

Large Bowel Auto-Immune Diseases: Current Recommendation for Surgery

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1. Abstract

There are two clinical features of autoimmune disease in the large intestine that we often find in our clinical practice, including ulcerative colitis and Crohn's Disease. The clinical picture that we need to understand is the change in bowel patterns over the past few weeks. Clinical symptoms that appear need to be diagnosed in comparison with other cases such as internal hemorrhoids, malignancies in the colon and rectum. Establishing a diagnosis in the earliest possible phase is very important in the management of these autoimmune intestines, by conducting a colonoscopy examination accompanied by a biopsy, it is hoped that we can rule out some of the differential diagnoses that may be found in these cases. For treatment, not all cases require operative measures, medical treatment can be expected to provide a good therapeutic response, so that the choice of operative therapy is done in cases that do not respond well after the medical therapy is given.

2. Review

Large bowel autoimmune diseases, later known as inflammatory bowel disease is a chronic inflammation involving the colon (caecum, ascending colon, transverse colon, descending colon, sigmoid colon) and the rectum [1]. The two main forms of this Inflammatory Bowel Disease (IBD) is ulcerative colitis and Crohn's disease, but in some study reported 5-15% patients with IBD could not differentiate between ulcerative colitis and Crohn's disease based on endoscopic and

histological assessment. These patients are classified as IBD-unclassified (IBD-U) which most common can be found in children than adults [1, 2].

The most common symptoms of this large bowel auto-immune disease are lower abdominal pain, watery diarrhea, bloody diarrhea and sometimes anemia from chronic hemorrhage. The current recommendation is to performed early diagnosis by complete colonoscopy as soon as the symptoms started with the main purpose is to distinguish between ulcerative colitis and Crohn's disease by biopsy and histopatologic examination. The other purpose of this complete colonoscopy is to exclude the colorectal malignancies and early polyp detection. The focus of the treatment of large bowel autoimmune disease is remission induction, maintaining the remission for long term clinical outcome and to reduce the risk of surgical optioin (colectomy) for acute cases [3].

In the last decades, the medical treatment for large bowel autoimmune disease already been announced and we have many treatment option based on availability and severity of this cases based on Mayo severity criteria for IBD [4].

For the initial treatment of active mild-to-moderate ulcerative colitis with 5-aminosalicylic acid (5-ASA), oral 5-ASA at 2-3g/day is recommended; 5-ASA enemas are also recommended, rather than oral treatment alone. For corticosteroid treatment in mild-to-moderate ulcerative colitis in patients in whom 5-ASA therapy has failed or is

not tolerated, oral prednisolone is recommended. In cases of 5-ASA treatment failure, options to consider include thiopurine, anti-tumor necrosis factor therapy, vedolizumab, or tofacitinib [3, 5].

All patients treated with 5-ASA should undergo monitoring for nephrotoxicity, with baseline renal function testing repeated after 2-3 months, and then annually thereafter [6].

The suggested surgical treatment for large bowel autoimmune disease in patients (1) in who initial medical therapy failed, (2) who relapsed after initial medical therapy, or (3) who prefer surgery over continued medical treatment. According to this current guidelines (British Society of Gastroenterology Guideline 2019, American Gastroenterological Association Guidelines 2019, European Crohn's and Colitis Organization Guidelines on Surgical Management 2019), surgical treatment is the last treatment option in this autoimmune cases especially in unresponsive treatment, complicated acute ulcerative colitis, uncontrolled hemorrhage and emergency presentation after relapse [7-9].

Although it was still debatable, current recommendation for laparoscopic colectomy for elective cases and especially in the high volume hospital is the preferable surgical option. On the other hand, for emergency and unstable cases, the safest conventional celiotomy is the option with one or two stage reconstruction depending on the surgeon preference and the intra operative haemodynamic stability of the patients.

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