HOW TO TREAT CROHN’S DISEASE OF THE ANUS

NATURAL HISTORY
CLASSIFICATION / SEVERITY ASSESSMENT
MANAGEMENT MEDICAL SURGICAL

INCIDENCE 3.8 – 80%
ISOLATED / DISEASE ELSEWHERE
SPECTRUM MINOR ANAL AILMENTS
SEVERE DISEASE
Nb. Differential diagnosis
TB, STD, Neoplasia, Hidradenitis
GENETICS
MALIGNANCY

“faecal incontinence is the result of aggressive surgeons and not of progressive disease.”
Alexander-Williams
Dis Colon Rectum 1976 19; 518-519

TREATMENT IS BEST CONSIDERED PALLIATIVE
SYMPTOM CONTROL
SYMPTOMS ARE OFTEN SURPRISINGLY WELL TOLERATED
“THE PATIENT IS THE ONE WITH THE DISEASE”
Shem The House of God
### Perianal lesions in a series of patients a follow up clinic

<table>
<thead>
<tr>
<th>Lesion</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin tag</td>
<td>75</td>
</tr>
<tr>
<td>Fissure</td>
<td>38</td>
</tr>
<tr>
<td>Low anal fistula</td>
<td>40</td>
</tr>
<tr>
<td>High anal fistula</td>
<td>12</td>
</tr>
<tr>
<td>Rectovaginal fistula</td>
<td>6</td>
</tr>
<tr>
<td>Ilostrectal abscess</td>
<td>32</td>
</tr>
<tr>
<td>Intersphincteric abscess</td>
<td>8</td>
</tr>
<tr>
<td>Perianal abscess</td>
<td>7</td>
</tr>
<tr>
<td>Supralevator abscess</td>
<td>6</td>
</tr>
<tr>
<td>Anorectal stricture</td>
<td>19</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>15</td>
</tr>
<tr>
<td>Anal ulcer</td>
<td>12</td>
</tr>
</tbody>
</table>

Keighley and Allan  
*Int J Colorectal Dis 1986*

---

**Hughes 1979**

<table>
<thead>
<tr>
<th>Ulceration</th>
<th>Fistula/Abscess</th>
<th>Stricture</th>
</tr>
</thead>
</table>

**Hughes 1992**

<table>
<thead>
<tr>
<th>Associated anal Conditions</th>
<th>Proximal intestinal disease</th>
<th>Disease activity</th>
</tr>
</thead>
</table>

**U F S A P D**
Perianal Crohn’s Disease Activity Index

<table>
<thead>
<tr>
<th>Metric</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge</td>
<td>0 – 4</td>
</tr>
<tr>
<td>Pain / Restriction of activities</td>
<td>0 – 4</td>
</tr>
<tr>
<td>Restriction of sexual activity</td>
<td>0 – 4</td>
</tr>
<tr>
<td>Type of perianal disease</td>
<td>0 – 4</td>
</tr>
<tr>
<td>Degree of induration</td>
<td>0 – 4</td>
</tr>
</tbody>
</table>

Irvine, J Clin Gastroenterol 1995; 20, 27-32

**SIMPLE PRACTICAL CLASSIFICATION**

**RECTUM NORMAL**

**SIMPLE ANAL PROBLEM**

**COMPLEX ANAL PROBLEM**

**RECTUM DISEASED**

**THE ACUTE ANUS IN CROHN’S DISEASE**

**SURGICAL EMERGENCY**

**REQUIRES EFFECTIVE DRAINAGE** (Antibiotics)

**PROBLEMS OF SPECIALISATION**

(INVESTIGATIONS)

**ASSESSMENT OF THE NON-ACUTE CROHN’S BOTTOM**

**EDUCATED DIGIT**

**EXAMINATION OF THE RECTUM** (rest of the gut)

**ENDOANAL ULTRASOUND**

**MRI**

**RECTAL EXAMINATION UNDER ANAESTHETIC**

**NORMAL RECTUM: SIMPLE ANAL PROBLEM**

- Tags / fibroepithelial polyps
- Anal fissures
- Haemorrhoids
- Low anal fistula Fistulotomy 8% - 100%

May be treated surgically if the symptoms justify the intervention

61 patients undergoing surgical treatment for fistula
13 – 140 months follow up

24 Seton
28 fistulotomy
9 advancement flap

5/28 low (simple) fistula recurred

NORMAL RECTUM: COMPLEX ANAL DISEASE

Multiple pathologies: tags and fistulae
- Stricture
- Dilatation
- Transsphincteric fistula
- Seton
- Lay open
- Horseshoe / multiple fistulae
- Complex fistula surgery
- "Rectovaginal" fistulae

Series report healing rates of 20–100% Koperen 5/9 recurred
Little appetite for heroic perineal surgery in the UK
  - Loose seton
  - Sepsis control

DISEASED RECTUM

Role of surgery limited to ensuring effective drainage of pus to allow maximal medical therapy

- Sepsis control / loose seton

 IMMUNE SUPPRESSION

AZATHIOPRINE (6M-P)
Extensively used first line treatment
Slow … 3 – 4 months to heal 30 - 50%
Risk of myelosuppression
Need monitoring

CICLOSPORIN
MYCOPHENELATE
TACROLIMUS

SALICYLATES
STEROIDS

METRONIDAZOLE
CIPROFLOXACIN

- Long course
- 50% healing rate
- Toxicity
- Recurrence

INFLIXIMAB

Anti TNF alpha antibody
Placebo controlled trial

Fistula closure 26% placebo 68% infliximab
All fistulae closed at 4 weeks 13% placebo 55% infliximab
Median duration of closure 3 months

Present et al NEJM 1999 3340:1398-1405

306 patients
3 doses 5 mg/kg at 0, 2 and 6 weeks
Responders (195) randomised at week 14
   - Placebo
   - Infliximab
End point … Time to loss of response
Median loss of response 14 weeks placebo >40 weeks infliximab
At 54 weeks 19% of placebo, 39% infliximab fistula free
Sands 2002 ACCENT 2 trial
26 patients 18 complex fistula 8 rectovaginal fistula
Combination of seton + immune suppression (80% infliximab)
FU 4.9 +/- 9.6 years
CDAI + imaging to assess response
Seton removed after 2-3rd dose
Initial response 44% for complex disease 62 % for simple
Relapse rate very unclear, Rectal involvement poor results

Adverse events
Perianal abscess
Infusion reaction
Delayed hypersensitivity
Drug induced lupus
Serious infections
TB
Pneumonia
Listeria
Sepsis
Cryptosporidiosis
Aspergillosis

NICE
Monoclonal antibody therapy
Patient has severe active Crohn’s disease
Treatment with other immunomodulators/steroids has not worked or there has been intolerable toxicity
Surgery is inappropriate
Cerolizumab pegol
Adalimumab

OTHER THINGS THAT HAVE BEEN TRIED
Fibrin glue
Fistula plugs (80%)
Direct injection of infliximab into fistulous tracts
Granulocyte colony stimulating factor
Thalidomide
Hyperbaric oxygen

10 year follow up of 109 patients
10 required rectal excision (5 for anal disease)
No other patient developed incontinence
Buchanan et al Am J Surg 1980 140(5) 642-4

30/97 patients required a stoma
Mueller et al J Gastrointest Surg 2007 11;529-37
DEFUNCTIONING

PROCTECTOMY

Perianal crohn’s disease and pregnancy

Caesar or not?

Malignancy (SCC Frisch 2000 Fistula cancer)
<table>
<thead>
<tr>
<th>SUMMARY</th>
<th>MANAGEMENT PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECTUM NORMAL</td>
<td>EMERGENCY TREATMENT DRAINAGE</td>
</tr>
<tr>
<td>SIMPLE ANAL PROBLEM</td>
<td>STABILISATION SETON</td>
</tr>
<tr>
<td>COMPLEX ANAL PROBLEM</td>
<td>OPTIMISE MEDICAL Rx</td>
</tr>
<tr>
<td>RECTUM DISEASED</td>
<td>ATTEMPT HEALING SURGERY</td>
</tr>
<tr>
<td></td>
<td>INFLIXIMAB / REMICADE</td>
</tr>
<tr>
<td></td>
<td>PROCTECTOMY</td>
</tr>
</tbody>
</table>

Assoc Coloproct Position Statement on Anal fistula
Williams et al Colorectal disease Oct 2007

CONCLUSION

Life long Illness
Management is approached with the palliative philosophy of symptom control
Many patients do avoid proctectomy