

Crohn's Disease of the Colon, Rectum, and Anus



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KEYWORDS

- Crohn's Disease • Perianal Crohn's Disease • Colonic Crohn's Disease
- Crohn fistula • Ileostomy

KEY POINTS

- Intra-abdominal abscesses associated with colonic Crohn's Disease (CD) that are addressed before definitive surgery may be associated with fewer stomas.
- Segmental colectomy for colonic CD is a viable option for patients with limited disease.
- The definitive operation for the patient with colonic CD is total proctocolectomy with end ileostomy (TPC/I).
- Fecal diversion when done to decrease colonic inflammation, perianal inflammation, and sepsis may become permanent.

CD of the large intestine is one of the more challenging forms of the disease to treat.¹ CD of the small bowel and ileocolic disease are often treated surgically without the need for an ostomy, whereas the decision tree for surgical treatment of CD of the colon, rectum, and anus frequently has an ostomy at an early branching point. Also, because an ostomy has such a life-changing impact, CD of the large intestine can require difficult decisions. Delays in treatment because of the fear of an ostomy can also lead to more complicated procedures. This review focuses on the less-common complications of CD of the colon, rectum, and anus as well as the surgical treatment options.

PRESENTATIONS OF CROHN'S DISEASE

Intra-Abdominal Abscess

Intra-abdominal abscesses can complicate the treatment of patients with CD and add additional steps in management. These steps can include percutaneous drainage, surgical drainage, and/or fecal diversion. Ideally, preoperative drainage of an abscess would obviate surgery in the acute setting, make future surgery technically easier for the surgeon and patient, and decrease the likelihood of the need for an ostomy.

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da Luz and colleagues² retrospectively reviewed the Cleveland Clinic, Ohio, experience with abdominal and pelvic abscesses in patients with CD from 1997 to 2007 and evaluated the efficacy of percutaneous drainage of abscesses in 94 patients. Patients with postoperative and perirectal abscesses were excluded from this review. Of this group of patients, 82% had ileocolic CD and 16% had colonic CD. An abscess was the initial presentation of CD in only 5 patients; 31 of 48 patients (65%) had what was considered a successful delay in surgery (median delay of surgery of 43 days). Factors associated with failure of percutaneous drainage were steroid use, colonic disease phenotype, and multiloculated abscesses. However, the size of the abscess was not associated with success or failure. As should be the goal with preoperative percutaneous drainage of intra-abdominal abscesses, initial percutaneous drainage did reduce the incidence of stoma creation when compared with initial surgical intervention (23% vs 58%, $P = .01$).

The nonsurgical viewpoint of intra-abdominal abscesses was summarized by an article from Massachusetts General Hospital.³ Gutierrez and colleagues³ reviewed 66 patients who were treated for intra-abdominal abscesses from 1991 to 2001. Of these, 37 patients had percutaneous drainage and 29 patients had surgical drainage of abscesses. The evaluation focused on the time to resolution of abscesses, which was not different between percutaneous and surgical drainage. The investigators also evaluated the need for surgery after percutaneous drainage and found that one-third of patients required surgery within 1 year. The investigators did not comment on whether or not patients treated with percutaneous drainage had a lower incidence of stoma creation.

Abdominal Wall Abscesses

In contrast to intra-abdominal abscesses, abdominal wall abscesses are less common. Abscesses of the abdominal wall typically indicate an underlying fistula. Neufeld and colleagues⁴ identified 13 patients over a 10-year period who were diagnosed with abdominal wall abscesses resulting from CD. Mean patient age was 32.8 years. In 2 patients, the abscess was the initial presentation of CD; 6 patients were found to have colonic CD, and 5 patients had ileocecal CD. All 13 patients ultimately had definitive surgery with resection of the source of the fistula. As the fistula is the source of the abscess, it must be addressed. The investigators noted that draining the abdominal wall abscess without addressing the fistula led to a 100% failure rate, and this is in contrast to percutaneous drainage of intra-abdominal abscesses that are not associated with fistulae. It was concluded that the presence of an abdominal wall abscess indicates complicated CD and that preoperative drainage can prepare the patient for definitive surgery.⁴

Unfortunately, much of the literature describing abdominal wall abscesses does not differentiate intra-abdominal abscesses from retroperitoneal (psoas) abscesses. A psoas abscess is most commonly the result of a mesenteric abscess extending through the mesentery into the retroperitoneal space overlying the psoas muscle.⁴ The formerly (now rare) classic presentation of an iliopsoas abscess is septic arthritis of the hip.⁵ While this was previously most commonly seen with spondylitis resulting from tuberculosis, CD is now a much more common cause.⁴

Toxic Megacolon

Toxic megacolon is uncommon in both ulcerative colitis (UC) and CD, occurring in only 1% to 5% of patients with CD. This condition may occur as an exacerbation of inflammatory bowel disease (IBD), but it is the initial manifestation of IBD in more than 60% of patients.⁶ Multiple factors have been shown to precipitate toxic megacolon, including anti-diarrheal agents, belladonna alkaloids, and opiates.⁷ The criteria for toxic

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