Perianal Crohn's Disease

Edmund Leung

Associate Professor

General Surgeon

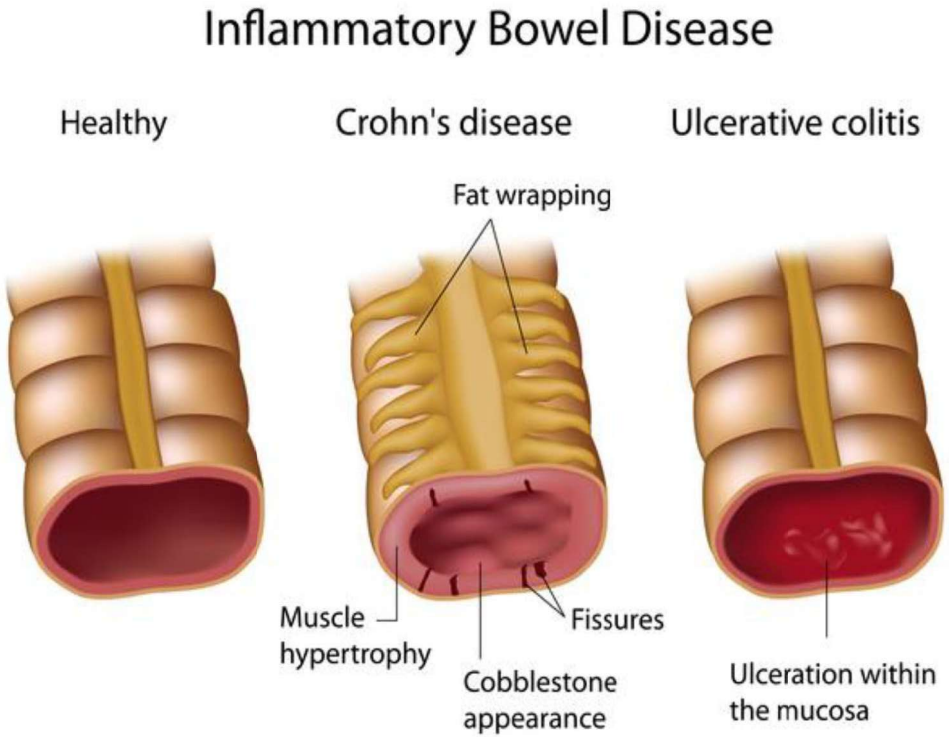
Declaration

- No relevant conflict of interest
- Paid consultant for Smith & Nephew Ltd (NZ)

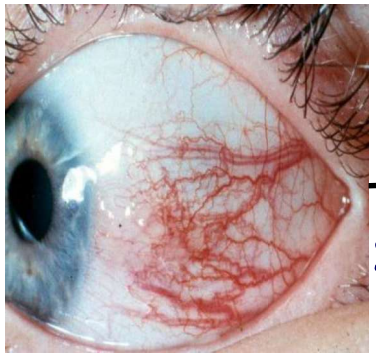
Crohn's Disease

Burrill B. Crohn (1884–1983)

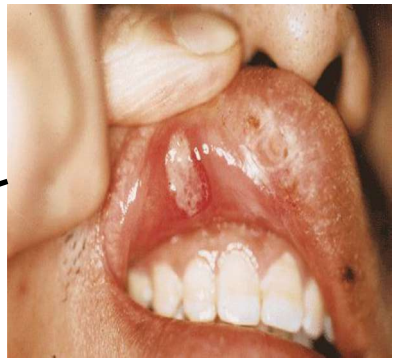
- Patchy *transmural* inflammation
- Affects the GIT anywhere (mouth to anus)
- Complicated by fistula / strictures



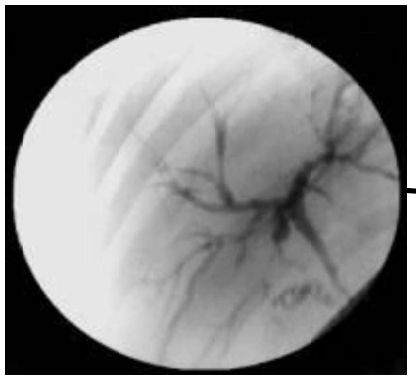
Extra-Intestinal Manifestations of Crohn's

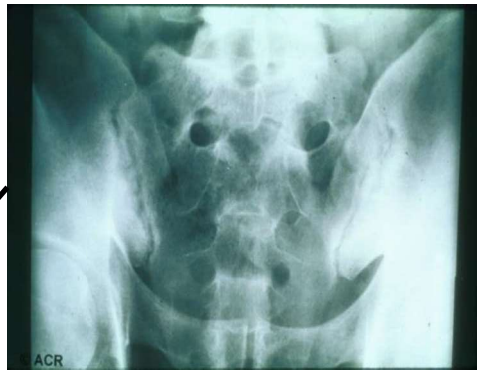


2-13%

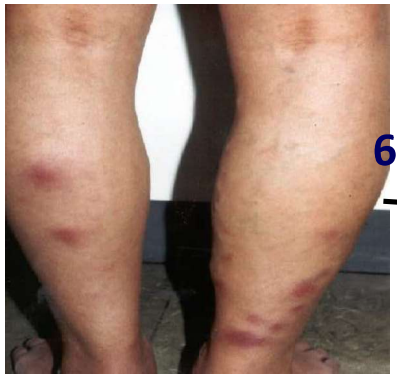


20-30%

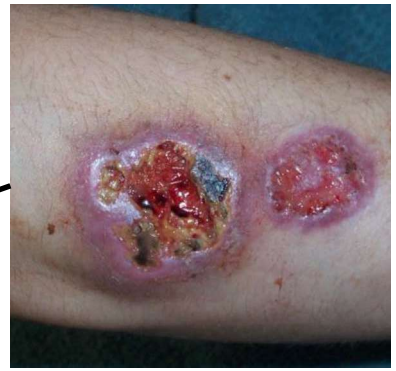




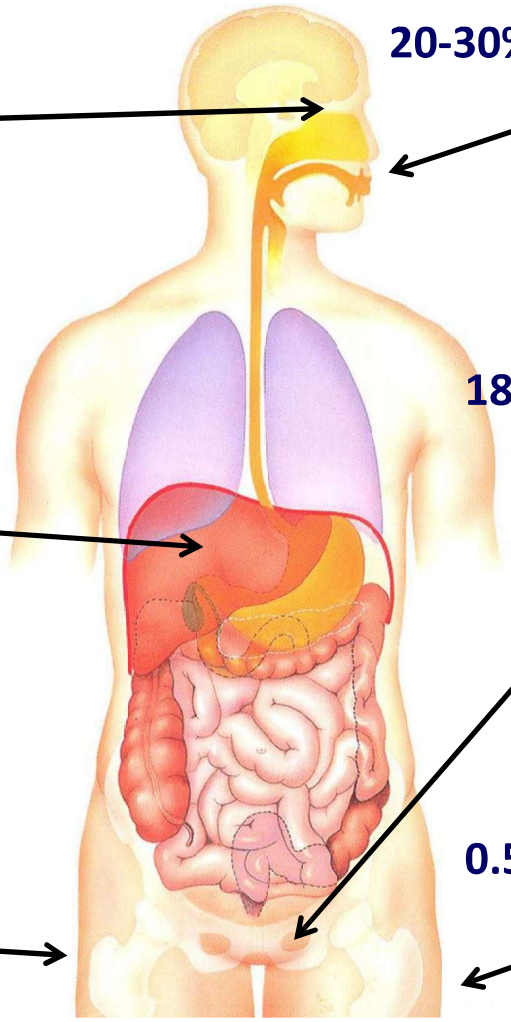
18-52%

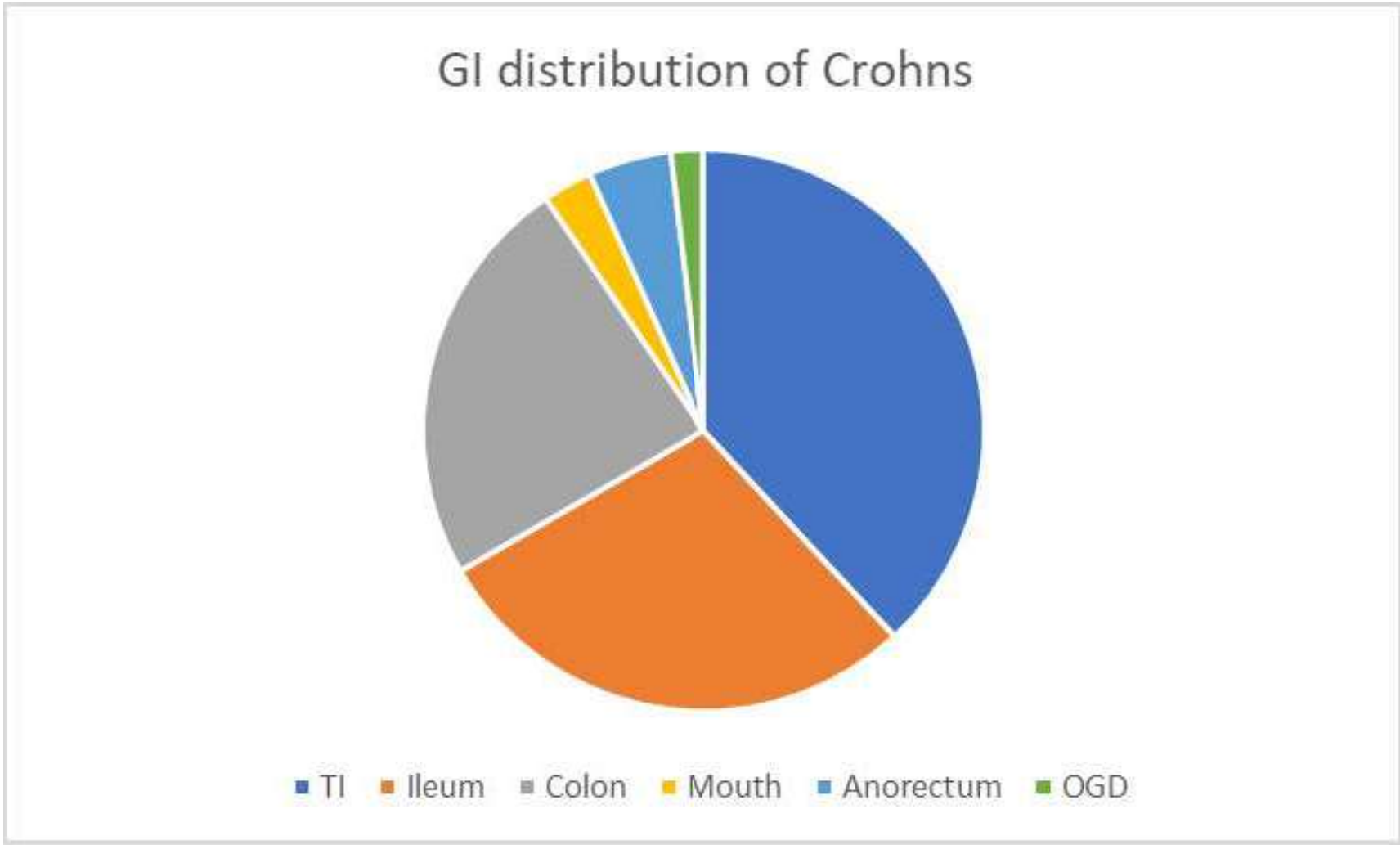


6-15%



0.5-2%

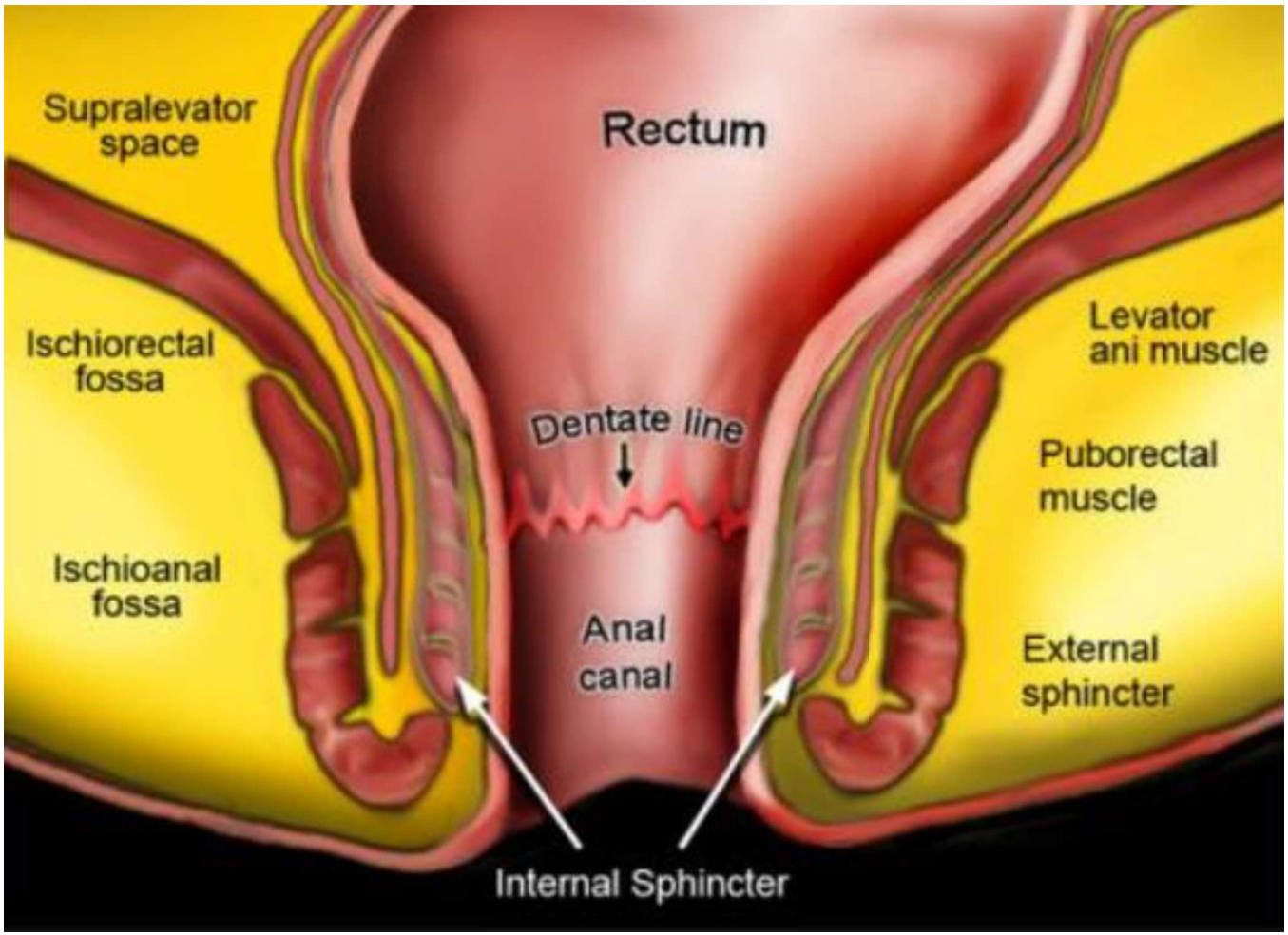



GI distribution of Crohns
TI
Ileum
Colon
Mouth
Anorectum
OGD

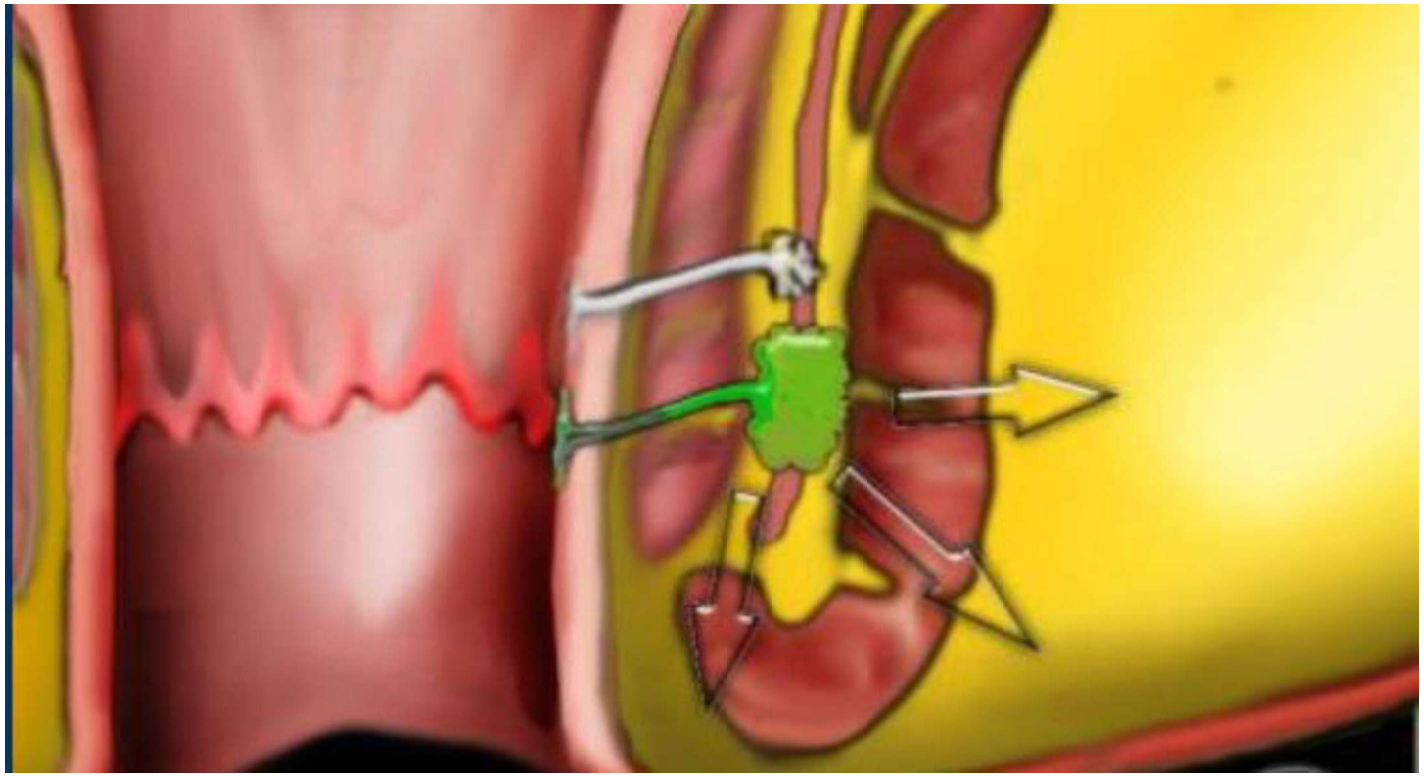
Perianal Crohn's

- Perianal abscess +/- fistula
- Anal fissure
- Anal stenosis

Normal anorectal anatomy



Perianal abscess

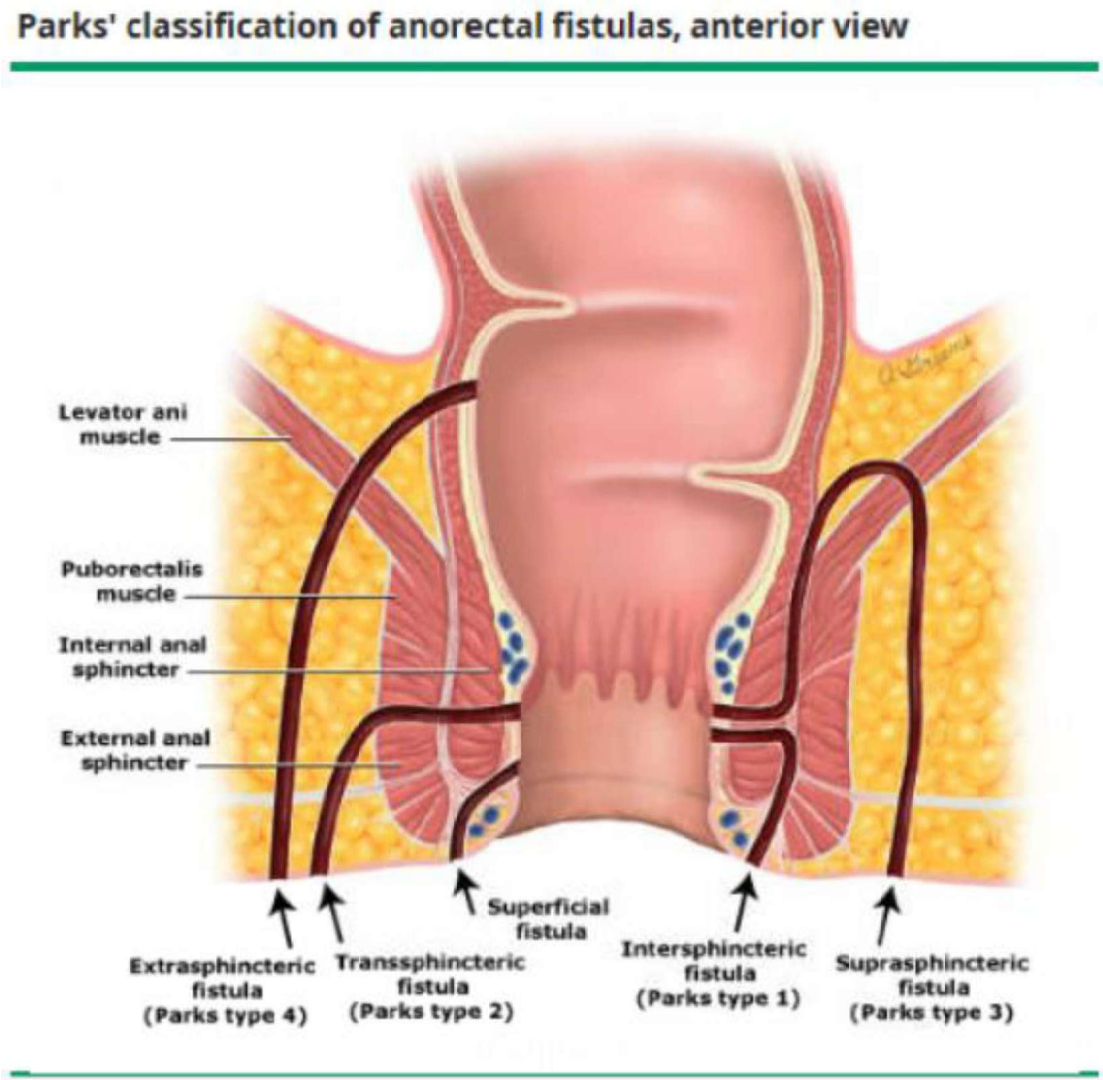


Perianal abscess

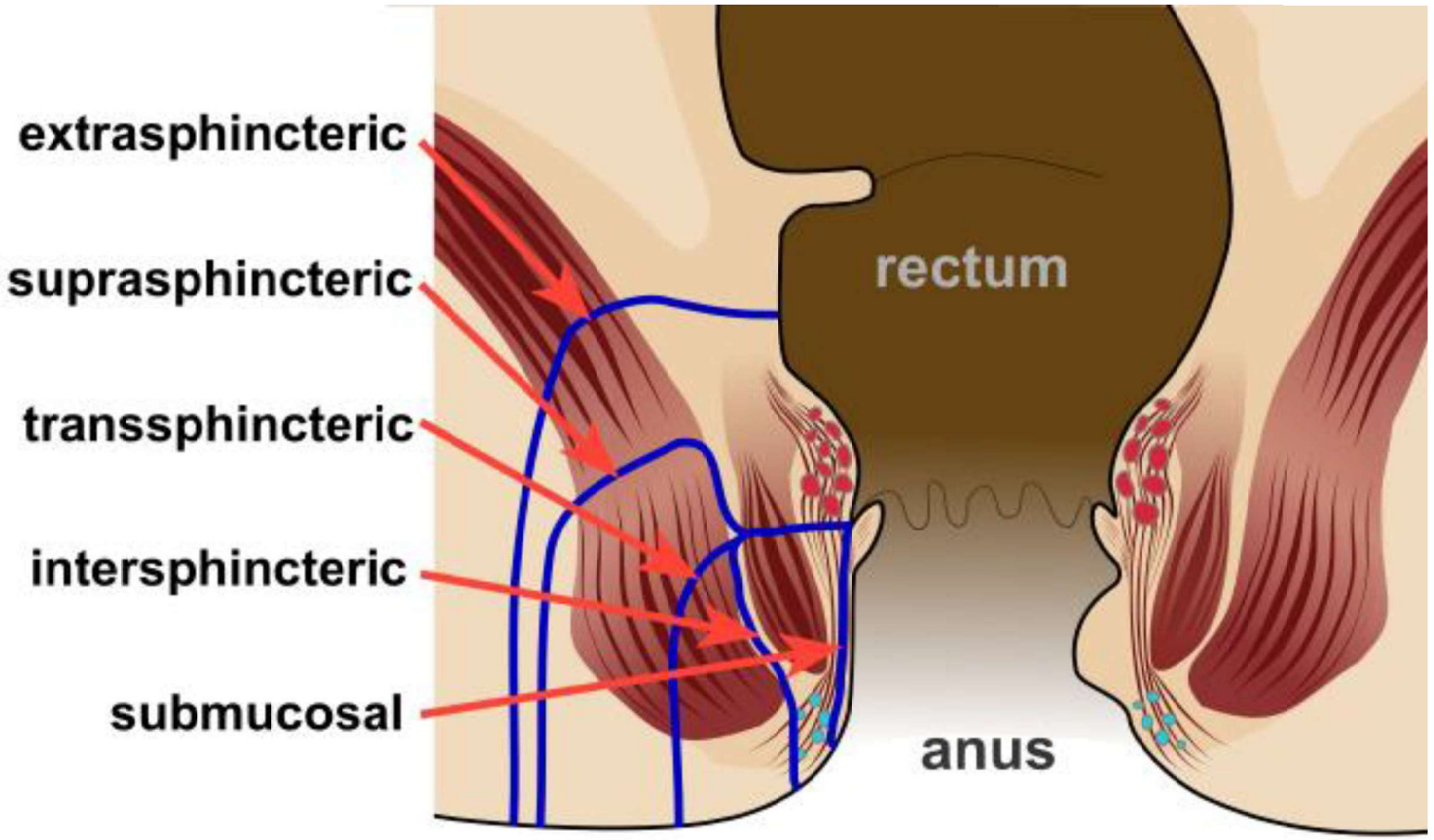
Treatment

- Incision and drainage +/- antibiotics
- No need for a biopsy now
  - Low yield due to acute inflammation
  - 90% cases are not Crohn's
- Needs follow-up 6 weeks later
  - If not healed by then, think fistula

Perianal fistula



Simple or complex

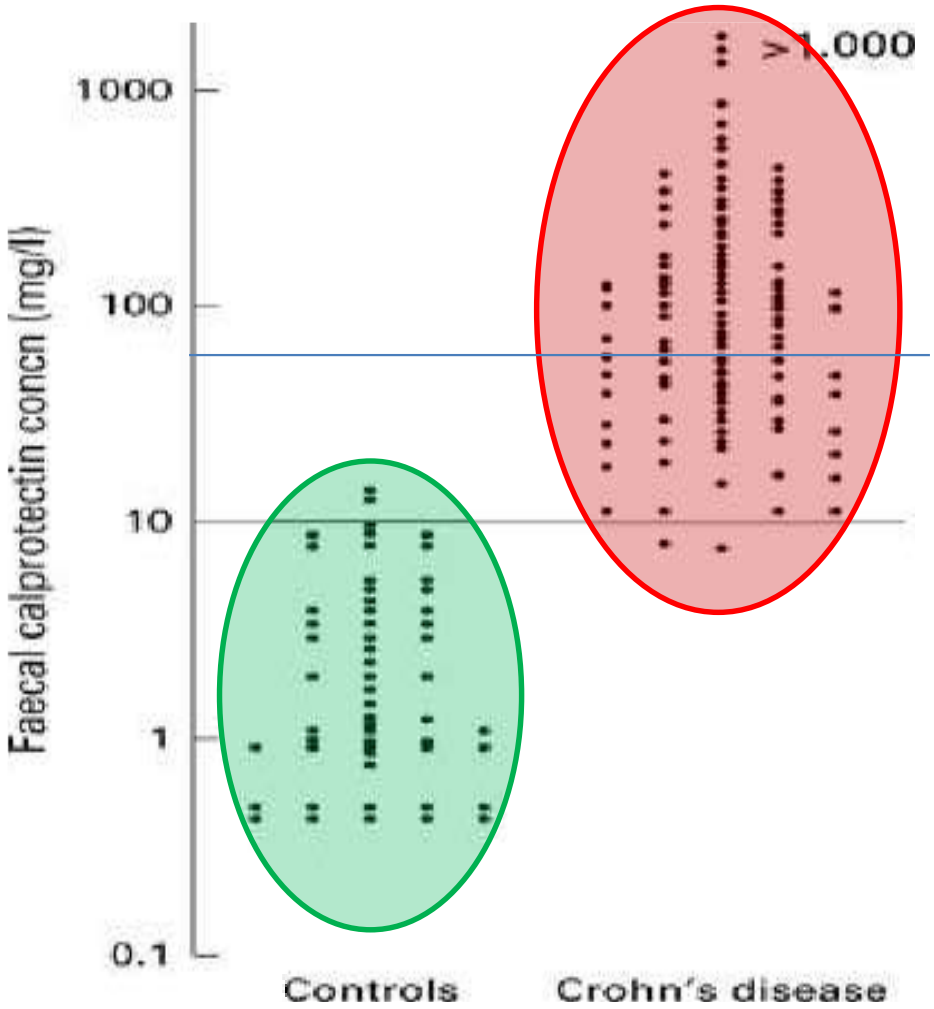


Watering can perineum

Investigations

- FCP (+/- Colonoscopy with TI biopsies +/- MRE)
- If complex fistula is expected, then MRI rectum
- If simple fistula, EUA and proceed
  - Fistulotomy
  - Seton

Faecal Calprotectin (FCP): Crohn's vs. Controls



250 μg/g

50 μg/g

Sensitivity 96%

In detecting established

Crohn's Disease *from* ***Controls***

Tibble *et al.* Gut 2000