5-ASA	5-Aminosalicylic Acid
CD	Crohn's Disease
FCP	Fecal Calprotectin
IL	Interleukin
IBD	Inflammatory Bowel Disease
TNF	Tumor Necrosis Factor

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Highlights from this CCP

Surgery is often required in up to 80% of Crohn's disease patients for medically refractory disease or complications such as a bowel obstruction, abscess or fistula.

- Patients should be stratified based on disease and surgery-related risk factors.
- Smoking is associated with a higher risk of postoperative disease recurrence; therefore, all patients should receive smoking cessation counselling.
- All patients should have an ileocolonoscopy 6 to 12 months after surgery to assess for endoscopic recurrence in the neo-terminal ileum.
- Goals of therapy: Reduce endoscopic and clinical recurrence and maintain disease remission.

Introduction

Although surgery is not curative, it is an important intervention to correct irreversible disease, such as a fibrotic stricture or medically refractory disease.

Clinical remission is often achieved with surgery; however, the majority of patients have postoperative disease recurrence, which is manifested by histologic or endoscopic findings with or without clinical symptoms.

The identification of risk factors for recurrence is important to determine the need for early medical prophylaxis after surgery versus not starting therapy and adopting a clinical monitoring approach.

There is no role for 5-ASA in the prevention of postoperative recurrence.

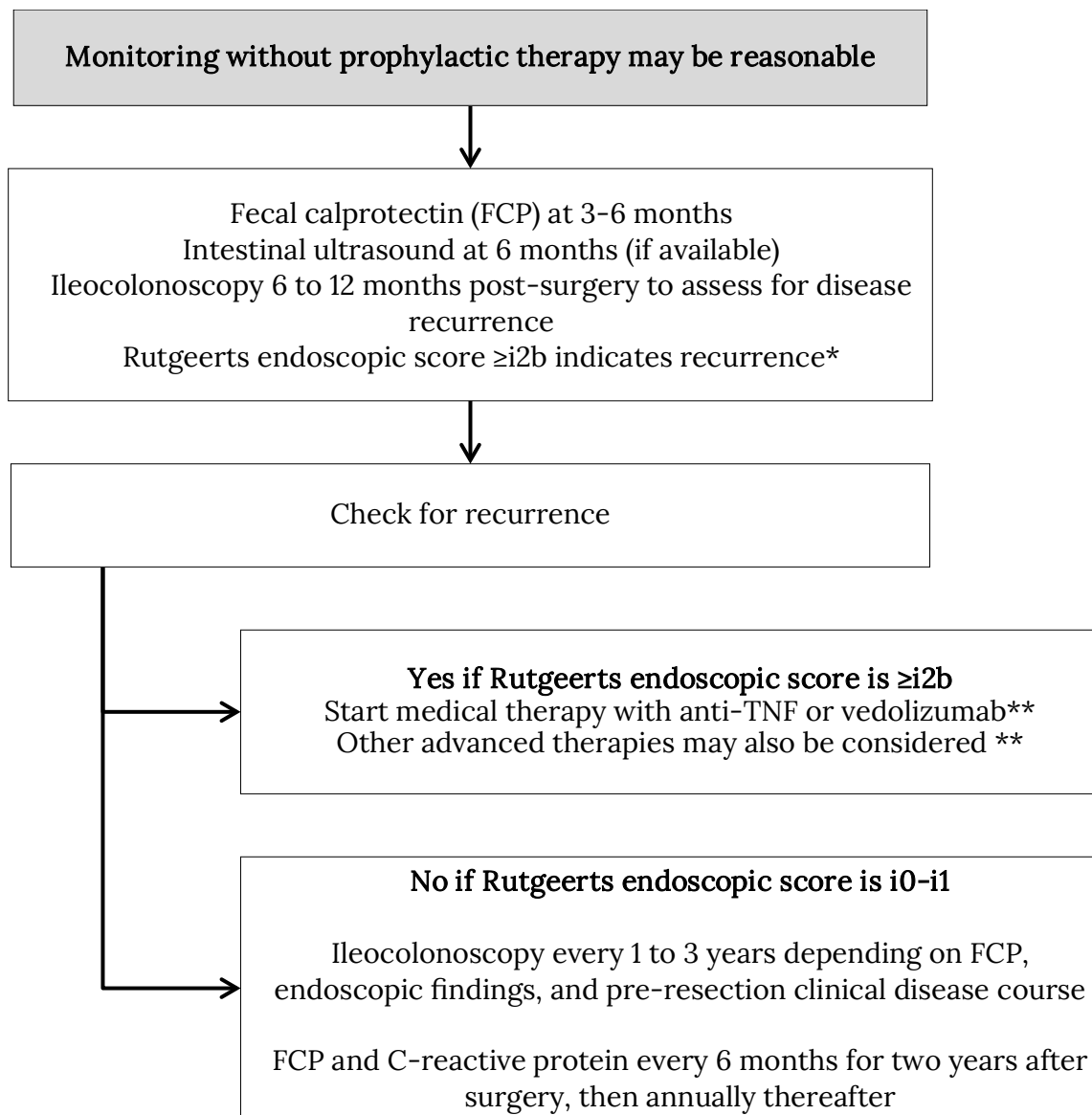
The algorithms below are best-practice clinical pathways for managing patients with Crohn's disease (CD) in clinical remission after surgery.

- Surgically induced clinical remission of Crohn's disease- low risk of recurrence (Flowchart 1)
- Surgically induced clinical remission of Crohn's disease- moderate/high risk of recurrence (Flowchart 2)

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Flowchart 1: Surgically induced clinical remission of Crohn's disease- low risk of recurrence

- Non-smoker
- Older patients (>50 years at diagnosis)
- First surgery for CD for short segment CD (i.e. <10 to 20 cm)
- Long-standing history of CD (>10 years)



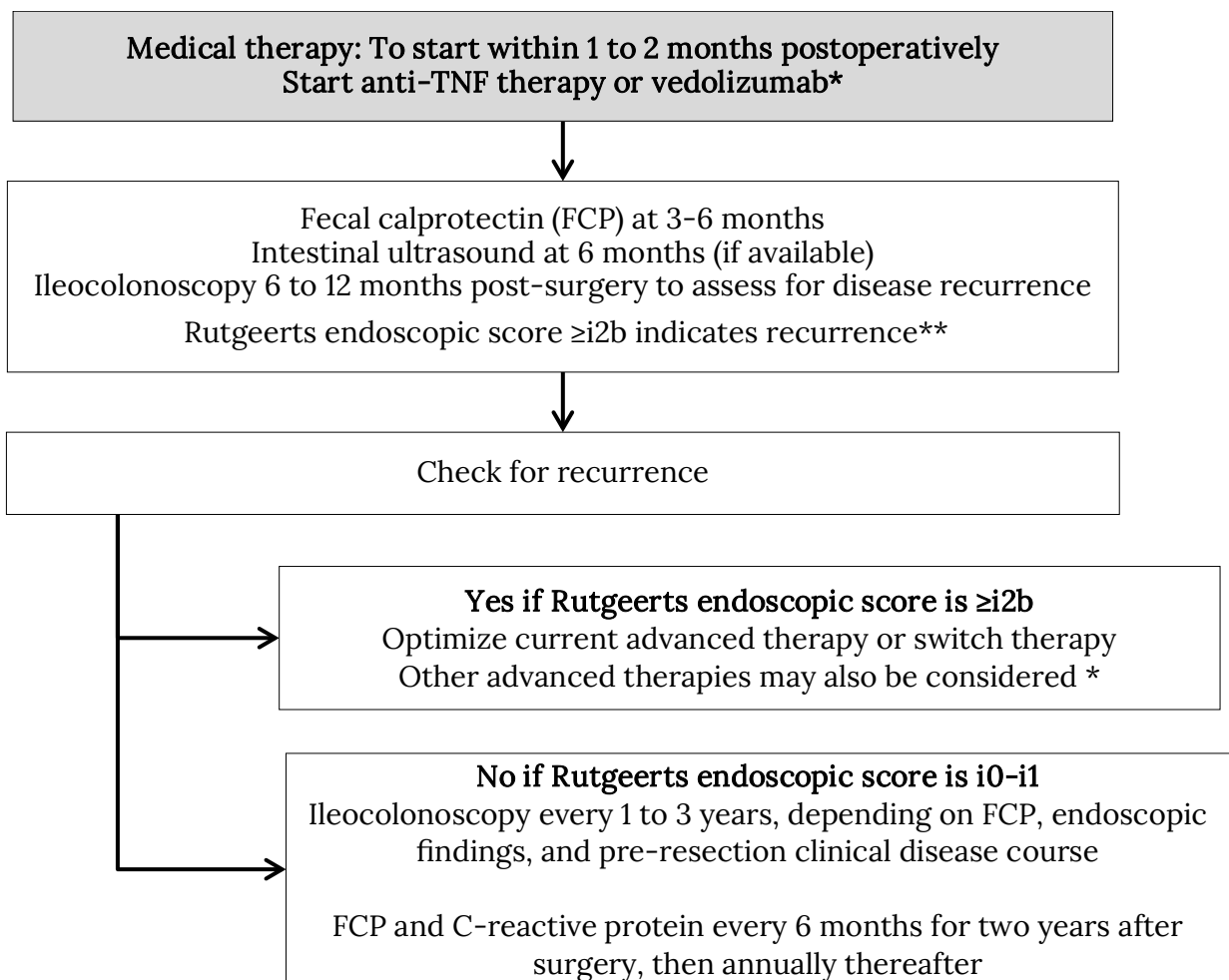
* Consider earlier ileocolonoscopy if symptoms or elevated FCP.

**Choice may depend on pre-resection advanced therapy used. Anti-IL-12/23 or anti-IL-23 therapies may be considered; however, prospective controlled data in this specific post-operative population are limited.

Flowchart 2: Surgically induced clinical remission of Crohn's disease- Moderate/high risk of recurrence

- Smoker
- Prior surgical history for CD
- Penetrating/fistulizing disease
- Residual luminal disease
- Younger age (< 30 years at diagnosis)
- Shorter disease duration prior to surgery
- Positive histologic resection margins

The risk of recurrence is greater according to the number of risk factors.



*Choice of biologic may depend on pre-resection advanced therapy used. Anti-IL-12/23 or anti-IL-23 therapies may be considered; however, prospective controlled data in this specific post-operative population are limited.

** Consider earlier ileocolonoscopy if symptoms or elevated FCP.

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Table 1: The modified Rutgeerts endoscopic scoring system predicts clinical recurrence based on endoscopic findings. The neo-terminal ileum is assessed during initial postoperative endoscopy and scored by the following scale:

Rutgeerts grade	Endoscopic finding	Decoding
i0	No lesions in the distal ileum	Post-surgery remission
i1	Not more than 5 anastomotic aphthous lesions in the distal ileum	Post-surgery remission
i2*	i2a: Lesions confined to the ileocolonic anastomosis i2b: > 5 aphthous lesions in neo-terminal ileum with or without lesions at the ileocolonic anastomosis	Substantial post-surgery recurrence
i3	Diffuse aphthous ileitis with diffusely inflamed mucosa between the multiple aphthae	Advanced post-surgery recurrence
i4	Diffuse inflammation, with larger lesions: large ulcers and/or nodules/cobble and/or narrowing/stenosis	Advanced post-surgery recurrence

*No clinical or surgical postoperative difference was observed between the i2a and i2b subcategories. The same treatment can be used for all patients classified under the i2 Rutgeerts category until more prospective studies are available (Rivière, Pauline et al.).

Other Resources

For Patients

[Crohn's and Colitis Canada: IBD Journey on Surgery \(link\)](#)

[UpToDate®: Crohn's disease \(Beyond the Basics\) \(link\)](#)

American Gastroenterological Association Institute: [Managing Crohn's Disease After Surgery: A Patient Guide \(2017\) \(link\)](#).

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References

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Nguyen GC et al. American Gastroenterological Institute guideline on the management of Crohn's disease after surgical resection. *Gastroenterology* 2016; 152:271-275 <https://doi.org/10.1053/j.gastro.2016.10.038>

Rivière, Pauline et al. "Comparison of the Risk of Crohn's Disease Postoperative Recurrence Between Modified Rutgeerts Score i2a and i2b Categories: An Individual Patient Data Meta-analysis." *Journal of Crohn's & colitis* vol. 17,2 (2023): 269-276. <https://doi.org/10.1093/ecco-jcc/jjac137>

Singh, S. and Nguyen GC. Management of Crohn's Disease after Surgical Resection. *Gastroenterology Clinics of North America* 2017; 46(3):563-575 <https://doi.org/10.1016/j.gtc.2017.05.011>