

## Antibiotic treatment guidelines for pouchitis in adults

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Surgical management of Ulcerative Colitis or Familial Adenomatous Polyposis may involve restorative proctocolectomy with ileal pouch–anal anastomosis, creating a reservoir (pouch) from the distal ileum to maintain continence. Pouchitis is an inflammatory condition of the ileal pouch, typically presenting with increased stool frequency and urgency.

There is a limited evidence base (few, small trials) for the utility of antibiotics in this condition. The optimal duration of antibiotic therapy is not clear. Antibiotics are associated with side effects, increased antimicrobial resistance and *Clostridioides difficile*.

Recommendations are for non pregnant adults and doses stated assume normal renal and hepatic function.

### Pre-Antibiotic Assessment in Suspected Pouchitis

Before initiating antibiotic therapy, clinicians should:

1. **Exclude alternative diagnoses** that may mimic pouchitis symptoms
2. **Assess for faecal stasis** and functional bowel disorders as potential contributors
3. **In patients with Ulcerative Colitis**, evaluate for immune-mediated pouchitis, which should be managed without antibiotics, according to established Ulcerative Colitis treatment protocols
4. **Cuffitis** does not require antimicrobial therapy (prednisolone /5ASA are first line)

### Antibiotic Therapy Guidelines

- **Duration:** Empirical guidelines recommend a 2-week course, although this is not evidence-based
- **First-line:** Metronidazole 400 mg oral three times daily
- **Second-line:** Co-trimoxazole 960 mg oral twice daily
- **Third line:** Ciprofloxacin 500mg oral twice daily if intolerance or allergy. Refer to [fluoroquinolone warnings](#) prior to prescribing

### Management of Recurrent or Non-Responsive Pouchitis (>3 episodes/year)

1. Discuss chronic pouchitis at **IBD MDT**, **consider non-antimicrobial therapies**
2. **Ensure NSAID cessation** and review dietary contributors. Note: probiotic formulations lack standardisation.
3. **Consider Rifaximin 550mg oral twice** daily for a maximum of 4 weeks then rediscuss at MDT. Consider cost and potential for antimicrobial resistance

### References:

BSG IBD Guidelines 2025. Moran GW, Gordon M, Sinopolou V, et al. Gut 2025;74:s1–s101.

AGA Clinical Practice Guideline on the Management of Pouchitis and Inflammatory Pouch Disorders. Barnes EL, Agrawal M et al. Gastroenterology 2024; 166:59-85

Rifaximin prophylaxis causes resistance to the last-resort antibiotic daptomycin. Turner, A.M., Li, L., Monk, I.R. *et al.* Rifaximin prophylaxis causes resistance to the last-resort antibiotic daptomycin. *Nature* **635**, 969–977 (2024).