



Concise Commentary: Crystallomancy and Ileal Pouch Surgery

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While the creation of an ileal pouch is a great leap forward in improving quality of life in patients with UC requiring surgery, even this surgeon will admit that long-term inflammatory conditions plague the outcomes of many patients. Identification of preoperative clinical and serologic markers that can robustly predict these adverse postoperative outcomes remains elusive. In this issue of *Digestive Diseases and Sciences*, authors from the IBD unit at the University of Chicago evaluated whether pathologic evaluation of the resected colon could predict pouch outcomes [1]. Their primary findings were that deep wall inflammation was associated with pouch fistulae and that terminal ileal inflammation was associated with afferent limb involvement.

While well-written, the authors concede that the paper has several significant limitations, including its retrospective design and patient selection bias. I would like to discuss other shortcomings of this study. First, the authors categorized patients into more than one adverse pouch outcome, an approach that seems scientifically and clinically groundless. In other words, a patient who started with cuffitis and then developed significant afferent limb disease would be classified as *both* cuffitis and afferent limb disease, rendering the distinction meaningless. Second, their reported incidence of afferent limb disease (30%) and inlet involvement (41%) is clearly not representative of large prospective studies, begging the question on how the endoscopist assessed inflammation and/or what patients were entered into the study. Third, the absence of a uniform pathologic system, including a standard definition of ‘deep inflammation’ or terminal ileal inflammation, was also a deficiency. Perhaps, all of these factors accounted for why this study did not validate our prospective study on the value of preoperative pathologic findings and surgical outcome that was published over a decade ago [2].

How should the authors’ findings impact clinicians? Quite frankly, deep wall inflammation found on the colectomy specimen has no influence on the *preoperative* discussion with a patient on the outcomes of pouch surgery. With regard to terminal ileal inflammation, it would be difficult not to offer an ileal pouch to a patient with UC if there was simply ‘inflammation’ noted in the ileum at colonoscopy. Perhaps, patients with inflammation deep into the wall or involving the terminal ileum should undergo more intensive follow-up and/or drug prophylaxis after pouch creation.

Crystallomancy refers to the art of using crystal balls to peer into the future. Much like crystallomancy, evidence for the robust contribution of pathology to the prediction of postoperative outcomes after ileal pouch anal anastomosis remains unproven. Validation studies across large IBD centers are still needed to fully assess the role of the pathologist in predicting a patient’s postoperative course after ileal pouch surgery.

References

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