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Editorial

Sectorization of Medical and Surgical Management of Inflammatory Bowel Disease☆

Sectorización del manejo médico y quirúrgico de la enfermedad inflamatoria intestinal

Crohn's disease (CD) and ulcerative colitis (UC) are immunologically based diseases that follow a chronic and recurrent course. Their incidence has increased in recent decades,[1] and both diseases cause significant decline in patient's quality of life. Due to their complexity and the need for coordinated action by gastroenterologists and surgeons, as well as specialized nursing staff, rheumatologists, dermatologists, radiologists, and pathologists, treatment entails high direct and indirect costs.[2]

As these diseases have a relatively low prevalence, patients receive suboptimal care throughout the different phases of the disease, whether due to a late or incomplete diagnosis or because adequate medical or surgical treatment is not available. The consequences of this situation are often irreversible.

The surgical management of patients with CD and UC is a particularly relevant issue. Some 20% of patients with UC and up to 70% of patients with CD will require surgical treatment due to failure of medical treatment of these diseases or the appearance of intestinal stenosis, abscesses, dysplasia, colorectal cancer, or perianal disease. In patients with UC, total proctocolectomy with ileal-anal pouch reconstruction is the most frequently used technique. In these cases, the experience of the surgeon is the most important determining factor for acute surgical complications and long-term reservoir function. In this regard, the number of daily bowel movements and fecal incontinence rates of patients with ileoanal pouch treated surgically by high-volume surgeons is significantly lower than those treated by less experienced surgeons.[3–5] In CD, laparoscopic surgery, with its well-known advantages, can only be offered at experienced centers with high volumes of colorectal operations. The experience of the surgeon even affects mortality, which, while still low, is 50% higher in hospitals centers with low surgical volumes compared to high-volume hospitals.[3–5] It is therefore necessary to individualize the level of patient care in order to ensure positive results for all procedures.

A consensus study by the Spanish Working Group on Crohn's Disease and Ulcerative Colitis (in Spanish, *GETECCU*) concluded that an inflammatory bowel disease (IBD) treatment unit should include a minimum of gastroenterologists, surgeons, nurse practitioners, radiologists, endoscopists, and stomal therapists.[6] Recently, a group of gastroenterologists specialized in IBD of the Catalonian Society of Gastroenterology (CSG) has developed a strategic plan for the organization of IBD units, with the aim to improve medical care for this disease in the region of Catalonia.[7] Part of this plan was to construct a map of the 58 public hospitals in Catalonia, based on the existence of a formally constituted IBD Unit, experience in the use of second- and third-line drugs (biological), volume of surgery and specific alternative therapies (cell therapy and clinical trials). This report revealed that only 50% of Catalonian hospitals have an IBD Unit, 36% have specialized nursing staff, 63% have monographic gastroenterology consultations for IBD and only 45% have an expert surgeon. The strategic plan proposes 4 levels of care: primary or local hospital (without a gastroenterology department); secondary hospital with gastroenterology department without an IBD Unit, or secondary hospital with an IBD Unit; highly specialized tertiary hospitals with IBD Units and highly specialized surgical units and option to be included in clinical trials.

It is clear that, in order to provide equitable, homogeneous, excellent medical care, it is essential to establish adequate bidirectional patient flow between the different levels of care, so that, depending on the requirements of the disease, the patient has easy access from local hospitals (primary hospitals) to specialized units.

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The role of surgeons and their opinions regarding the structure and function of IBD Units are key points in the organization of this patient flow, although this information has not been available to date.

This issue of Cirugía Española, presents the results of a survey that included the participation of members of the Spanish Association of Surgeons (in Spanish, AEC) that addresses this matter.[8] The survey included questions about the organization, multidisciplinary management and surgical treatment at the workplaces of the respondents. Although only 15% of AEC surgeons answered, the authors obtained representation from all the Spanish autonomous communities, including 48 tertiary hospitals. Among the most relevant aspects of the study, it is worthy of note that 48.5% of surgeons do not have an IBD Unit available, and 42% report that there is no surgeon at their hospital specially dedicated to IBD treatment (results which were very similar to those obtained by CSG). Furthermore, there were significant differences in the possibility of using a laparoscopic approach in both elective and urgent surgery. It is also especially striking is that the number of pouch procedures completed annually is very low. In fact, only 24% of tertiary hospitals conduct more than 5 ileoanal pouches per year. It should be remembered that hospitals that perform a high number of procedures (>10 ileoanal pouches/year) obtain better results in terms of number of daily bowel movements, daytime and nighttime incontinence, and sexual dysfunction.

It is also important to note that a majority of these surgeons believed that patients would benefit from treatment at specialized medical centers, and that national registries are needed for IBD surgery, especially for ileoanal pouch surgery.

Therefore, it is imperative for scientific societies, the Healthcare Administration, and hospitals themselves to facilitate and collaborate in the organization of these two-way circuits between primary centers and IBD units in order to ensure impartial, quality healthcare, regardless of the patients' place of residence. In the case of surgery, it would be particularly relevant to develop a map of accredited regional surgery units as well as a national registry for certain interventions. This registry should have sufficient quality indicators to maintain accreditation in order to maximize the experience of infrequent treatments in which the volume of interventions is a decisive factor in the final outcome.

CD and UC are currently incurable diseases. However, medical professionals can (and must) improve the quality of life of patients who are affected by these pathologies, and we have a wide range of medical and surgical options to do so. It is our responsibility that these therapeutic options be offered promptly and equitably.

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