Perianal Crohn’s disease

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Perianal CD is distressing and often debilitating for patients. The most common presentation is with a perianal abscess: perianal swelling, redness and pain, followed by discharge of pus or faecal drainage to perianal skin or vagina, representing To r u K o n o , 1955–2021, Sapporo Higashi Tokushukai Hospital, Higahi-ku, Sapporo, Hokkaido, Japan. - a fistulous connection. Management requires a combination - of medical and surgical treatments. The role of surgery is to control infection in the first instance, and later to minimise recurrent infection, r educe drainage and to o ff er potential for fistula cure. If a fistula is seen at the time of abscess drainage, a seton may be placed. Otherwise, further examination under anaesthesia will be required for placement of draining seton(s) - by an experienced colorectal surgeon. MRI may aid identification of occult fistulae or sources of ongoing sepsis. Long-term drainage with setons prevents - further tissue loss from undrained infection but also allo ws safe initiation of biological therapy . Infliximab or adalimumab therapy may be combined with seton insertion in the early phase of management of perianal fistulae. Once fistula dis - charge has reduced, typically after two or three doses, the seton can be removed. Laying open of fistulae (fistulotomy), com - monly performed for fistulae resulting from the more common cryptoglandular perianal abscess, should generally be av oided in CD as the wound edges heal poorly . Potentially curative surgical options include advancement flaps, fibrin glue, fistula plugs, lig ation of the intersphincteric coupled with sutured closure of the internal fistula opening. ® The over-the-scope clip (OTSC) and video-assisted anal fis tula treatment (V AAFT) have only been used in small numbers of patients (see Chapter 80). Injection of adipose-derived mesenchymal stem cells into tissue surrounding complex anal fistula tracts is well tolerated and when used in combination with established treatments may increase fistula healing rates. The mechanisms of action are uncertain but are thought to relate to regenerative and anti-inflammatory cytokines produced by stem cells. The treat ment is expensive and further trials are needed. A diverting stoma may o ff er significant quality of life benefit in selected patients and should be o ff ered to symptomatic patients in the presence of intractable symptomatic perianal disease or proctitis, or failure to control perianal sepsis. Proctectomy is a good option for some patients and a permanent stoma should not be viewed as a treatment failure as it may again o ff er significant improvement in quality of life in selected patients. Rectovaginal fistulae hardly ever close with medical management alone, and surgery to repair rectovaginal fistulae has relatively low success rates. Failure of surgical repair may result in further deterioration in symptoms if there is additional loss of functional anorectal, vaginal or perineal tissue, and ultimately stoma rates are high in this group of patients.

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