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Transperineal ultrasonography in perianal Crohn disease: A valuable imaging modality

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Aims of treatment for Crohn disease have moved beyond the resolution of clinical symptoms to objective end points including endoscopic and radiological normality. Regular re-evaluation of disease status to safely, readily and reliably detect the presence of inflammation and complications is paramount. Improvements in sonographic technology over recent years have facilitated a growing enthusiasm among radiologists and gastroenterologists in the use of ultrasound for the assessment of inflammatory bowel disease. Transabdominal intestinal ultrasound is accurate, affordable and safe for the assessment of luminal inflammation and complications in Crohn disease, and can be performed with or without the use of intravenous contrast enhancement. Perianal fistulizing disease is a common, complex and often treatment-refractory complication of Crohn disease, which requires regular radiological monitoring. Endoanal ultrasound is invasive, uncomfortable and yields limited assessment of the perineal region. Although magnetic resonance imaging of the pelvis is established, its access is often uncomfortable and yields limited assessment of the perineal region. Magnetic resonance imaging (MRI) of the pelvis has been described extensively for the assessment of perianal Crohn disease. However, this resource has limited frequent use for some patients. Endoanal ultrasound has also been described for the assessment of perianal Crohn disease, but is invasive, often poorly tolerated in the context of active perianal sepsis and impossible to perform if anal stenosis is present. With this technique, perianal views are incomplete and pathological changes expanding to the gluteal region cannot be assessed.

Transperineal ultrasound has been described as a simple and painless method to examine perianal pathology and provides imaging quality comparable with both endoanal ultrasound and MRI. For the assessment of perianal Crohn disease, including abscess collections, fistulas and sinus tracts, transperineal ultrasound has been validated by several groups (7-10).

Using case examples, we illustrate the utility of transperineal ultrasound in the assessment of patients with perianal Crohn disease. We hope to advocate for its wider use in Canadian practice. We summarize the clinical studies to date evaluating this imaging modality in this population.

CASE 1
A 26-year-old woman with ileocolonic and perianal Crohn disease undergoing therapy with adalimumab and methotrexate was referred for investigation of increasing perianal pain. Transperineal ultrasound was performed. Figure 1 shows the level of the low anal canal. There are two low internal openings at one o’clock and six o’clock. The tract at one o’clock (Figure 1 [A]) was observed on the left anterolateral wall; from this, there is a transphincteric tract that runs laterally to the

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Transperineal ultrasound for the assessment of perianal Crohn disease was first described by Stewart et al (7) in a cohort of 54 patients being investigated for perianal inflammatory disease. Regular convex, high-frequency, high-resolution linear probes were used. All patients had perianal pathology identified at ultrasound, and 49 had perianal fistulas (intersphincteric, transphincteric and extrasphincteric) or sinuses, of whom 30 underwent surgical intervention and validation of ultrasonographic findings. Of these, 26 patients had perianal fistulas and/or sinuses tracts confirmed in the exact anatomical location and course accurately identified on preoperative sonography. Although the location and course of the fistula was confirmed surgically in three patients, the internal opening could not be seen. In one patient, a high perirectal internal opening was not detected on ultrasound but observed at the time of surgery, although the course of the fistula tract was correctly identified on ultrasound (7). The study found transperineal ultrasound to be an accurate and painless technique for the assessment of perianal inflammatory disease and recommended implementing transperineal sonography as a routine sonographic procedure for the evaluation of these patients.

These findings were reproduced in a larger cohort by Mallouhi et al (10). In this study, involving 87 patients with suspected perianal inflammatory disease, transperineal ultrasound performed well in the diagnosis (area under the curve \( r = 0.85; P<0.001 \)) and characterization (\( r=0.65; P<0.001 \)) of disease when compared with surgical findings. For the detection of perianal fistulas and abscesses, sensitivity and specificity of transperineal ultrasound ranged from 94% to 100% (10). A smaller study involving 25 patients by Wedemeyer et al (11) confirmed high sensitivity and specificity of transperineal ultrasound, when compared with pelvic MRI, for the diagnosis and characterization perianal fistulas and/or abscesses with excellent agreement between the two imaging methods (kappa >0.83). Comparison of transperineal ultrasound and endoanal ultrasound was performed in a study involving 46 patients with perianal Crohn disease by Maconi et al (9). In this study, transperineal ultrasound was accurate for diagnosis and classification of perianal fistulas and/or abscesses, with a sensitivity of 84.9%.

**DISCUSSION**

The benefits of transperineal ultrasound are clear. The technique is simple, painless, inexpensive and can be performed in real-time in an outpatient clinic setting or in a radiology department. It is accurate, correlates well with surgical findings and performs well against established methods for perianal imaging including endoanal ultrasound and pelvic MRI. The relative simplicity of the technique and lack of patient preparation required lends itself to point-of-care testing as part of a complete physical assessment in the outpatient clinic setting, enabling prompt clinical decision making. However, despite this, transperineal ultrasound is performed routinely at only a small number of centres worldwide. A possible explanation for this may be the steep learning curve needed to establish proficiency in scanning and interpretation, and the limited opportunities for training. While there are no published guidelines regarding the number of scans or time required to establish proficiency, it has been suggested that competent ultrasonographers will achieve competency in 12 months (7).
CONCLUSION

Transperineal ultrasound yields high detection rates, and comprehensive and accurate assessment of perianal fistulas and their complications in patients with Crohn disease. Complex perianal disease requires urgent, even emergent assessment. Although pelvic MRI is currently considered to be the modality of choice for evaluating patients with perianal Crohn disease, transperineal ultrasound has many advantages including lower cost, high patient tolerance, timely access and easy repeatability. Performed by appropriately skilled operators, point-of-care transperineal ultrasound in an outpatient clinic setting offers the possibility of prompt and informed clinical decision making. This technique is currently underestimated and underused by gastroenterologists and radiologists, despite being first described >10 years ago as an efficient and accurate diagnostic tool in the investigation and characterization of perianal Crohn disease.

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