Surgical Anorectal Diseases; When Should We Suspect a Perianal Crohn’s Disease? An Updated Mini-Review

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Abstract
Rectal sparing is a typical but not constant feature of Crohn’s disease, but anorectal complications, such as perianal abscess and fistulas are common. These lesions can be the first manifestation of the disease heralding more proximal intestinal involvement, as well. In the present study, we tried to attract the attention of all clinicians who examine patients with anorectal diseases to suspect Crohn’s disease perianal involvement and to differentiate it from other commonly seen disorders.

Keywords: Anorektal Disease; Crohn’s Disease; Perianal Diseases; Anal Fissure; Perianal Abscess; Perianal Fistula

Crohn’s disease is commonly complicated by perianal manifestations. These lesions can be the first manifestation of the disease heralding more proximal intestinal involvement, as well. The surgeon plays a pivotal role in caring for these patients. Differentiation of perianal Crohn’s disease from the more commonly seen sporadic anorectal diseases such as anal fissure, fistula, ulcer or stenosis is not easy. One should keep in mind the possible diagnosis of Crohn’s disease involving the anal region primarily or secondarily. In a study by Hellers, et al, perianal fistula occurred in 12% of patients with ileal disease, 15% with ileocolonic disease, 41% with colonic disease that not involving the rectum, and 92% of patients with colorectal Crohn’s disease [1]. In an other study, Crohn’s colitis was associated with perianal complications in 52% of cases versus 14% when small bowel was the sole site of disease [2]. In addition, they found that when an anal lesion is the manifesting sign, Crohn’s disease will soon develop elsewhere in the intestine. Perianal Crohn’s disease may herald the development of intestinal manifestations by several months to several years. About two thirds of patients with perianal disease will be diagnosed with intestinal disease within 1 year, another third within 1 to 5 years [3]. A small proportion with Crohn’s disease may persist in having isolated perianal involvement, as well. Therefore, the gastroenterologists and surgeons should be aware of this uncommon clinical presentation.

Recurrent perianal fissures, especially if they are located at uncommon locations like lateral or superior (anterior wall of) anus, frequent abscesses or complicated fistulas and non-healing anal ulcers should suggest an anorectal Crohn’s disease. Manifestations of perianal involvement usually falls into 3 categories: tissue destruction, which includes fissures, tags, and deep ulcers lined with granulation tissue; fistulae and abscesses, which are often multiple and complex and are frequently related; and rectal stricture, which is a result of long-standing or even healed Crohn-related inflammation [4]. Proctalgia, bleeding, discharge, itching and scaling, constipation, fecal incontinence, recurrent infections and sepsis are among the commonest symptoms. After taking a detailed history, physical examination including digital rectal exam and well-performed rectosigmoidoscopy to assess the proximal parts of the gastrointestinal tract are sine qua non for the differential diagnosis. In elderly patient population and patients with recurrent anorectal symptoms, a total

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colonoscopy should be planned. The first perianal examinations should be followed by a pelvic magnetic resonance imaging (MRI) which is now considered the noninvasive gold standard for perianal fistula assessment, with a high sensitivity and specificity inflammation [5]. Endoanal or endorectal ultrasonography (EUS/ERUS) has also gained a popularity in the evaluation of anorectal diseases including Crohn’s disease [6]. Currently, the higher diagnostic quality of EUS and pelvic MRI precludes the use of computed tomography and fistulography.

A detailed history along with a thorough clinical exam provides the treating physician with invaluable information upon which to base further investigations and management decisions. An excellent working relationship between the gastroenterologist and the colorectal surgeon is mandatory to provide these patients with the best care possible. Other than abscess drainage, medical management (corticosteroids, antibiotics, immunomodulators, infliximab, etc) to control proximal disease often precedes any surgical attempt to cure the disease [7]. Poor wound healing and recurrences often complicate surgical interventions, culminating in a sizable percentage of these patients needing a proctectomy. Patience is a virtue in treating this complicated condition.

Fissures in patients with Crohn’s disease tend to be broad-based, have undermining edges, and are most often found posteriorly [4]. However, anterior or lateral locations are more common than the sporadic cases. Multiple fissures or unhealing anal ulcer or fissures should be evaluated in detail to diagnose Crohn’s disease. A perianal abscess should always be drained in both sporadic cases and known or undiagnosed Crohn’s disease. Although sometimes difficult to identify, every abscess should be assumed to have an associated internal fistulous opening, and be treated accordingly. Even it is not the subject of our present paper, we should say that all perianal abscesses drained several times or recurrent and complicated perianal fistulas should be treated in experienced colorectal centers dealing with inflammatory bowel diseases. Since medical treatment of Crohn’s disease has good results after the introduction of new immunomodulators such as certolizumab, adalimumab, mycophenolate mofetil or tacrolimus etc., surgery including Seton procedure or creation of an ostomy in complicated cases should be undertaken at later stages or in unresponsive patients [3,4].

In conclusion, perianal involvement of Crohn’s disease is not a rare clinical entity and can be seen as the first manifestation of the disease. Therefore, in daily outpatient clinical examination, Crohn’s disease should be kept in mind, especially in persistent, recurrent, unhealing lesions at atypical localizations of perianal region.

**Bibliography**


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