Disclosures

• No relevant disclosures or conflicts of interest
Talk Overview

• Decisions for proctectomy in FAP
• Management of rectal polyps after IRA
• Management of pouch polyps
• Mucosectomy
FAP Surgical Options

- Total Proctocolectomy with End Ileostomy
- Total Proctocolectomy with Ileal Pouch-Anal Anastomosis
- Total Abdominal Colectomy with Ileorectal Anastomosis
Colorectal Surgery for FAP

Risk of Neoplasia in Pouch or Rectum
Bowel function & Quality of Life
Desmoid risk
Risk of Decreased Fertility
Risk of Sexual Dysfunction
Surveillance Regimens
# TAC/IRA vs. TPC/IPAA

<table>
<thead>
<tr>
<th>Factor</th>
<th>IRA</th>
<th>IPAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Complexity/Time</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Sexual/Urinary Complications</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Fecundity</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Desmoid Risk</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Bowel Frequency</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Leakage/Seepage</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Managing Future Cancer Risk</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Surveillance</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

✓ = favorable/advantage
## Risk of Proctectomy after IRA: Rectal and Colonic Polyp Counts

<table>
<thead>
<tr>
<th>Polyp Count</th>
<th>N with IRA</th>
<th>% Requiring Proctectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rectum</td>
<td>Colon</td>
<td></td>
</tr>
<tr>
<td>&lt;20 &lt;1000</td>
<td>95</td>
<td>0%</td>
</tr>
<tr>
<td>&lt;20 &gt;1000</td>
<td>17</td>
<td>13%</td>
</tr>
<tr>
<td>&gt;20 &lt;1000</td>
<td>32</td>
<td>15%</td>
</tr>
<tr>
<td>&gt;20 &gt;1000</td>
<td>33</td>
<td>56%</td>
</tr>
</tbody>
</table>

*Church JM, et al. Dis Colon Rectum, 44:1249-1254, 2001*
## Fate of the Rectum and Cancer Risk after IRA in the Pouch Era

<table>
<thead>
<tr>
<th>Pouch Era (&gt; 1983)</th>
<th>N</th>
<th>F/U (months)</th>
<th>Proctectomy N (%)</th>
<th>Cancer N (%)</th>
<th>Interval to Proctectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>135</td>
<td>60</td>
<td>3 (2%)</td>
<td>0 (0%)</td>
<td>104 months</td>
</tr>
</tbody>
</table>

Updated CCF Data

- 243 patients underwent IRA for FAP, 1993-2015
  - Median age at index surgery was 25 years (range 8-74)
  - Median follow-up: 171 months (IQR 113 months)

- 15 patients (6.1%) eventually had a proctectomy
  - 7 patients had their IRA at another institution
  - 6 (2.5%) for cancer

Liska D, et al.  Paper #91 (poster)
Factors to Consider

- Number of polyps
- Genotype
- Desmoid disease
- Obesity
- Desire for family (Fertility)
- Age
Patient Case

• 11 yo girl, diffuse colonic and rectal polyposis
• Bleeding, eating disorder, depression, delayed
• Lx IRA in 2013
• Rectum: 20-80 polyps
• Sulindac: 150 mg PO bid
• Future: matured physically and emotionally; will get proctectomy
Management of Rectum after IRA

- Annual flexible proctoscopy (earlier if needed)
- No formal bowel prep, just enemas
- Can be done in clinic office
- OR or endoscopy suite if needed
- Remove all polyps $\geq 5$ mm
- Ablate or leave $< 5$ mm

* don’t routinely use chemoprevention
Decision for Proctectomy after IRA

- Increasing number and size
- Cannot be controlled endoscopically
- Rectal cancer
- +/- adenoma with HGD

→ Completion proctectomy and IPAA
IPAA
Pouch Adenomas

- Adenoma incidence 35-45% at 10 years$^{1,2,3}$
- Increases with time from surgery
  - 7%, 35%, 75% at 5, 10, 15 years$^2$
- HGD in pouch adenomas: 10%-18%
  - St. Mark’s, Dutch Registry, CCF

Risk Factors for Pouch Adenomas

- Recent retrospective review, 192 patients, f/u 12.8 yrs
- Multivariate Cox regression analysis:
  - male sex
    - (HR = 2.4, p=0.002)
  - presence of gastric adenomas
    - (HR = 1.8, p=0.0059)
  - age at the time of IPAA ≤18 years
    - (HR = 2.5, p=0.0020)

Management of Pouch/ATZ

• Annual flexible pouchoscopy (earlier if needed)
• No formal bowel prep, just enemas
• Can be done in clinic office without sedation
• OR or endoscopy suite if needed
• Remove all polyps $\geq 5$ mm
  - snare, transanal excision

* Consider chemoprevention with diffuse small polyps
Diffuse Pouch Polyps
Pouch Cancers

- Cancer incidence 1-3%$^{1-3}$
- **Distinguish pouch from ATZ**

Pouch Excision for Neoplasia

• Indications: diffuse polyposis, cancer, HGD*
• Surgery:
  - excision with mucosectomy and redo IPAA
  - excision and end ileostomy
Mucosectomy
Summary

• Judgment and selection are key
• Neoplasia common after surgery, increases with time
• Patient compliance is required
• Fastidious surveillance and polypectomy is essential
• Patients can have good cancer prevention while preserving quality of life