

PERIANAL CROHN'S DISEASE

Incidence: 3.8% to 60-80% (depending on definition)

65% occurs concurrently or after diagnosis of Crohn's

Approximately 75% will develop perianal disease within 10 years

50% with perianal disease will have ileal disease within 5 years

Perianal disease is a distinct phenotype of Crohn's

Spectrum of disease

- Fissure:
 - 21-35% of perianal lesion
 - Bluish and painless
 - No increase in manometry
 - Most common posterior
 - Abscess or fistula follows in 25%
- Skin tags and hemorrhoids:
 - skin tags occur from lymphedema and enlarge with inflammation
 - Hemorrhoids are rare
- Cavitating ulcer:
 - 2-5% in the anus or rectum
 - Predict future intestinal disease
 - Extremely painful
- Abscess & fistula:
 - abscess in 23-62% and linked to fistula
 - 92% with rectal disease will have fistula
 - Either from cryptoglandular infection or from anal fissure or ulcer
 - "Watering-can anus"
 - Trans-sphincteric abscess is commonest (30 to 45%)
 - 30% heals spontaneously, 50% healed with stenosis
- Rectovaginal fistula:
 - 5 to 10 % and most are low
 - Worst symptoms with high fistula
- Anorectal stricture:
 - most in the rectum and all with proctitis
 - 2 types: spasmodic and from infection
- Carcinoma:
 - Crohn's have an increase risk of adenocarcinoma

Assessment

- Thorough investigation needed.
- Colonoscopy and small bowel series
- Endoanal US:
 - increase in wall thickness confined to mucosa, submucosa and internal sphincter
 - Help locate a collection

- MRI:
 - useful to evaluate internal and external sphincter integrity
 - *Most studies suggest that MRI is the evaluation of choice for complex perianal disease*
- EUA:
 - aim to detect any infection
 - Careful probing with H₂O₂

Medical treatment

- Steroids and aminosalicylates:
 - patients with perianal disease are resistant to steroids
 - topical aminosalicylates might be useful
- Antibiotics:
 - metronidazole and cipro
- Immunomodulators:
 - 6-MP & azathioprine
 - Methotrexate
 - Cyclosporin A
 - Mycophenolate and tacrolimus
 - Anti TNF

Surgical treatment

- Emergency treatment of sepsis:
 - I & D with antibiotics and avoid sphincter damage
 - Damage limitation: "Bridge"
 - Seton...followed by fistulotomy
 - Diverting stoma for patients who face proctectomy
- Definitive surgery:
 - Fistula:
 - high success rate with fistulotomy for low level lesion,
 - more likely on absence of rectal disease
 - Staged procedure with seton is required for complex fistula
 - Surgery + remicade?
 - Rectal advancement flap:
 - avoids dividing sphincter
 - Proctitis is associated with flap failure
 - Fissure:
 - glycerine trinitrate, botox, diltiazem
 - Sphincterotomy for symptomatic fissures without proctitis non responsive to topical meds
 - Resection of proximal disease:
 - approximately 50 % improvement in perianal disease but perianal disease should not be an indication for resection
 - Proctectomy:
 - severe perianal disease non responsive to other treatment

- Lower incidence of perineal complication if preceded by diversion
- Novel treatment: fibrin glue
 - poorer results for Crohn's
 - GCSF as alternative to fibrin glue

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