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Summary

Medical treatment or surgery: What is the solution to complex IBD emergencies?

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Postgraduate Teaching Programme Barcelona 2026 | Presentation

October 17, 2026

Multidisciplinary collaboration between gastroenterology and surgery optimizes timing and outcomes in IBD emergencies, with medical stabilization often enabling safer delayed surgery and early surgical intervention potentially preventing complex emergencies in selected patients.

KEY POINTS

- The speaker presented a case of complex Crohn's disease with enterocutaneous fistula, abscess, and severe malnutrition successfully stabilized with antibiotics, ustekinumab, and cholestyramine before definitive surgery six months later, avoiding high-risk emergency operation.
- Broad-spectrum penicillins were reported to aggravate IBD flares in a Danish population-based cohort study published approximately one year ago and should be avoided in acute settings; ciprofloxacin shows resistance rates of 40 to 70 percent.
- The speaker uses intestinal ultrasound as first-line imaging to minimize radiation exposure in young patients and reported it can distinguish inflammatory from fibrotic strictures and detect abscesses.
- The LYRIC trial 10-year follow-up data showed therapy-free remission in 36 percent of early ileocecal resection patients versus 13 percent in the infliximab-first group, with number needed to treat of five; post-hoc analysis suggested benefit especially in patients around 20 years of age.
- Emergent IBD surgery carries approximately 40 percent morbidity compared to nearly zero mortality in elective surgery; delayed surgery after multiple medical therapies was associated with increased ileostomy rates and complications.

– The speakers advocate for routine joint gastroenterology-surgery consultations and multidisciplinary team assessment to optimize surgical timing, prevent emergencies, and consider early resection as a treatment option rather than salvage procedure in selected younger patients with uncomplicated terminal ileitis.

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