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Summary

Surgical management of PSC/IBD

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Mechanisms & Personalised Medicine | Surgery | IBD | Hepatobiliary

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The speaker presented a surgical perspective on managing colorectal disease in patients with PSC and IBD, emphasizing that PSC transforms even clinically mild colitis into a high-risk oncological field requiring tailored surgical strategies based on disease phenotype and liver function.

KEY POINTS

- The speaker stated that colorectal cancer risk in PSC-IBD is elevated 2.8 to 3.4-fold compared to IBD alone, with higher mortality particularly in younger patients and increased risk after liver transplant.
- Yearly high-resolution endoscopy is recommended for PSC-IBD patients, and distinguishing ulcerative colitis from Crohn's disease is critical because j-pouch reconstruction is unsuitable for Crohn's disease.
- Surgical timing depends on whether colon or liver disease predominates: cancer, high-grade dysplasia, or refractory colitis warrant colectomy first if liver function permits, while decompensated liver disease requires transplant first with surgery deferred until graft stability.
- The speaker recommended portosystemic gradient below 15 mm mercury as preferable for safer surgery, noting that surgical risk including anastomotic leak and mortality increases with portal hypertension.
- Three main reconstructive options are end ileostomy, ileorectal anastomosis with rectal surveillance, or j-pouch; the speaker stated that about 40% of patients retain permanent ileostomy with good quality of life.
- The speaker noted that PSC patients undergoing pouch surgery face higher rates of pouchitis and pouch failure than typical ulcerative colitis patients, and advised three-stage procedures over two-stage based on a French study showing higher anastomotic leak rates without diversion.

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