Title: Management of Perianal Crohn's Disease

Objective: Provide direction to management of patients with perianal Crohn's disease

Patient population: patients diagnosed with Crohn's disease with a recent surgical resection

INTRODUCTION

Perianal Crohn's disease is a form of Crohn's disease which causes inflammation around the anus. Perianal manifestations of Crohn's disease include perianal fistula, perianal abscess, anal canal lesions (fissures and stricture). It affects up to a third of individuals living with Crohn's disease. **Management of perianal fistulas requires a multidisciplinary approach (gastroenterology, radiology and colorectal surgery).**

Symptoms include:

- Pain and/or itching around the anus
- Anal bleeding and/or passing pus/mucus
- Urgency to pass stools or incontinence

Fistulas can be classified as simple or complex:

Simple perianal fistula: low fistula, confined to the anal canal with a single external opening without abscess or stricture. Based on Parks classification system, this includes intersphincteric fistula (Parks type 1) and superficial fistula.

Complex perianal fistula: high fistula, passes through or above muscle layer with single or multiple external openings with or without abscess. Based on Parks classification system, this includes the suprasphincteric fistula and the entire sphincter apparatus.

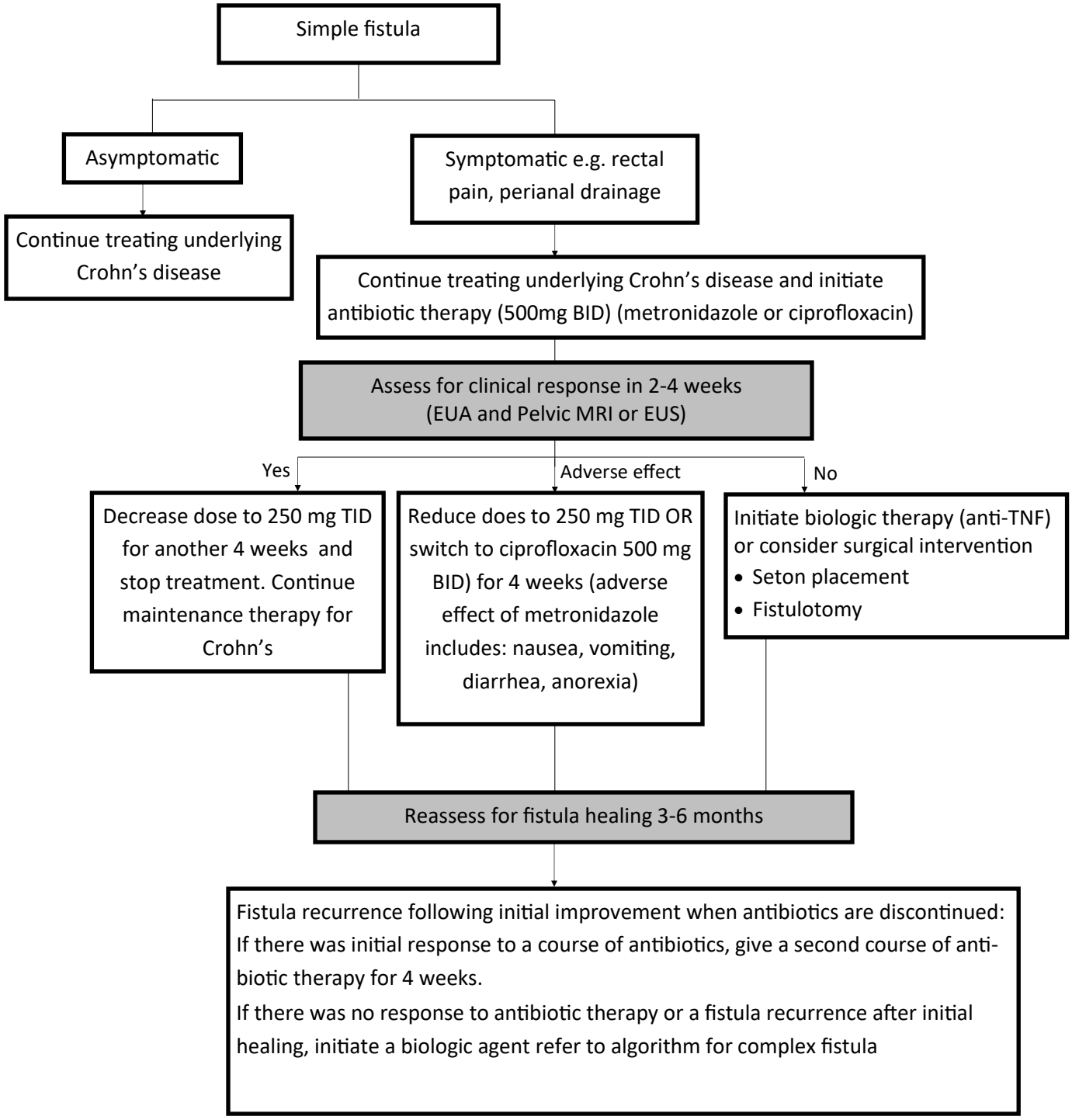
Therapy for perianal fistulas are guided by imaging studies and physical examinations such as pelvic magnetic resonance imaging (MRI) or rectal endoscopic ultrasound (EUS), imaging with pelvic computed tomography (CT), rectosigmoid endoscopy, examination under anesthesia (EUA). These procedures help to define the fistula anatomy and exclude the presence of a perianal abscess.

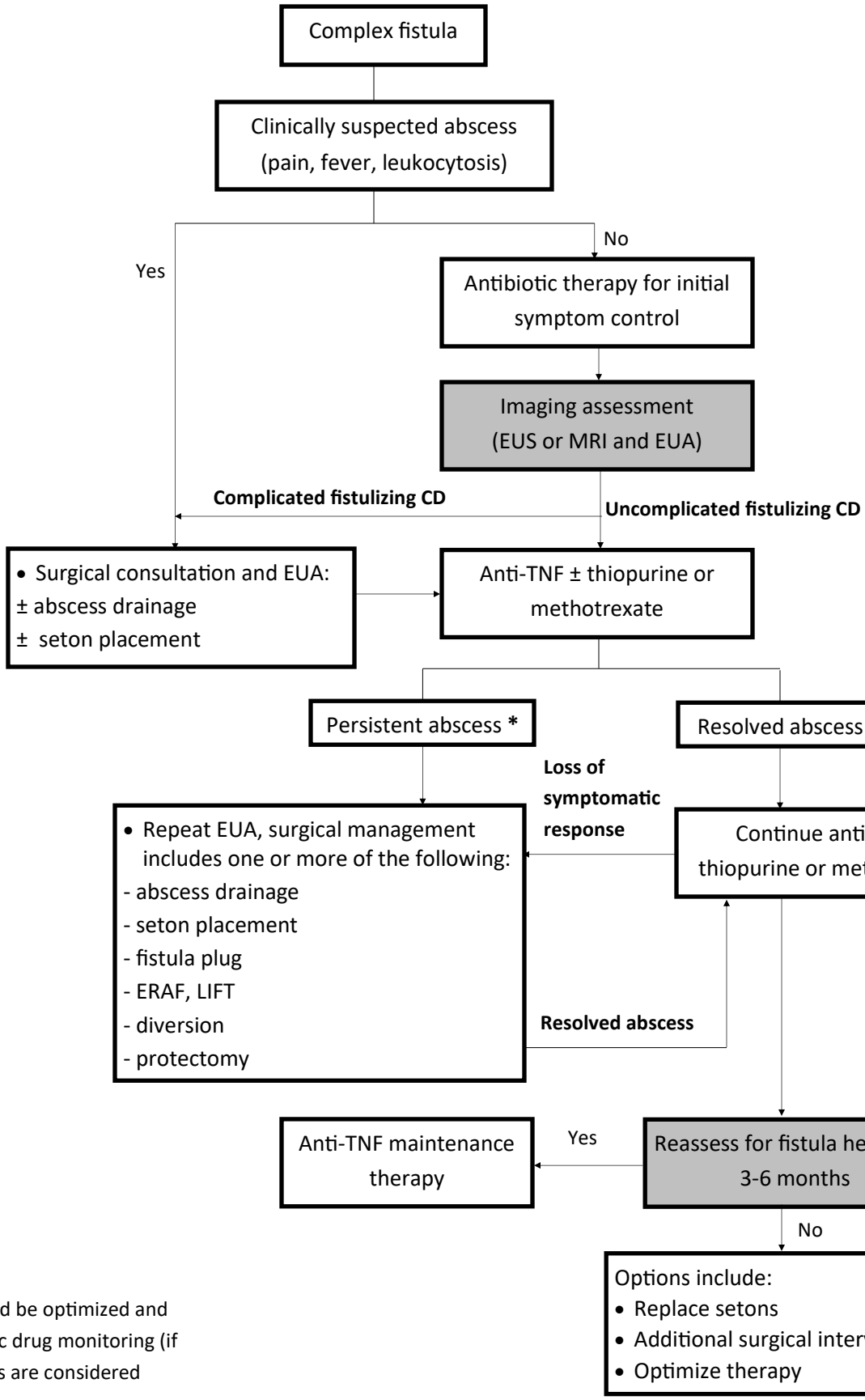
Goal of therapy: Complete fistula closure is the primary therapeutic goal, however this is not often achieved.

If radiography is not used to document fistula closure, symptomatic remission without the occurrence of any complications (eg, anal stenosis, perianal abscess, systemic sepsis, fecal incontinence) or the need for fecal diversion or proctectomy is an acceptable outcome. Symptomatic response should not be the goal of therapy but may be useful to assess early improvement with therapy. In addition, symptomatic response may be an acceptable outcome in some cases when symptoms are only intermittent and not associated with the development of the previously mentioned complications.

(Definition of remission and response—see Table 1)

The following algorithms are best practice clinical pathways for management of simple and complex perianal fistula.





*Medical therapy should be optimized and informed by therapeutic drug monitoring (if needed) before patients are considered refractory to treatment

Notes:

ERAF: Endorectal advancement flap

LIFT: Litigation of intersphincteric fistula tract

Table 1. Defining Remission and Response in Patients with Perianal, Fistulizing CD

Complete remission	Symptomatic and radiographic remission (as defined below)
Symptomatic remission	Absence of both pain and drainage from the fistula tract (absence of drainage with application of gentle pressure)
Symptomatic response	Meaningful improvement in symptoms of pain and drainage as judged by both the patient and physician in the absence of remission. Response should not be considered a desirable final outcome, but is useful to assess early response to treatments.
Radiographic remission	Absence of inflammation in any fistula tract and the absence of any abscess

REFERENCES

Steinhart *et al*. Clinical Practice Guideline for the Medical Management of Perianal Fistulizing Crohn's Disease: The Toronto Consensus IBD 2019*;* 25(1):1-13.

Parks *et al*. A classification of fistula-in-ano. BJS Society 1976;63(1):1-12.

Lightner *et al.* Interdisciplinary Management of Perianal Crohn's Disease. Gastroenterol Clin North Am 2017; 46 (3):547-562