The effects of diversion of intestinal contents on the progress of Crohn’s disease of the large bowel

J. H. BURMAN, H. THOMPSON, W. T. COOKE, AND J. ALEXANDER WILLIAMS

From the Nutritional and Intestinal Unit, The General Hospital, Birmingham

SUMMARY This study shows that faecal diversion by ileostomy or colostomy results in an improvement in the patient’s general health which is substantiated by the haematological and biochemical findings. However, in the bowel distal to the diversion there is always histological evidence of mucosal and transmural disease and complications such as fistulae may still occur. In only two patients (7%) was restoration of bowel continuity successful.

Preliminary reports have suggested that in Crohn’s disease of the colon diversion of intestinal contents by defunctioning ileostomy or colostomy would so ‘rest’ the distal diseased bowel that restoration of the faecal stream might be feasible later (Truelove, Ellis, and Webster, 1965; Oberhelman, Kohatsu, Taylor, and Kivel, 1968). Successful restoration of intestinal continuity was reported recently in three out of 18 (16-6%) patients (Oberhelman, Kohat, Taylor, and Porteous, 1970).

This paper presents a study of 29 patients with Crohn’s disease in whom defunctioning ileostomy or colostomy has been performed. These patients have been reviewed in an attempt to evaluate: (1) the clinical improvement after diversion, (2) the degree of resolution of disease activity in the bypassed bowel, and (3) the feasibility and success of restoration of continuity.

Patients

There were 15 men and 14 women in this study which extended from 1947 to 1969 with a mean follow up of 10 years. All had Crohn’s disease of the large bowel diagnosed by barium studies, together with histological evidence.

There was evidence of previous small bowel disease in eight patients and concurrent small bowel disease was observed at operation in seven. In addition, small bowel disease developed subsequently in six patients between eight months and six years after colectomy. Three patients in this series are dead: one from acute haemorrhagic ileitis five years after pan-proctocolectomy, the second from multiple entero-enteric fistulae one year after colectomy, and the third from small bowel infarction seven years after closure of the colostomy.

Methods

Indices of general health before and after diversion were taken from historical records. Details of weight and haemoglobin levels (24 patients) were collected, together with values of serum albumin (21 patients) and serum seromucoid (15 patients).

An assessment of disease activity in the defunctioned bowel was sought from the subsequent course of events in each case either from sigmoidoscopy and biopsy or from histological examination after later excision. At sigmoidoscopy mucosal ulceration and friability with contact bleeding were taken to be criteria of continued activity of the disease. Histologically evidence of continued activity was inferred from the presence of an inflammatory cellular infiltrate, mucosal ulceration, submucosal oedema and fibrosis, or the presence of giant cells. Finally, the presence and progress of perianal disease was observed.

Results

THE EFFECT OF DIVERSION ON THE GENERAL HEALTH OF THE PATIENT

Following diversion, all but one patient showed improvement in general health. This patient became
acutely depressed. Of the 18 patients with accurate weight records, 15 gained weight, two lost weight, and one remained the same. In those patients where records were available, haemoglobin values rose in every case but one (Fig. 1) and serum albumin levels rose in all but three cases (Fig. 2). An anticipated fall in serum seromucoid levels took place in every case but one; in only six patients, however, did the values fall to the normal level (Fig. 3). Figures 1, 2, and 3 show the average of the values found up to two months before diversion and up to 12 months after diversion in each patient. The Figures show patients subdivided into those in whom some bowel resection was undertaken at the time of diversion and those in whom only diversion was performed. Although the improvement observed was usually greater if some diseased bowel was also resected, there is no significant difference between the two subgroups.

PERIANAL DISEASE
Perianal disease was observed in 10 patients before diversion. Two patients had a fissure in ano, seven had a fistula in ano, and one man had both. After diversion, over a mean follow-up period of 25 months, all the fissures healed as did one fistula. However, in six patients the fistula in ano did not heal. Three patients developed rectal stricture and in one (case 11, Table I) this was the main indication for the subsequent proctectomy. Furthermore, four patients who had initially not been observed to have perianal disease developed a fistula in ano after diversion. Careful inquiry into the history before diversion revealed no evidence of these patients having previously had perianal disease.

THE EFFECT OF DIVERSION ON THE DISEASE ACTIVITY OF THE BYPASSED BOWEL
The defunctioned bowel was later excised from 15 patients after an interval of between two and 105 months (mean 37 months) after the diversion operation. The indications for this subsequent resection, together with the operative and pathological descriptions of the bowel removed, are shown in Table I. In none of the excised specimens was the defunctioned bowel normal. Table II shows the percentage frequency with which certain histological features were noted in these 15 cases before and after diversion. While it will be appreciated that these figures are a crude measurement, nonetheless they confirm the macroscopic impression that the defunctioned bowel had not returned to normal. A survey was then made of eight of the patients in whom the rectal remnant is still retained. Table III shows the proportionate frequency with which sigmoidoscopic and biopsy abnormalities were

Fig. 1. Mean haemoglobin levels in g per 100 ml in patients before and after diversion of the faecal stream (a) when part or all of the diseased colon was excised at the time of diversion and (b) when no resection was performed.
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Fig. 2. Mean serum albumin levels in g per 100 ml before and after diversion of the faecal stream (a) when part or all of the diseased colon was excised at the time of diversion and (b) when no resection was performed.

Fig. 3. Serum seromucoid levels in mg per 100 ml in patients before and after diversion of the faecal stream (a) when part or all of the diseased colon was excised at the time of diversion and (b) when no resection was performed.
Abnormality patients

Macroscopic
Mucosal ulceration 100 53
Linear ulceration 40 13
Cobblestone mucosa 40 13
Bowel wall thickening 70 73

Histological
Chronic inflammatory cellular infiltration 80 53
Submucosal oedema and fibrosis 70 47
Crypt abscesses 40 40
Epithelial cell follicles 40 20
Giant cells 90 40
Lymph node hyperplasia 50 27

Table I Rationale for the later resection and appearances of the defunctioned large bowel

THE FATE OF DIVERTED BOWEL WHEN RETURNED TO CONTINUITY

Five patients have had the bowel continuity restored (from between eight weeks and 33 months after diversion). Two are well with no symptoms. Of the remaining three, one underwent proctectomy three months later because of severe recurrent proctitis, noted before and after diversion. Although there is an overall improvement after diversion, in none of these patients were the findings entirely normal in the rested bowel.

Table II Incidence of abnormalities in 15 patients found in the colon at the diversion operation and subsequently at the resection

Table III Sigmoidoscopy and biopsy findings before and after diversion in eight patients still retaining defunctioned bowel

1 Mean period since diversion 25 months
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a second required an emergency loop ileostomy two months after because of diarrhoea and the development of a colocutaneous fistula, and the third suffered ill health for seven years, developing fistulae both entero-cutaneous and entero-vesical, and eventually died of mesenteric infarction. In the two successful cases recent sigmoidoscopy and biopsy revealed a friable mucosa with histological evidence of a chronic inflammatory reaction.

NEOPLASIA
Neoplasia has not been observed in any patient in this survey.

Discussion
In all our patients diversion of the faecal stream away from an area of active colitis has had a beneficial effect upon the patient. Their general health has improved and this has been borne out by the haematological and biochemical evidence. The fact that similar improvement occurs whether or not the diseased colon is resected suggests that it is due to the fact that faeces are no longer passing over the diseased bowel.

In only two patients has restoration of the faecal stream been successful, and in none have the histological findings at biopsy returned to normal. While it can be argued that slight mucosal ulceration and chronic inflammatory reaction are non-specific changes and that these patients can be controlled by medical means after restoration of faecal flow, we have only found this to be practicable in two (7%) in our series. Perianal disease has developed de novo in four patients after diversion and rectal stricture in three others. As a result of our experience we feel that there is only a small chance that ‘resting’ the large bowel will lead to healing in Crohn’s colitis sufficient to allow restoration of the faecal stream.

Requests for reprints to J.A.W., The General Hospital, Birmingham, B4 6NH.

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