Symposium

Crohn's Disease:
Anal Lesions

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Mr. Lockhart-Mummery

When you invited me to speak at your meeting in Minneapolis in 1965, nine years ago, I read a paper on anal lesions in Crohn’s disease and talked about some of their peculiarities, such as the high incidence and that they were often early manifestations. Perhaps I should apologize for returning again to the same subject, but from our rather larger series of Crohn’s disease at St. Mark’s Hospital now, some interesting facts have emerged on analysis, and it is some of these that I present now.

We have included, as anal lesions, anal ulcers and characteristic edematous tags and skin changes, as well as the more usual perianal abscesses and fistulas, and have taken into account such lesions appearing at any time during the course of the illness. Using these criteria, the overall incidence in our series of more than 400 patients has been 61 per cent, but you will see from Figure 1 that the incidence has varied according to the site of the disease. Whereas only about a third of patients with disease confined to the terminal ileum have an anal lesion, such lesions occur in about two thirds of those patients with disease involving the large bowel diffusely, or the distal part of the large bowel. In our earlier papers from St. Mark’s on large-intestinal Crohn’s dis-

ease,2 about ten years ago, we estimated the incidence of anal lesions in primary colonic Crohn’s disease to be between 75 and 80 per cent, but experience with the larger series has shown a somewhat lower incidence.

We have been particularly interested in the subsequent course of a group of patients in whom an anal lesion was the sole presenting symptom at St. Mark’s. There have been 20 such patients who came to us with anal disease, but who had no other symptom or physical sign at that time. In those who were investigated, no evidence of involvement of any other part of the gastrointestinal tract was found, though, unfortunately, in the earlier years when some of these patients were first seen, investigations of the gastrointestinal tract were not as complete as those we carry out nowadays. Of these 20 patients, six have had no intestinal involvement to date, and 14 have since developed disease somewhere in the gastrointestinal tract. The six patients all had an anal fistula in which typical histologic features of Crohn’s disease were found when first seen, and tuberculosis was fully excluded. These six were all fully investigated when first seen, and no evidence of gastrointestinal Crohn’s disease was found.

The lengths of the follow-up periods range from one and a half to more than nine years. The patient followed for only

one and a half years is believed to be still unhealed, but he has not returned to England recently; the others are all known to have healed and to be in good health.

The other 14 patients now have Crohn's disease within the gastrointestinal tract; in ten of these cases there has been histologic proof, either following resection or after biopsy, while in the other four, the diagnosis has been made on the basis of clinical and radiologic evidence. The sites of subsequent intestinal disease are shown in Table 1: in half of these cases the site of involvement was the terminal ileum. Perhaps an anal lesion can be a precursor of disease in almost any part of the gastrointestinal tract.

The intervals between diagnosis of the original anal lesion and the subsequent diagnosis of gastrointestinal disease are shown in Figure 2. In more than half - eight of 14 of the patients - the disease developed within five years, and in another four, within five to ten years, after the original anal lesion. However, in two cases, more than ten years elapsed before subsequent bowel disease was diagnosed; in one, 11 years, and in the other, 25 years. Regrettably, in only half of these 14 cases were there definite features of Crohn's disease in the original anal histology, but the subsequent course of the disease leaves no doubt in my mind that the anal lesions were in fact initial manifestations of Crohn's disease. I am rather doubtful about the patient with a 25-year interval, as she had 20 years' freedom from symptoms after the anal lesion healed, then some years of minor symptoms, which did not take her to her doctor, and then developed unremitting diarrhea, which led to the establishment of a diagnosis of Crohn's disease involving the terminal ileum, with classic macroscopic and microscopic features.

**Table 1. Sites of Subsequent Disease in 14 Patients**

<table>
<thead>
<tr>
<th>Location</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminal ileum</td>
<td>7</td>
</tr>
<tr>
<td>Terminal ileum and colon</td>
<td>3</td>
</tr>
<tr>
<td>Diffuse colon</td>
<td>1</td>
</tr>
<tr>
<td>Sigmoid colon or rectum</td>
<td>3</td>
</tr>
</tbody>
</table>

**Fig. 1. Incidence of anal lesions and initial site of Crohn's disease, based on 419 patients, St. Mark's Hospital.**