SESSION 4
PERIANAL DISEASE: WHAT IS NEW?

CASE-BASED BREAKOUT WORKSHOP

A 34-year-old male presents to the emergency department with recurrent perianal pain. On exam, there is a perianal abscess, confirmed by magnetic resonance imaging (MRI) of the pelvis (4 cm perianal abscess associated with a high transsphincteric fistula with multiple branches and hyperenhancement on T2 weighted imaging). The patient experienced a similar episode one year ago with complete resolution of symptoms after an incision and drainage procedure. An ileocolonoscopy at the time of the initial episode was normal including biopsies of the terminal ileum and colon.

Discussion Point 1

a. What are the possible causes of this patient's presentation?

b. How can you differentiate cryptoglandular fistulas from Crohn's disease (CD)?

c. Are any additional diagnostic tests required?

His fecal calprotectin is 350 µg/g, Computed Tomography Enterography (CTE) is normal, and video capsule endoscopy demonstrates numerous aphthous ulcers in the third tertile of the small bowel suggesting a diagnosis of CD. Clinically, the abscess drains spontaneously and there is no longer perianal pain. The patient is afebrile and there is no longer an abscess clinically. However, the patient experiences daily fistula drainage requiring multiple changes of gauze throughout the day.

Discussion Point 2

a. What is your management strategy?

b. Which anti-tumor necrosis factor (TNF) therapy would you suggest?

c. Are non-anti TNF therapies effective?

The patient is treated with infliximab (IFX) 5 mg/kg induction, followed by 5 mg/kg every 8 weeks and methotrexate 15 mg orally weekly. After 3 months the patient continues to have perianal drainage daily. On exam, exudate can be expressed by gentle finger palpation. However, there is no evidence of an abscess. Digital rectal exam (DRE) demonstrates mild anal canal stenosis. IFX serum trough concentrations are 9 µg/mL and fecal calprotectin is <9 µg/g.

Discussion Point 3

a. How and when do you normally assess for fistula healing?

b. What are potential reasons why his fistula is still draining?

c. How would you manage this patient now?

Despite escalation of IFX to 10mg/kg every 4 weeks and resultant IFX serum trough concentrations of 25 µg/mL, as well as serial dilation of the anal canal stricture, the patient continues to have perianal drainage after 3 additional months. The patient's symptoms are bothersome and impacting his quality of life.

Discussion Point 4

a. What are potential rescue treatment options?

b. How do you decide which treatment to choose?