AGA Clinical Practice Guideline: Management of Pouchitis and Inflammatory Pouch Disorders

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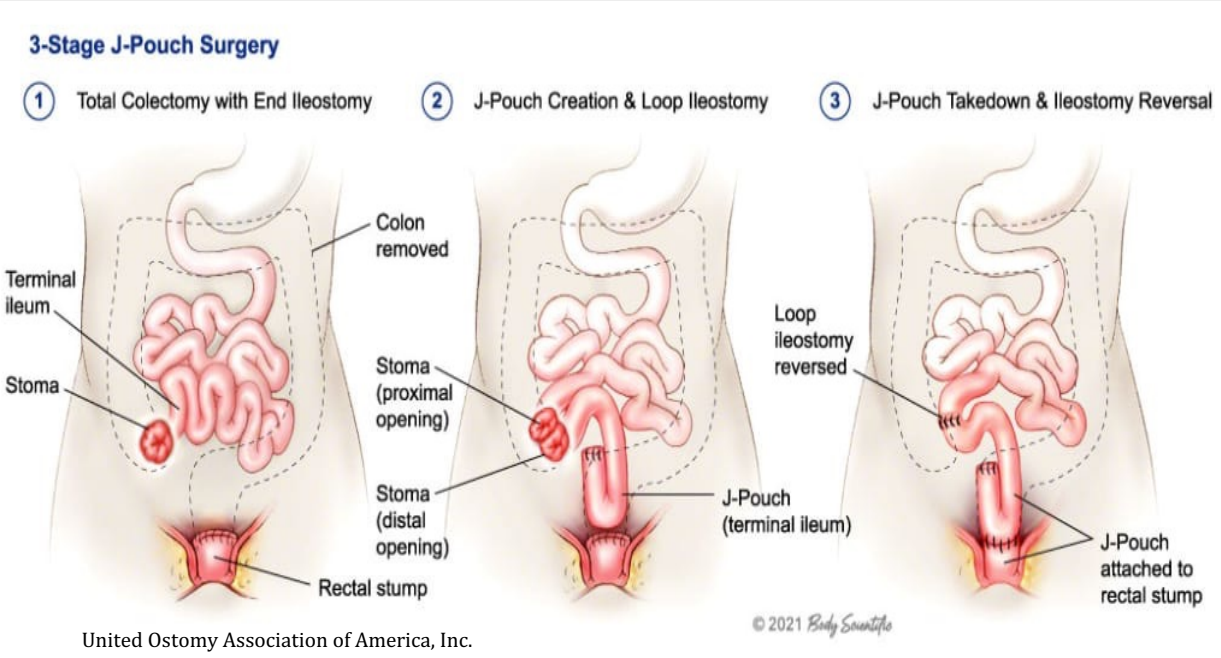
Background - Pouchitis

- Most common complication after restorative proctocolectomy with ileal pouch-anal anastomosis (IPAA) for patients with UC.
- 48% of patients develop pouchitis within the first 2 years; 80% chance for all patients who have undergone IPAA
- ↑ incidence rates within the first 2 years after IPAA over recent decades.
- 17% of patients develop chronic symptoms of pouchitis.
- 10% of patients may develop Crohn's like disease of the pouch.
- Workup for pouchitis: can consider C. difficile testing and endoscopic evaluation of pouch.

Formation of Pouch



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Types of Inflammatory Pouch Disorders

Intermittent Pouchitis	Isolated and infrequent episodes of typical pouchitis symptoms that **resolve with therapy** (most commonly antibiotics) or **resolve spontaneously**, followed by extended periods of normal pouch function (typically months to years).
Chronic Antibiotic-Dependent Pouchitis	Recurrent episodes of pouchitis that **responds to antibiotic therapy but relapses shortly after stopping antibiotics** (typically within days to weeks). Often requires recurrent or continuous antibiotic therapy or other advanced therapies to achieve symptom control. Not defined by number of pouchitis episodes within a 12-month time-period.
Chronic Antibiotic-Refractory Pouchitis	Relapsing–remitting or continuous symptoms of pouchitis with **inadequate response to typical antibiotic therapy** often needing escalation to other therapies.
Crohn's-Like Disease of the Pouch	Diagnostic criteria including presence of a: • Perianal or other fistula that developed at least 12 months after the final stage of IPAA surgery • Stricture of the pouch body or pre-pouch ileum • Presence of pre-pouch ileitis • Pouchitis and Crohn's disease of the pouch can occur simultaneously

Barnes, Edward L., et al. "AGA clinical practice guideline on the management of pouchitis and inflammatory pouch disorders." Gastroenterology, vol. 166, no. 1, 2024, pp. 59–85.

AGA Recommendations for UC Patients with IPAA

PREVENTION of Pouchitis

- No recommendation in favor of/against use of probiotics for primary prevention of pouchitis.
- Suggests against using antibiotics for the primary prevention of pouchitis.*

TREATMENT of Crohn's-Like Disease of the Pouch

- Obtain endoscopic evaluation of the pouch with confirmation of inflammation and rule out alternative etiologies.
- Use corticosteroids.*
  - Ileal release budesonide preferred; short duration (<8 weeks)
- Use advanced immunotherapies.♣

TREATMENT of Cuffitis

- Use therapies that have been approved for the treatment of UC.*
  - First line→ topical therapies (mesalamine suppositories, corticosteroid suppositories/ointment
  - Refractory cuffitis → UC- directed therapies including advanced immunosuppressive therapies♣

Endoscopic View of Pouch

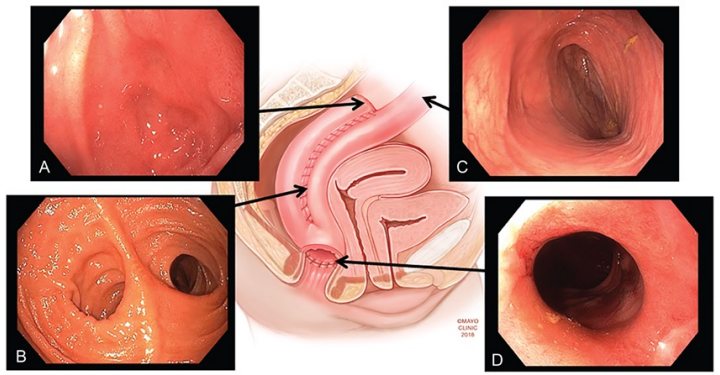

FIGURE 2. Normal pouch anatomy. Cross-sectional view of a normal J pouch configuration with endoscopic views of (A) the tip of the J pouch, (B) "owls' eye" appearance in the pouch body, (C) afferent limb just proximal to the pouch body, and (D) anal transition zone leading to rectal cuff.

Advanced Immunotherapies♣

- TNF–a antagonists (i.e. infliximab, adalimumab, golimumab, certolizumab pegol)
- Vedolizumab
- Ustekinumab
- Risankizumab
- Ozanimod
- Tofacitinib
- Upadacitinib

TREATMENT of Pouchitis

1. **Patients with infrequent symptoms** → use antibiotics.*
   - Ciprofloxacin and/or metronidazole is preferred.
   - Duration: typically 2-4 weeks.
   - Combination of antibiotics may be more effective in patients who do not respond to single-antibiotic therapy.

2. **Use of probiotics**
   - Infrequent episodes: no recommendations for/against probiotics.
   - Recurrent episodes that respond to antibiotics: use probiotics for preventing recurrent pouchitis.*

3. **Chronic Antibiotic-Dependent Pouchitis**
   - Use chronic antibiotic therapy to treat recurrent pouchitis.*
     - Lowest effective dose of antibiotics with gap periods (i.e. one week per month) or cyclical antibiotics to prevent antibiotic resistance.
   - Obtain endoscopic evaluation of the pouch with confirmation of inflammation and rule out alternative etiologies.

4. **Chronic Antibiotic-Refractory Pouchitis**
   - Use advanced immunosuppressive therapies to treat recurrent pouchitis.*
     - Therapies approved for treatment of UC or CD♣
   - Obtain endoscopic evaluation of the pouch with confirmation of inflammation and rule out alternative etiologies.
   - Use corticosteroids.*
     - Controlled ileal release budesonide is preferred.
     - Short duration (<8–12 weeks)
   - No recommendation in favor of/against use of mesalamine.

Quinn KP, Lightner AL, Faubion WA, Raffals LE. A Comprehensive Approach to Pouch Disorders. Inflamm Bowel Dis. 2019 Feb 21;25(3):460-471. doi: 10.1093/ibd/izy267. PMID: 30124882.
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*Conditional Recommendation by AGA