ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 11, Issue, 06, pp.4386-4388, June, 2019

DOI: https://doi.org/10.24941/ijcr.35169.06.2019

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

MANAGEMENT OF FISTULA IN ANO: AN OVERVIEW

***[1]Dr. Naveed Anjum Qureshi and [2]Dr. Viney Sambyal**

[1]Junior Consultant SMVD Narayana Superspeciality Hospital Katra, India
[2]Lecturer Medicine, Post Graduate Department of Medicine, GMC Jammu, India

ARTICLEINFO

Article History:
Received 24th March, 2019
Received in revised form
18th April, 2019
Accepted 19th May, 2019
Published online 30th June, 2019

Key Words:
Fistula-in-ano,
Fistulectomy.

**Corresponding author:*
Dr. Naveed Anjum Qureshi

ABSTRACT

Background: Fistula-in-ano is an abnormal communication between the anal canal or rectum and the perianal skin. Most commonly caused by an anorectal abscess resulting from cryptoglandular infection. Patient usually presents with intermittent or constant purulent perianal discharge. There is usually a history of anorectal abscess that ruptured spontaneously or was surgically drained. Digital rectal examination remains the main stay of diagnosis in anorectal fistula cases**.** ***Methods*****:** Data of 69 patients who were admitted at SMVD Superspeciality Hospital Katra from 1st May 2016 to 30th April 2018 was analyzed retrospectively. In addition to clinical examination, routine investigations and Digital Rectal Examination, MRI fistulography was done in all cases and appropriate surgical management was done. Data was analyzed retrospectively for intraoperative findings, nature of surgery, intra and postoperative complications and recurrence. ***Results*****:** Most common mode of presentation in our study was perianal discharge and discomfort (98%). 66 (95.6%) patients were males with a male to female ratio of 13.2:1. Young adults (40-50 years) were most commonly involved comprising 28 patients (40.5%). 55 Patients (79.7%) had single opening. 27 patients (40%) had previous history of surgical drainage of perianal abscess. 55 Patients (80%) had posterior opening while 14 patients (20%) had anterior opening. Fistulectomy and fistulotomy were performed in 55 patients (80%) and 4 patients (20 %) respectively. ***Conclusion*****:** Anal fistula is a common disease which results from cryptoglandular infection. The complexity of the disease poses challenges to the surgeon. Early diagnosis and appropriate management are the key to success.

Citation: Dr. Naveed Anjum Qureshi and Dr. Viney Sambyal. **2019.** "Management of fistula in ano: an overview", *International Journal of Current Research*, 11, (06), 4386-4388.

INTRODUCTION

Fistula-in-Ano is a common surgical pathology presenting worldwide. It is an abnormal communication between the anal canal or rectum and the perianal skin, which causes a chronic inflammatory response (Shruti Yadu, 2018). There is usually a history of perianal abscess that ruptured spontaneously or was surgically drained (Babu, 2015). The occurrence of such abscess is mostly secondary to infection of an anal gland (Cryptoglandular hypothesis of Eisenhammer) (Adams, 1981). The anal fistula, as a chronic inflammatory process, does not heal spontaneously. Although the conservative management, which consists of antibiotic therapy against the Gram-negative organisms and anaerobic bacteria, may be effective in the acute and early phase of the anal disease, surgery remains the elective treatment (Roberto Cirocchi, 2009). The prevalence of non-specific anal fistulae has been estimated to be 8.6 to 10/100,000 of the population per year, with a male to female ratio of 1.8:1.1 (Shruti Yadu, 2018). Chronic anal fissure, Tuberculosis, lymphogranuloma inguinale, inflammatory bowel disease, colloid carcinoma of rectum can also lead to development of anal fistula. Fistulae have been reported following stradle injury or probing an abscess or low anal fistula (Gupta, 2006). Occasionally ingested foreign bodies, such as fish or chicken bones may penetrate the rectum. Stradle injury after falling astride, a sharp object or as a result of a road traffic accident may result in a high anorectal fistula. Milligan and morgan in 1934 classified the fistulas into high and low depending weather the internal opening lies above or below the anorectal ring. Park classified fistulas into sub-mucosal, intersphinteric, suprasphinteric and extrasphinteric (Murtaza Akhter, 2012). Although commonly done investigations in fistula-in-ano are Sigmoidoscopy, Colonoscopy, Fistulography, transrectal ultrasound, MRI fistulography, and Fistuloscopy. Digital rectal examination remains the main stay of diagnosis in anorectal fistula cases (Adams, 1981).

MATERIALS AND METHODS

Data of 69 patients who were admitted with disgnosis of fistula-in-ano at SMVD Superspeciality Hospital Katra from 1st May 2016 to 30th April 2018 was analyzed retrospectively. In addition to clinical examination, routine investigations and Digital Rectal Examination, MRI fistulography was done in all

cases and appropriate surgical management was done. Data was analyzed retrospectively for intraoperative findings, nature of surgery, intra and postoperative complications and recurrence. Patients with history of inflammatory bowel disease, tuberculosis, carcinoma rectum were excluded from the study.

RESULTS

Most common mode of presentation in our study was perianal discharge and discomfort (98%). 66 (95.6%) patients were males with a male to female ratio of 13.2:1 (Table 1).

Table 1. Sex distributions

Sex	No of patients	(%)
Male	66	95.6
Female	3	4.4
Total	69	100

Table 2. Age distribution

Age	No of Patients	(%)
<40 Years	9	13.04
40-49 Years	28	40.5
50-59 Years	19	27.5
>60 Years	13	18.8

Table 3. Socioeconomic status

Socioeconomic Status	Frequency	%
low	43	62.31
high	26	37.68
total	69	100

Table 4. Site of external opening

Opening	Frequency	%
Posterior	55	80
Anterior	14	20
Total	69	100

Table 5. Clinical Presentation

Presentation	Frequency	%
Pain and discharge	67	97.1
Perianal swelling	6	8.6
Perianal abscess h/o	27	39.1
Recurrent fistula-in-ano	5	7.24

Table 6. Level of fistula

Type of fistula	Frequency	%
Low	59	85.5
High	10	14.4

Table 7. Nature of surgery

Type of surgery	Frequency	%
Fistulectomy	49	71.01
Fistulotomy	8	11.5
Seton placement	11	15.9
Curettage	1	1.44

Table 8. Recurrence

Followup	Frequency	%
Complete healing	67	97.1
Recurrence	2	2.9

Young adults (40-50 years) were most commonly involved comprising 28 patients (40.5%) (Table 2). 55 Patients (79.7%) had single opening. 27 patients (40%) had previous history of surgical drainage of perianal abscess. 55 Patients (80%) had posterior opening while 14 patients (20%) had anterior opening (Table 4). Fistulectomy and fistulotomy were performed in 49 patients (71.01%) and 8 patients (11.5%) respectively, seton placement was done in 11(15.9%) patients, whereas curettage for sub mucous fistula was done in 1 (1.4%) patient (Table 7). Most of the patients belonged to lower socioeconomic status (62%). 55 patients (80%) had posterior opening whereas only 14 patients (20%) had an anterior opening. In our study only 2 patients had a recurrence over 6 months follow up (Table 8).

DISCUSSION

In our study, mean age was 42 years. Similar mean age has been noted by Sidhdharthr et al. (2015). Sainio P also reported a mean age of subjects with fistulae to be 38.5 years (Sainio, 1985.) However, in another study Kumar v et al reported a peak incidence in age group 31-60 years**.** In this study of 69 patients 64 were (95.6%) were found to be male and 5 patients (4.4%) were female. In study by Sidhdhartha *et al,* found 76% of male patients which is much lower than our study (Sidharth, 2015). In a study by kumar v et al there is a more male dominance in reported series comparable to our study. 97% patients had perianal pain and discharge as a presenting symptom. 39.1% patients had history of perianal abscess. Most common mode of presentation was discharge. While least common was perianal irritation in 10% subjects. In a study by Siddhartha r et al 72% patients pain around the anal region, discharging wound was the presenting complaint in 70% of the patients. In a study by Kumar et al also discharge and external opening were the commonest complaint and were present in all subjects (100%). Further discharge was found to be present in 50% subjects and pain in 52 % subjects, 8% subjects also reported bleeding per rectum (Sidharth, 2015; Sainio, 1985; Hamdani *et al.,* 2009).

Conclusion

Anal fistula is a common disease which is world wide in occurrence, imposes challenges to the surgeon due to the complex nature of the disease. Based upon the observations made in our study, we can conclude that early diagnosis and appropriate management is the key to success and reduce the recurrence rates.

REFERENCES

Adams D., Kovalcik PJ. 1981. Fistula in ano. *Surg Gynecol Obstet.*153:731-2.

Babu AK., Naik MB., Babu MR., Madhulikia M. 2015. Seton - as a gold standard treatment for high fistula in ano. *J Evidence Based Med Healthcare.,* 2(11):1687-93.

Gupta PJ. 2006. Frequency fistulotomy: a better tool radio frequency fistulotomy: a better tool than the conventional techniques in anal fistula. *Indian J Surg.*, 68:48-52

Hamdani A., Haigh PI., Liu IL. et al., 2009. Who is at risk of developing chronic anal fistula or recurrent anal sepsis after initial perianal abscess? *Dis colon Rectum.,* 52(2):217-21.

Murtaza Akhter. 2012. Fistula in Ano-An Overview. JIMSAJanuary-March vol25 no 1.

Roberto Cirocchi, Eriberto Farinella, Francesco La Mura et al., 2009. Fibrin glue in the treatment of anal fistula: a systematic review. *Ann Surg Innov Res.,* 3: 12.

Sainio P. 1985. Fistula in ano. Clinical fearures And long term results of surgery in 199 adults. *Ann Chir Gynaecol.,* 151(2):169-76.

Shruti Yadu, Aradhna Toppo. 2018. Clinical presentation and outcome of fistula in ano cases. International Surgery Journal sept;5(9):3006-3010.

Sidharth R., Kumar G A., Sreedhar S. 2015. Clinical Study Of fistula in ano. *J evol medical Dent Sci.,* 4(86):15082-87.

Vasilevsky CA., Gordon PH. 2007. Benign anorectal: Abscess and Fistula. The ASCRS textbook of colon and rectal surgery. New York, NY: Springer, 192-214.

****