

WHEN DIARRHOEA IS NOT JUST SIMPLE FOOD POISONING.

INFLAMMATORY BOWEL DISEASE (IBD) REFERS TO A GROUP OF TWO chronic diseases with inflammation of the gastrointestinal tract: (1) Ulcerative Colitis (UC) and (2) Crohn's Disease (CD). In UC, inflammation and ulceration affects the mucosa (inner lining) of the colon and rectum only. Unlike UC, the inflammation and ulceration in CD is not confined to the colon and rectum, but may occur anywhere from the mouth to the anus.

IBD affect predominantly young people with a peak incidence usually between the ages of 10 and 40 years, although they can also occur in people of any age. While this is largely a 'Western' disease affecting Caucasians more than Asians, the incidence of IBD appears to be rising in Asia in recent years. The causes of IBD remain unknown, although it is believed that IBD results from an overactive immune response to environmental triggers (infection, drugs, or other agents) in genetically susceptible individuals. Recent studies suggested that some genetic changes may increase one's risk of developing IBD. Smoking has been found to increase the risk of CD, but paradoxically decreases the risk of UC through yet unknown mechanisms. The underlying mechanisms of IBD are complex and not completely understood.

A patient with UC typically presents with bloody diarrhea. Other associated symptoms include:

- abdominal cramps
- stool urgency
- sense of incomplete passage of stools

Symptoms of CD are less specific, but typically include abdominal pain, diarrhea, and weight loss. CD may cause intestinal obstruction due to strictures (or narrowing), fistulae (discharging openings especially near the anus), or abscesses (painful swellings containing pus). Both UC and CD are associated with an increased risk of colonic cancer. Professional guidelines recommend that patients with UC should have a colonoscopy after 8 to 10 years to re-evaluate the disease extent. For those with more extensive or severe UC, colonoscopies should be performed every three years in the second decade, every two years in the third decade, and annually in the fourth decade of disease because the risk of cancer developing increases with each passing decade.

The diagnosis of IBD is confirmed by clinical evaluation and a combination of blood tests, endoscopic examinations, x-rays and biopsies. Most patients are managed initially with medications that suppress the immune system. However, in severe disease that does not respond to medical therapy or when there are complications of the disease or development of colonic cancer, surgery is required.

The clinical course of IBD is marked by episodes of exacerbation and remission. A severe attack of UC is a potentially life threatening illness in which the patient can present with massive bleeding from the ulceration in the gut, or develop perforation of the colon from the severe inflammation. Approximately 20 to 30 percent of patients with extensive UC will end up with a colon resection. Because

the inflammation and the disease are confined only to the colon & rectum in UC, surgical resection that removes the entire colon and rectum can result in a cure for UC. This is different in CD, where the disease can affect the entire intestinal tract from the mouth to the anus. Hence surgery in CD is not curative and surgery is performed only for the management of complications. At least 50 percent of patients with CD will require surgery in the first 10 years of disease and approximately 70 to 80 percent will require surgery within their lifetime. Professional guidelines recommend that patients requiring surgery for IBD are best managed under the joint care of a Colorectal Surgeon trained in IBD surgery and a Gastroenterologist with specialized interest in IBD.

Indeed, top IBD centers of the world such as the Digestive Disease Institute, Cleveland Clinic (Ohio), USA were able to produce superior clinical outcomes using such integrated care models. Surgery, when employed appropriately, can achieve better quality of life for patients afflicted with this chronic disease. Many young patients with poorly controlled UC suffer from poor energy levels and are easily fatigued due to the chronic colonic inflammation and anemia from the bloody diarrhea. The frequent stools and urgency also made it difficult for them to be socially active. Young adults are often reluctant to undergo surgery. Many are 'sentimental' about keeping the 'original' colon and rectum when in fact, these severely diseased organs are hurting them both physically and socially. Nowadays, IBD surgery can be performed through a minimally invasive laparoscopic (keyhole) approach. In UC, the entire colon and rectum can be removed through this 'keyhole' approach and a "new-rectum" reconstructed using the small intestines joined to the anus such that the patient is able to pass motion normally via the anus. Many young patients are able to regain their energy level and pursue an active lifestyle once the chronically inflamed colon and rectum are removed. In fact, for UC, surgical removal of all the diseased colon and rectum results in a cure and the patients no longer requires any immune suppression drugs.■



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