

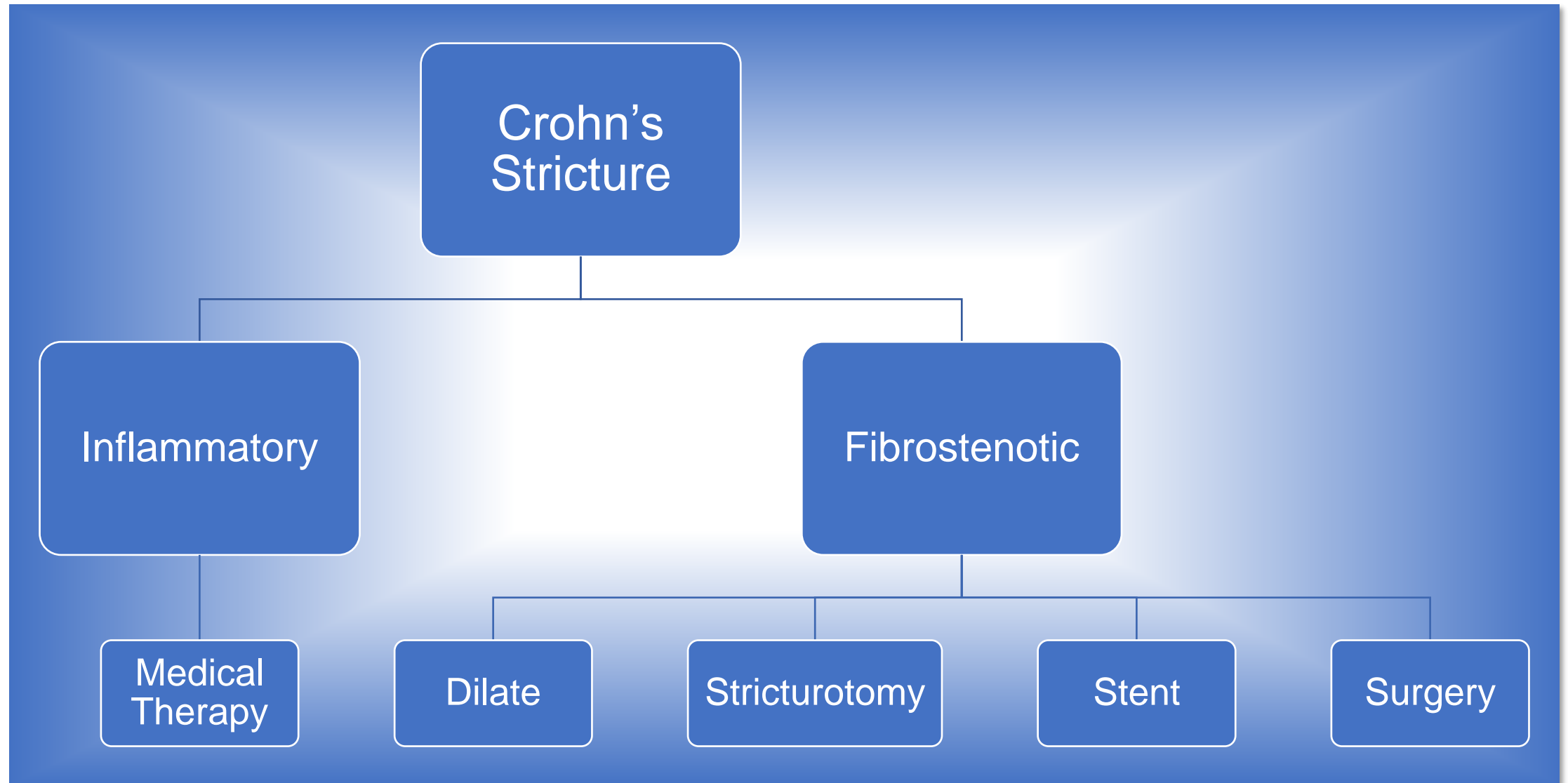
Advanced Endoscopy for the IBDologist

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Crohn's Strictures

- ~30% will develop strictures within 10 years of diagnosis.
 - Most will be ileocolonic
- Fibrostenotic strictures
 - Primary
 - Postoperative (Anastomotic)

Stricture Management

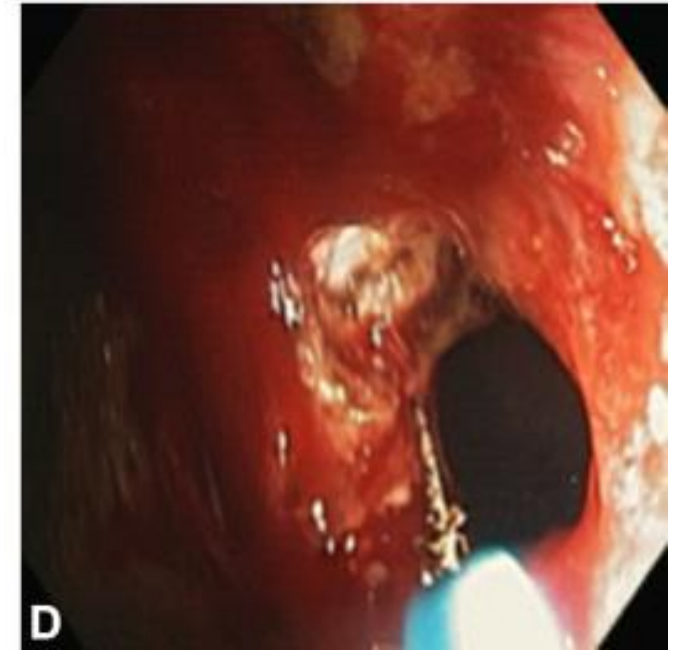
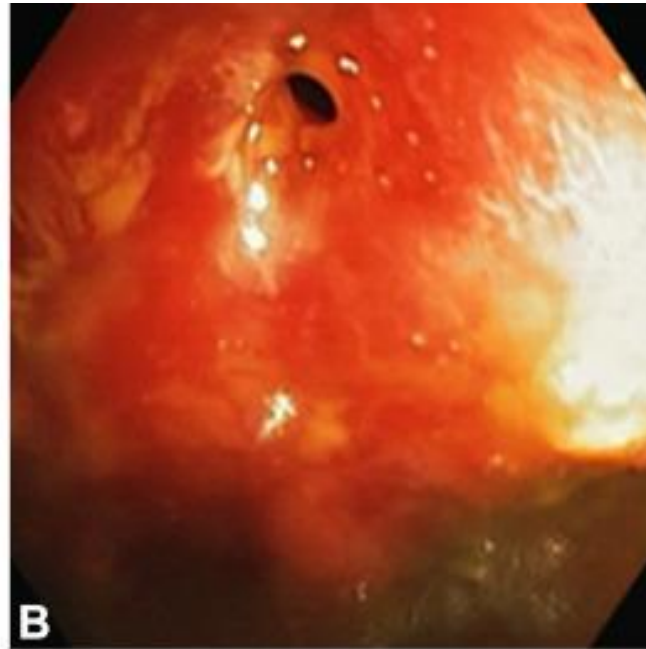
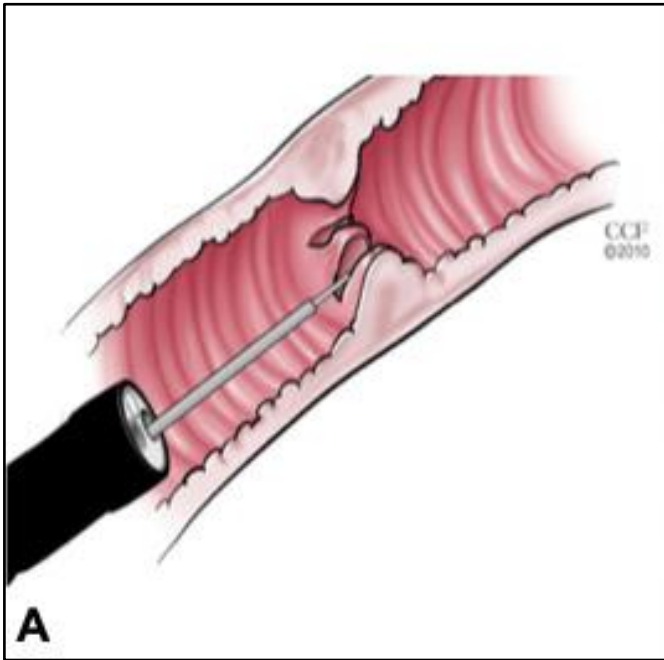


Road Map: Pre-intervention Planning

- Imaging
 - CTE
 - MRE
- Delineate stricture characteristics
 - Number (<5 more amenable to intervention)
 - Severity
 - Type (inflammatory vs fibrotic)
 - Length
 - Associated fistulae or abscesses

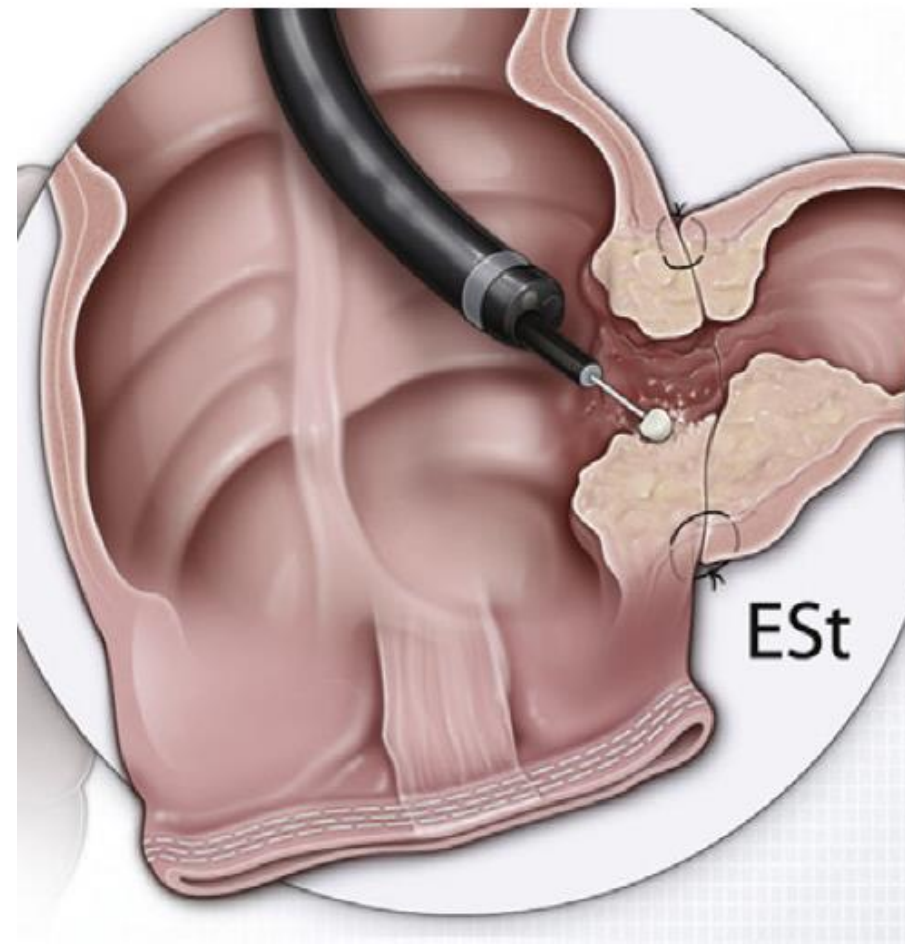


Strictureotomy/Electroincision

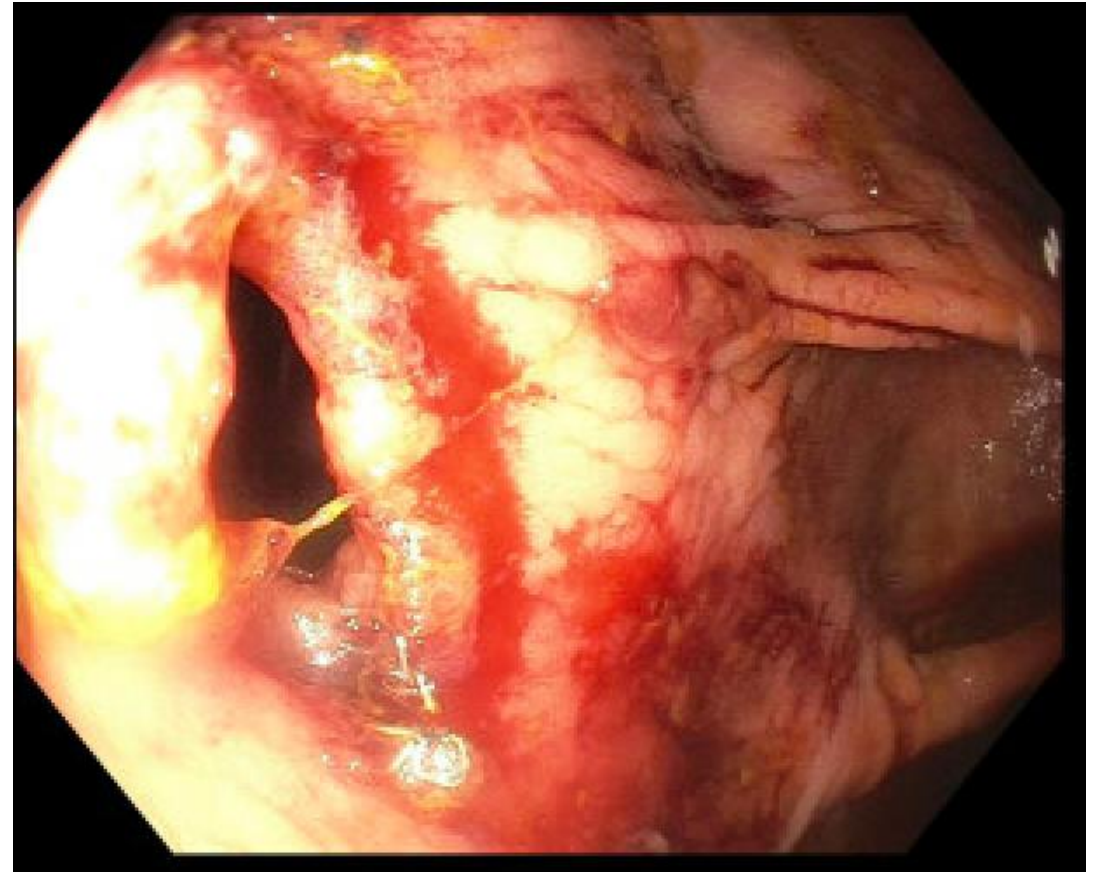
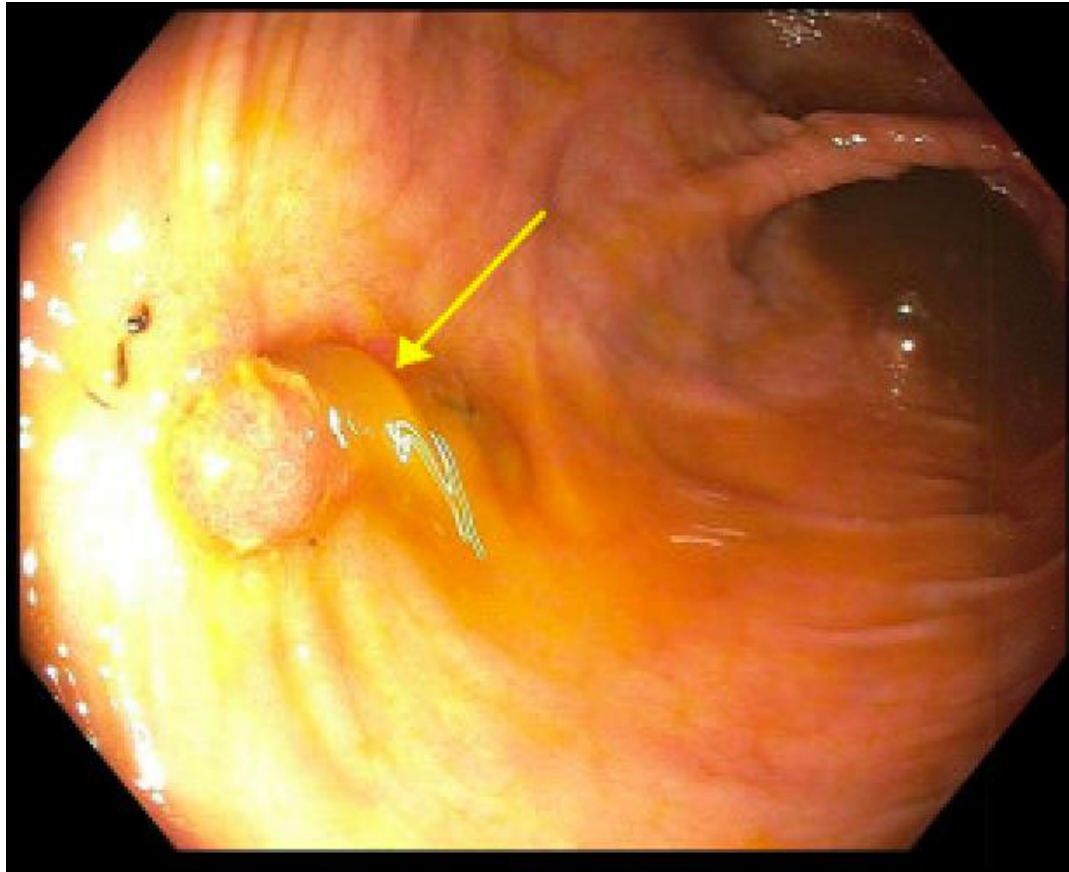


Endoscopic Strictureotomy vs ICR

- 35 patients (ESt) vs 147 patients (ICR)
- Similar need for subsequent stricture surgery
- Major AEs: 10% per procedure (ESt) vs 32% (ICR)

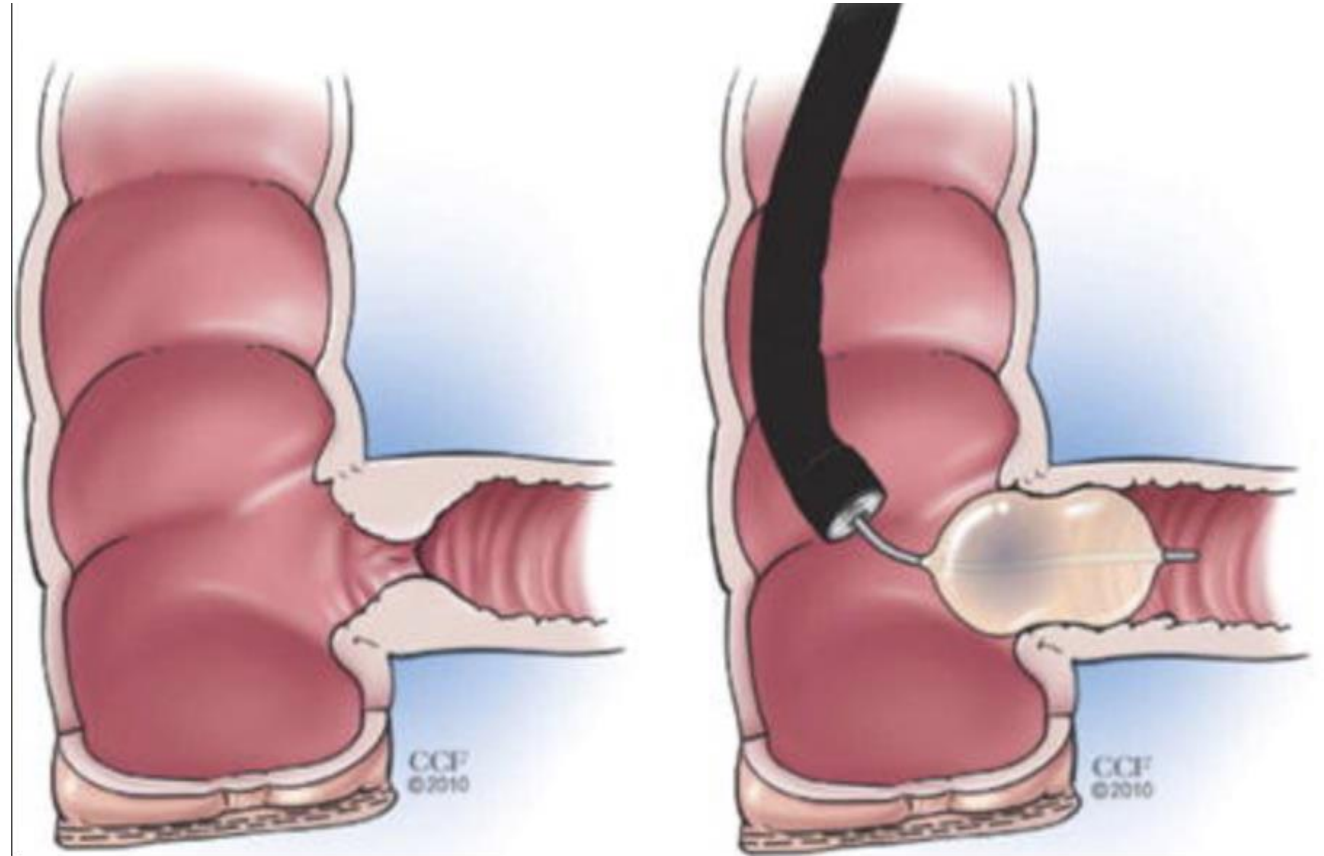


Endoscopic Balloon Dilation



Endoscopic Balloon Dilation

- For native or anastomotic strictures
- ≤ 5 cm in length
- No associated fistula, abscess, mass
- Nonangulated

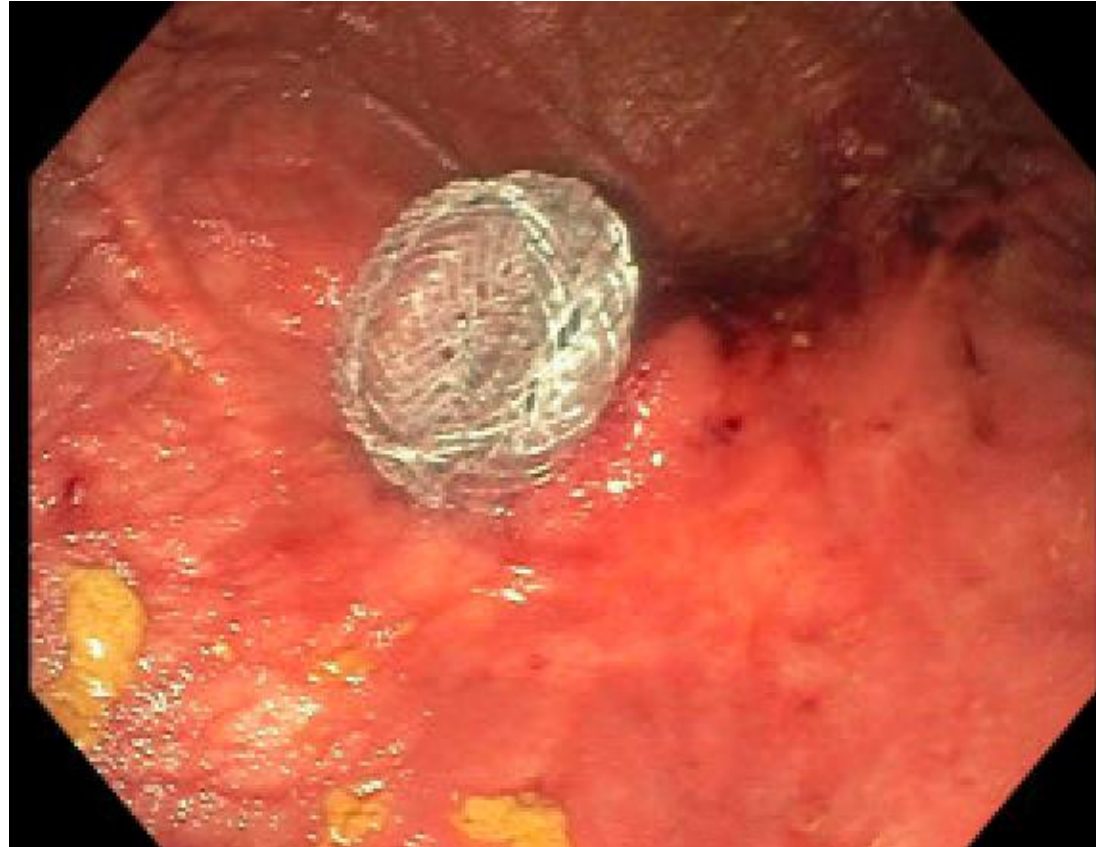


Comparison of Endoscopic Dilation vs Surgery for Anastomotic Stricture in Patients With Crohn's Disease Following Ileocolonic Resection

Lei Lian,^{*,‡,§} Luca Stocchi,[‡] Feza H. Remzi,[‡] and Bo Shen^{*}

- Retrospective study of ileocolic anastomotic strictures (n=307)
- Average surgery delayed by EBD = 6.45 years.

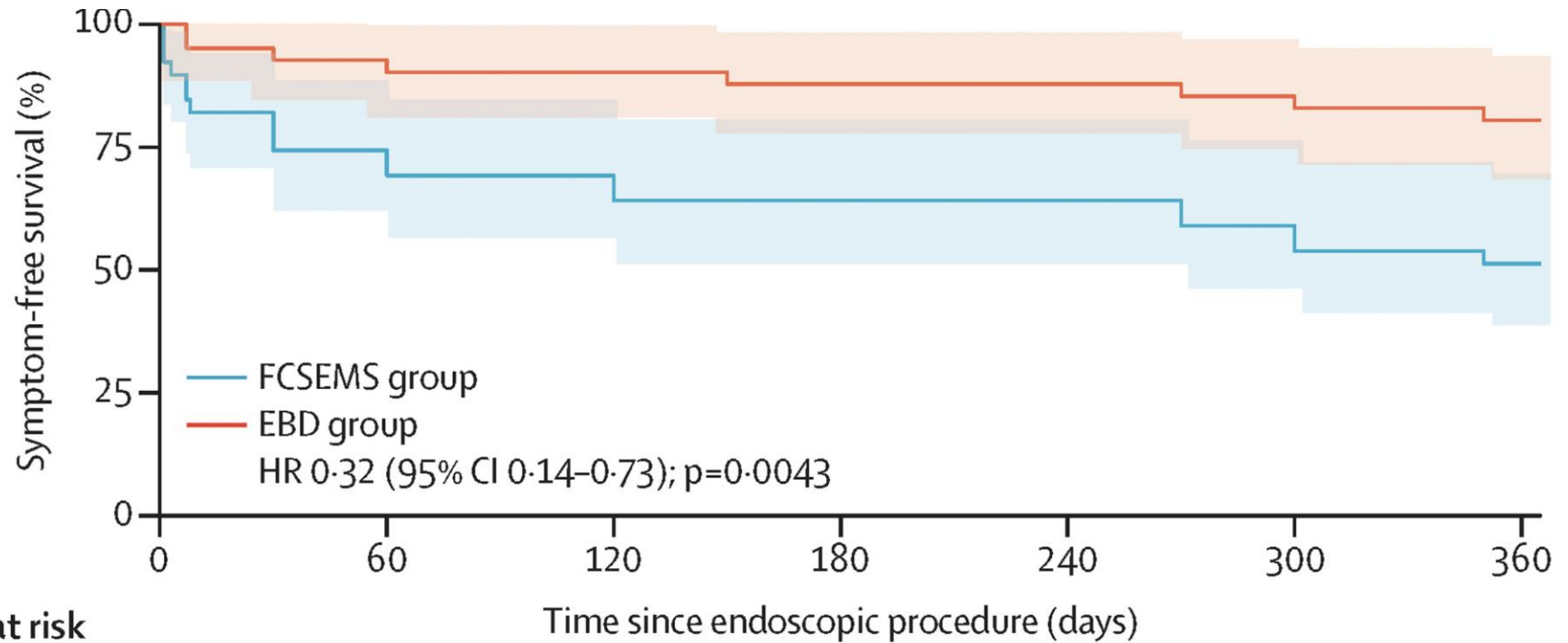
Stents for Strictures



Stent: Meta Analysis

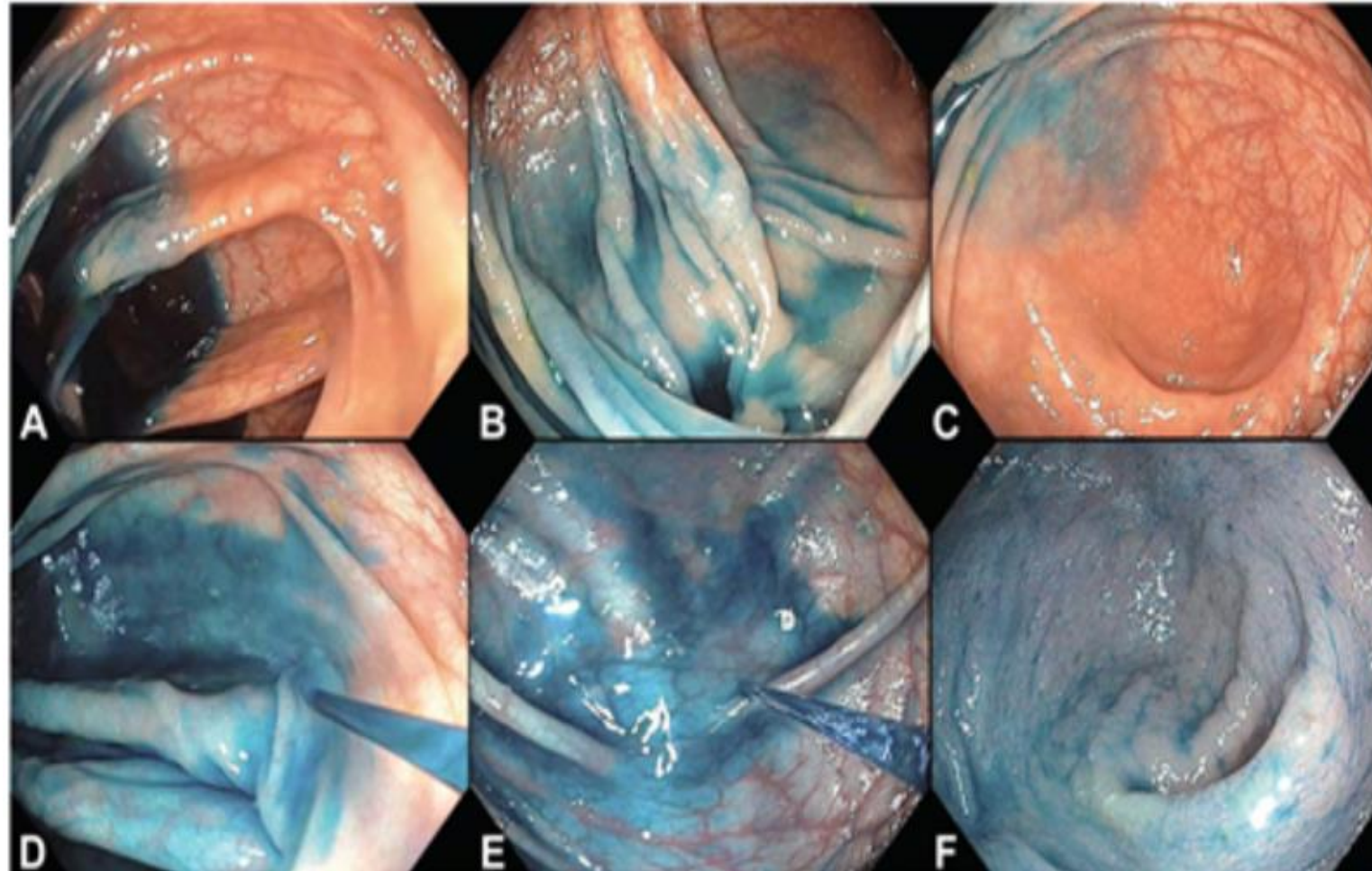
- Anastomotic (75%) > Native (25%)
- Technical success rate: 93%
- Clinical success rate: 61%
- Repeat stent: 10%
- Perforation: 2.7%
- Distal stent migration: 37%
 - Mostly fully covered, self-expandable metal stents

ProtDilat RCT



	0	60	120	180	240	300	360
Number at risk (number censored)							
FCSEMS group	39 (0)	29 (10)	27 (2)	25 (2)	25 (0)	23 (2)	20 (3)
EBD group	41 (0)	38 (3)	37 (1)	36 (1)	36 (0)	35 (1)	33 (2)

Chromoendoscopy



Kaltenbach et al. GIE 2017;86:962-71.

Colorectal Cancer in UC

- Risk of CRC in UC = 4.7/1000 patient years
- Risk of CRC in UC is decreasing over the past 4 decades




Cumulative risk of CRC in UC:

10 years	1%
20 years	2%
>20 years	5%

Visible Dysplasia



Chromoendoscopy: How To

<p>Lesion detection</p>	<p>Pan chromo-endoscopy</p>	<p>Water jet channel using auxillary foot pump or biopsy channel using spray catheter</p>	<p>Indigo carmine (0.8%, 5ml ampule): 2 ampules + 250ml water (0.03%) Methylene blue (1%, 10ml ampule): 1 ampule + 240ml water (0.04%)</p>	 	
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SCENIC Guidelines 2021

- High definition colonoscopy recommended for dysplasia surveillance
- WLE, chromoendoscopy (dye and virtual), and NBI all acceptable when using HD colonoscope.
- Random biopsy with high risk patients

High Risk

- The following should have HD-WLE and chromoendoscopy:
 - PSC
 - Previous neoplasia
 - Active inflammation
 - Tubular colon

Chromoendoscopy

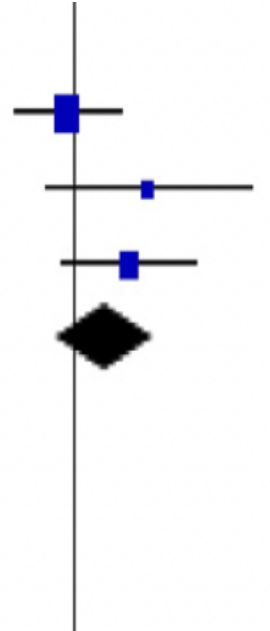
Chromoendoscopy vs high definition white light endoscopy

Iacucci 2017	22	90	23	90	36.2%	0.96 [0.58 - 1.59]
Mohammed 2015	11	53	5	50	11.0%	2.08 [0.78 - 5.55]
Park 2016	21	102	13	108	24.4%	1.71 [0.91 - 3.23]
Subtotal (95% CI)		245		248	71.6%	1.36 [0.84 - 2.18]

Total events 54 41

Heterogeneity: $\tau^2 = 0.06$; $\chi^2 = 3.02$, $df = 2$ ($P = .22$); $I^2 = 34\%$

Test for overall effect: $Z = 1.26$ ($P = .21$)



Top 3 Things to Optimize Quality in IBD:

- #1 Imaging before endoscopic intervention
- #2 Endoscopic balloon dilations > stents
- #3 High definition endoscopes with or without chromoendoscopy for dysplasia detection

Thank You!

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