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Perianal Abscesses During Tirzepatide Treatment: A Report of Two Cases

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Abstract

Tirzepatide is increasingly used in the management of obesity and is associated with gastrointestinal adverse effects, including nausea, diarrhea, vomiting, and constipation. Although constipation is well recognized, anorectal infectious complications have not been specifically described in association with tirzepatide therapy. We report two women with obesity who developed perianal abscesses during tirzepatide treatment. The first patient, aged 31 years, developed constipation after initiation and dose escalation of tirzepatide and was diagnosed with a perianal abscess approximately seven months after starting treatment. The second patient, aged 42 years, developed marked constipation, with bowel movements occurring once every three to four days, and subsequently developed a perianal abscess after approximately three months of treatment at the 5-mg weekly dose. Both patients required surgical drainage and antibiotic therapy. Gastroenterological evaluation, including colonoscopy and computed tomography enterography, revealed no findings suggestive of Crohn's disease in either patient. The temporal association between tirzepatide-related constipation and perianal abscess does not establish causality, particularly because most perianal abscesses are cryptoglandular in origin. Nevertheless, these cases highlight a potentially relevant anorectal event in patients receiving tirzepatide and support awareness of new perianal symptoms in patients who develop significant constipation during treatment.

Categories: General Surgery, Endocrinology/Diabetes/Metabolism, Gastroenterology
Keywords: anorectal complications, constipation, obesity, perianal abscess, tirzepatide

Introduction

Obesity and type 2 diabetes mellitus are closely interrelated chronic metabolic disorders and frequently coexist in clinical practice. Weight reduction is a central component of obesity management, and tirzepatide has demonstrated substantial efficacy in achieving clinically meaningful weight loss in individuals with obesity [1]. Longer-term data also suggest that tirzepatide-induced weight reduction may improve metabolic outcomes and reduce progression to type 2 diabetes in individuals with obesity and prediabetes [2]. In this context, incretin-based therapies have become increasingly important in the management of obesity and type 2 diabetes mellitus.

Tirzepatide is a dual agonist of the glucose-dependent insulinotropic polypeptide and glucagon-like peptide-1 receptors and has demonstrated substantial efficacy in both weight reduction and glycemic control [1,2]. Gastrointestinal adverse effects represent the most frequently reported adverse events associated with tirzepatide, including nausea, diarrhea, vomiting, and constipation [1,2]. In the SURMOUNT-1 trial, constipation was reported in approximately 12-17% of patients receiving tirzepatide [1].

Most perianal abscesses arise from cryptoglandular infection originating from the anal glands, although secondary causes such as Crohn's disease should be considered, particularly in recurrent or complex perianal disease [3,4]. Despite the recognized effects of tirzepatide on gastrointestinal motility and bowel habits, perianal abscess has not, to our knowledge, been specifically described as a clinical event occurring during tirzepatide treatment.

We present two women who developed constipation during tirzepatide therapy followed by perianal abscess requiring surgical drainage. These observations are presented to raise awareness of a possible anorectal clinical event while emphasizing that a causal relationship between tirzepatide, constipation, and perianal abscess cannot be established from two cases.

Case Presentation

Case 1

A 31-year-old woman with obesity (height: 155 cm) started tirzepatide at a dose of 2.5 mg once weekly in December 2025. At baseline, her body weight was 105 kg (body mass index (BMI): 43.7 kg/m^2). Baseline laboratory evaluation showed a hemoglobin A1C (HbA1C) of 5.5%, fasting plasma glucose of 82 mg/dL, fasting insulin of 12 µIU/mL, and a calculated homeostasis model assessment for insulin resistance (HOMA-IR) of 2.43. The lipid profile showed a total cholesterol level of 180 mg/dL, low-density lipoprotein (LDL)

cholesterol of 118 mg/dL, high-density lipoprotein (HDL) cholesterol of 38 mg/dL, and triglycerides of 124 mg/dL. The HbA1c and fasting plasma glucose values were within the normoglycemic range. HOMA-IR was interpreted descriptively rather than using a fixed diagnostic cutoff because HOMA-IR thresholds vary across populations and assay methods.

After four weeks of treatment, the tirzepatide dose was increased to 5 mg once weekly in January 2026. Before initiation of tirzepatide, she had no history of chronic constipation and reported regular bowel habits. She also had no known history of hemorrhoids, anal fissure, anorectal fistula, previous perianal abscess, or anorectal surgery. No new medication or clinically apparent condition that could otherwise explain the development of constipation was identified during treatment.

During tirzepatide therapy, her bowel movements decreased to approximately once weekly. Stool consistency was classified as Bristol Stool Form Scale type 2, and straining during defecation was present. She did not use laxatives and attempted dietary measures to manage her bowel symptoms. Her body weight decreased from 105 kg to 75 kg (BMI: 31.2 kg/m^2), corresponding to a 28.6% reduction from baseline body weight.

In July 2026, approximately seven months after initiation of tirzepatide, she presented with perianal pain. Physical examination showed a localized erythematous and swollen perianal lesion with a draining opening (Figure *1*). On the basis of the clinical findings, she was diagnosed with a perianal abscess.



FIGURE 1: Clinical appearance of the perianal abscess in Case 1.

Localized perianal erythema and swelling with a draining ulcerated opening are visible at presentation.

Cross-sectional imaging was performed as part of the diagnostic evaluation. Computed tomography demonstrated a 15 × 25 mm loculated collection in the right perianal region (Figure *2*).

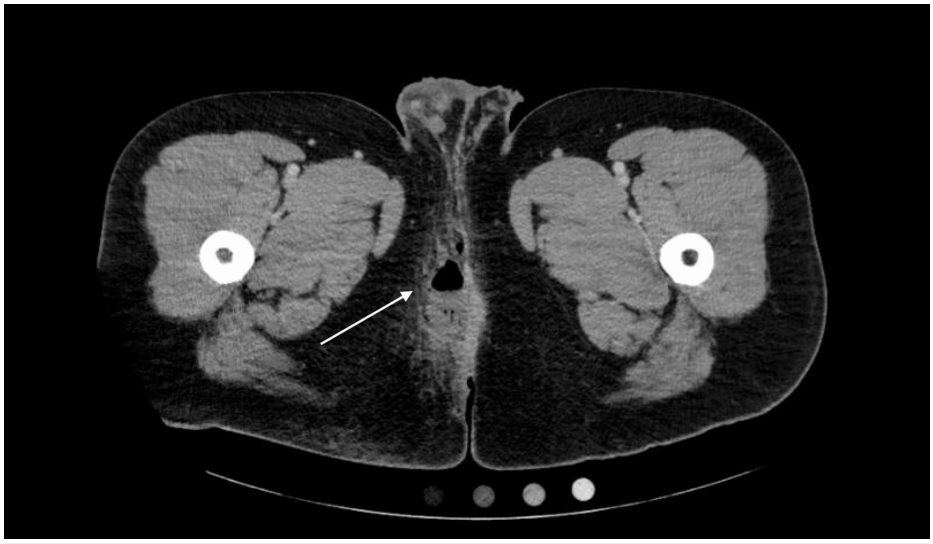


FIGURE 2: Computed tomography finding in Case 1.

Axial CT image demonstrating the perianal lesion/collection indicated by the arrow.

Because of the occurrence of perianal disease, she underwent gastroenterological evaluation for potential secondary causes, particularly Crohn's disease. Colonoscopy documented a normal terminal ileum and no endoscopic findings suggestive of Crohn's disease. Representative colonoscopic images are shown in Figure *3A*-*3C*. Computed tomography enterography showed no bowel wall thickening or other radiological findings suggestive of Crohn's disease.

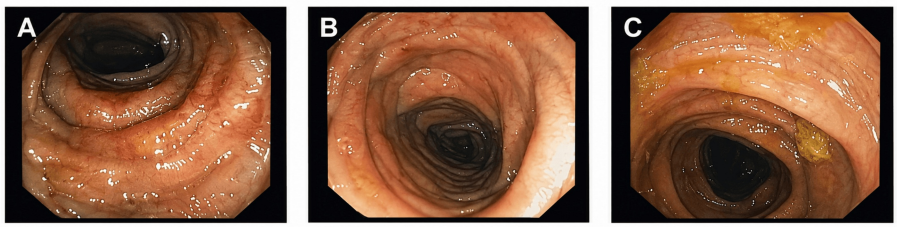


FIGURE 3: Colonoscopic findings in Case 1.

Panels A, B, and C show representative images from the colonoscopic examination. The examination report documented a normal terminal ileum and no endoscopic findings suggestive of Crohn's disease.

The abscess was surgically drained by the Department of General Surgery. Amoxicillin/clavulanate therapy was administered after drainage. The perianal abscess resolved clinically, and antibiotic therapy was discontinued after resolution. Tirzepatide was discontinued. No recurrence of the perianal abscess was observed during follow-up.

Case 2

A 42-year-old woman with obesity (height: 160 cm) started tirzepatide at a dose of 2.5 mg once weekly in December 2025. At baseline, her body weight was 103 kg (BMI: 40.2 kg/m^2). Baseline laboratory evaluation showed an HbA1c of 6.3%, fasting plasma glucose of 105 mg/dL, fasting insulin of 8 µIU/mL, and a calculated HOMA-IR of 2.07. The lipid profile showed a total cholesterol level of 167 mg/dL, LDL cholesterol of 110 mg/dL, HDL cholesterol of 44 mg/dL, and triglycerides of 64 mg/dL. The HbA1c and fasting plasma glucose values were in the prediabetes range. HOMA-IR was interpreted descriptively rather than using a fixed diagnostic cutoff because HOMA-IR thresholds vary across populations and assay methods.

One month later, the tirzepatide dose was increased to 5 mg once weekly. Before initiation of tirzepatide, she had no history of chronic constipation and reported regular bowel habits. She also had no known history of hemorrhoids, anal fissure, anorectal fistula, previous perianal abscess, or anorectal surgery. No new medication or clinically apparent condition that could otherwise explain the development of constipation was identified during treatment.

During tirzepatide therapy, her bowel movements decreased to approximately once every three to four days. Stool consistency was classified as Bristol Stool Form Scale type 1, and straining during defecation was present. She did not use laxatives and attempted dietary measures to manage her bowel symptoms. Her body weight decreased from 103 kg to 82 kg (BMI: 32.0 kg/m²), corresponding to a 20.4% reduction from baseline body weight.

After approximately three months of treatment with the 5-mg weekly dose, in April 2026, she developed perianal pain and was evaluated by the Department of General Surgery, where a perianal abscess was diagnosed. Computed tomography demonstrated several loculated perianal collections in the right perianal region, the largest measuring 2 × 3 cm (Figure *4*).

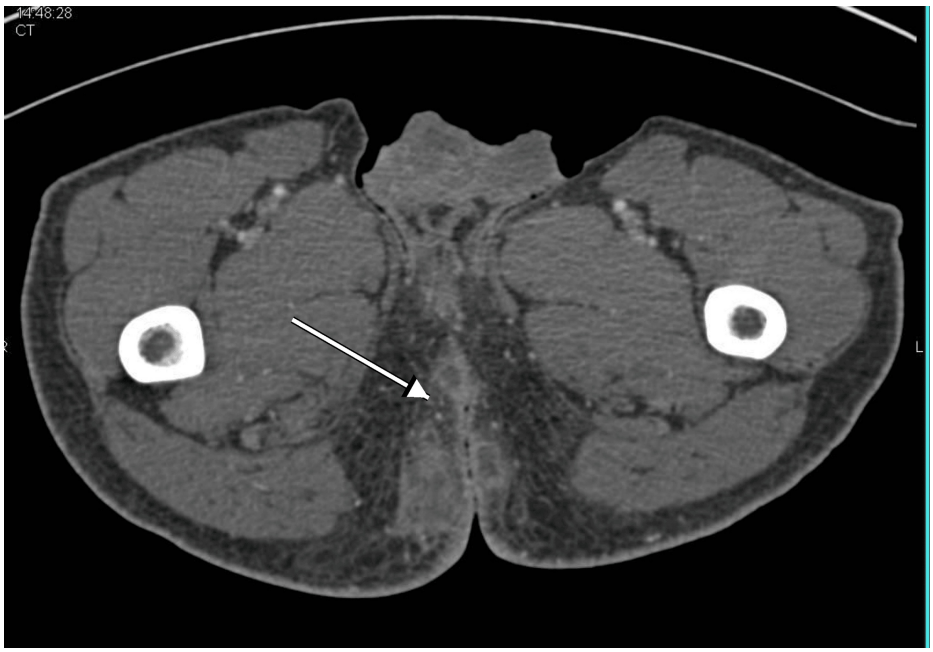


FIGURE 4: Computed tomography finding in Case 2.

Axial pelvic CT image demonstrating several loculated perianal collections in the right perianal region, the largest measuring 2 × 3 cm. The relevant perianal abnormality is indicated by the arrow.

She was also evaluated by the Department of Gastroenterology for possible underlying Crohn's disease. Colonoscopy documented a normal terminal ileum and no endoscopic findings suggestive of Crohn's disease. Representative colonoscopic images are shown in Figure *5A*-*5C*. Computed tomography enterography showed no bowel wall thickening or other radiological findings suggestive of Crohn's disease.

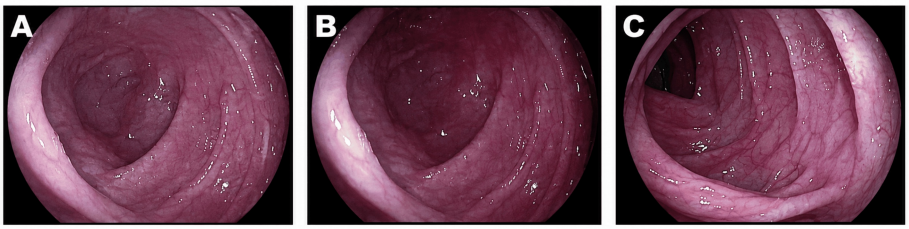


FIGURE 5: Colonoscopic findings in Case 2.

Panels A, B, and C show representative images from the colonoscopic examination. The examination report documented a normal terminal ileum and no endoscopic findings suggestive of Crohn's disease.

Surgical drainage was performed, and abscess culture yielded *Escherichia coli*. Amoxicillin/clavulanate therapy was administered after drainage. The perianal abscess resolved clinically, and antibiotic therapy was discontinued after resolution. Tirzepatide was discontinued. No recurrence of the perianal abscess was

observed during six months of follow-up after surgical drainage and discontinuation of tirzepatide.

Discussion

The notable common feature of these two cases was the development of new-onset constipation during tirzepatide treatment before the occurrence of perianal abscess. Tirzepatide-associated constipation is well established in randomized clinical trials [1,2]. In our patients, the change in bowel habits was characterized objectively by reduced bowel movement frequency, hard stool consistency according to the Bristol Stool Form Scale, and straining during defecation. Case 1 reported approximately one bowel movement per week with Bristol type 2 stools, whereas Case 2 reported one bowel movement every three to four days with Bristol type 1 stools. Neither patient used laxatives, and both attempted dietary measures to manage their bowel symptoms.

A recently published case report described painful perianal fissuring and excoriation associated with hard stools in a patient who developed severe constipation after tirzepatide dose escalation [5]. This observation suggests that clinically important anorectal symptoms may occur in some patients who experience substantial changes in bowel habits during tirzepatide therapy. However, such observations do not establish a direct mechanistic relationship between constipation and perianal abscess.

Perianal abscess most commonly results from obstruction and infection of the anal glands and is therefore predominantly cryptoglandular in origin [3,4]. Accordingly, the occurrence of perianal abscess in our patients may have been coincidental. Although constipation preceded the abscess in both cases, we did not demonstrate a direct anatomical or pathophysiological pathway linking altered bowel habits to cryptoglandular infection. A proposed pathway involving hard stools, local trauma, or fissuring therefore remains hypothetical and should not be interpreted as a mechanism demonstrated by these cases.

Secondary causes of perianal disease were also considered. Neither patient had a known history of hemorrhoids, anal fissure, anorectal fistula, previous perianal abscess, or anorectal surgery before initiation of tirzepatide. In addition, both patients underwent gastroenterological evaluation, including colonoscopy and computed tomography enterography, with no endoscopic or radiological findings suggestive of Crohn's disease.

The available microbiological and radiological findings were added to further characterize the abscesses. Abscess cultures from both patients yielded *Escherichia coli*. In Case 1, computed tomography demonstrated a 15 × 25 mm loculated collection in the right perianal region. In Case 2, computed tomography demonstrated several loculated perianal collections in the right perianal region, the largest measuring 2 × 3 cm. These findings provide additional clinical characterization but do not establish a specific drug-related mechanism.

Both patients underwent surgical drainage followed by amoxicillin/clavulanate therapy, with subsequent clinical resolution. Tirzepatide was discontinued in both cases. No recurrence was observed during three months of follow-up in Case 1 and six months in Case 2. However, the absence of recurrence after tirzepatide discontinuation should not be interpreted as evidence of a positive drug dechallenge because surgical drainage and antibiotic therapy were administered concurrently, making it impossible to determine the independent effect of drug withdrawal.

Recent pharmacovigilance studies have evaluated adverse-event reports associated with tirzepatide and have investigated both established and previously unrecognized safety signals [6,7]. To our knowledge, published reports have not specifically identified perianal abscess as an adverse clinical event associated with tirzepatide. Therefore, the present observations should be regarded as hypothesis-generating rather than evidence of a new adverse drug reaction.

This report has several limitations. First, it includes only two patients and cannot establish causality. Second, perianal abscess is a relatively common clinical condition and may have occurred independently of tirzepatide exposure. Third, although constipation was characterized using bowel movement frequency, Bristol Stool Form Scale, straining, and laxative use, these treatment-emergent symptoms were not retrospectively classified according to Rome IV criteria. Finally, the simultaneous use of surgical drainage, antibiotic therapy, and tirzepatide discontinuation prevents assessment of the individual contribution of drug withdrawal to clinical recovery. Additional case reports and larger pharmacovigilance analyses are needed to determine whether perianal abscess occurs more frequently than expected among patients receiving tirzepatide.

Conclusions

We describe two women who developed perianal abscesses during tirzepatide treatment after experiencing new-onset constipation. Both patients required surgical drainage followed by amoxicillin/clavulanate therapy and subsequently achieved clinical resolution. Tirzepatide was discontinued in both cases, and no recurrence was observed during three months of follow-up in Case 1 and six months in Case 2.

Although the temporal sequence raises the possibility of an association, these observations do not establish a causal relationship between tirzepatide, constipation, and perianal abscess. Perianal abscess is most commonly cryptoglandular in origin, and the events described in these two patients may have been coincidental. Clinicians should nevertheless remain attentive to new anorectal symptoms in patients who develop substantial changes in bowel habits during tirzepatide treatment. Further case reporting and larger pharmacovigilance studies are needed to determine whether this represents a reproducible safety signal or a chance association.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Onur Eksi

Acquisition, analysis, or interpretation of data: Onur Eksi, Merve Soyhan

Drafting of the manuscript: Onur Eksi

Critical review of the manuscript for important intellectual content: Merve Soyhan

Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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