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STRICTURING CROHN'S DISEASE: SURGICAL MANAGEMENT.

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Introduction. More than two thirds of patients with Crohn's disease (CD) will face one or more surgeries during the course of life. Stenosis is a frequent complication, occurring in one third of patients, and obstruction is the most common indication for surgery. Stricturing and penetrating disease often coexist in the same patient.

Aim and Methods. The purpose of this review is to focus the surgical approach in the management of stricturing CD. The Authors have conducted a review of the literature of the last two decades and have revised critically their own experience.

Results and Discussion. Evaluation of patients with suspect of stenosis can be performed by endoscopy and imaging techniques, such as ultrasonography (US), CT-enterography (CTE) or MR-enterography (MRE). Patients with CD-strictures who are not responders to conservative therapy and show signs of vascular suffering or perforation risk should be operated urgently. Elective surgery is indicated in patients with persistent obstruction, despite medical therapy, especially if it is a long-lasting stenosis with a major fibrotic component. Also, in cases of stenosis without signs of flogosis, early surgery is a valid alternative to medical therapy. In all patients it is important to evaluate the ongoing therapy, considering that steroids increase the risk of postoperative complications; also the biologicals lead to an increase in complications. Endoscopic balloon dilation (EBD) is indicated in stenosis of large intestine, in stenosis of ileo-colonic anastomosis and ileum also, when they can be reached by the colonscopy/enteroscopy. Surgery (resection or strictureplasty, open or laparoscopic surgery) is based on a variety of factors, including the number, length and location of the strictures, the length of residual intestine, the presence or absence of complications (perforation, abscesses), the experience of the surgeon and, not least, the patient's preference. The intervention of choice is still resection. Concomitant abscess recommend TC-guided drainage or surgical drainage. A wide stapled side-to-side anastomosis (SSSA) would be the best, as it would have lower complication rates, compared to the conventional handsewen end-to-end anastomosis (HEEA). The strictureplasty (Mikuliks, Finney, Michelassi, Taschieri, Fazio, Poggioli and other variants) are reserved for selected cases with stenosis, especially of the small bowel.

Conclusions. The management of patients with stricturing CD requires a multidisciplinary approach. Optimization of preoperative medical treatment can reduce the incidence of complications and probably of recurrence of the disease, and represents, therefore, the first step in the management of strictures in CD patients. Stenosis treatment may require medical theray, EBD, strictureplasty or intestinal resection. The choice between EBD, strictureplasty or resection, either laparoscopic or open surgery, is based upon the occurrence of complications of the disease, the residual intestinal length and upon the location, number and length of each stenosis.