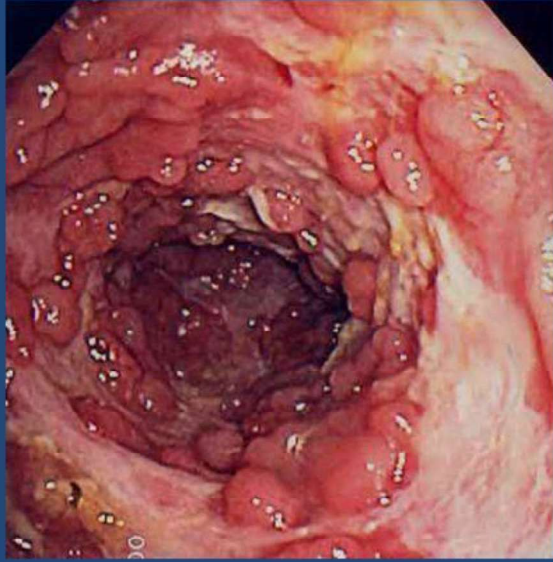
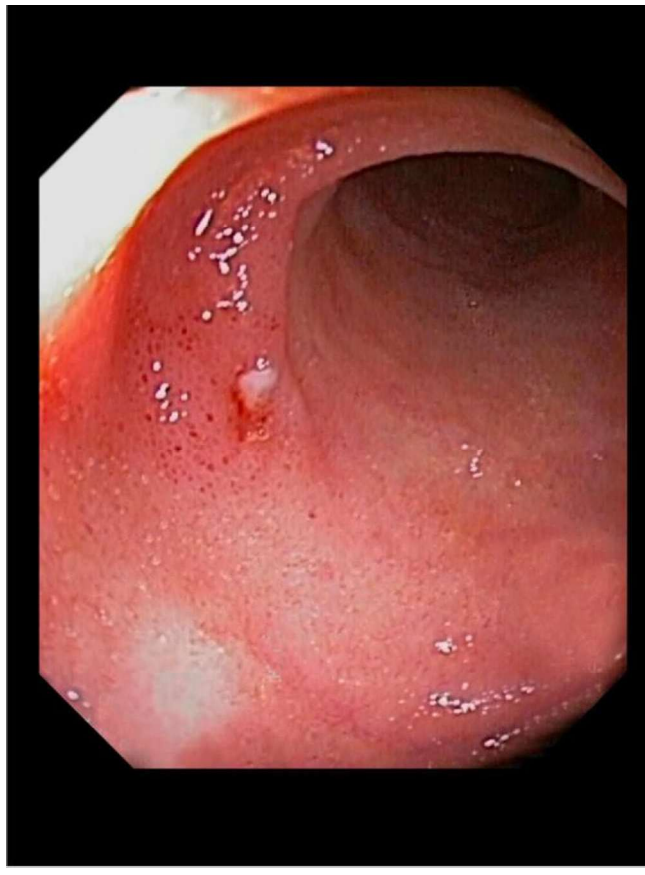


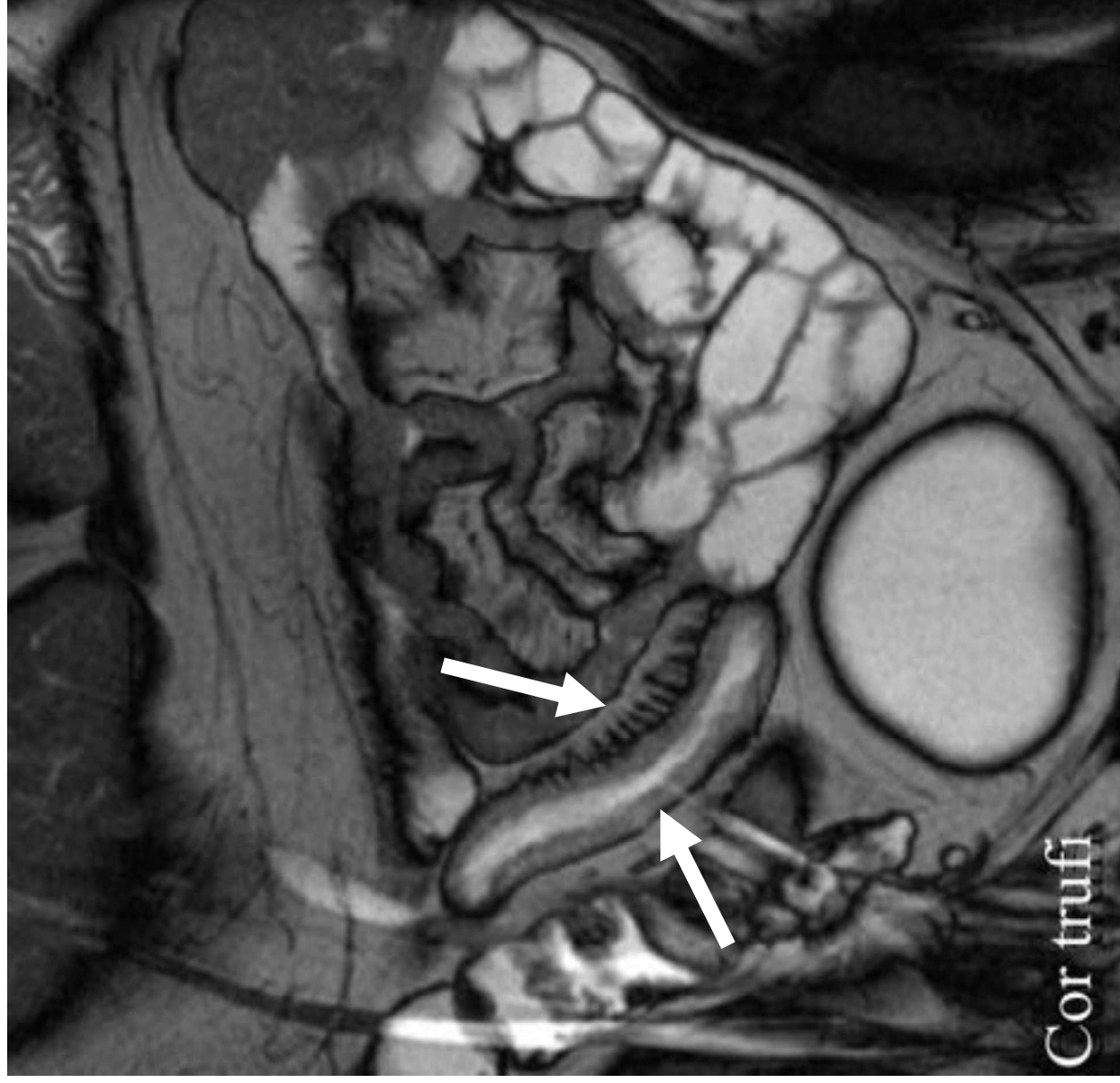
Colonoscopy / Enteroscopy



Colon with Crohn's disease



MR Enterography (MRE)



Pros & Cons of Faecal Calprotectin

Main advantages of faecal calprotectin assay

- Measures mucosal inflammatory activity at level insufficient to $\uparrow$ ESR/CRP
- Good sensitivity for detecting organic inflammatory disease
High NPV for absence of intestinal inflammation
- May predict IBD relapse in patients in clinical remission
- Quantifiable, inexpensive and acceptable test for patients

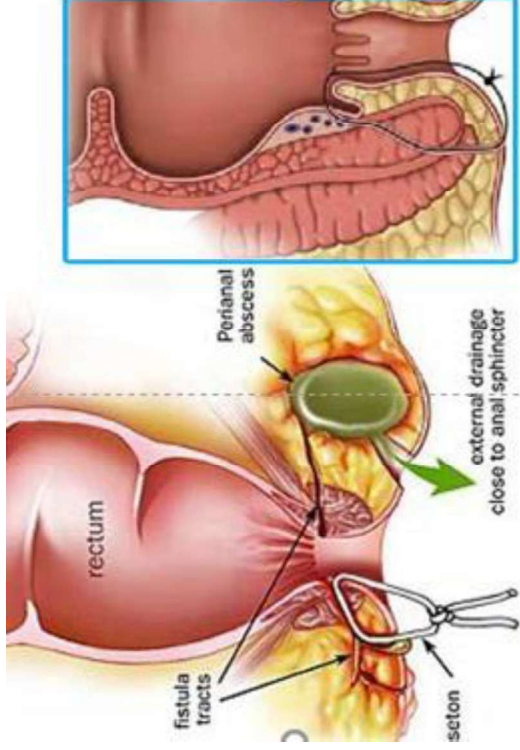
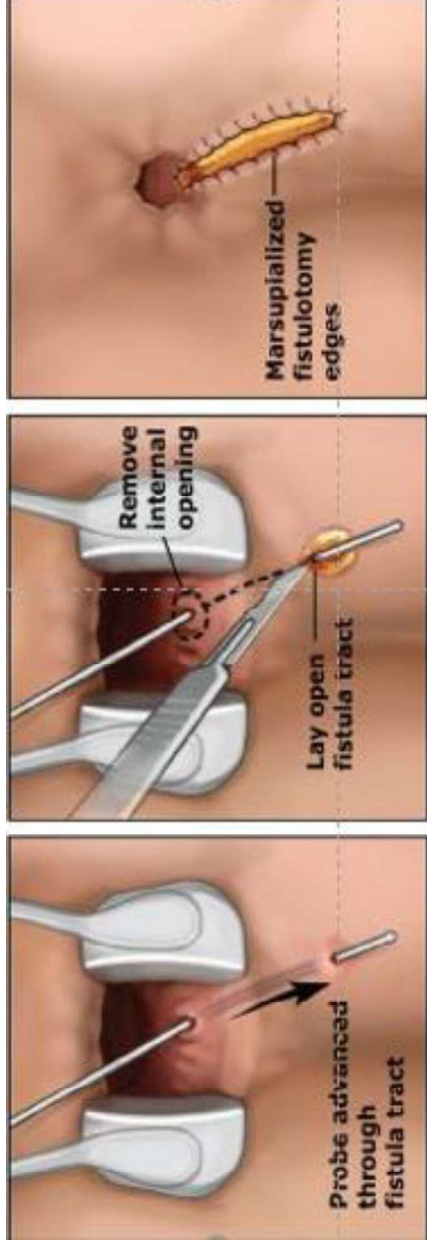
Main disadvantages & limitations of faecal calprotectin

- NSAID enteropathy
Stop regular NSAIDs for 4 weeks before testing
- Bleeding (at least 100mL daily) may increase faecal calprotectin
Neutrophils in menstrual / nasal bleeding may contaminate samples
- Not specific to IBD, simply indicates *gut inflammation*
– E.g. diverticulitis / Diaphragm disease

EUA for suspected simple fistula

- Confirm no sepsis or drain sepsis
- Confirm simple or complex fistula
- Biopsy for granuloma
- Treat fistula (fistulotomy or seton)

First line surgical fistula treatment



If suspected complex fistula, MRI

- Non-invasive
- Regional anatomy shown to the surgeon
- No less accurate than USS, which can be painful, invasive and operator-dependent

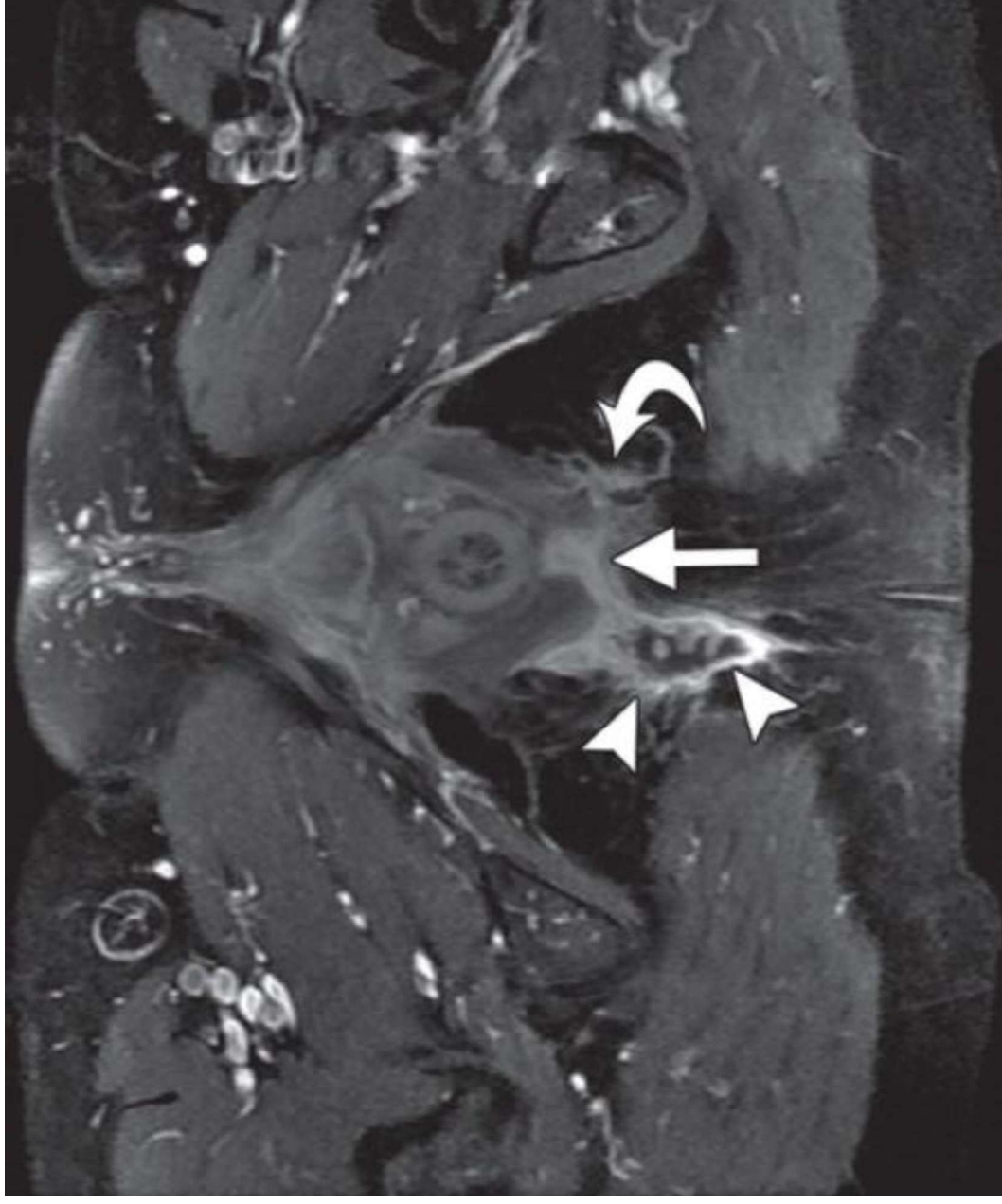
Simple linear intersphincteric



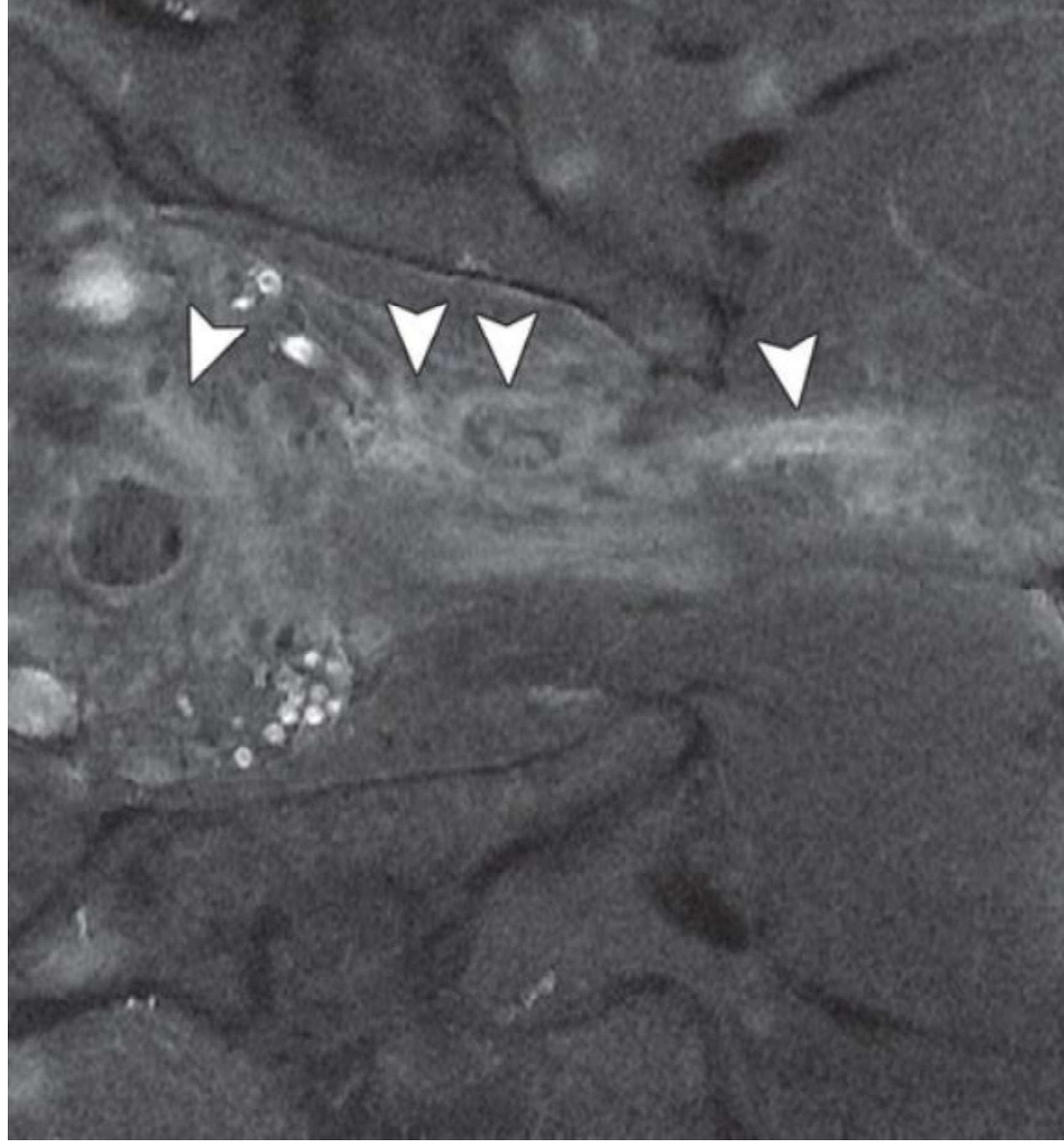
Simple transphincteric



Complex transphincteric



Complex ++ supralelevator



Refer for medical therapy

- Simple fistula
 - Asymptomatic – observe +/- antibiotics
 - Symptomatic – antibiotics +/- medical therapy
 - Non healing – medical therapy
- Complex
 - Seton with antibiotics and medical therapy

Metronidazole +/- Ciproxin

- Based on studies in the 1980s
- 4 open-labelled and 1 RCT: 8-52 patients
 - End point:
 - fistula closure at ~10-12 weeks after surgery
 - 50% in combination with ciproxin
 - 40% alone in the RCT (52 patients)

Medical therapy

