A 55-year-old patient was diagnosed with juvenile rheum atoid arthritis, and treated with boluses of steroids since childhood. She carries a bilateral hip prosthesis with several replacements, the last one in the right hip three years ago. In 1987 she was diagnosed with ileocolonic fistulizing Crohn’s disease (A, L, B, P according to the Montreal classification). She was treated with steroids, 5-ASA, azathioprine, and finally anti-TNFα, with a partial response; three years ago, without medical advice, she decided to quit all treatment except 5-ASA.

She was admitted to our hospital with a deteriorated general condition. The physical examination revealed a necrotic ulcer located in the right trochanter region, with fecal material and multiple fistulous orifices in the sacral, perianal, and vaginal regions. A CT scan revealed several fistulous tracts from the ileum to the right psoas muscle, with ectopic gas in the cellular subcutaneous and muscular tissues of the lower right limb, and also concentric mural thickening at the colon and terminal ileum.

Urgent surgery was performed with diverting lateral ileostomy and surgical cleaning, remaining the prosthesis exposed. Broad spectrum antibiotheraphy, systemic steroids, and parenteral nutrition were initiated. Once the acute period was over, azathioprine therapy was initiated. The hip prosthesis was surgically cleaned, and a primary closure of the trochanterial ulcer was carried out.

A psychiatric evaluation was made for a diagnosis of major depressive disorder.

DISCUSSION

A transmural pattern of Crohn’s disease may result in fistula development in some patients. Fistulous tracts can reach the nearest intestinal loops and result in enteroenteral fistulas, more commonly ileoileal, ileocecal or ileosigmoid in nature. Sometimes fistulous tracts have dead ends, which result in abdominal abscesses; rarely a fistulous tract may start at the colon wall and lead to other sections of the gastrointestinal tract (stomach, duodenum), thus causing malabsorption syndrome as a result of abnormalities in the luminal phase of digestion causing bacterial overgrowth. Furthermore, fistulas can reach pelvic organs including the bladder and vagina. Enterocutaneous fistulas often appear areas with surgical scarring (1,2).

When Crohn’s disease follows a fistulizing pattern treatment includes: metronidazole (500 mg/8 h), azathioprine/6-mercaptopurine, and anti-TNFα. In cases unresponsive to medical therapy surgery must be indicated (3,4).

We just described a patient with fistulizing Crohn’s disease and severe perianal disease who was treated with

Fig. 1.
azathioprine and infliximab. Initially the patient decided to discontinue her medication, and hence her disease developed a severe fistulizing pattern affecting the right quadriceps muscle, which required aggressive surgical therapy and intensive medical care as well.

REFERENCES