Clinics and Research in Hepatology and Gastroenterology (2011) **35**, 519—520

Available online at ScienceDirect
www.sciencedirect.com

Elsevier Masson France
EM|consulte
www.em-consulte.com/en

COMMENTARY

The second European evidence-based consensus on the diagnosis and management of Crohn's disease (part 3)

Claude Eugene

Clinique Saint-Louis, 8, rue Saint-Louis, 78300 Poissy, France

Available online 3 August 2011

The second European evidence-based consensus on the diagnosis and management of Crohn's disease was recently published in the *Journal of Crohn's and Colitis* by a working group of the ECCO (European Crohn's and Colitis Organisation) [1—3].

The main recommendations of the first two parts, which are based on the definitions and the diagnosis of Crohn's disease (CD) on one hand [1] and its management on the other [2], were treated in the previous articles. The ECCO distinguished seven distinct situations: postoperative recurrence, fistulating CD, CD in children and adolescents, CD and pregnancy, CD and psychosomatic symptoms, extraintestinal manifestations of CD and alternative treatments. The first two situations are addressed in the present article.

Postoperative recurrence

Around 80% of patients with CD require surgical intervention. Surgery is not curative and recurrence is frequent. Endoscopic data show that in the absence of treatment, recurrence after ileocaecal resection is observed in 65% to 90% of cases within one year and in 80% to 100% of cases within 3 years. The rate of clinical recurrence is about 20% to 25% per year.

There are several known factors of early recurrence: smoking, a history of intestinal resection (including appendectomy), penetrating disease, the presence of perianal lesions, the need for an extensive intestinal resection and the absence of prophylactic treatment. The postoperative course depends on the severity of the endoscopic lesions and an ileocolonoscopy is recommended in the year following the intervention since its result can contribute to the therapeutic decision. The value of a clinical or biological (CRP, etc.) diagnosis of recurrence is uncertain. Ileocolonoscopy is the reference method. Ultrasound, MRI and capsule endoscopy are currently being evaluated.

Prophylactic treatment is recommended after intestinal resection and it is highly recommended that patients quit smoking. Thiopurine drugs are more effective than mesalazine and imidazole drugs. Mesalazine at high doses (4 g/day) is an option in cases of isolated ileal resection. Imidazole drugs can be effective in cases of ileocaecal resection but are less well tolerated. Prophylactic treatment should be started within 2 weeks of surgery. The recommended duration is at least 2 years.

Fistulating CD

The most effective imaging method for the work-up of complex perianal fistulas is pelvic MRI. Anorectal ultrasound done under general anaesthesia by an expert (after having

DOI of original article:10.1016/j.clinre.2011.03.002.
E-mail address: ceugene@club-internet.fr

2210-7401/$ - see front matter
doi:10.1016/j.clinre.2011.06.009

ruled out rectal stenosis) gives equivalent results. Fistulography is not recommended. On the other hand, it is advisable to perform a proctosigmoidoscopy for evaluating inflammatory lesions. The examination under general anaesthesia in the hands of an experienced surgeon is the reference method and enables simultaneous treatment.

There is no consensus on the classification of fistulas in CD. Most experts divide them into simple and complex. The Parks classification [4] is often used by surgeons.

The therapeutic approach varies according to whether it is a simple or complex fistula:

- simple fistula. If there is an abscess, emergency drainage should be undertaken. If the fistula is symptomatic, the non-cutting Seton procedure or fistulotomy are the available options. Antibiotics are added: metronidazole or ciprofloxacin;
- complex fistula. The Seton procedure is recommended.

Active luminal CD must be treated in parallel, using thiopurines as first-line therapy (in addition to antibiotics) and anti-TNF agents as second-line therapy. Several studies showed that the combination of infliximab and the Seton procedure produce better results than either one alone. Corrective surgery (mucosal flap or fistula plug) in combination with infliximab can be effective. Clinical assessment is sufficient in clinical practice, but the situation is better quantified by the Perianal Crohn's Disease Activity Index (PACDAI); MRI should be used for clinical trials.

Maintenance treatment is recommended for at least one year: thiopurines, Seton, or a combination of the two.

It is not possible to address the different types of fistulas here [3].

Comments

Details concerning the ECCO work methods, evidence levels and grades of recommendations according to the Oxford Centre for Evidence-Based Medicine have not been given here to avoid unnecessary lengthening of the text.

Postoperative recurrence

Surgery is not a curative treatment for CD. As indicated in the ECCO consensus [3], the efficacy of antibiotics, mesalazine and even thiopurines as prophylaxis for postoperative recurrence is poor [5,6]. On the other hand, infliximab clearly appears to be effective [7], including at small doses (3 mg/kg), after a period of 3 years at the dose of 5 mg/kg started 15 days after the surgery [8]. If these latest results [8] are confirmed, it could have positive consequences with regard to side effects and the cost of this biotherapy.

Fistulas

According to the ECCO recommendations [3], antibiotics, thiopurines and conservative surgery (abscess drainage, Seton placement) are the bases of simple and complex fistula treatment. Infliximab or adalimumab are used as second-line treatment. Adalimumab was shown to be beneficial in patients that did not respond to infliximab in a recent series of 16 patients evaluated by MRI and PCDAI [9].

Disclosure of interest

The author declares that he has no conflicts of interest concerning this article.

References

[1] Van Assche G, Dignass A, Panes J, Beaugerie L, Karagiannis J, Allez M, et al. The second European evidence-based consensus on the diagnosis and management of Crohn's disease: definitions and diagnosis. J Crohns Colitis 2010;4:7—27.
[2] Dignass A, Van Assche G, Lindsay JO, Lémann M, Söderholm J, Colombel JF, et al. The second European evidence-based consensus on the diagnosis and management of Crohn's disease: current management. J Crohns Colitis 2010;4:28—62.
[3] Van Assche G, Dignass A, Reinisch W, van der Woude CJ, Sturm A, De Vos M, et al. The second European evidence-based consensus on the diagnosis and management of Crohn's disease: special situations. J Crohns Colitis 2010;4:63—101.
[4] Parks AG, Gordon PH, Hardcastle J. A classification of fistula-in-ano. Br J Med 1976;63:1—12.
[5] Sandborn WJ, Feagan BG. The efficacy of azathioprine and 6-mercaptopurine for the prevention of postoperative recurrence in patients with Crohn's disease remains incertain. Gastroenterology 2004;127:990—7.
[6] Peyrin-Biroulet L, Deltenre P, Ardizzone S, D'Haens G, Hanauer SB, Herforth H, et al. Azathioprine and 6-mercaptopurine for the prevention of postoperative recurrence in Crohn's disease: a meta-analysis. Am J Gastroenterol 2009;104:2089—96.
[7] Regueiro M, Schraut W, Baidoo L, Kip KE, Sepulveda AR, Pesci M, et al. Infliximab prevents Crohn's disease recurrence after ileal resection. Gastroenterology 2009;136:441—50.
[8] Sorrentino D, Paviotti A, Terrosu G, Avellini C, Geraci M, Zarifi D. Low-dose maintenance therapy with infliximab prevents postsurgical recurrence of Crohn's disease. Clin Gastroenterol Hepatol 2010;8:591—9.
[9] Echarri A, Castro J, Barreiro M, Carpio D, Pereira S, Lorenzo A. Evaluation of adalimumab therapy in multidisciplinary strategy for perianal Crohn's disease patients with infliximab failure. J Crohns Colitis 2010:654—60.