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Review Article

Current management of spontaneous intra-abdominal abscess in Crohn's disease

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ABSTRACT

Crohn's disease (CD) is a chronic transmural disease process with approximately 10% of patients developing spontaneous intra-abdominal abscess during the first 5 years after the diagnosis. The symptoms are often nonspecific. The treatment modalities include the use of wide-spectrum antibiotics, imaging-guided percutaneous drainage (PD) and surgical drainage with or without resection. The best initial treatment strategy has not been settled controversial, as there are only retrospective studies with small sample sizes available in the literature. The majority of the patients would eventually need surgery. However a highly selected patient population with small abscess in the absence of fistulas or bowel strictures, especially those naive to immunomodulators or biologics, may respond to medical treatment alone with wide-spectrum antibiotics. The increased use of PD drainage in the last few years has been shown to reduce postoperative morbidities and risk of fecal diversion, allowing for subsequent elective surgery. Varied success rates of PD drainage have been reported in the literature. The initial surgical intervention of CD-related spontaneous abdominal sepsis is mandatory in patients with diffuse peritonitis due to free perforation. Surgery is also indicated in those with failed initial medical treatment and/or PD. This review article was aimed to evaluate the treatment modalities for spontaneous intra-abdominal abscess in CD patients and propose an algorithm for the best management of this complication.

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Tratamento atual de abscesso intra-abdominal espontâneo na doença de Crohn

Palavras-chave:
Doença de Crohn
Abscesso abdominal

RESUMO

A doença de Crohn (DC) é um processo patológico transmural crônico, em que aproximadamente 10% dos pacientes desenvolvem um abscesso intra-abdominal espontâneo durante os primeiros 5 anos após o diagnóstico. Com frequência os sintomas são inespecíficos.

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Tratamento
Drenagem percutânea
Tratamento cirúrgico

As modalidades terapêuticas são o uso de antibióticos de amplo espectro, drenagem percutânea (DP) orientada por imagem, e drenagem cirúrgica com ou sem ressecção. A melhor estratégia terapêutica inicial ainda não ficou estabelecida e há controvérsias, visto que a literatura conta apenas com estudos retrospectivos com pequenas amostras. Em sua maioria, os pacientes acabarão necessitando de cirurgia. Mas uma população altamente selecionada de pacientes, com pequeno abscesso na ausência de fístulas ou constrições intestinais, especialmente aqueles que jamais foram medicados com imunomoduladores ou agentes biológicos, podem responder exclusivamente ao tratamento clínico com antibióticos de amplo espectro. Foi demonstrado que o uso mais frequente da DP nos últimos anos diminui as morbidades pós-operatórias e o risco de desvio fecal, o que possibilita uma subsequente cirurgia eletiva. Na literatura, têm sido relatados percentuais de sucesso variados com a DP. A intervenção cirúrgica inicial para a sepse abdominal espontânea relacionada à DC é obrigatória em pacientes com peritonite difusa, devido à perfuração livre. Também há indicação cirúrgica naqueles pacientes que não conseguiram obter sucesso com o tratamento clínico inicial e/ou DP. Esse artigo de revisão teve por objetivo avaliar as modalidades terapêuticas para o abscesso intra-abdominal espontâneo em pacientes com DC; além disso, propõe um algoritmo para o melhor tratamento dessa complicação.

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Core tip

Crohn's disease (CD) is a transmural chronic illness with approximately 10% of patients developing spontaneous intra-abdominal abscess within the first 5 years after the diagnosis. CD spontaneous intra-abdominal abscess can be managed with broad-spectrum antibiotics, imaging-guided percutaneous drainage or surgical therapy. The best strategy of treatment is controversial because the current literature is based on retrospective series. This review aims to discuss the role of different treatment options for spontaneous abdominal abscess in CD patients and propose an algorithm for management this complication.

Introduction

Crohn's disease (CD) is a chronic inflammatory disease process that can affect any parts of the gastrointestinal tract, with the terminal ileum being the most frequent location. Its etiology is likely multifactorial. The Montreal Classification defines the phenotype in three categories: stricturing, penetrating and non-stricturing/non-penetrating.[1] A few retrospective studies have shown a progression from inflammatory to penetrating phenotype within 5 years after the diagnosis of CD, more frequent during the first 2 years. Many CD patients may present with fistulas during the disease course, due to the fact that there is a transmural bowel involvement by CD. Approximately 10% of the patients would develop spontaneous intra-abdominal abscess.[2] Spontaneous septic complications are often detrimental to disease outcome as well as cost to the healthcare system. Nonetheless, almost one third of patients using immunomodulators and/or biological therapy can develop spontaneous intra-abdominal abscesses.[3,4]

Intra-abdominal abscess is defined as an extra-intestinal infected fluid collection on imaging studies. Spontaneous abscess should not be misinterpreted as abscess from postoperative complications. Therefore, an abscess presenting within 3 months after surgery can be arbitrarily defined as postoperative complications and should not be considered or treated as spontaneous abdominal abscess.

Symptoms of abdominal abscess can be unspecific. The most common symptoms are abdominal pain, fever, diarrhea, and nausea.[3] The presence of acute peritonitis or free perforation from CD is rare. Spontaneous intra-abdominal abscesses are frequently located in the right lower quadrant and they can be exclusively in the abdomen, pelvis or the proximity of psoas muscle. Patients with psoas abscess may present with flank or back pain and limp.

The management of intra-abdominal abscess used to be interventional. The surgical modalities include abscess drainage with or without bowel resection and with or without the construction of a stoma. On the other hand, computerized tomography (CT) or ultrasound (US) imaging-guided percutaneous drainage (PD) has recently gained popularity. The best approach for CD-related intra-abdominal abscess has been in debate. *The European Crohn's and Colitis Organization* (ECCO) recommends that a CD patient with a spontaneous intra-abdominal abscess should be managed with broad-spectrum antibiotics, imaging-guided percutaneous drainage or surgical drainage followed by delayed resection if necessary.[5] If abdominal sepsis is contained, elective surgery should be performed. Conservative medical management should not be considered, if abdominal sepsis persists. However, the published literature has shown conflicting results. Ananthakrishnan et al. analyzed the nationally representative hospitalization sample from more than 1000 American hospitals, including 3296 adult CD-related, non-elective hospitalizations that were complicated by intra-abdominal abscesses. Approximately 39% were

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