The evolving role of Surgery in IBD
An interactive case presentation

The Gastroenterology Foundation of South Africa
IBD Interest Group
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Presenter: Dr Amisha Maraj
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Ms PP
• 56 year old female
• First Presentation: 1/10/2001
• Referred by GP - 4 day history of perianal abscess + fever

• Episodes of diarrhoea
• Describes stool bubbling through vagina
• No extra-intestinal manifestations of IBD
• Smoker (since 25 years old; 40 cigarettes a day)
Relevant history:
• Diagnosed at Kings College Hospital with Crohn’s disease in 1968 following a haemorrhoidectomy
• 1969 - Gastroscopy: “Coarse mucosal pattern in the 2nd part of the duodenum “
  - Barium Meal: “There were several abnormal segments of small bowel strictures and in the right side deep ulceration. The terminal ileum was abnormal and narrowed.”
• 1971 - Johannesburg General Hospital - Terminal ileal resection
• only complaint being diarrhoea.
• CaCX, radiation
• Recurrent perianal abscess which was managed by her GP

• COPD
• Medication: On HRT
• Occupation - Project manager at FNB - Stress at work
• No children
• Family history - diabetes
Impact of changes in management over time

Surgery
• Terminal ileal resection

Medical therapy
• Steroids
• Immunosuppressants – Azathioprine + Methotrexate
• Biologics – Infliximab
• Antibiotics
**Examination**

- Pyrexial
- BP 120/80
- HR 75
- Abdomen – previous scars
- PV – nil apparent
- Perineum: abscess on the left which was closely related to the anus and evidence of a chronic fistulous tract

**Assessment**

- perianal abscess & complex fistula – in the background of Crohn’s
• 2/10/2001
  • Drainage of perianal abscess + placement of Seton
  • Sigmoidoscopy + Biopsy

• 3/10/2001
  • Referred to gastroenterologist
  • therapy for Crohn’s– Asacol 400mg tds, Methotrexate ; Flagyl 400mg tds
  • SSRI/HRT

• 5/10/2001
  • Healing but still a lot of pain
  • Continue Crohn’s treatment
  • Additional analgesia
Evolution of drugs

Medical therapy

• Mesalazine widely used in the past now generally considered little benefit

• Now:
  • Steroids
  • Azathioprine
  • Methotrexate
  • Biologics – Infliximab
  • Antibiotics
• 24/10/2001
  • Colonoscopy – active disease
    • Reached caecum
    • Ileocolonic stenosis at anastomosis
    • Rectum – multiple areas of inflammation
    • Rectal and anal stenosis
    • Inflamed polyp anteriorly

• 8/5/2002
  • EUA / Relook perineum
  • Washout + Closure of rectal defect with monocryl 2.0
  • Laparotomy + ileostomy

• 27/8/2002
  • Closure of ileostomy

• 13/9/2002
  • Laparotomy – small bowel stenotic stricture – resection + anastomosis
• 5/8/2013
  • EUA
    • Rectovaginal fistula - tract from posterior vaginal wall to rectum at 12 ‘0 clock
    • Placement of Seton
      • Biopsy of fistulous tract - moderately differentiated adenocarcinoma 2cm
        granulomatous lesion on left labia
      • Biopsy Small cystic deposit of mucinous secreting adenocarcinoma

• Neoadjuvant chemo + DXT

• 21/8/2013
  • Gastroscopy mild gastritis; Hpylori negative
  • Sigmoidoscopy mucosal lesion at anorectal junction - Biopsy – no features of malignancy
21/8/2013
- **MRI**
  - Ulcer with Fistula tract at anterior anorectal junction
  - No definitive malignant masses but malignant ulcer is possible

- **CT chest/abdomen/pelvis**
  - Diffuse emphysematous changes
  - No evidence of mets

13/1/2014
- **Abdominoperineal resection + posterior vaginectomy (pT1N0M0)**
- Permanent end colostomy
- IGAP flap
Q1. Risk of anal adenocarcinoma in perianal fistulas secondary to Crohn’s disease?

What is the incidence?
A. 20/1000 patient years
B. 200/1000 patient years
C. 0.2/1000 patient years
D. 2/1000 patient years

**Answer C**

**ECCO guidelines 2016**

In patients with CD, adenocarcinoma complicating perianal or enterocutaneous fistula tracts can occur but is rare.
1. Meta-analysis of 20 clinical trial 1965-2008 – incidence of cancer relating to CD associated fistula was 0.2/1000 patient years.
2. 17 year follow up study of 6058 CD patients -> only 4 developed fistula associated adenocarcinomas
Fistula-related adenocarcinomas

- can arise in patients with long-standing perianal CD
- may be associated with adenomatous transformation

Factors associated with malignant transformation
- Early onset disease
- Disease duration > 10 years
- Chronic colitis/high inflammatory activity
- Persistent chronic fistulas and stenosis
- More common in females, tend to be younger

ECCO guidelines 2016
Q2. What is the proportion of squamous carcinoma to adenocarcinoma in malignant Crohn's perianal fistula?

A. SCC
B. Adenomatous

Answer B

A. SCC 31%
B. Adenomatous 59%

Rectum 59%

ECCO guidelines 2016
Q3. Frequency and modality of surveillance?

- Regular surveillance recommended for CD patients with chronic persisting perianal fistula to detect ano-rectal carcinomas
  - Routine biopsy of any suspicious lesion
  - Biopsy under anaesthesia
  - Curettage of fistula tract when needed

Red flags
- Long duration
- Change in symptoms – new onset pain***
Treatment of Simple perianal fistulae

Uncomplicated low anal fistula
- simple fistulotomy
- perianal abscess – incision + drainage

Symptomatic simple perianal fistulae
- seton placement
- +antibiotics (metronidazole and/or ciprofloxacin)

• Recurrent/ refractory (not responding to antibiotics)
  • thiopurines or anti-TNFs can be used as second line therapy

ECCO guidelines 2016
Treatment of Complex perianal fistulae

**Surgical treatment of sepsis**
- incision + drainage of abscess
- seton placement
  - Timing of removal depends on subsequent therapy

**Medical treatment**
- **first line therapy** - infliximab (adequate source control sepsis surgically)
- ciprofloxacin +anti-TNF improves short term outcomes
- anti-TNF treatment + thiopurines – to enhance the effect of anti-TNF

ECCO guidelines 2016
Continuing therapy for perianal Crohn’s disease

Combination of drainage and medical therapy = maintenance therapy
  • Thiopurines
  • Infliximab
  • seton drainage

Medical treatment failure
  • considered for a diverting ostomy
  • proctectomy
Anti TNF therapy – Carcinogenic risk

• Lymphoma
• Leukaemia
• Carcinoid tumor
• Ca Colon
• Breast Lung
• Melanoma
• Non Melanotic skin cancers (BCC SCC)

References

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