PERIANAL DISEASE (ANAL FISSURE) IN CROHN`S DISEASE. CASE REPORT

E. Miuțescu¹, Dana Iovânescu¹

Abstract:
The aim of this paper was to emphasize the difficulties in diagnosis of a case of Crohn`s disease with perianal manifestation. We present the case of a young male with anal fissures which was treated for several months with topical applications and surgery. When the diagnosis of inflammatory bowel disease was considered and colonoscopy with intubation of the terminal ileum performed, we detected small-bowel mucosal breaks. The capsule endoscopy permitted the evaluation of extent and severity of the inflammation. We must keep in mind that Crohn`s disease may present itself as perianal disease, which in some cases may precede the intestinal manifestations.

Keywords: perianal disease, capsule endoscopy, Crohn disease

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Introduction
The perianal lesions of Crohn`s disease remain frequently unknown or neglected although they appear in almost 50% of patients. It is difficult to consider this diagnosis, especially when the intestinal symptoms are absent. Progress made by capsule endoscopy, magnetic resonance imaging and ultrasound permitted the obtaining of a better knowledge of the natural history of Crohn`s disease, of perianal lesions and the evaluation of the integrity of the anal sphincter. The correct diagnosis of the lesions permitted a good management of the therapy and a better surveillance of the efficiency of the therapy.

Case Report
The patient A.B is a 24 year old male who works as a computer-operator in our town. He presented in our clinic in March 2006 with perianal pain. He visited many times the family doctor who recommended treatment with Proctolog suppository and Detralex, but the symptoms persisted. In November he suffered for 10 days from diarrhea with 3-4 watery stools a day. In January the anal pain became severe and the patient sought medical care in a specialized proctologic clinic where the diagnosis was hemorrhoidal disease and anal fissure. They performed 2 thrombectomies (as an outpatient) and a sphincterotomy (as an inpatient); the pain remained the same.

The physical examination revealed an underweight patient (60 kg for 1,85 m height- BMI=17,5kg/m²), with skin erythematous lesions on the back, which can not be considered as cutaneous manifestations of Crohn disease.

When the patient presented in our clinic there were no abnormal laboratory data (hemoglobin =15g%, leukocytes 8200/mm³, erythrocyte sedimentation rate=13mm per hour).

Examination of the anal region detected an anal fissure located in the lateral position of the anus (at 7 o clock) with thickened clear-cut edges, very painful at
palpation. Anoscopy allows visualization of anal fissure. The presence of ongoing anal fissure raised suspicion of Crohn’s disease and we decided to continue to explore this patient. Colonoscopy revealed in the descending, transverse and ascending colon, rare aphthous ulcers. The cecum and ileocecal valve were normal. The last 10 cm of the ileum presented ulcers with a stellate appearance.

The gastroscopy noted a mucosal break (3-4mm) in the lower esophagus and the duodenal bulb with slightly patchy erythema.

Histology revealed chronic duodenitis with focal atrophy type Marsh II. The 2 specimens of duodenal mucosa presented villi of 20-400 microns, LIE 8-15% C/V ratio 1/3-1/1. In the chorion there exist mixed inflammatory infiltrations moderate, blood stasis and microhemorrhage. Giardia is absent. The intestinal mucosa examination presents edema which thickened villi, microhemorrhages congestion, mixed inflammatory infiltrate (more than 60 eosinophils/field which rose the suspicion of eosinophilic enteritis) and caliciform cells hyperplasia. The colonic mucosa presents erosions, hemorrhages, edema, moderate mixed inflammatory infiltration, large lymphoid follicles and focal fibrosis. Cryptitis was very rare.

Despite of no histological proof, the diagnosis of Crohn’s disease can not be removed.

We recommended treatment with sulfasalzine and hence decided to further explore the patient. For a correct evaluation of the extent and severity of the inflammation we decided to perform a capsule endoscopy which revealed:

- edema of the gastric mucosa with acute type erosions,
- the duodenum reveals erythema and rare 3-4mm ulceration and rare 4-5 mm ulcers of small profundness.
- the jejunum presents some about 4 mm polyps smoothly- surfaced, few ulcerations and ulcers (in the area of one of them blood was present). The surface of the mucosa presented itself as profoundly deformed in the neighbourhood of some of the ulcers. The capsule traversed with difficulty some ulcerated areas with maybe some partial stenosis of the small bowel.

The ileum presents rare ulcerations and ulcers. Some of these modify the aspect of the mucosa having a stricture behaviour. The terminal ileum exhibits deep ulcers with a cobblestoned appearance. One of these ulcers bled. Just before the ileocecal valve, the mucosa presents multiple erosions with hematic crusts.

To this young man with perianal pain with anal fissure which didn’t respond to medical and surgical treatment and highly suggestive endoscopic lesions we established the diagnosis of enteral-colonic-ana Crohn’s disease. The perianal lesions can be classified as U1b F0S0. We recommended therapy with glucocorticoid.

Discussion

Crohn’s disease has a predilection for the distal small bowel, the colon and the rectum. Perianal disease is another common presentation for between 20-80% of cases depending on the inclusion criteria, the quality of the examination and on the degree of specialization of the clinic (1). Perianal lesions can precede the diagnosis of Crohn’s disease in 20-40% of cases (2).

In 24% of cases perianal the disease may appear before the intestinal manifestation of Crohn’s disease sometime 4 years prior (3,4). In 20% of the cases the onset of perianal disease occurs concomitantly with the onset of intestinal symptoms. In our case, the anal fissure preceded the intestinal lesions by 6 months. The more distal al colon level the lesions are, the more frequent the perianal disease. In colic presentations of Crohn’s disease, perianal disease appeared in 30-50% of the cases and in rectal diseases this appeared in 80-100%. The presence of small bowel disease didn’t preclude the perianal disease in our patient. The perianal disease is often serious. They tend to complicate with suppuration which is frequently disabling, difficult to treat and relapsing. In a paper which followed the evolution of perianal disease 10 years after the diagnosis, 20% still have a fissure, 35% had also a fistula and 40% seemed to be cured (5). The consequences of perianal can be potentially serious. The risk of anal incontinence is between 11-39% and the risk of proctectomy is 5-40% (6,7,8).

Conclusion

It is important to consider the diagnostic of Crohn’s disease in the patient with a relapsing perianal disease with a bad response to regular treatment. Such a patient must be further explored to confirm or not Crohn’s disease. The treatment of the perianal Crohn’s disease (anal fissure) is mainly conservative and directed toward the inflammatory disease.
Fig. 1. Ulcerations of the ileum in Crohn’s disease (endoscopic pillcam).

Fig. 2. Ulcerations of the ileum in Crohn’s disease (endoscopic pillcam).

Fig. 3. Ulceration of the ileum in Crohn’s disease (endoscopic pillcam).

References: