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

Reference no.: CG-GASTRO/2020/029

- **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.