Preventing Perianal Disease
We Can Do Better
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Adler and colleagues1 at the University of Michigan, Ann Arbor, analyzed deidentified data from 2001 to 2016 in a large US administrative database to investigate the effectiveness of steroid-sparing therapy (SST) to prevent perianal disease in patients aged 5 to 24 years with Crohn disease. Steroid-sparing therapy included a thiopurine, methotrexate, or an anti–tumor necrosis α factor agent. Patients who were already receiving immune therapy or a biologic agent or who had already been diagnosed as having perianal disease at the time of cohort inception were excluded. The outcome of interest was the proportion of patients who developed perianal disease based on at least 90 days of exposure to SST. Overall, 20% of patients developed perianal disease during the study period. More than 55% of them had begun SST before perianal disease developed. The authors commented that SST use was lower than expected. The risk for developing perianal disease was decreased by more than 50% when adjusted for patient variables (hazard ratio, 0.43; 95% CI, 0.35-0.52). The use of immunomodulators reduced the risk by 52%, and anti–tumor necrosis α factor use decreased risk by 47%. The authors concluded that these therapies are effective in reducing the risk for the development of perianal disease and should be used more often.1

Clinicians are tasked with balancing safety with efficacy for any condition they are expected to manage. Knowing that Crohn disease is a chronic inflammatory and penetrating disease, it is even more important to consider interventions that can prevent complications. As stated above, in the national database of high-risk patients used in the study by Adler and colleagues,1 20% developed perianal disease among those diagnosed as having Crohn disease when they were younger than 25 years. If 20% developed perianal disease despite a 56.1% use of SST, there is more work to be done to manage complications. Early use of both immunomodulators and biologic agents in the pediatric population with Crohn disease has been shown to be associated with better outcomes and can decrease disease progression.2,3 Studies like this one by Adler and colleagues,1 in which there is an adequate number of patients (n = 2214) from across the country, add significant information to the literature. Given that in a short amount of time (2 years) there was a 59% decreased risk of perianal complications associated with the use of SST, the findings should be compelling to parents and patients. The benefits of avoiding surgery, pain, and physiologic dysfunction cannot be understated.

So why then do more clinicians not prescribe SST therapy in patients with Crohn disease? There are multiple reasons, some from the health care professional side, some from the patient perspective, and some from a third party. Clinician lack of knowledge or ineffective counseling can be eliminated with proper education and data such as these by Adler and colleagues.1 Patient fear of adverse effects might actually be exaggerated, with data suggesting that patients are much more willing to accept risk when there is appropriate efficacy and improved quality of life.4 The economic burden of Crohn disease is not insignificant, and data suggest that over time biologics are cost saving because they prevent emergency department visits, hospitalizations, and surgical procedures.5 Some clinicians and patients are concerned when they hear that the use of a biologic agent is forever. However, that is not necessarily true, with the data by Adler and colleagues1 demonstrating a statistically significant reduction in the risk of perianal complications within just 2 years with the use of SST. Furthermore, the risk of dysfunction and complications is higher with active inflammation compared with the risk of adverse effects from medications. The
use of generic immunomodulators and biosimilar agents helps to control costs. Ultimately, individualizing care based on risk factors of disease and on patient preference, along with shared decision-making, will help change the future natural history of Crohn disease.

REFERENCES