

## Pouch - Endoscopic Examination in patients with Ileal Pouch Anal Anastomosis (IPAA) - Summary UHDB Clinical Guideline

Reference no.: CG-GASTRO/2023/029

- **Pouch anatomy and types of IPAA**
  - Check the type of pouch prior to procedure to correlate endoscopically. J pouch is the most commonly formed pouch constructed from a double loop of ileum.
- **Endoscopic assessment**
  - Use a slim or a paediatric colonoscope, inflate minimally and intubate as less proximally as possible as the pouch capacity is usually small.
  - The normal functioning J pouch has an 'owl's eye' configuration on inflation, with one 'eye' leading to the afferent limb (and the proximal bowel) and the other to the tip of the J pouch, with a long sharp 'beak' of mucosa between the two.
- **Type of anastomosis and presence of rectal cuff:** A stapled anastomosis has a short residual cuff of the rectal mucosa as opposed to a handsewn anastomosis where the anastomosis is right down to the dentate line (ie. no residual cuff is present). This information might be useful in assessing for the cuff during pouchoscopy and diagnosing cuffitis.
- **Structured reporting**
  - The following landmarks should be identified, photographed and reported in a J pouch:
    - Pouch inlet and body (akin to the rectal region in normal anatomy)
    - Efferent limb
    - Tip of the J (in J pouch, blind end)
    - Afferent limb leading proximally to the terminal ileal mucosa, avoid intubating beyond normal mucosa
    - Pouch outlet on withdrawal of the scope and retroflexed image (to demonstrate dentate line/ anal transition zone/ rectal cuff)
  - Assessment and reporting should focus on the following parameters:
    - configuration, distensibility of the pouch body
    - severity, extent and distribution of mucosal inflammation if any, and
    - presence of backwash ileitis, cuffitis or inflammatory polyps.