



# One Day Surgery Times

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Another feather in the cap of The Indian Association of Day Surgery: 'Progress of Day Surgery in India', an article, published in The Ambulatory Surgery Journal, official publication of The International Association for Ambulatory Surgery, only of its kind in the world, where articles are written by invitation. Those interested in reading can do so from the internet by following this link: <http://79.171.35.173/joomla/index.php/ambulatory-surgery-journal>

**From the Editors Desk:**

**Anal Surgeries as Day Care:  
Conti.....**

**Fistula-in-ano:**

*"If you want to take revenge and ruin a surgeons reputation, send him a patient with a fistula-in-ano....."*



We would hear this from our learned seniors, very often. Not understanding why, initially, but, realizing later that it can be true. The discomfort to the patient, the recurrences of fistulas, are all now too familiar and dreaded. These articles are in a very simplified form, so that, everyone can appreciate the complexities of diseases in General Surgery and its possibilities as a Day Case.

**Theories:** again, like any anal affliction, Anal fistula is also mired in controversies, as to how it happens, how to identify, how to classify and how to treat. As with the differences in the presentation of the disease, the treatment and approach, varies.

But, the most common causes of a fistula-in-ano formation is sequel to peri-anal abscess. Inflammatory bowel disease like Crohn's disease, trauma, secondary to anal fissures, carcinoma, radiation therapy, actinomycoses, tuberculosis, and chlamydial infections are some known causes of a Fistula.

**Definition:** A fistula-in-ano is a hollow tract lined with granulation tissue connecting a primary opening inside the anal canal to a secondary opening in the perianal skin. Secondary tracts may be multiple and from the same primary opening.

For some reason, this disease is more commonly seen in the male patients.

**Types:** 1) Inter-Sphincteric, 2) Trans-Sphincteric; 3) Supra-Sphincteric; 4) Extra-Sphincteric-Sub-cutaneous; Sub-mucosal.

**Goodsall's rule:** is in relation to the external opening of an anal fistula to its internal opening. Fistulas can be described as anterior or posterior relating to a line drawn in the coronal plane across the anus, the so called transverse anal line. Anterior fistulas will have a direct track into the anal canal. Posterior fistulas will have a curved track with their internal opening lying in the posterior midline of the anal canal. An exception to the rule are anterior fistulas lying more

than 3 cm. from the anus, which may have a curved track (similar to posterior fistulas) that opens into the posterior midline of the anal canal.

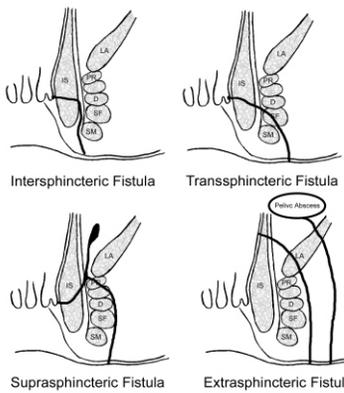
**Pre-op investigations** are routine. MRI and Fistulogram are often used for complex fistulas, but, a word of caution, these are images, sometimes can be misleading. Intra operative dye sinogram with diluted methylene blue and few drops of hydrogen peroxide, instilled from the external opening, under vision, shows the internal opening in most cases, along with delineation of the tract. This test is performed by the operating surgeon themself.

**Surgical management:** Most important part of surgery is to identify the Continence mechanism of the anal sphincter and preserve it while operating. Therefore, to know the type of Fistula is mandatory, for example, Sub-cutaneous/Sub-mucosal type do not involve the Anal Sphincter, thus surgery is straight forward laying open and excising the fistulous tract, the healing takes place secondarily. If the tract is involving the sphincter, then a 'set-on' tie should be considered, where, after opening the tract up to the sphincter muscle, a suture is passed through the tract and tied tightly to the muscles, causing gradual cutting of the sphincter and simultaneously allowing it to heal, so that the continence is preserved. This thread may need changing periodically, so as to complete the cutting of the fistulous track without damaging it.

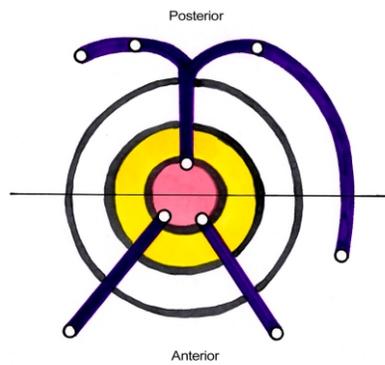
In complicated fistulas, with tracts extending upto the groin, the inguinal region, buttocks and thighs, the approach varies. After complete excision of the tracts, primary closure with a corrugated or suction drain is also performed. Coring out of the fistulous tract from the external opening to the internal region, leaving the outer skin intact, is also a commonly used method for dealing with the fistula tract.

**Post op care** includes Seitz bath, thrice daily, with light packing of the wounds with simple gauze soaked in hydrogen peroxide and povidon iodine and a dressing pad cover. Oral stool softeners, Laxatives, painkillers and antibiotics can be given, if required. Use of antiseptic and antibiotic creams vary from patient to patient.

**Complications:** include: recurrence, post surgical deformity, like anal stenosis or incontinence. Apart from these, the minor problems faced are delayed healing, sinus formation, hypertrophy of granulation tissue. These complications may require further surgical correction depending on the magnitude of complication. These can be immediate or delayed, hence require long term follow up.

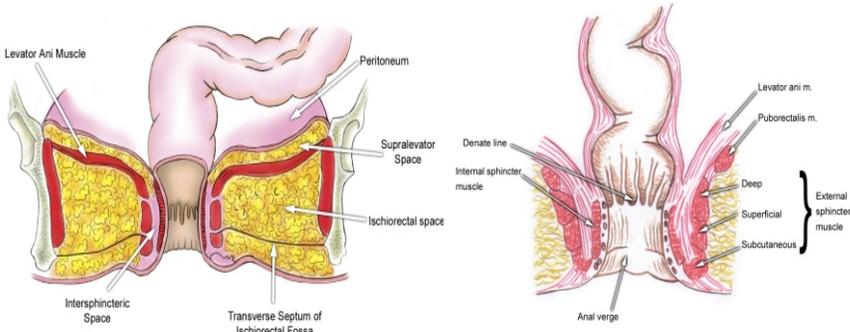


IS - Internal sphincter  
 SM - Submucosal ext. sphincter  
 SF - Superficial ext. sphincter  
 D - Deep external sphincter  
 PR - Puborectalis muscle  
 LA - Levator ani muscle



Goodsall's rule

Types of Fistula-in-ano



Anatomy of the anal canal



Fistula-in-ano



Dye-sinogram



Low fistula



Fistulectomy



Anterior Fistula, laid open



**ONE-DAY SURGERY INDIA**  
 2006

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**Extended stay:** Appendix, Gall stones, Hysterectomy, etc.

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**In conclusion:** among several types of fistulas and their management, the best surgical options vary from patient to patient. Even in the best of hands, recurrence rate is commonly seen. Please remember, no doctor would want to harm the patient, but, there are certain things beyond our control, a recurrent fistula is one of them.

- Dr. T. Naresh Row

**Patient's convenience and safety is our prime concern.**