



LAP de Crohn

**Nouveautés
& prise en charge
chirurgicale**

P DE CROH

Bekkar, Dr A. Séné

**SE EN CHARGE
ICALE**

Kwiatek

**EAUTÉS DE
RISE EN CHARGE
URGICALE**

roudhis

LIENS D'INTÉRÊTS : LAURENT SIPROUDHIS

Au cours des 3 dernières années, avec les sociétés pharmaceutiques suivantes

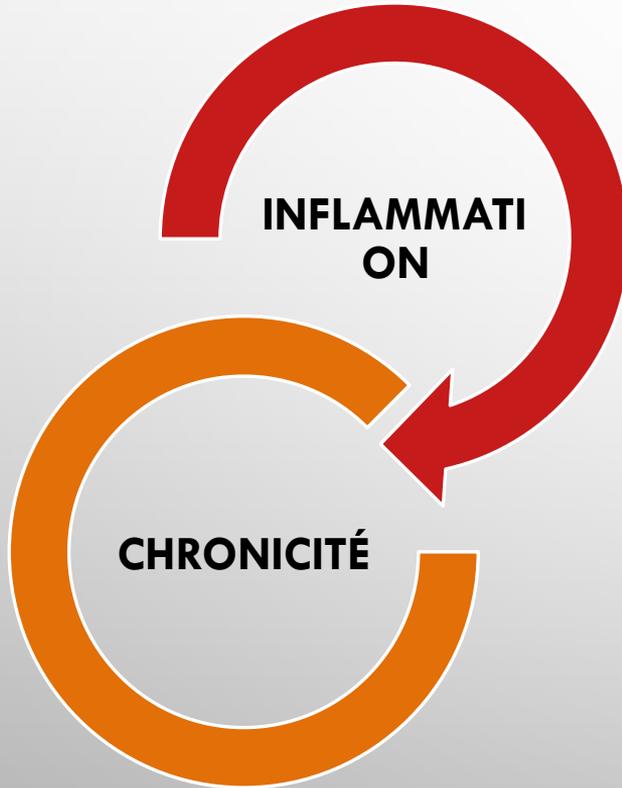
Recherches cliniques

- Takeda, Gilead, Janssen, AbbVie, Celltrion

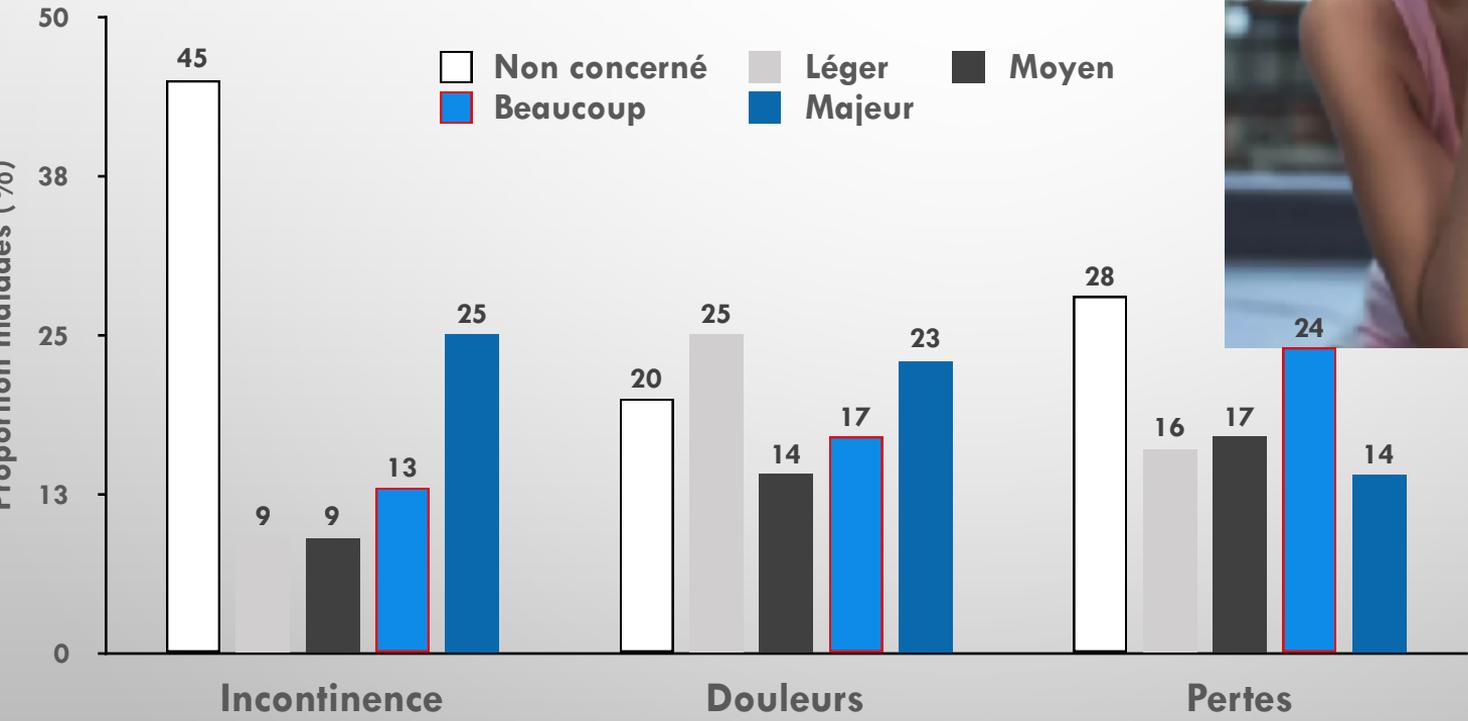
Cours, formations

- Takeda, AbbVie, Janssen, Amgen

LÉSIONS PRIMAIRES & SECONDAIRES



LES TROIS QUARTS DES MALADES AYANT UNE FISTULE ONT DES MANIFESTATIONS DÉPRESSIVES; TREIZE POUR CENT D'ENTRE EUX ONT DES IDÉES SUICIDAIRES



MAHADEV S, ET AL. DIS COLON RECTUM. 2011;54:579-85; CHAPARRO M, ET AL. GASTROENTEROL. 2011;140:S-736.

LE FARDEAU DES FISTULES ANALES



2 ans

Durée moyenne de suppuration avant le diag. de Crohn¹



26%

Risque cumulatif d'apparition d'une suppuration anale²



50-80%

Proportion de suppuration considérées comme complexes³⁻⁶



42%

Taux de récurrence des fistules complexes après 10 ans⁶

- 1. HELLERS G, ET AL. GUT. 1980;21:525-7; 2. SCHWARTZ DA, ET AL. GASTROENTEROL. 2002;122:875-80; 3. CHAPARRO M, ET AL. GASTROENTEROL. 2011;140:S-736; 4. BELL SJ, ET AL. ALIMENT PHARMACOL THER. 2003;17:1145-51; 5. EGLINTON TW, ET AL. DIS COLON RECTUM. 2012;55:773-7; 6. MOLENDIJK I, ET AL. INFLAMM BOWEL DIS. 2014;20:2022-8.

MESSAGE: 2 IDÉES FAUSSES (PEUT-ÊTRE)



LE TRAITEMENT DE RÉFÉRENCE EST LA
BIOTHÉRAPIE



LE TRAITEMENT DE RÉFÉRENCE EST LA
CHIRURGIE DE DRAINAGE PUIS D'ÉPARGNE
SPHINCTÉRIENNE





ON
DEVRAI
T FAIRE



ON
FAIT



ON
POURR
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FAIRE

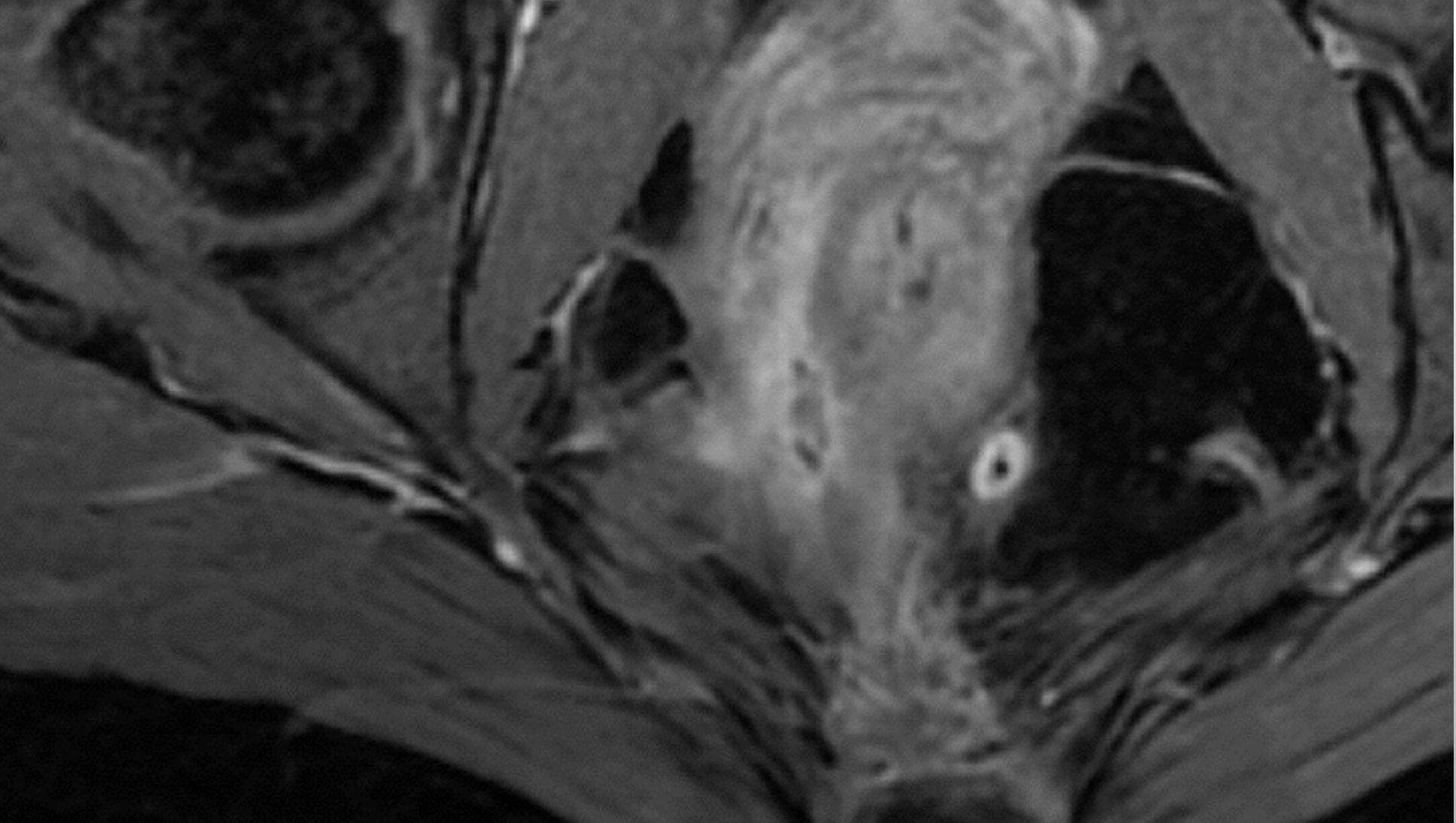




n fait

pourrait
re

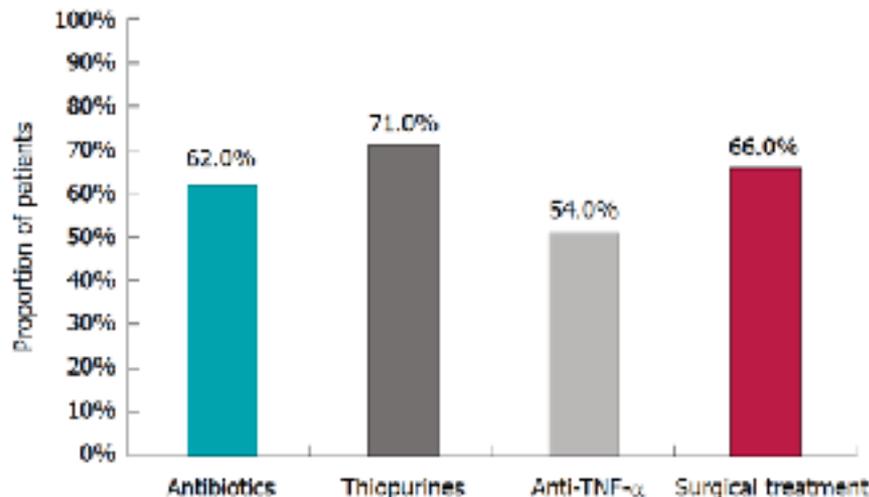
devrait faire



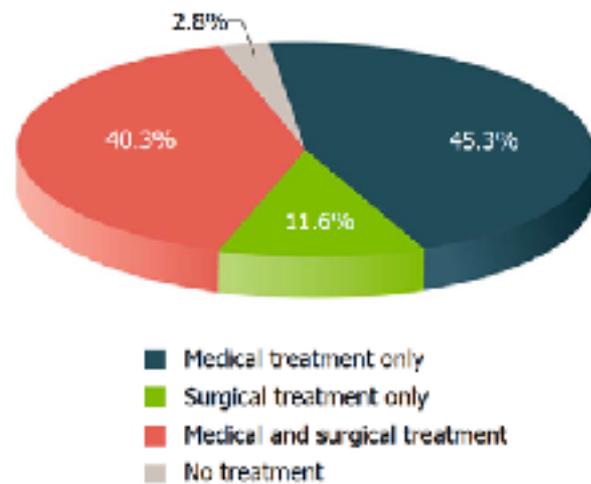
Burden and outcomes for complex perianal fistulas in Crohn's disease: Systematic review

Jurán Fanes, Walter Reinisch, Ewa Rupniewska, Shahnaz Khan, Joan Ferrs, Javona Mona Khalid, Daniele Bojic, Izidenshan Patel

Proportion of patients receiving types of treatment in a retrospective Spanish study ($n = 313$)¹



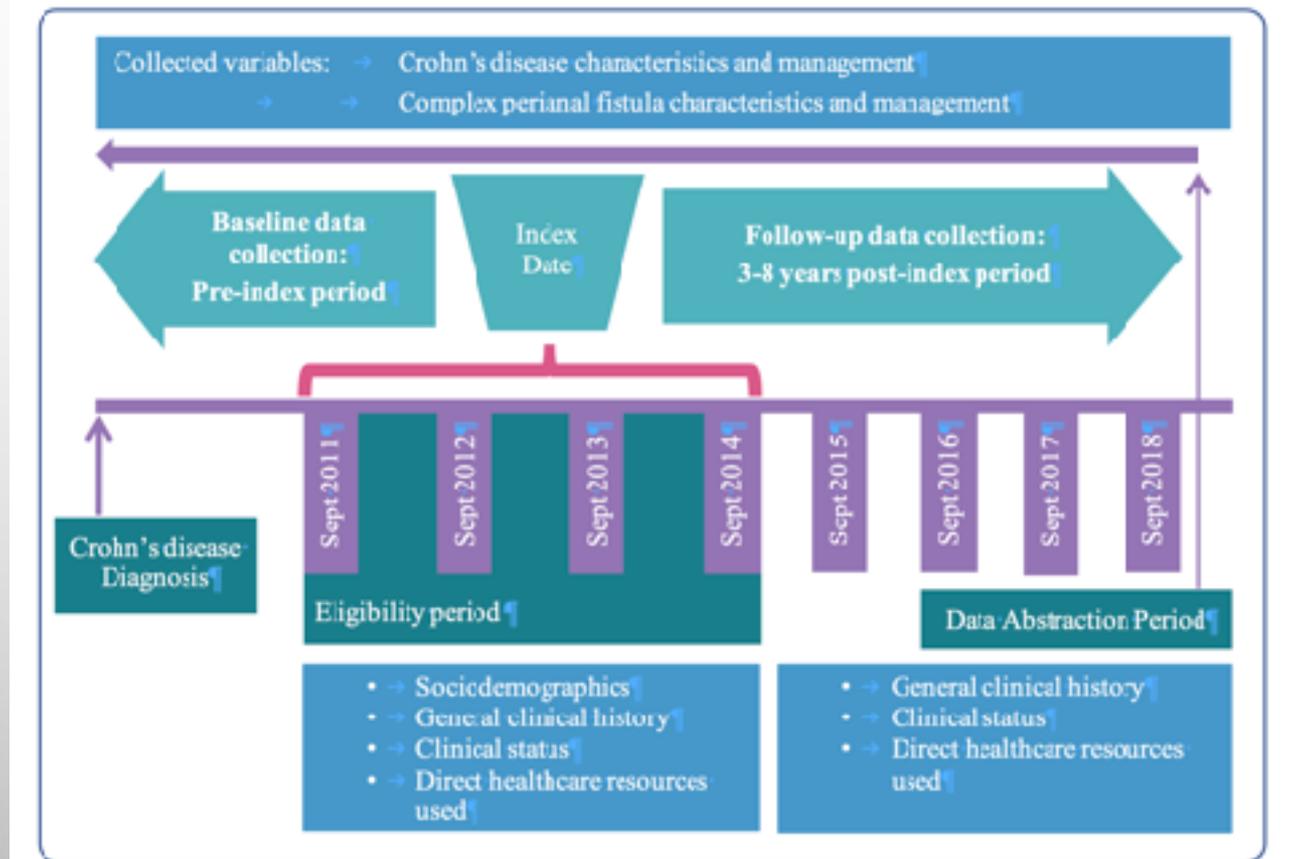
Proportion of patients receiving types of treatment in a retrospective Dutch study ($n = 181$)²



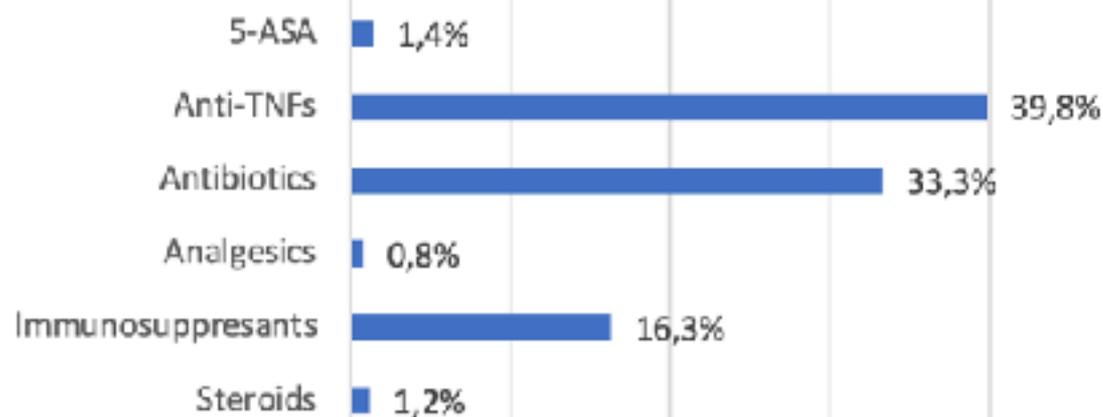
ETUDE PREFACE

498 CPFS COMPLEXES

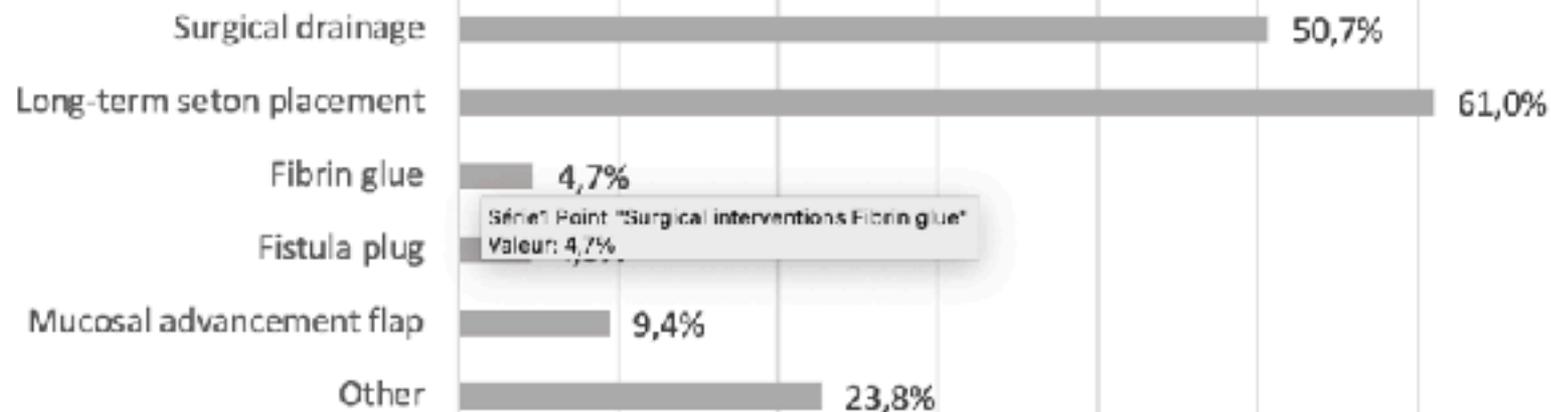
- SUIVI MÉDIAN 6.0 ANS
- 372 À DATE INDEX
- 126 PENDANT LE SUIVI



Medications



Surgical interventions



0% 10% 20% 30% 40% 50% 60% 70%

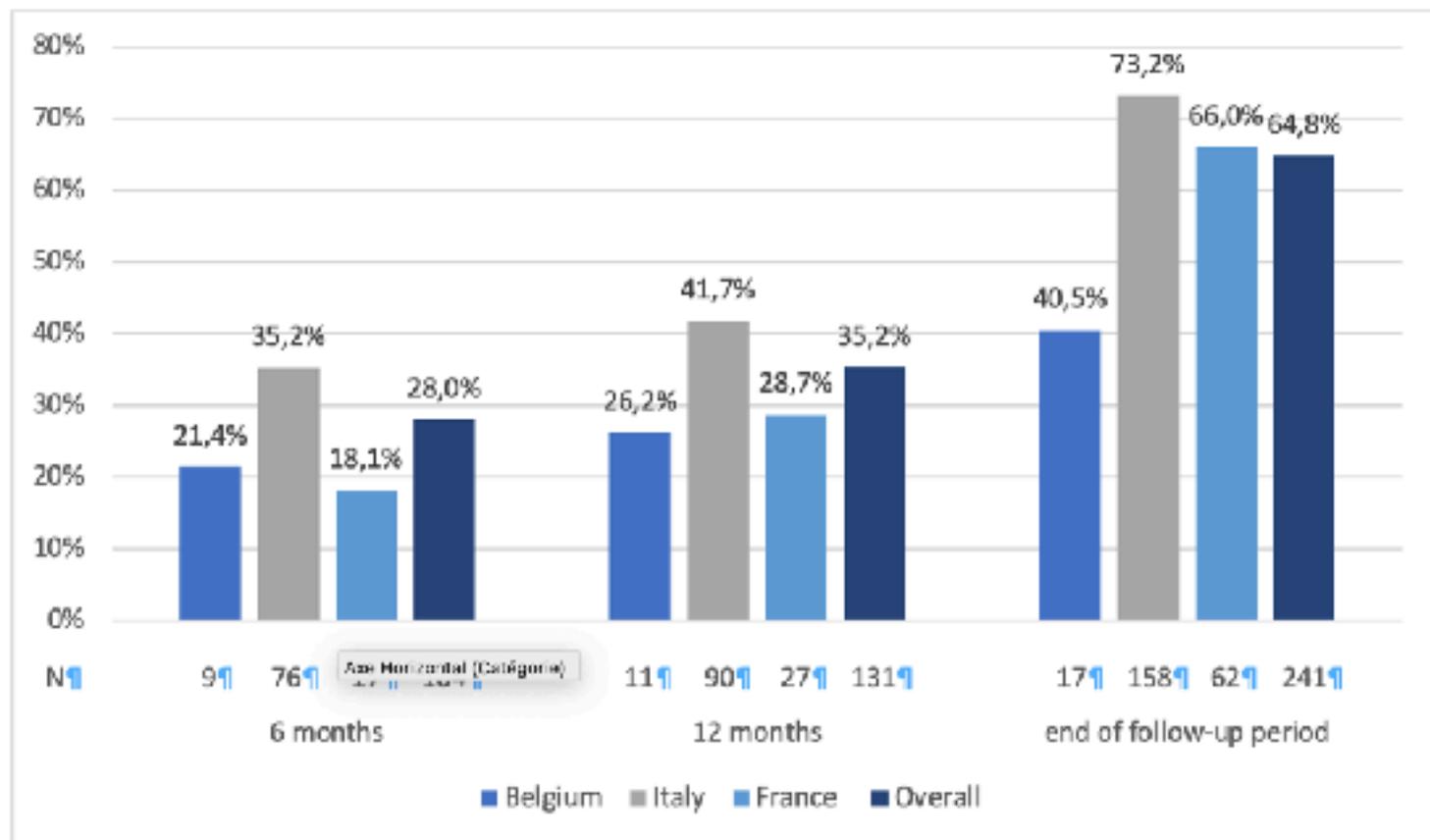
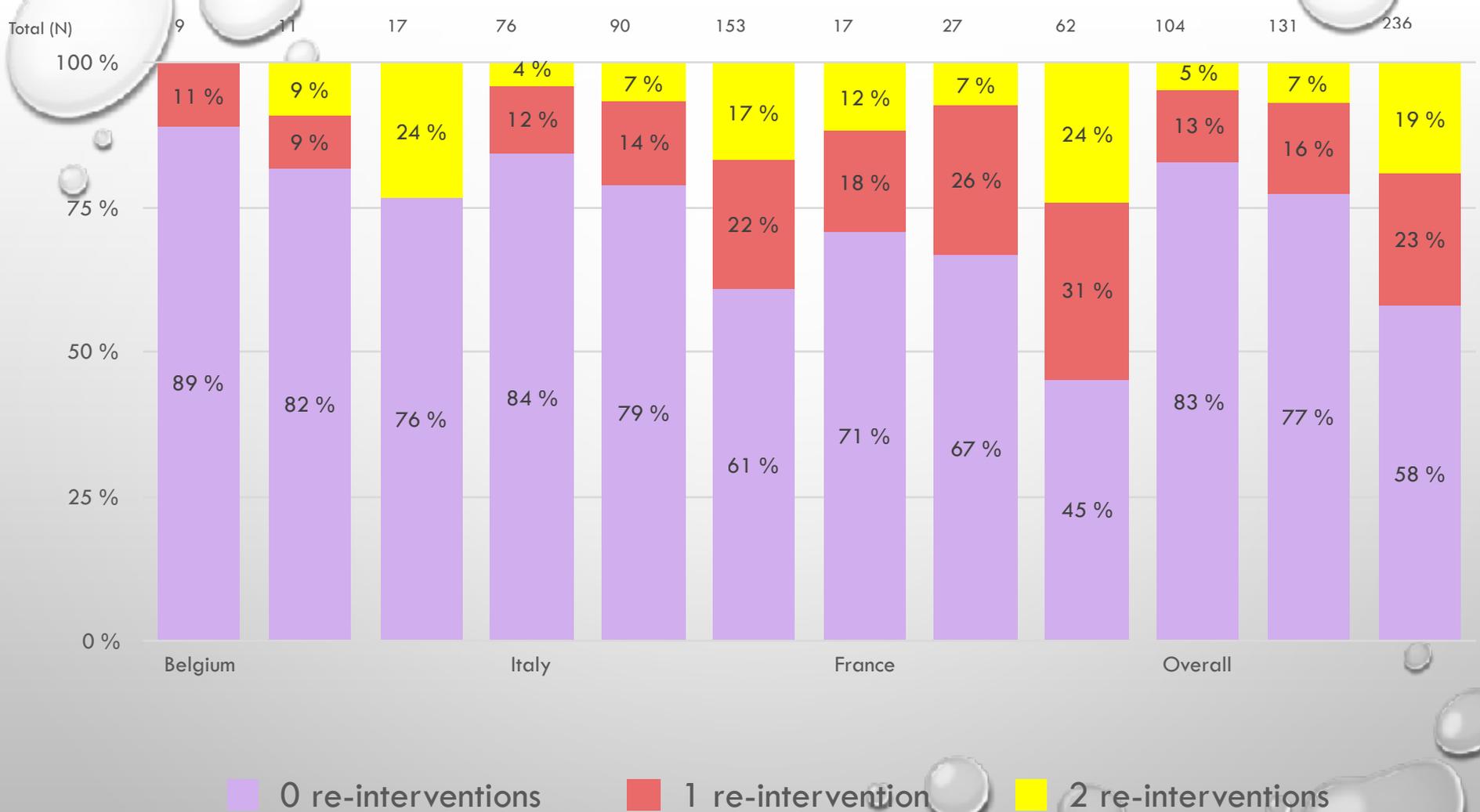


Figure 4: Fistula remission rates observed corresponding to the complex CPFs treated at index date by patient





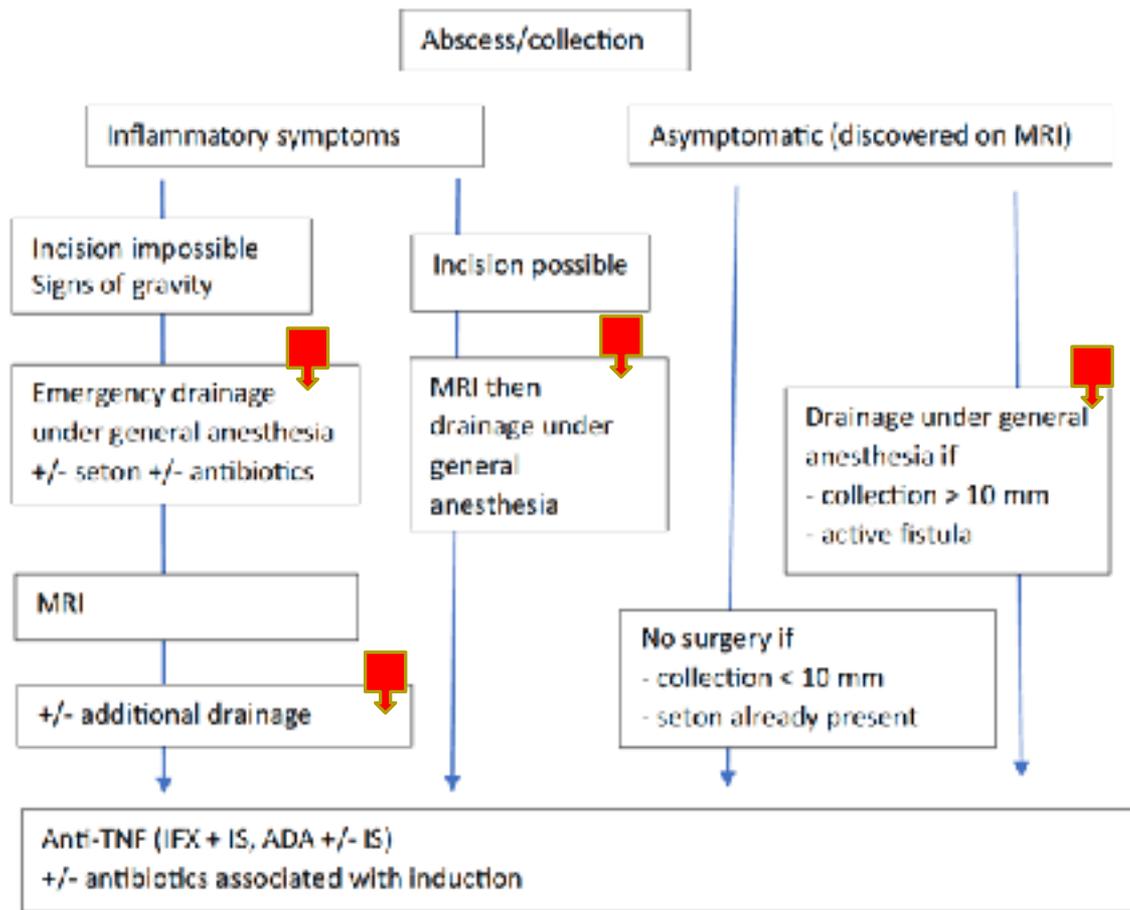
Management of perianal fistulas in Crohn's disease: a 2021 update of the French National Society of Coloproctology consensus

D. Bouchard¹ · F. Pigot¹ · V. de Parades² · G. Staumont³ · L. Abramowitz⁴ · L. Siproudhis⁵ · Members of the SNFCP · Members of the GETAID

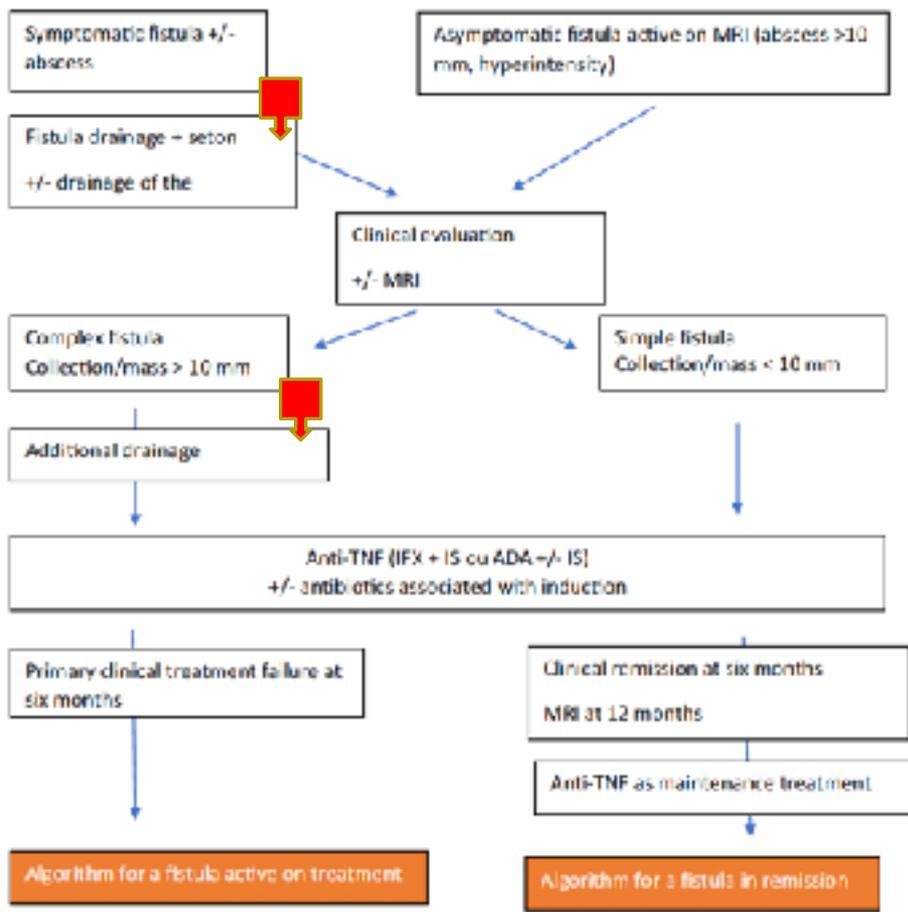
Received: 19 October 2021 / Accepted: 29 July 2022

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Anal abscess or collection in Crohn's disease



Anal fistula in Crohn's disease
Active clinically and/or on MRI and never treated



Anal fistula in Crohn's disease active on anti-TNF treatment

Primary treatment failure (clinically at 6 months, on MRI at 12 months) or relapse after remission

Clinical, physical and MRI evaluation

Pain, discharge, induration

Pain, induration and discharge on pressure, cutaneous orifice open

MRI: collection/mass >10 mm, hyperintensity

Fistula well drained, seton in place
Recent aggravation/appearance of activity
Decrease or recent cessation of anti-TNF treatment, IS

Restart or optimize anti-TNF treatment, switch or swap

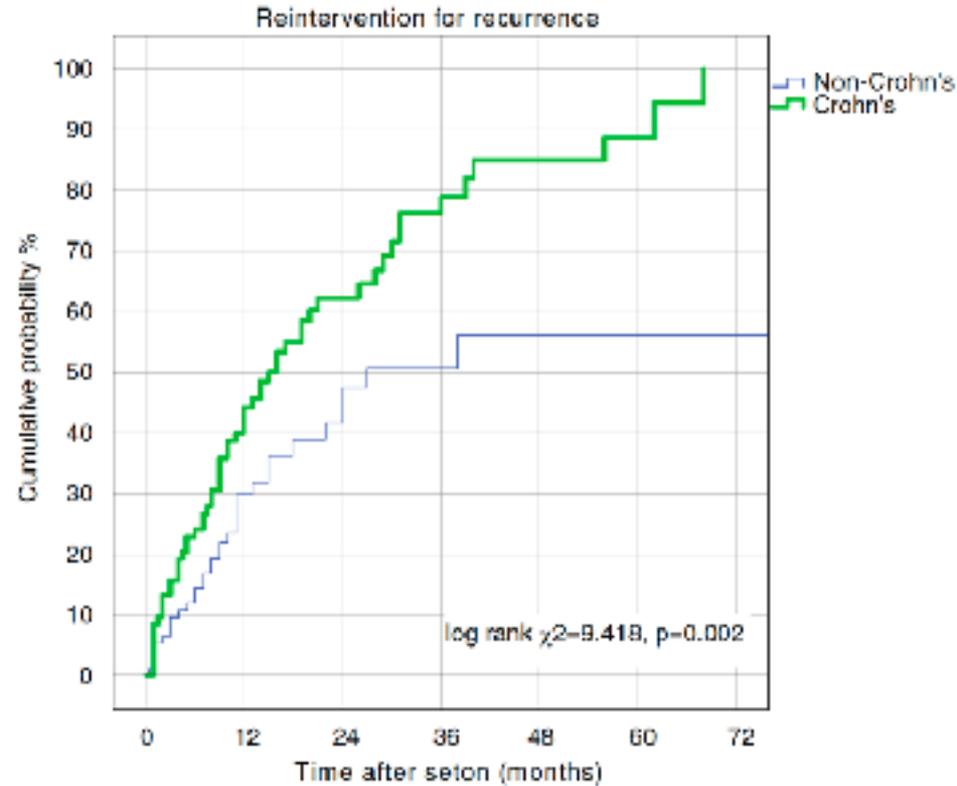
Injection of stem cells

Medical treatment underway effective against luminal disease
Symptomatic abscess
Collection/cavity > 10 mm
Seton recently removed

Drainage
Seton

Pursue or optimize anti-TNF treatment or switch

LE « DRAIN PERDU » EST UNE MAUVAISE STRATÉGIE



No. at risk						
Crohn's	83	43	18	9	4	2
Non-Crohn's	84	36	20	10	5	4

MESSAGE

ON DRAINE ET ON
REDRAINE.....

C'EST UN PROCESSUS
(TROP) LENT

RAIN PERDU



fait

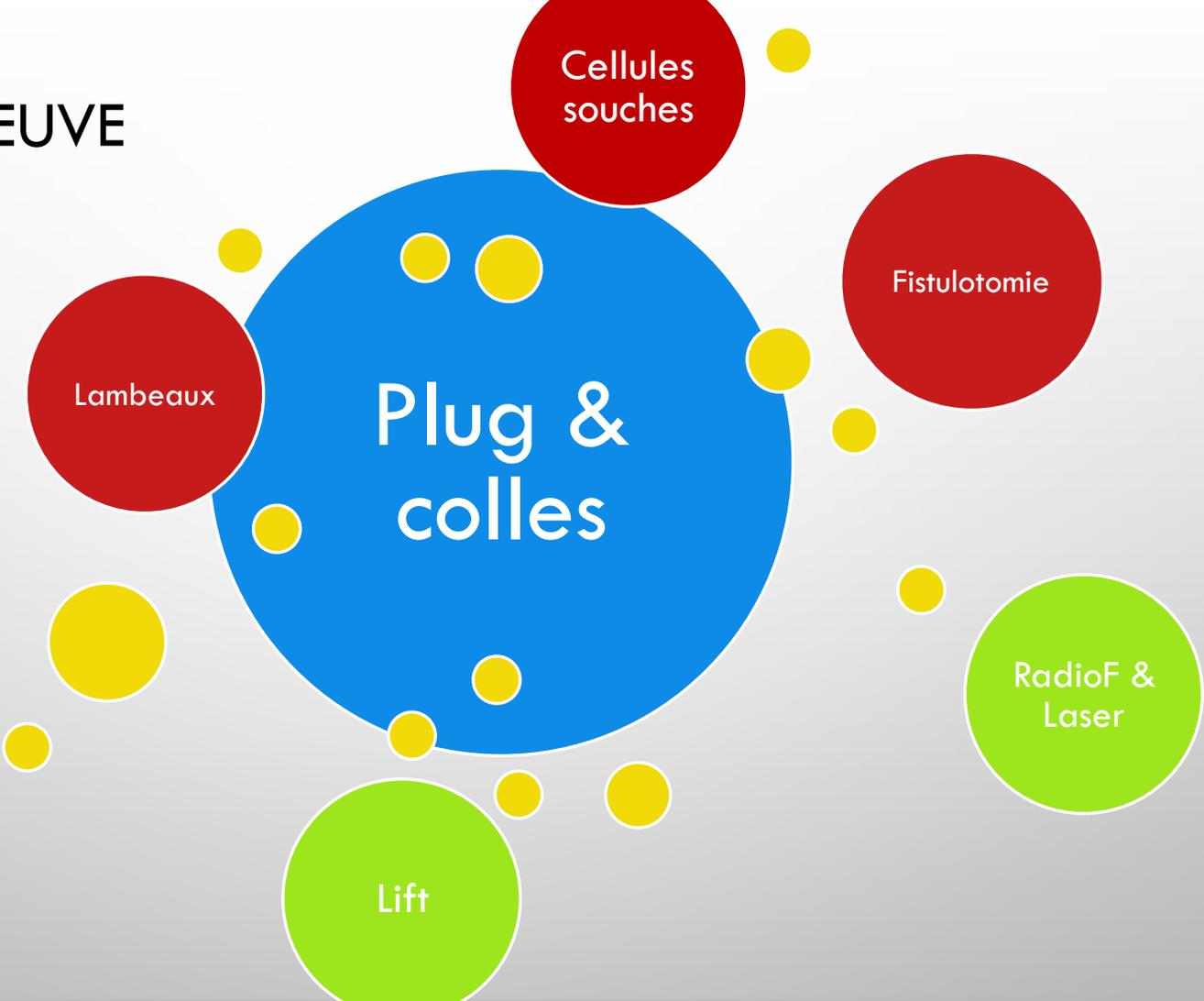
pourrait
re

devrait faire



RÉPARER?

NIVEAU DE PREUVE



LES COLLES....

COLLE SYNTHÉTIQUE

COLLE DE FIBRINE AUTOLOGUE

- FIBRINOGENÈ AUTOLOGUE
- THROMBINE HUMAINE

COLLE DE FIBRINE HÉTÉROLOGUE

- TISSUCOL®, BIOCOL®, BÉRIPLAST®
- FIBRINOGENÈ, FACTEUR XIII ET PLASMINOGENÈ
- APROTININE BOVINE





COLLE DE FIBRINE : ESSAI CONTRÔLÉ GETAID

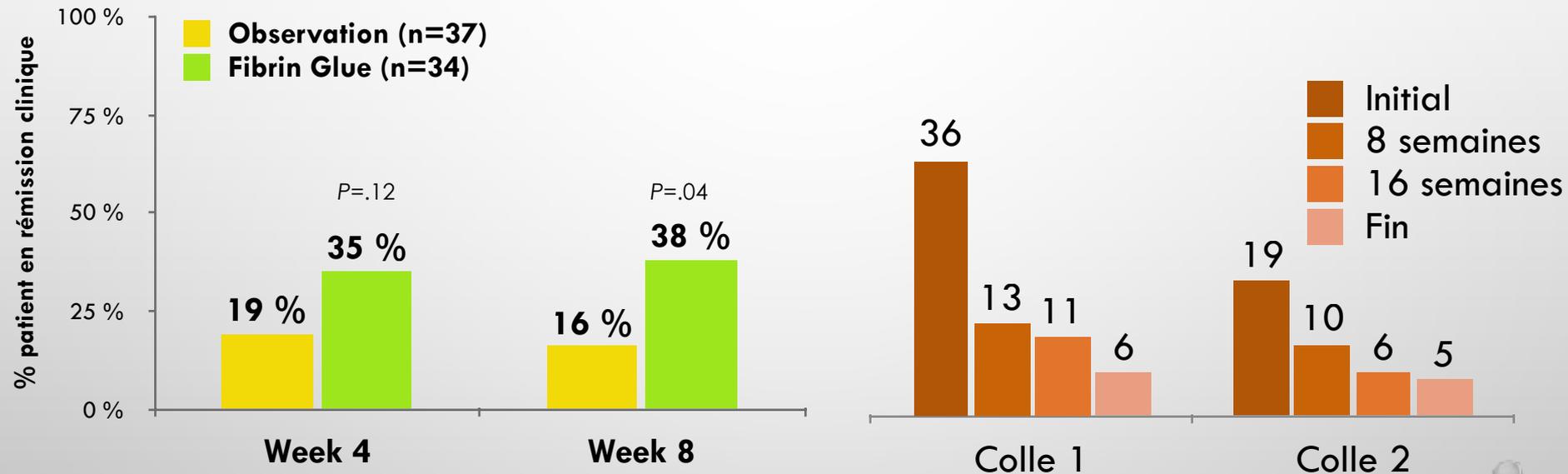
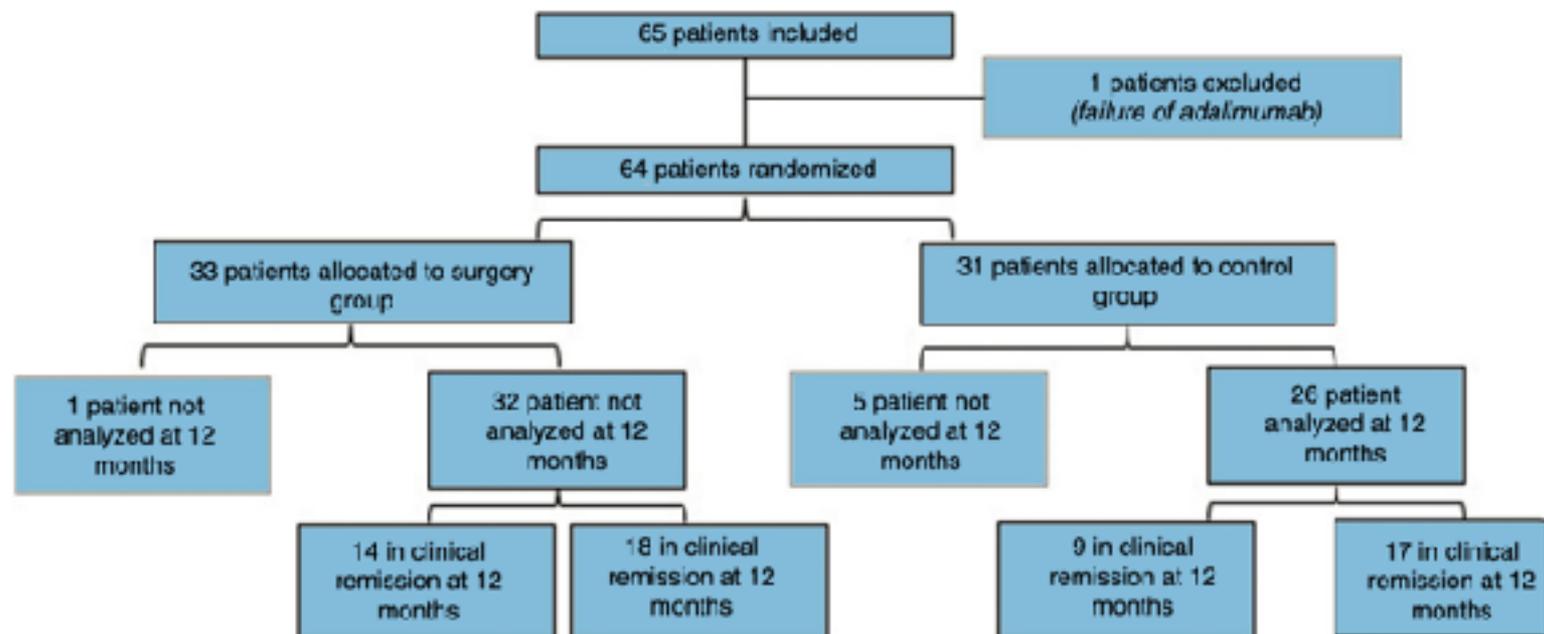


Figure 1. Disposition of patients (values in parentheses represent the number of patients in simple/complex strata)



ORIGINAL ARTICLE

Surgical closure, mainly with glue injection and anti-tumour necrosis factor α , in fistulizing perianal Crohn's disease: A multicentre randomized controlled trial



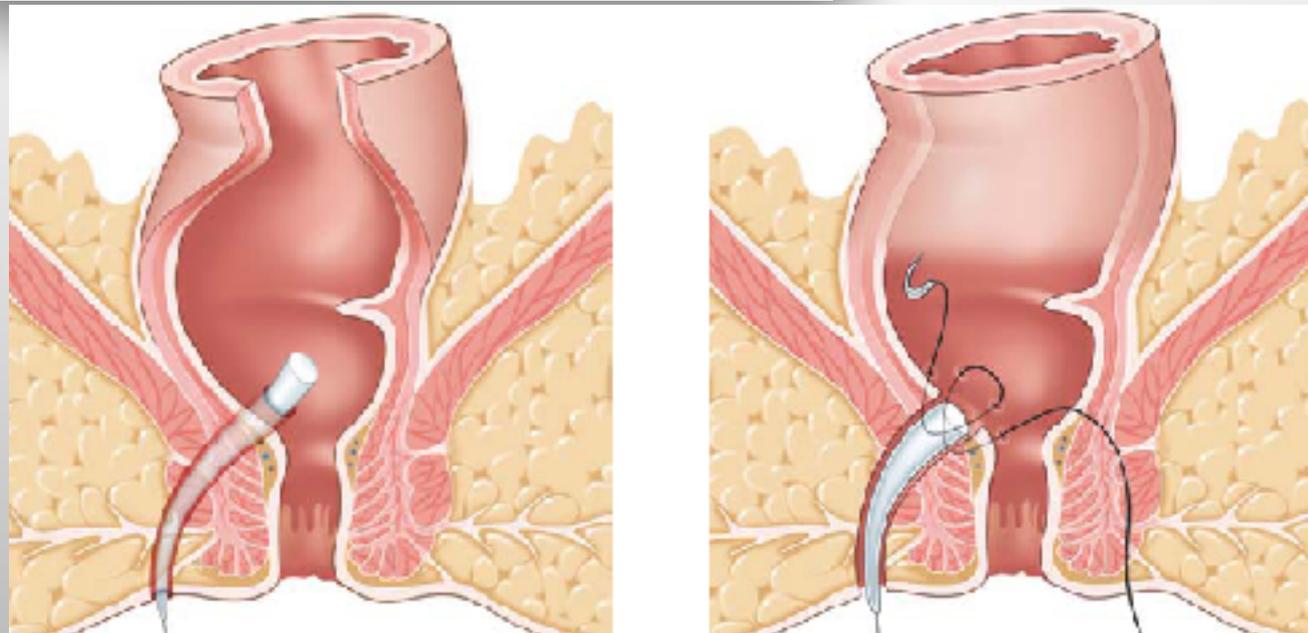
ETUDE FACC

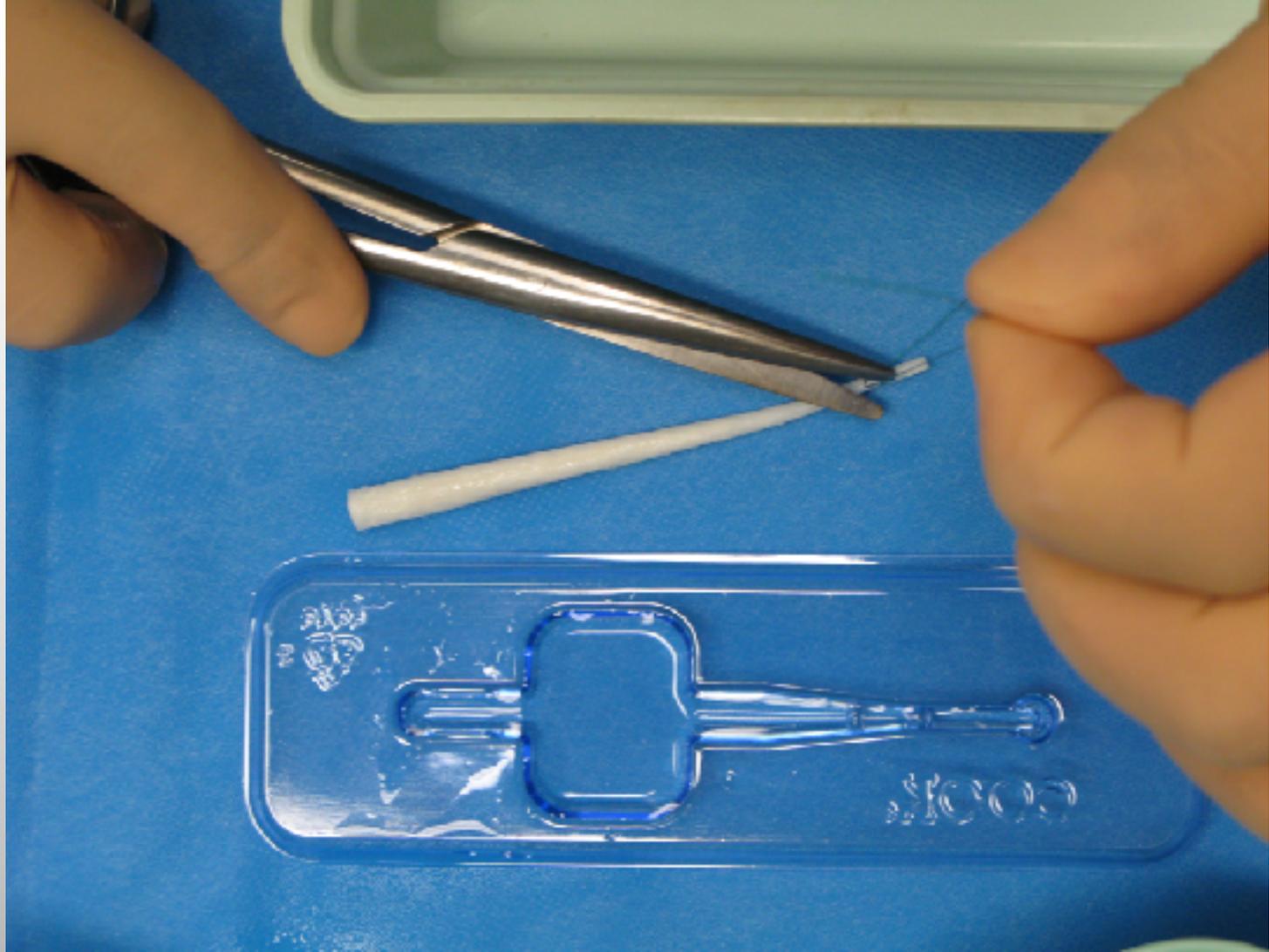
	Bras chirurgie	Bras surveillance	P
	n=33	n=31	
rémission clinique à 6 mois	18/32 (56%)	17/29 (59%)	
rémission clinique à 12 mois	18/32 (56%)	17/26 (65%)	NS
• Fistule simple	71%	63%	
• Fistule complexe	52%	67%	
IRM (hyposignal T2)			
• 6 mois	10/21 (48%)	8/18 (44%)	
• 12 mois	9/19 (47%)	10/17 (59%)	
• 24 mois	11/16 (69%)	7/11 (64%)	
PDAI #			
• 12 mois	3,14	2,26	
• 24 mois	2,77	2,33	

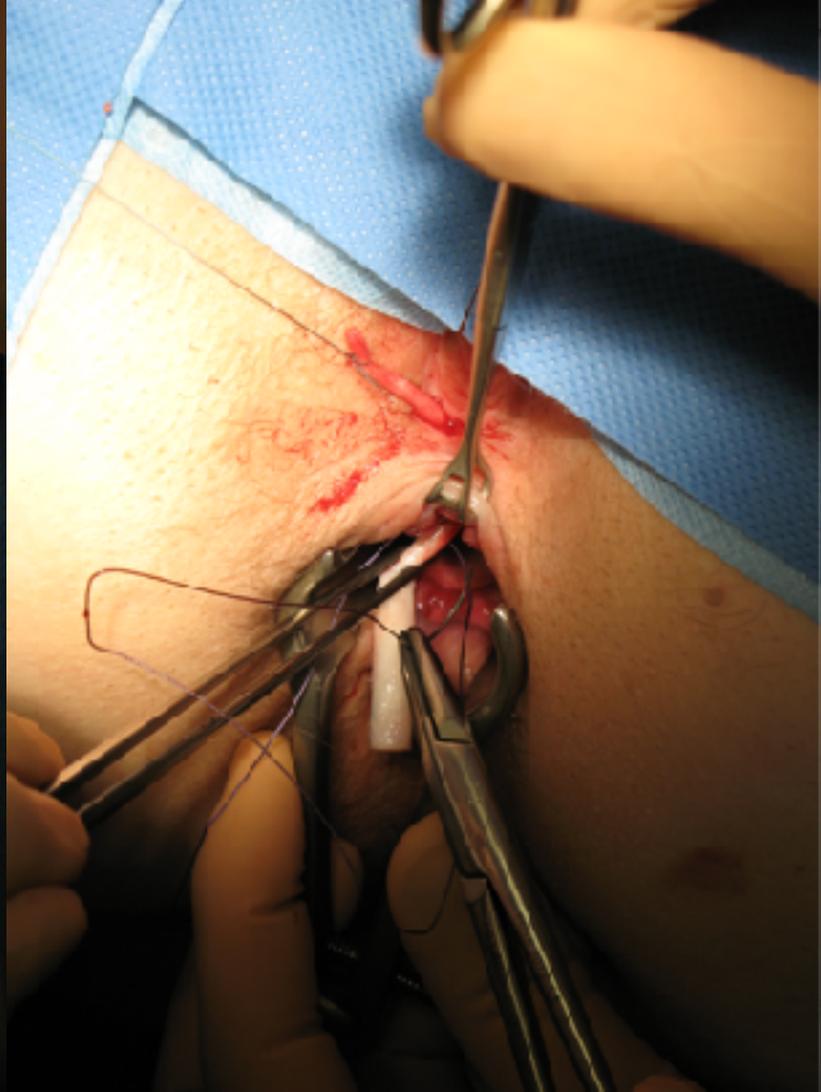
Efficacy of Anal Fistula Plug in Closure of Crohn's Anorectal Fistulas

Lynn O'Connor, M.D., Bradley J. Champagne, M.D., Marsha A. Ferguson, M.D.,
Guy R. Orangi, M.D., Marion E. Schertzer, M.D., David N. Armstrong, M.D., F.R.C.S.
Georgia Colon & Rectal Surgical Clinic, Atlanta, Georgia

80% de succès?

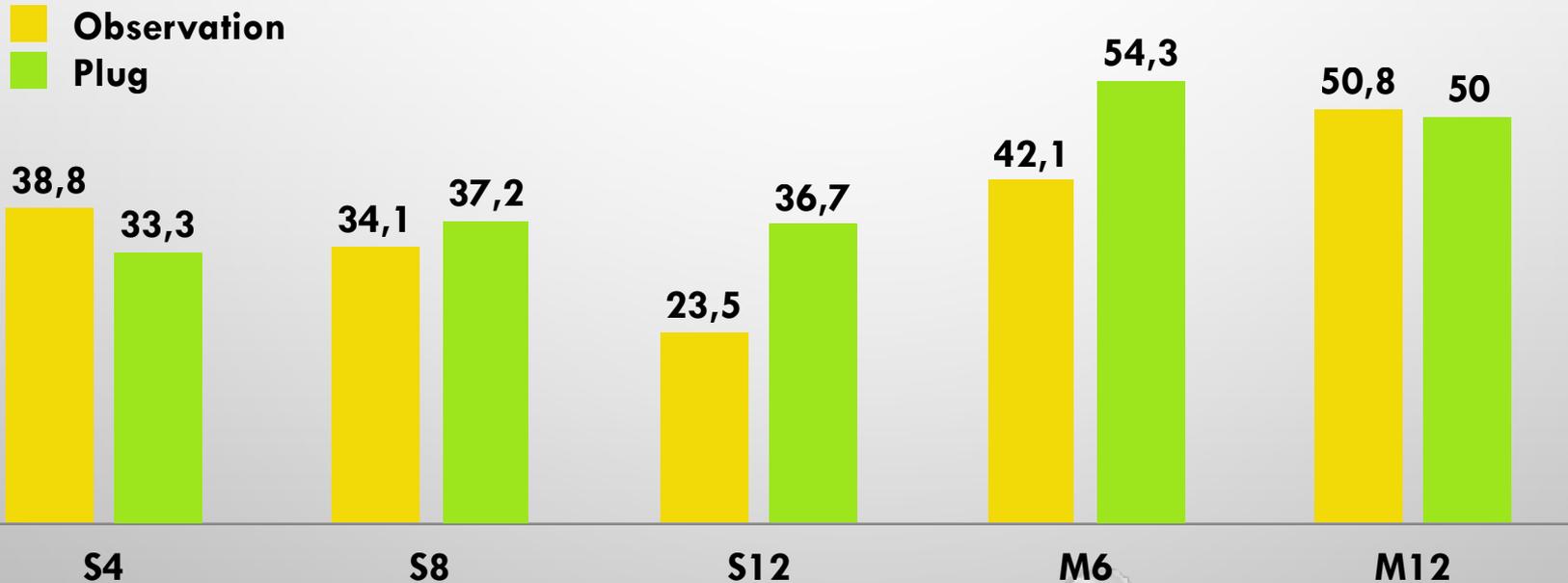


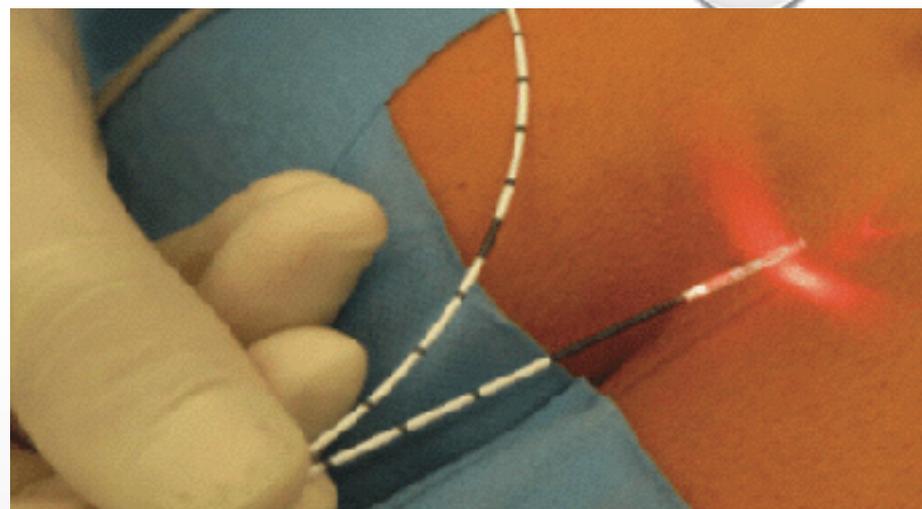
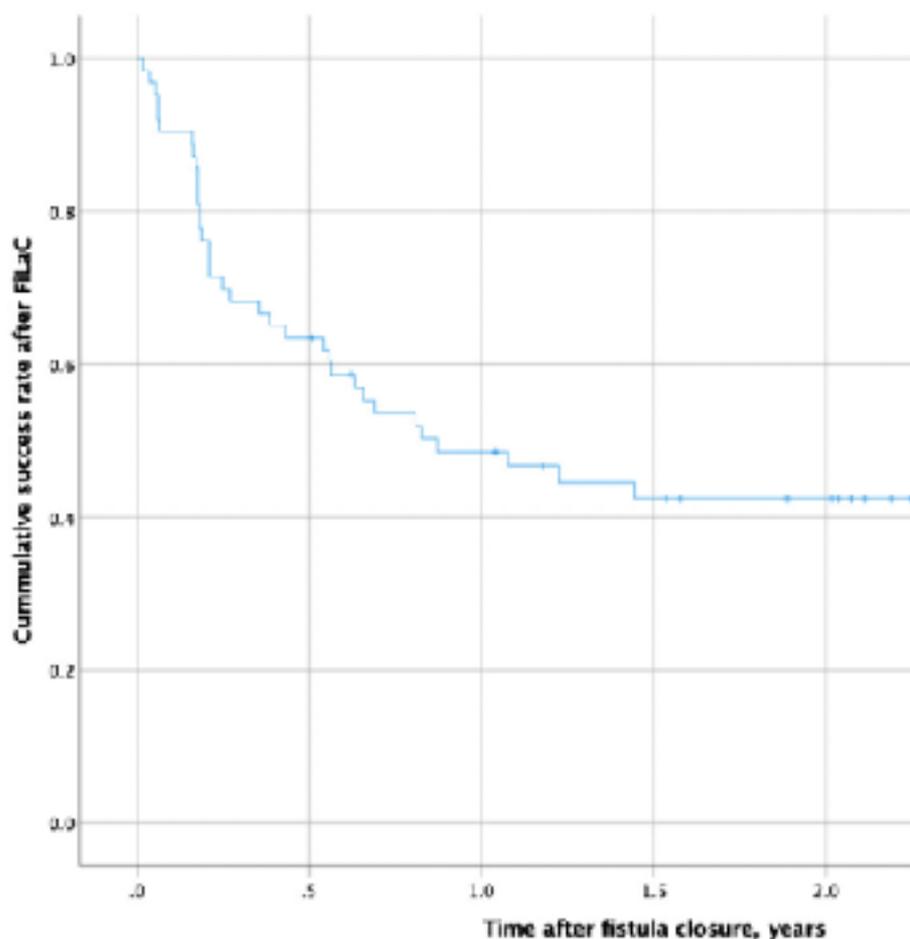






Rémission clinique





International Journal of Colorectal Disease
<https://doi.org/10.1007/s00384-021-03912-8>

ORIGINAL ARTICLE

Fistula Laser Closure (FiLaC™) for fistula-in-ano—yet another technique with 50% healing rates?

Andreas Nordholm-Carstensen¹ · Helene Penegaard² · Kåkke Bartholin Hagen¹ · Peter-Martin...

Accepted: 12 April 2021

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Prospective and multicentre study of radiofrequency treatment in anal fistula

Marie Sautereau¹ | Dominique Bouchard² | Charlène Brochard³ | François Pigot² |
Laurent Siproudhis³ | Jean Marie Fayette⁴ | Cécile Train⁴ | Anne Laurain⁵ |
Charlotte Favreau² | Laurent Abramowitz⁵



	Healed fistulas at 12 months (n = 17)	Unhealed fistulas at 12 months (n = 32)	Total (N = 49)	p-value
Type of fistula				0.142
LTS fistulas	5 (45.5%)	6 (54.5%)	11 (22.4%)	
HTS fistulas	7 (33.3)	14 (66.7)	21 (42.9%)	
C fistulas	1 (12.5)	7 (87.5)	8 (16.3%)	
CD fistulas	4 (44.4)	5 (55.6)	9 (18.4%)	
Median of joule (J)	2725.0J (825-8775)	1325.0J (425-7225)	1500J (425-8775)	0.049

Original Article

Fibrosis and MAGNIFI-CD Activity Index at Magnetic Resonance Imaging to Predict Treatment Outcome in Perianal Fistulizing Crohn's Disease Patients

Kyaa L. van Rijn,¹ Elise M. Meima-van Praag,^{2,3} Patrick M. Bessuyt,⁴
Geert R. D'Haens,⁴ Krisztina B. Geese,⁴ Karin Horsthuis,⁴
Harmanna J. Snijder,⁵ Jeroen A. W. Tielbeek,^{4,1} Christianne J. Buskens,⁶
Jaco Steyer,⁶

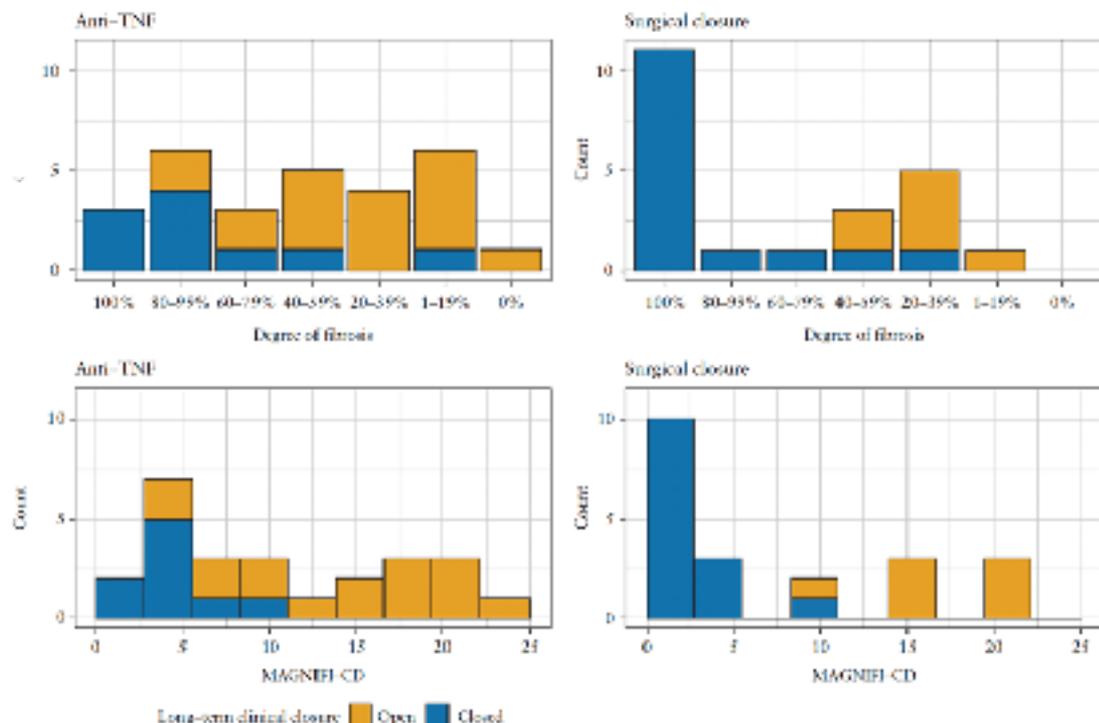


Figure 6. Degree of fibrosis and MAGNIFI-CD index at post-treatment MRI in relation to long-term clinical closure per treatment group. The degree of fibrosis was assessed on all 60 scans (28 anti-TNF and 32 surgical closure) and the MAGNIFI-CD index on the 49 scans (26 anti-TNF and 23 surgical closure) which had a post-contrast sequence.

100%

Original article

doi:10.1111/coa.12524

Combined strategies following surgical drainage for perianal fistulizing Crohn's disease: failure rates and prognostic factors

A. Herissay*, L. Siproudhis†, E. Le Bailh*, A. Merlini L'Heritier*, T. Wallenhorst*, G. Bouguen* and C. Brochard† 

Failure of treatment (%)

80%

60%

40%

20%

0%

Seton removal

Sphincter-sparing technique

0

1

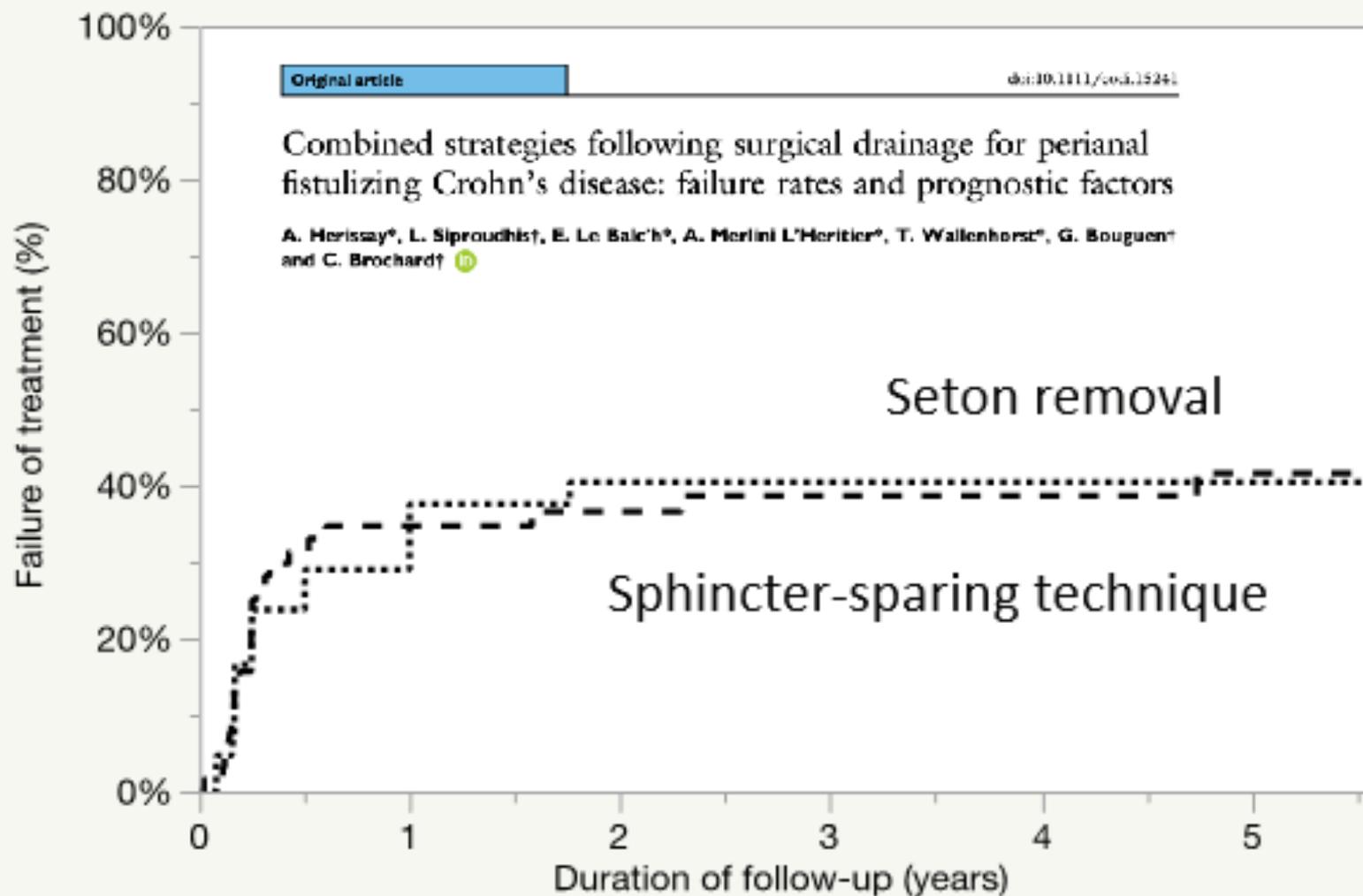
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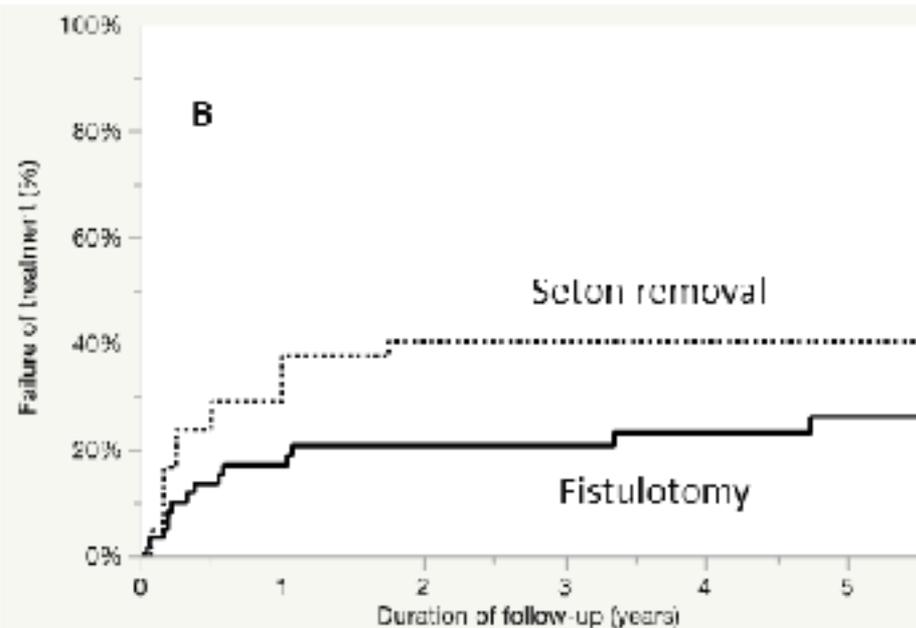
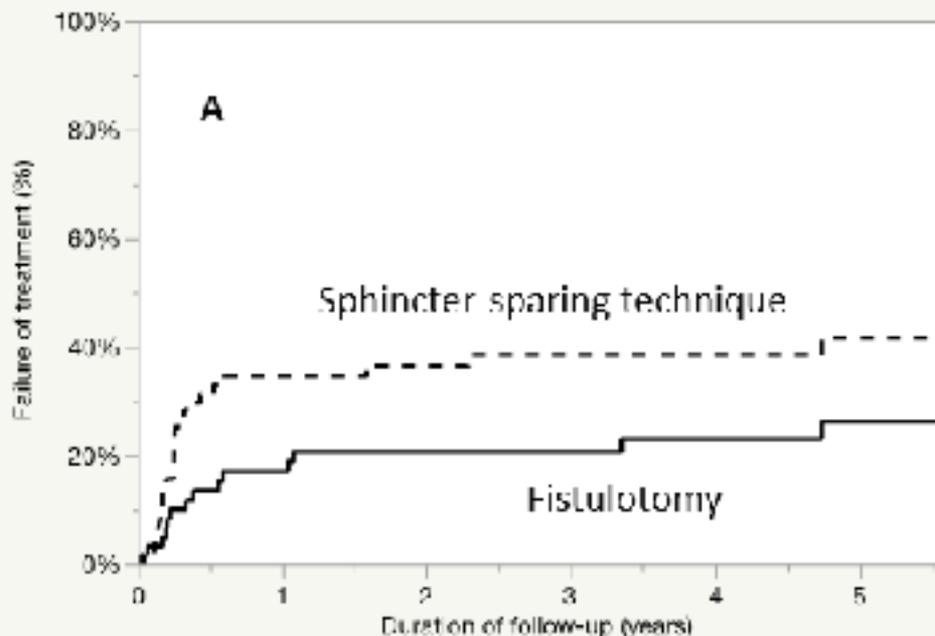
5

Duration of follow-up (years)



Combined strategies following surgical drainage for perianal fistulizing Crohn's disease: failure rates and prognostic factors

A. Herissay^a, L. Siproudhis^a, E. Le Bailh^a, A. Merlini L'Heritier^a, T. Wallenhorst^a, G. Bouguent^a and C. Brochard[†] 





ECCO Guideline/Consensus Paper

ECCO Guidelines on Therapeutics in Crohn's Disease: Surgical Treatment



Statement 1.3. ECCO CD Treatment GL (2019)

Fibrin glue may be a potential treatment, with limited efficacy, for patients with complex perianal Crohn's disease (SL4).

Statement 1.8. ECCO CD Treatment GL (2019)

Anal fistula plugs (AFP) should not be routinely considered for perianal fistula disease in Crohn's disease, as other modalities are equally effective (SL3).

Statement 1.1. ECCO CD Treatment GL (2019)

No prospective study directly compares medical or surgical treatment of complex perianal Crohn's disease fistulae, either in isolation or in combination with both modalities. Observational studies support a combined medical/surgical approach to control sepsis and luminal activity (SL5).

Statement 2.1. ECCO CD Treatment GL (2019)

Pain, sepsis and symptoms from complex perianal Crohn's disease refractory to medical or surgical interventions can be controlled by a diverting stoma. However, the fistula healing rate and stoma disease rate are limited (SL4).

Statement 1.2. ECCO CD Treatment GL (2019)

Advancement tags are a therapeutic option for patients with Crohn's disease and complex perianal fistulae (SL4).

Statement 1.4. ECCO CD Treatment GL (2019)

Ligation of the intersphincteric fistula tract is an option for treatment of patients with Crohn's disease and complex perianal fistulae (SL4).

Statement 1.7. ECCO CD Treatment GL (2019)

Adipogen: adipose derived stem cell therapy could be an effective and safe treatment for complex perianal fistulae in patients with Crohn's disease (SL3).

Statement 1.8. ECCO CD Treatment GL (2019)

Autologous adipose derived stem cells may have positive effect for patients with Crohn's disease and complex perianal fistulae with good tolerability and safety (SL4).

The image features a decorative background. On the left side, there are several overlapping, rounded rectangular shapes in shades of blue, orange, and purple. The right side of the image has a light blue gradient background with several realistic water droplets of various sizes scattered across it. The text is centered on the right side.

MESSAGE

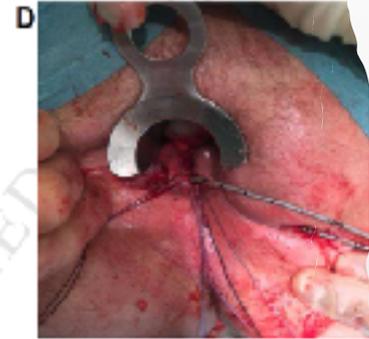
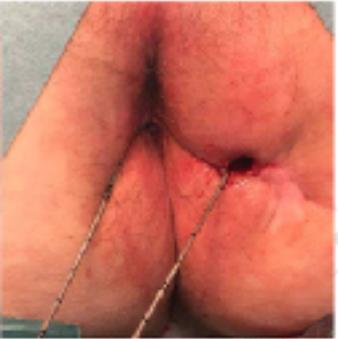
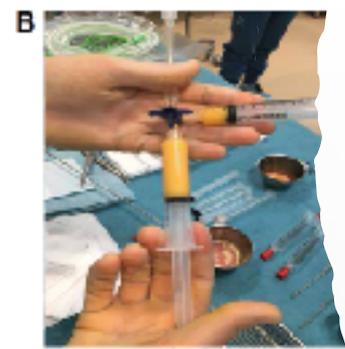
ON POURRAIT MIEUX FAIRE EN
COMMENÇANT PAR ABANDONNER CE
QUI NE MARCHE PAS



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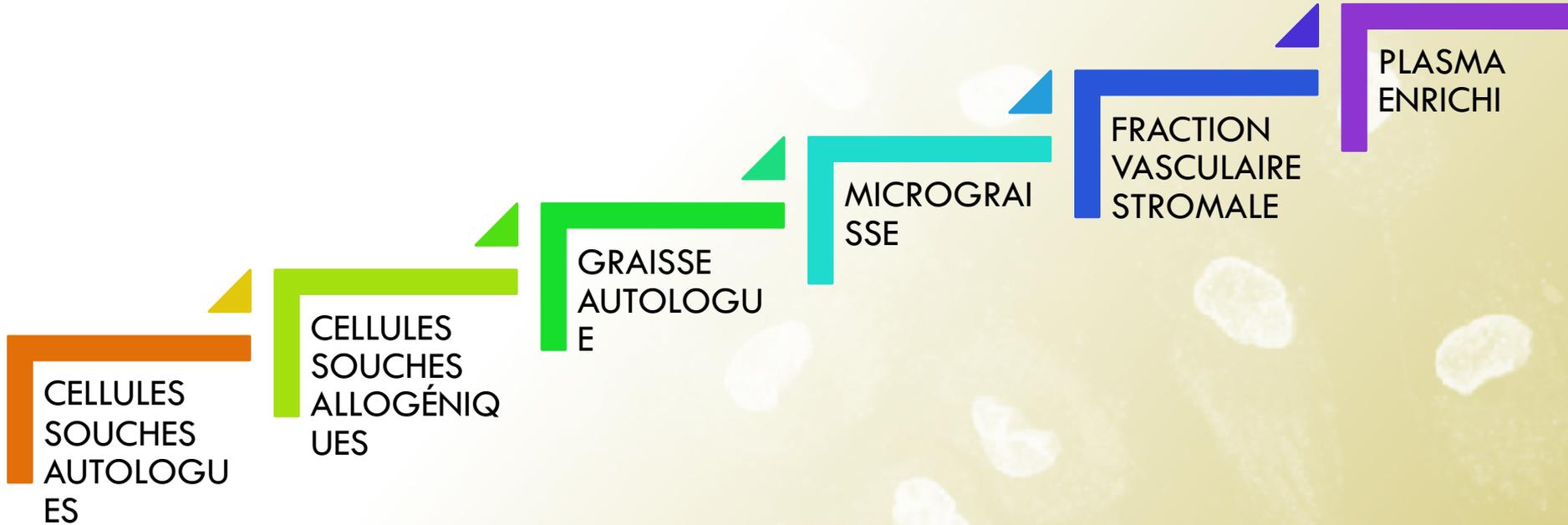
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CIBLER LE PROCESSUS DE CICATRISATION

LES OUTILS



CELLULES SOUCHES ?



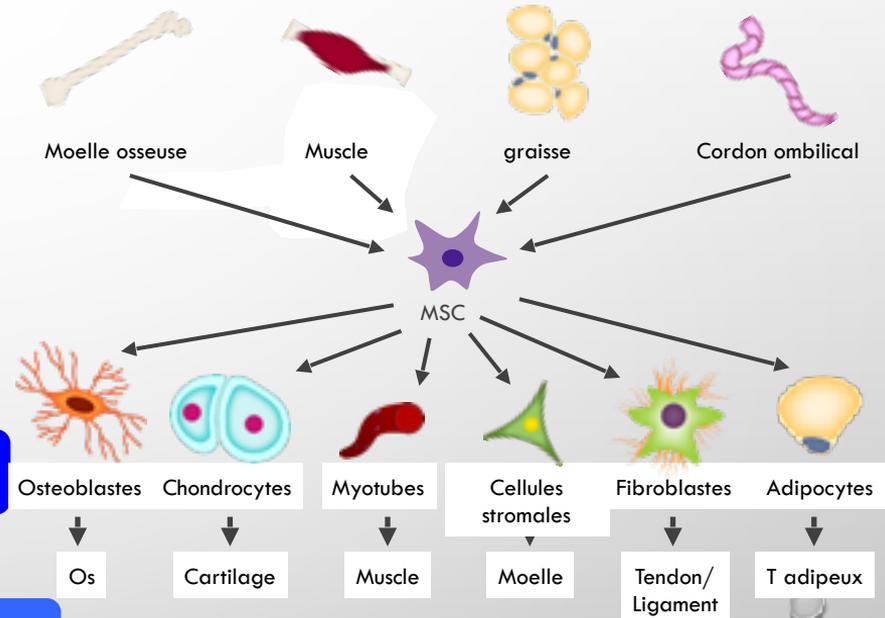
Fonctions immunomodulatrices^{1,2}

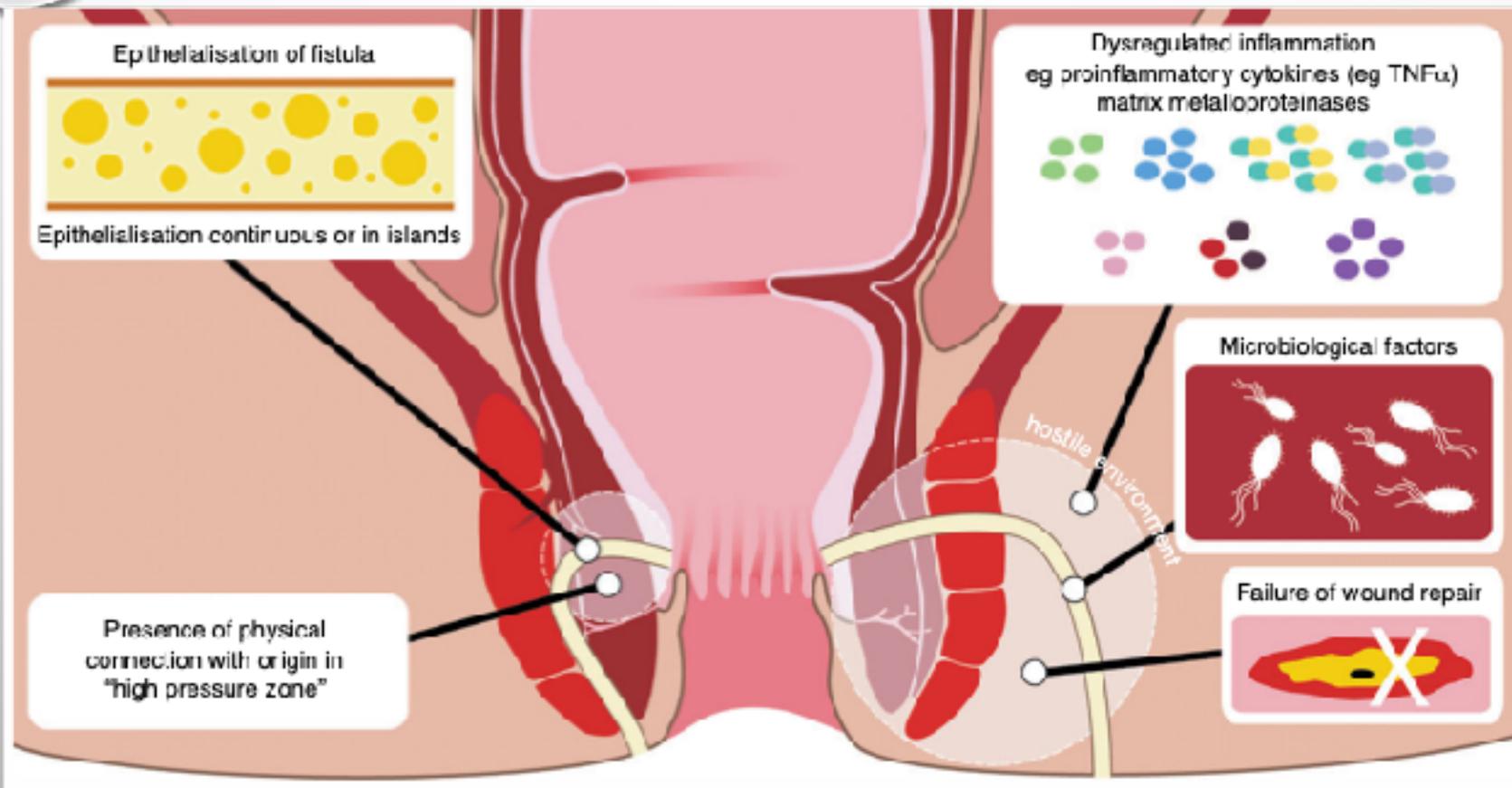


Contrôle de la cicatrisation par le biais de facteurs paracrines³



Différenciation cellulaire constituant le processus de réparation tissulaire⁴⁻⁶





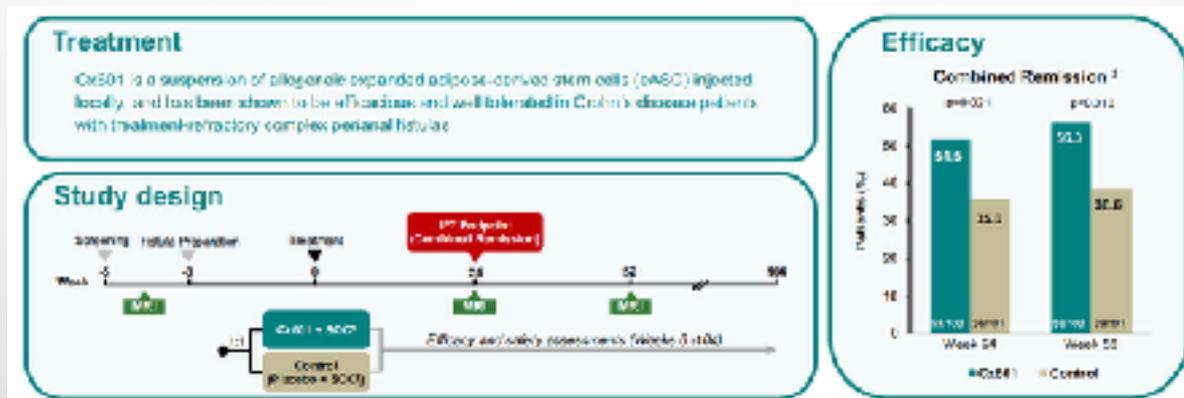
Expanded allogeneic adipose-derived mesenchymal stem cells (Cx601) for complex perianal fistulas in Crohn's disease: a phase 3 randomised, double-blind controlled trial



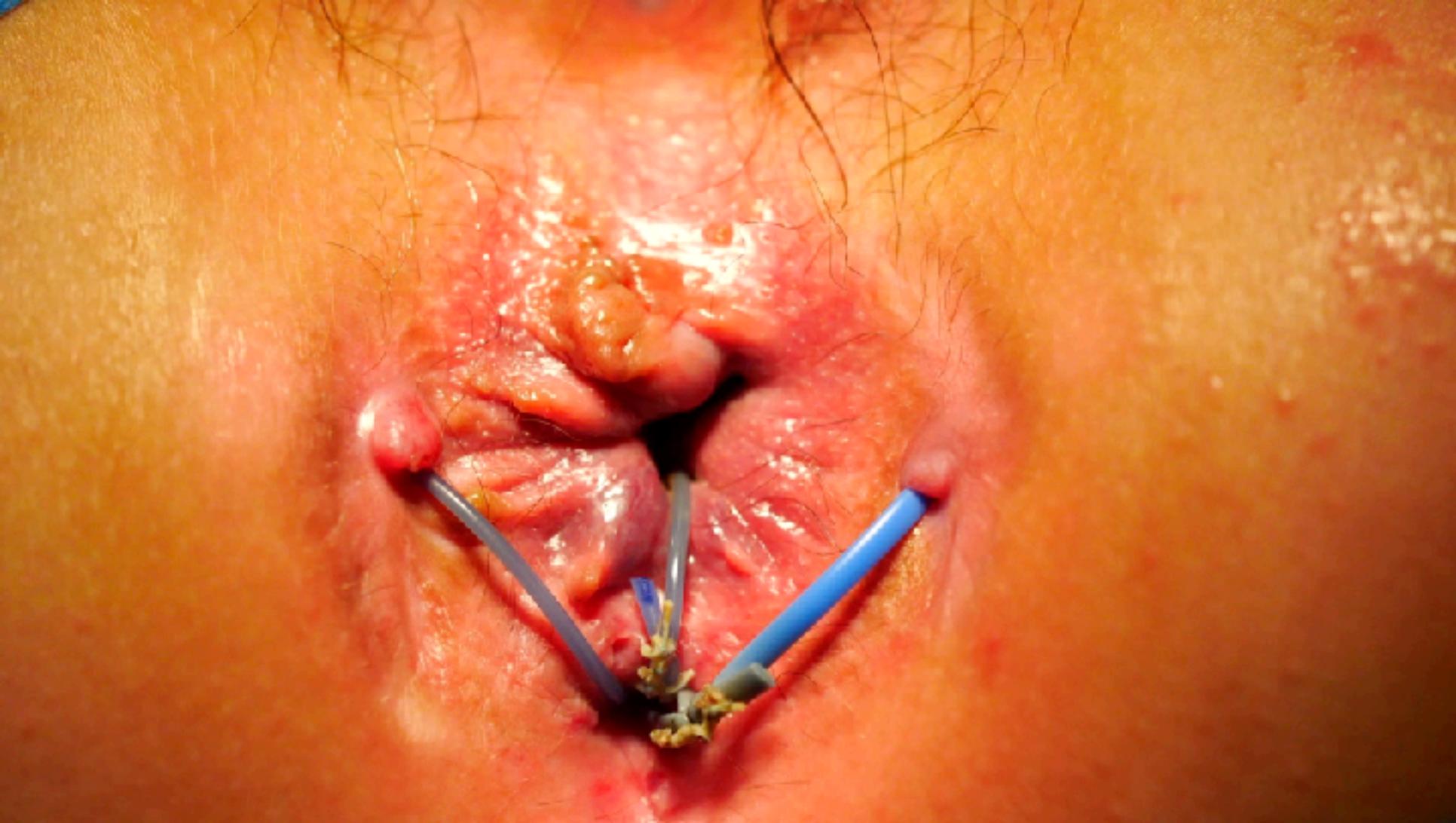
Long-term Efficacy and Safety of Stem Cell Therapy (Cx601) for Complex Perianal Fistulas in Patients With Crohn's Disease



Julian Panés,¹ Damián García-Olmo,² Eyal Van Assche,³ Jean-Frédéric Colombel,⁴



population (N=205) Patients, N (%)	Darvadstrocel (N=103)	Témoins (N=102)
E Indésirables	79 (76.7)	74 (72.5)
Liés au traitement	21 (20.4)	27 (26.5)
Evt indésirables graves	25 (24.3)	21 (20.6)
Liés aux traitements	7 (6.8)	7 (6.9)
Abscesses/ fistules	16 (15.5)	10 (9.8)



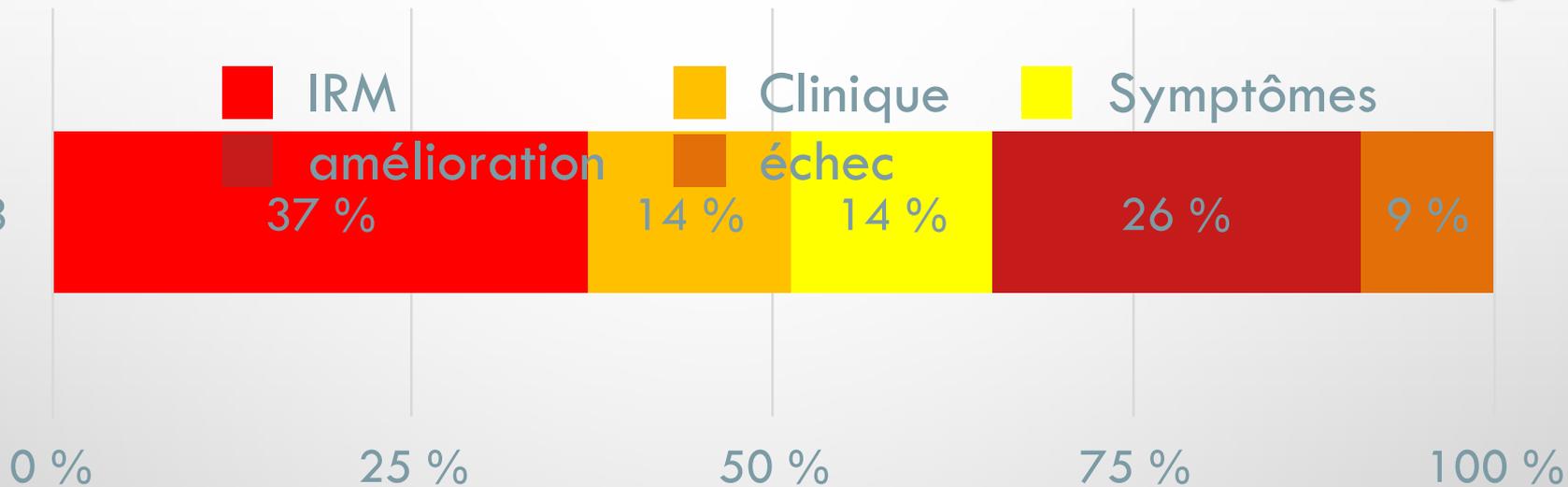


n (%) or median [IQR 25-75]	Global population N= 43
Sex (M/F)	22/21
Age (years)	37 [26-45]
BMI	24 [21-28]
Obesity	08 (19)
Smoking	
• Smoker	12 (28)
• Former smoker	05 (12)
• No smoker	26 (60)
Characteristics of luminal CD	
Duration of Crohn's disease (months)	94 [36-170]
<i>Montreal Classification</i>	
A1 < 16	07 (16)
A2 < 40	32 (74)
A3 ≥ 40	04 (9)
L1	08 (19)
L2	13 (30)
L3	20 (47)
B2 / B3	08 (19) / 08 (19)
Extra-intestinal manifestations	07 (16)
Luminal remission at referral	36 (84)
Harvey Bradshaw score at referral	01 [1-2]

Prior treatments <u>before drainage</u>	
<i>Surgery</i>	
Ileal and/or colonic resection	08 (19)
Ileal anal anastomosis	02 (05)
Ileostomy	01 (02)
<i>Medical treatment</i>	
Anti-TNF α / optimization	35 (81) / 20 (57)
Biologics (others than Anti TNF)	07 (16)
Immunosuppressant AZA or 6MP / MTX	31 (72) / 05 (12)
Anal fistulas	
<i>Past history</i>	
Duration of anal fistula (months)	64 [29 – 106]
Past drainage < 3years / > 3 years	14 (33) / 29 (67)
Emergency surgeries	4 [2-5]
Restoration surgery (Yes)	15 (35)
Last duration of loose seton (months)	4 [1-11]
Status at referral	
High fistulas (F2) (Yes)	43 (100)
Complex fistulas (Yes)	26 (60)
Horseshoe extension (Yes)	16 (37)
Supralelevator extension	04 (09)

Follow-up (months)	Referral	[1-3]	[3-6]	[9-12+]	Last visit
N	43	42	42	41	43
Clinical assessment					
PDAI	06 [5-8]	03 [1-4]	03 [0-6]	02 [0-4]	00 [0-4]
Anal pain/discomfort	27 (63)	10 (24)	11 (26)	07 (17)	06 (14)
Discharge	37 (86)	25 (60)	22 (52)	14 (34)	16 (37)
F0*	00 (00)	14 (34)	15 (36)	19 (46)	22 (51)
F1*	00 (00)	01 (02)	02 (05)	03 (07)	03 (07)
F2*	43 (100)	27 (64)	25 (59)	19 (46)	18 (42)
Anal Stricture	08 (19)	05 (12)	03 (07)	01 (02)	00 (00)
Anal Ulcerations	01 (02)	00 (00)	01 (02)	00 (00)	00 (00)
MRI assessment					
Fistula healing	00 (00)				17 (40)
Main tract length (mm)	53 [35-100]				20 [00-50]
Maximal tract depth (mm)	06 [03-09]				03 [00-07]
Inflam. tract and masses	39 (91)				15 (35)
Branched tracts	30 (70)				14 (33)

N = 43



INSPIRE: 6-month interim analysis from an observational post-marketing registry on the effectiveness and safety of darvadstrocel in patients with Crohn's disease and complex perianal fistulas

Oded Zmora,¹ Daniel C Baumgart,² William Faubion,³ Marc Ferrante,⁴ Krisztina Gece,⁵ Elisabeth Genestin,⁶ Parnia Geransar,⁶ Gary Hantsbarger,⁷ Chitra Karki,⁷ Philip Tozer,⁸ Julian Panés⁹

¹Shamir Medical Center, Tel Aviv, Israel; ²University of Alberta, Edmonton, AB, Canada; ³Mayo Clinic, Rochester, MN, USA;

⁴University Hospitals Leuven, KU Leuven, Leuven, Belgium; ⁵Amsterdam UMC, Amsterdam, Netherlands;

⁶Takeda Pharmaceuticals International AG, Zurich, Switzerland; ⁷Takeda Pharmaceuticals USA, Inc., Cambridge, MA, USA;

⁸St Mark's Hospital and Academic Institute, London, UK; ⁹Hospital Clinic de Barcelona, Barcelona, Spain



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[https://www.gastrojournal.org/abstract/S0016-5052\(20\)14204](https://www.gastrojournal.org/abstract/S0016-5052(20)14204)

Figure 2. Patient enrolment and data availability.

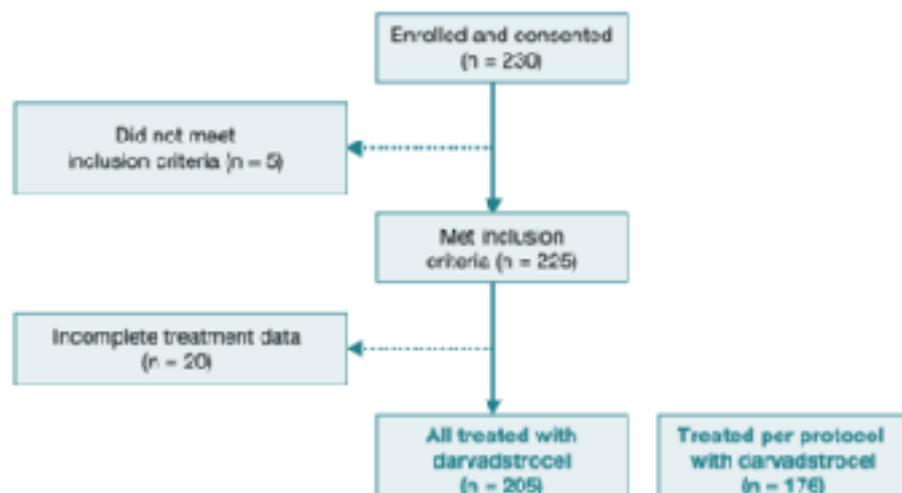
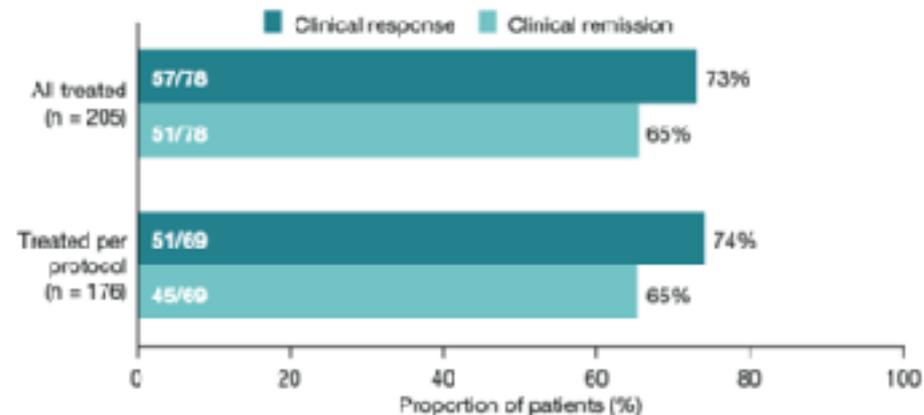
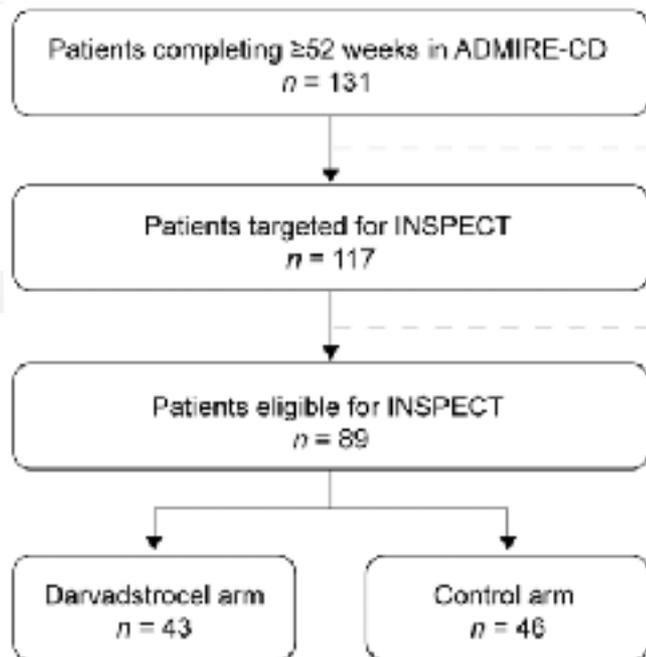
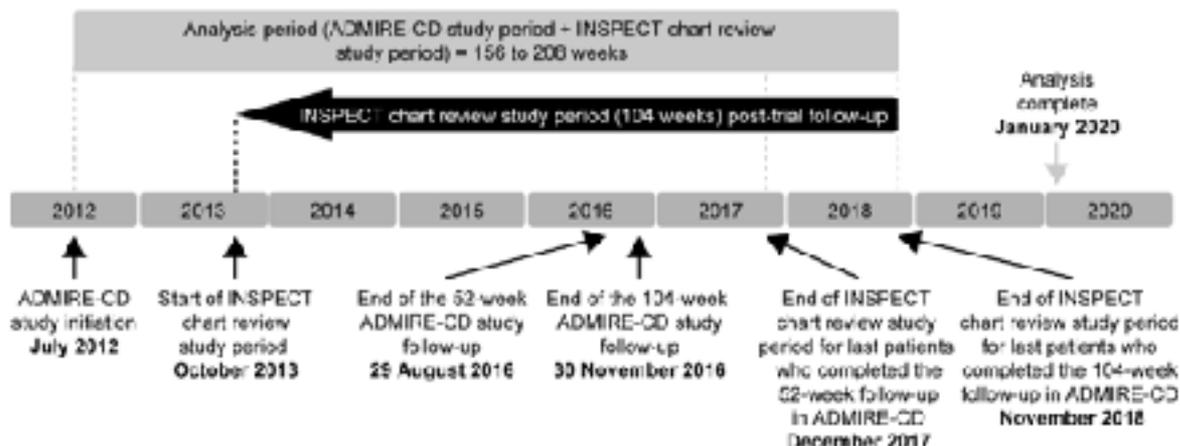


Figure 3. Clinical response and remission outcomes at 6 months after a single administration of DVS.



INSPECT: A Retrospective Study to Evaluate Long-term Effectiveness and Safety of Darvadstrocel in Patients With Perianal Fistulizing Crohn's Disease Treated in the ADMIRE-CD Trial

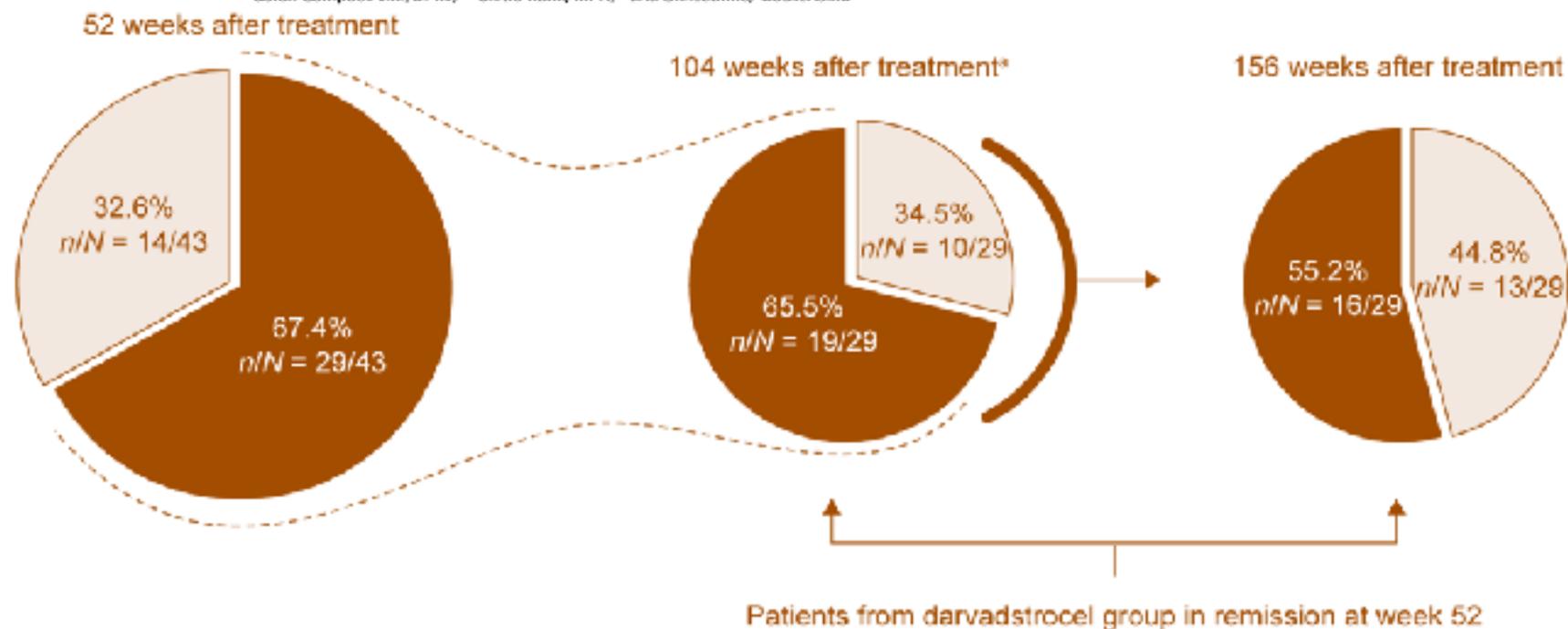


INSPECT: A Retrospective Study to Evaluate Long-term Effectiveness and Safety of Darvadstrocel in Patients With Perianal Fistulizing Crohn's Disease Treated in the ADMIRE-CD Trial

Julian Panés, MD, PhD,^{1,2} Gerd Bouma, MD,¹ Marc Ferrante, MD,^{1,3} Torsten Kucharzik, MD,⁴ María Pachury, MD,⁵ Fernando de la Portilla de Juan, MD,⁶ Walter Reinisch, MD,^{7,8} Francesco Selvaggi, MD,⁹ Jörg Techelitsch, MD,¹⁰ Neil R. Brett, PhD,¹¹ Martin Ladouceur, PhD,¹² Matthias Binek, MD,¹³ Gary Hartebarger, PhD,¹⁴ Sarah Campbell-Hill, DPhil,¹⁵ Chitra Karki, MPH,¹⁶ and Christiana Buskeru MD¹⁷

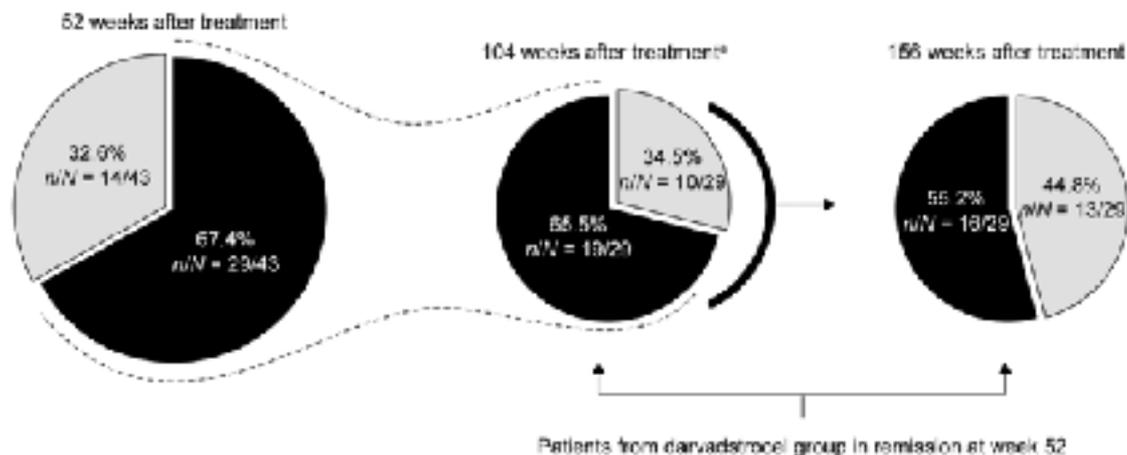
Darvadstrocel

■ In remission □ Not in remission

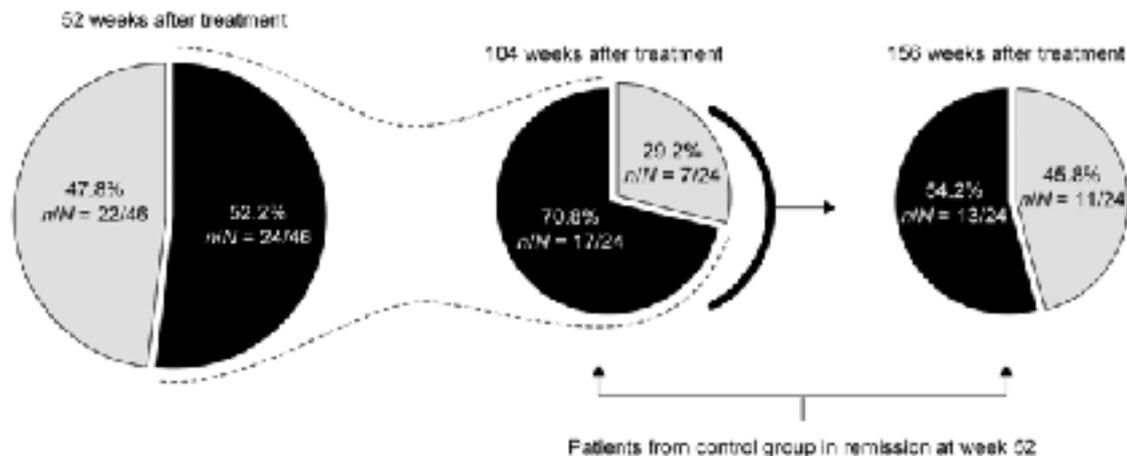


Darvadstrocol

■ In remission □ Not in remission

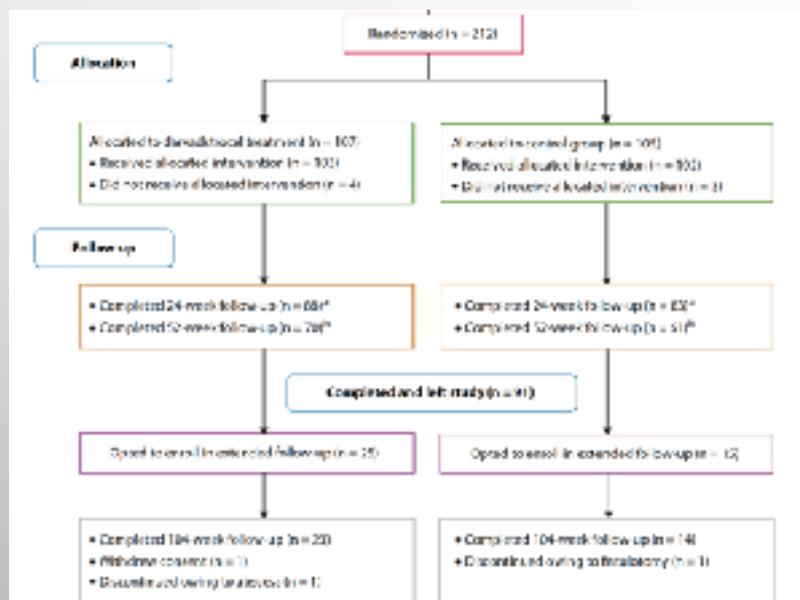


Control



Follow-up Study to Evaluate the Long-term Safety and Efficacy of Darvadstrocel (Mesenchymal Stem Cell Treatment) in Patients With Perianal Fistulizing Crohn's Disease: ADMIRE-CD Phase 3 Randomized Controlled Trial

Damián García-Olazo, M.D., Ph.D.¹ • Inmaculada Gilaberte, M.D., Ph.D.²
 Matthias Binek, M.D., Ph.D.³ • André J.L. D'Hoore, M.D., Ph.D.⁴ • Dark Lindner, M.Sc.⁵
 Francesco Selvaggi, M.D.⁶ • Antonino Spinelli, M.D., Ph.D.^{5,7} • Julian Panés, M.D.⁸



TESAE details	Darvadstrocel (n = 25)		Control (n = 15)	
	Patients, n (%)	Events, n	Patients, n (%)	Events, n
Any TESAEs	3 (12.0)	3	1 (6.7)	1
TESAE intensity				
Mild	0	0	0	0
Moderate	3 (12.0)	3	0	0
Severe	0	0	1 (6.7)	1
TESAE relationship to study treatment				
Related	0	0	0	0
Not related	3 (12.0)	3	1 (6.7)	1
TESAEs by system organ class and preferred term, start–end date				
Gastrointestinal disorders				
Anal fistula	1 (4.0)	1	0	0
day 377–378				
Infections and infestations				
Anal abscess	1 (4.0)	1	0	0
day 538–542				
Musculoskeletal and connective tissue disorders				
Fistula discharge	1 (4.0)	1	1 (6.7)	1
day 399–402			day 627–629	

Control: curettage with placebo administration.

TESAE = treatment-emergent serious adverse event.

CELLULES Souches

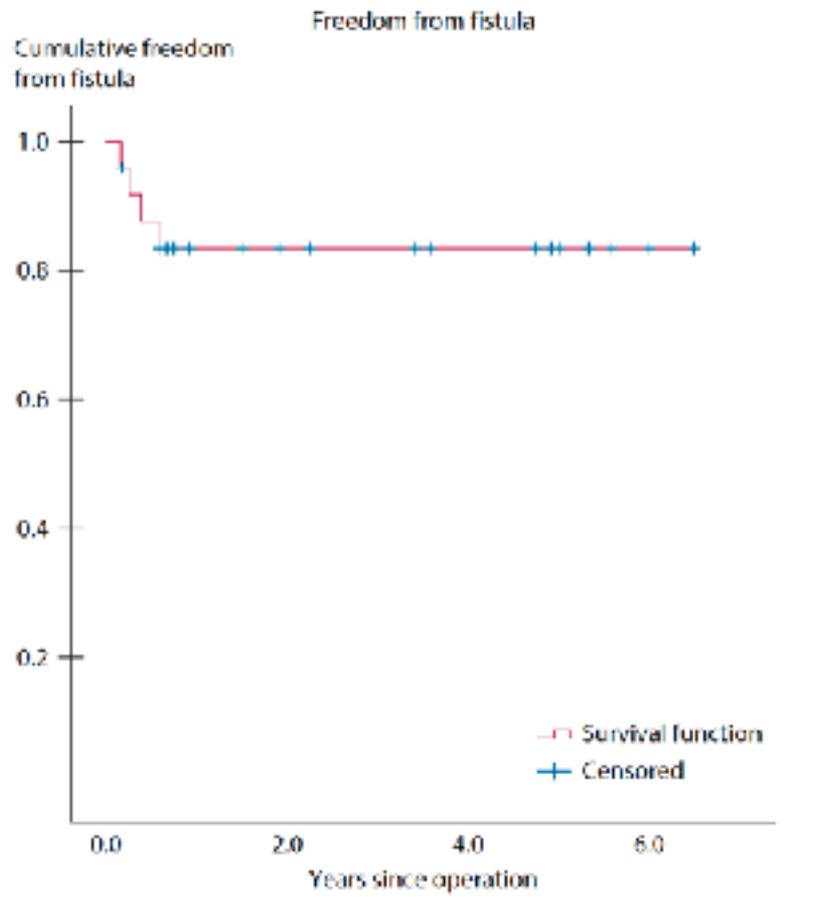
EFFET ANTI INFLAMMATOIRE MARQUÉ

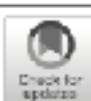
EFFET CICATRISATION ET
RECONSTRUCTION ?

RETRAITEMENT PROBABLEMENT
NÉCESSAIRE

QUI EST LA POPULATION CIBLE
IDÉALE ?

Long-term Results of Mucosal Advancement Flap Combined With Platelet-rich Plasma for High Cryptoglandular Perianal Fistulas



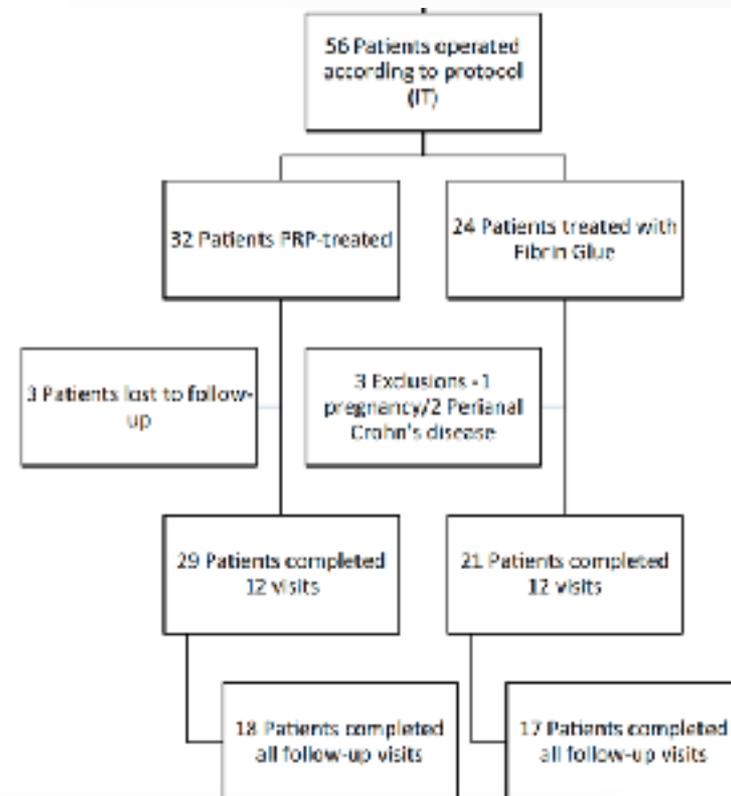


Platelet-rich plasma (PRP) versus fibrin glue in cryptogenic fistula-in-ano: a phase III single-center, randomized, double-blind trial

Fernanda de la Perilla¹ · María Virginia Durán Muñoz-Cruzado¹ · María Victoria Maestro¹ · Ana María García-Cabrera¹ · María Luisa Rojas¹ · Jorge Manuel Viquez-Monreal¹ · Rosa María Jimenez-Rodríguez¹ · José Manuel Díaz-Pérez¹ · Francisco Javier Pacillo¹

	IT (n = 56)		ITm (n = 50)		PP (n = 35)	
	Fibrin	PRP	Fibrin	PRP	Fibrin	PRP
Overall	10 (41.7%)	15 (48.4%)	10 (43.5%)	12 (44.4%)	7 (50%)	8 (40%)
Complete	4 (16.7%)	7 (22.6%)	3 (13%)	6 (22.2%)	2 (14.3%)	4 (20%)
Partial	14 (58.3%)	21 (71%)	13 (56.5%)	18 (66.7%)	9 (64.3%)	12 (60%)
Non-healing	10 (41.7%)	9 (29%)	10 (43.5%)	9 (33.3%)	5 (35.7%)	8 (40%)
<i>P</i>	0.608		0.432		0.568	

IT, intention to treat; ITm, modified intention to treat; PP, protocol patients





Efficacy of autologous fat graft injection in the treatment of anovaginal fistula

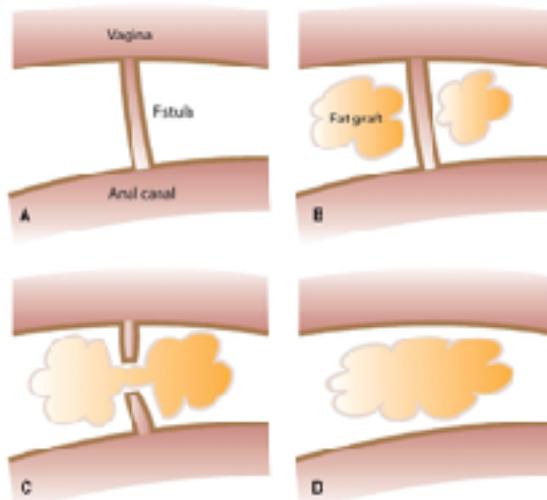
S. Norderval^{1,2,3} · L. Lundby⁴ · H. Hoegaard⁴ · S. Buntze^{1,2,3} · S. Weum^{5,6} · L. de Weerd^{6,7}



Rectovaginal fistula closure with micro-fragmented autologous adipose tissue injection

Alessandro Sturale¹ · Bernardina Fabiani¹ · Felipe Celecon Porzio¹ · Claudia Menconi¹ · Gabriele Nalcini¹

Fig. 1 The various steps of the procedure shown schematically. a Anovaginal fistula, b fat graft injected around the fistula, c fistula transected transversely, d viable fat graft in the area where the fistula was located





Mix and fragmented adipose tissue injection for the treatment of complex anal fissures: a pilot study assessing safety and feasibility

S. Hattler¹, A. Houtak², E. Adami², L. Elmer², C. Mowatt²

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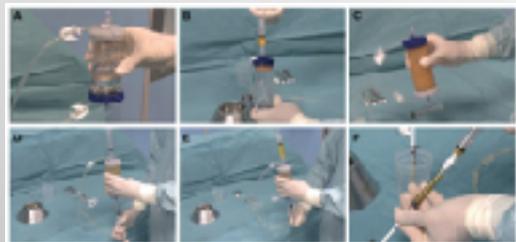




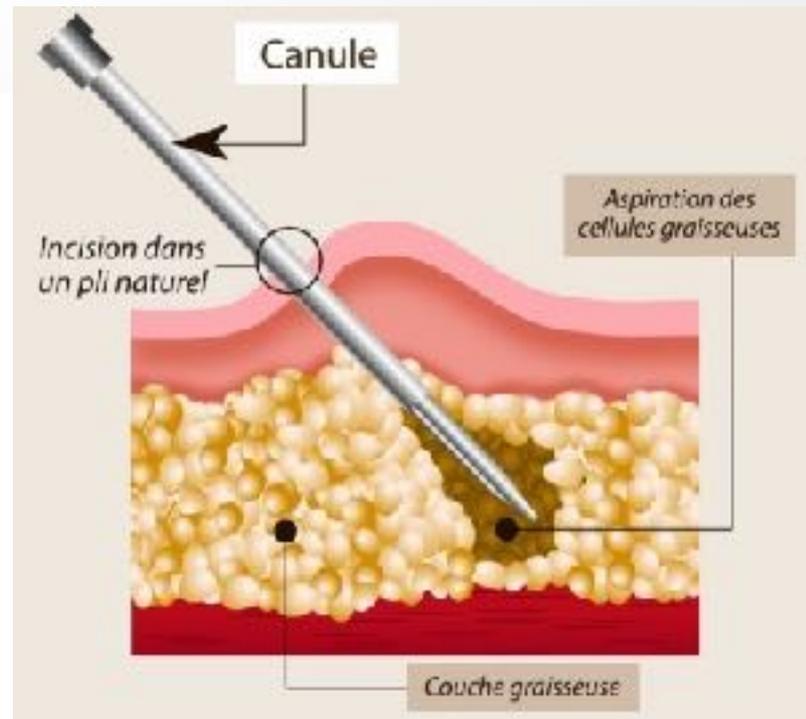
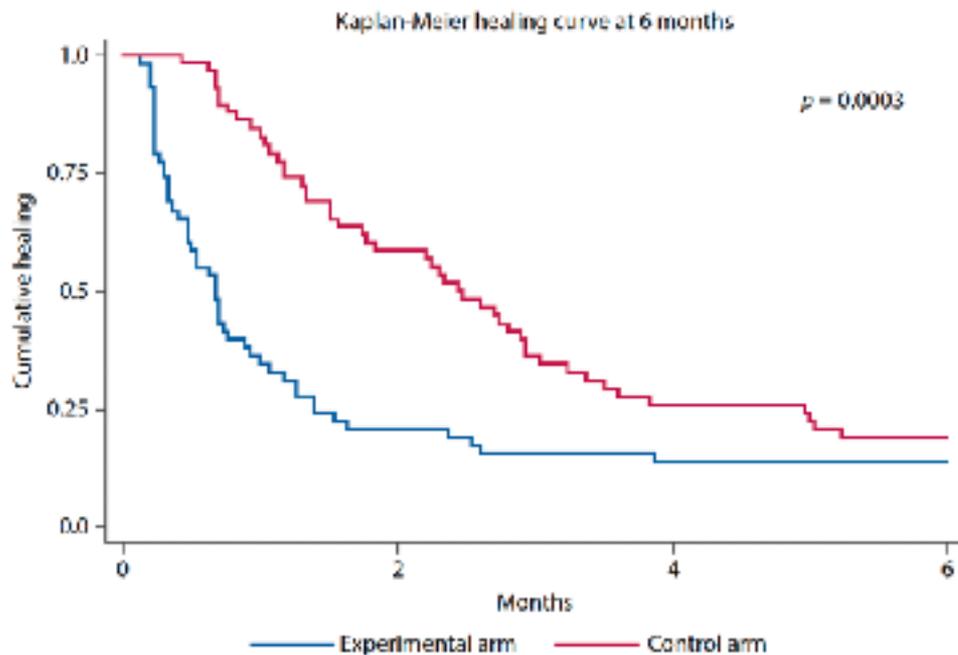
Fig. 4 a Debridement of fistula tract. b Closure of internal opening using 2/0 polydioxanone stitches for the muscular layer. c Injection of the final Lipogems[®] product through 1-ml syringes around the internal opening



Fig. 5 a Mucosal flap closed with 2/0 Vicryl stitches. b Injection of the final Lipogems[®] product through 1-ml syringes around the mucosal flap. c Injection of the final Lipogems[®] product through 1-ml syringes around the fistula tract

Efficacy and Safety of Treatment of Complex Idiopathic Fistula-in-Ano Using Autologous Centrifuged Adipose Tissue Containing Progenitor Cells: A Randomized Controlled Trial

Siriona Ascanelli, M.D.¹ • Paolo Zamboni, M.D.² • Diara Campioni, Ph.D.¹
 Maria Grazia Sibilla, M.D.¹ • Laura Chimisso, M.D.¹ • Ilaria Zollino, M.D., Ph.D.¹
 Giorgia Valpiani, M.Sc., Ph.D.⁴ • Paolo Carrozzino, M.D.¹

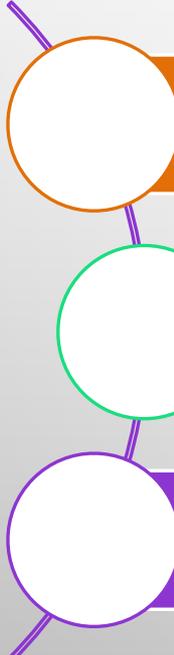


<i>Surgical procedures</i>	<i>acAT Injection group (n = 58)</i>	<i>No acAT Injection group (n = 58)</i>	<i>p value</i>
Internal opening identification, n (%)	58 (100)	58 (100)	0.999
External opening			
One	43 (74.1)	44 (75.8)	0.999
Two	13 (22.4)	11 (18.9)	
Three	2 (3.4)	3 (5.2)	
Cone-like fistulectomy + IO suture	20 (34.5)	30 (51.7)	0.061
Cone-like fistulectomy + advanced flap	15 (25.8)	16 (27.6)	0.834
VAAFT + IO suture	20 (34.5)	10 (17.2)	0.034
VAAFT + advanced flap	3 (5.2)	2 (3.5)	0.648
Duration of operation, min, median [1Q–3Q]	85 [80–100]	55 [50–65]	<0.001
Amount of acAT, mL injected, median [1Q–3Q]	16 [14–18]	–	–

acAT = autologous centrifuged adipose tissue; IO = internal opening; 1Q–3Q = first and third quartiles; VAAFT = video-assisted anal fistula treatment.

<i>Outcome results</i>	<i>acAT injection group (n = 58)</i>	<i>No acAT injection group (n = 58)</i>	<i>p value</i>
Healing time, days, median [1Q–3Q]	16 [8–30]	60.5 [33–88]	<0.001
Complete closure at 4 wk, n (%)	37 (63.8)	9 (15.5)	<0.001
Complete closure at 8 wk, n (%)	47 (81.1)	25 (43.1)	<0.001
Complete closure at 3 mo, n (%)	51 (87.9)	37 (63.8)	<0.001
Complete closure at 6 mo, n (%)	50 (86.2)	47 (81.03)	0.477
Recurrence at 6 mo, n (%)	8 (13.7)	11 (18.9)	0.477
Recurrence at 12 mo, n (%)	2 (3.4)	0 (0)	0.496
Reoperation for recurrence, n (%)	7 (87.5)	8 (80)	0.802
Healed patients after second procedure, n (%)	5 (71.5)	8 (100)	0.104
Overall healing rate, n (%)	55 (94.8)	55 (94.8)	0.246
Time taken to return to work/daily activity, median [1Q–3Q]	3 [2–5]	17.5 [15–25]	<0.001

PAS D'ALTERNATIVE SÉDUISANTE



BANDONNER CE QUI NE FONCTIONNE PAS

PRUDENCE DANS LES « APPROCHES
HÉROÏQUES »

NEUX ÉVALUER LES « FONDAMENTAUX »

CE QUI N'EST PAS EBM





ON NE SE DONNE PAS LES MOYENS

ON TRAÎNE TROP LONGTEMPS DANS LES
PRISES EN CHARGE

ON DOIT MODIFIER LES OBJECTIFS
THÉRAPEUTIQUES EN FONCTION DU STADE
DE LA MALADIE

Long-term Outcome of Perianal Fistulizing Crohn's Disease Treated With Infliximab

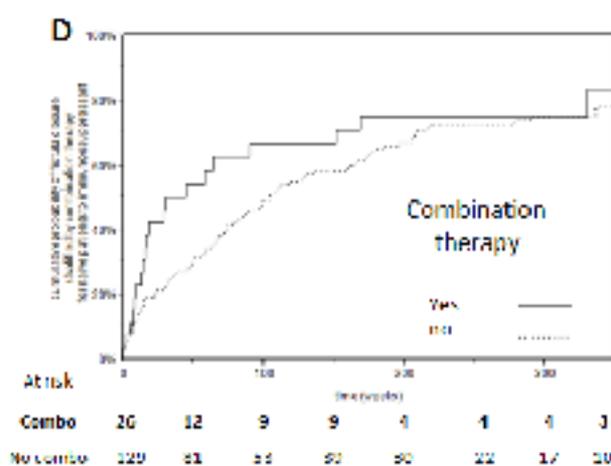
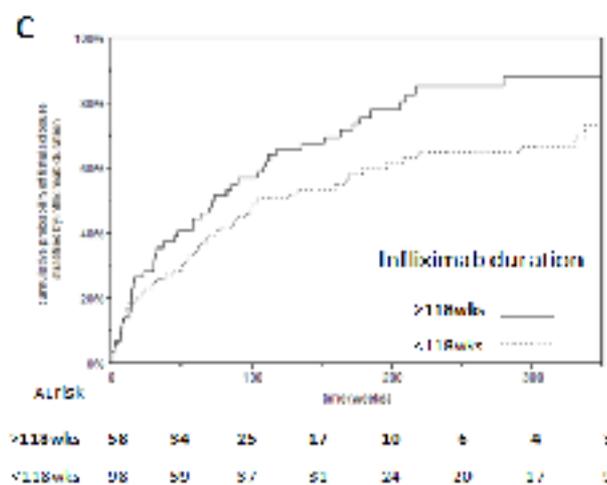
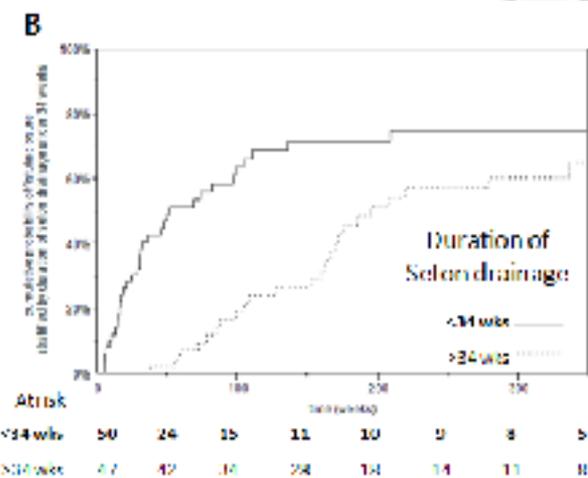
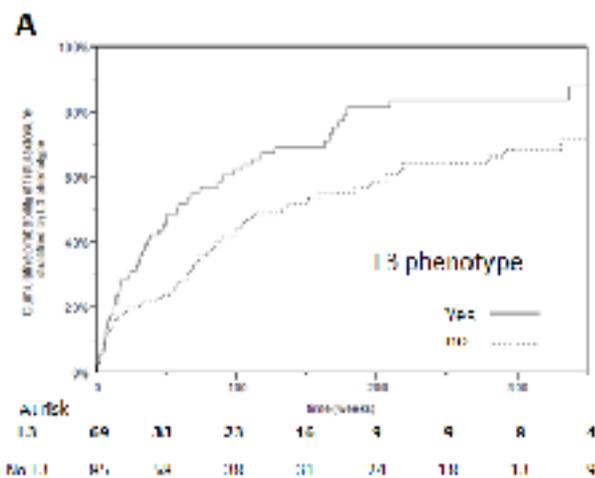


Fig. 3



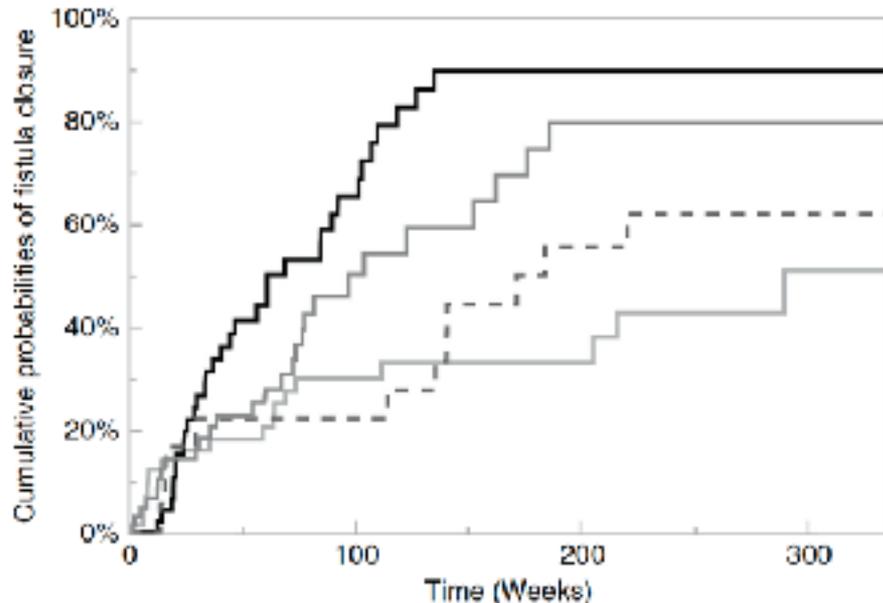
ORIGINAL ARTICLE

Identification of the optimal medical and surgical management for patients with perianal fistulising Crohn's disease

Mathilde Laland¹ | Marie François¹ | Ferdinando D'Amico^{2,3} | Camille Zailot² |
 Charlene Brochard⁴ | Marie Dewitte⁴ | Laurent Siproudhis⁴ |
 Laurent Peyrin-Biroulet³ | Guillaume Bouguen⁴

	Univariate analysis (log-rank)	Multivariate analysis HR (CI 95%), p-value
Prior PCD surgery	0.007	1.53 (0.70-3.27), 0.27
Seton at inclusion	0.005	1.15 (0.51-2.32), 0.66
Complementary perineal surgery	0.004	1.00 (0.50-1.86), 0.51
Complementary surgery within 52weeks	<0.0001	2.18 (1.22-3.99), 0.007

Abbreviations: CI, confidence interval; HR, hazard ratio; PCD, perianal fistulising Crohn's disease.



— Seton and additional surgery within 1 y	47	11	11	2
— Seton alone	62	13	5	4
- - Seton and additional surgery > 1 y	18	15	9	5
— No seton	58	24	15	6

ON NE SE DONNE PAS LES MOYENS

- IDENTIFIER TOUT LES SUFFURATIONS, TOUT METTRE EN ŒUVRE À LA PHASE INITIALE (DRAINAGE, COMBO, ANTIBIOTIQUES)

ON TRAÎNE TROP LONGTEMPS DANS LES PRISES EN CHARGE

- NE PAS LAISSER LES DRAINS PERDUS (ORGANISATION DES TRAJETS)

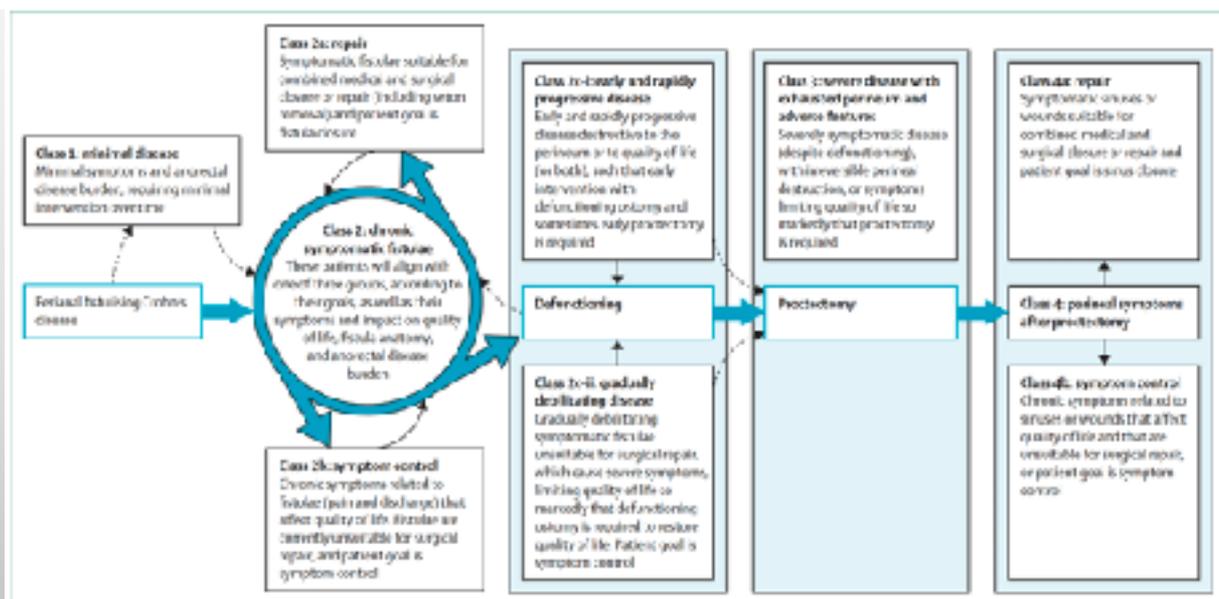
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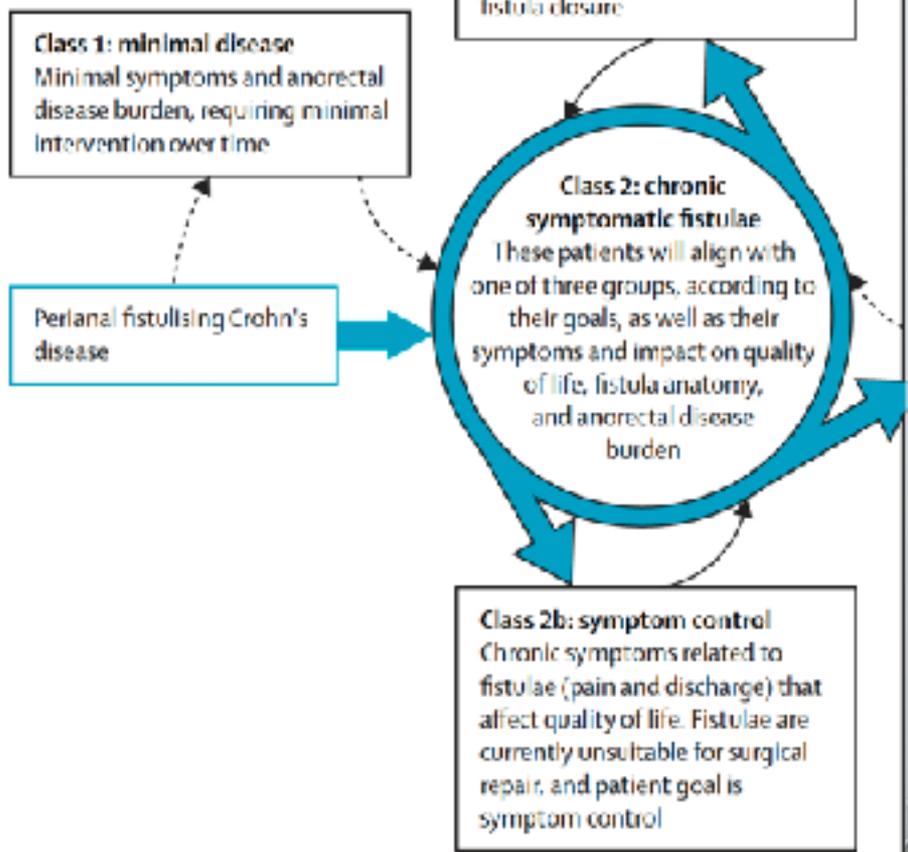
- FISTULE ACTIVE OU FISTULE CICATRICIELLE



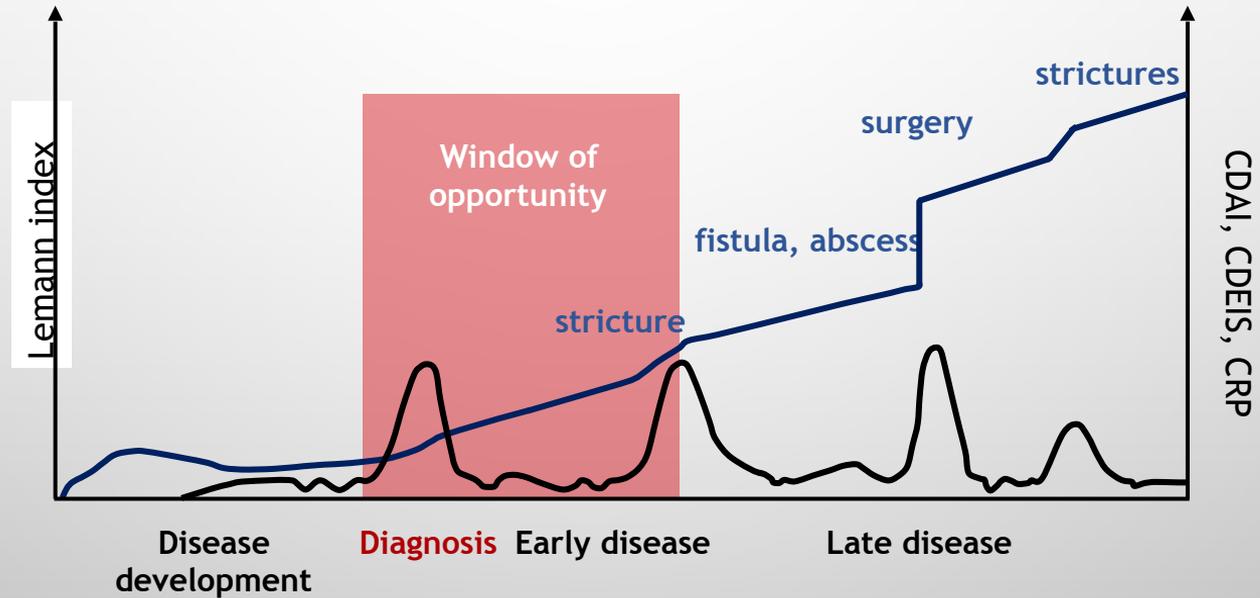
Classifying perianal fistulising Crohn's disease: an expert consensus to guide decision-making in daily practice and clinical trials

Jeroen Geidof, Nusrat Iqbal, Jean-Frédéric LeBlanc, Sulak Anandabaskaran, Rachel Sawyer, Christianne Buskens, Willem Bemelman, Krisztina Gece, Lilli Lundby, Amy L. Lightner, Silvia Danese, Antonino Spinelli, Michele Carvello, Omar Faiz, Janindra Warusawitarne, Phillip Lung, Darryl De Looze, André D'Hoore, Séverine Vermeire, Ailsa Hart, Phil Tozer





LA FENÊTRE D'OPPORTUNITÉ



MESSAGE:
FENÊTRE
D'OPPORTUNITÉ

