



Management of complex Fistula-in-Ano via IFTAK technique

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Abstract : A fistula-in-ano is an epithelial-lined tract connecting the anal canal to the perianal skin. Classification of the fistula is determined in relation to the anal sphincters (Park classification and St.James university hospital classification). Treatment focuses on control of the infection and maintaining fecal continence. Many treatment modalities are available, and novel treatments are steadily proposed and tested. This article will review the fundamental principles of fistula-in-ano diagnosis and treatment with interception of fistula track with the application of ksharsutra.

IndexTerms - introduction , etiology, epidemiology , Pathophysiology, history and physical examination, evaluation , treatment and management , follow up , conclusion , reference ,

I. INTRODUCTION

A fistula-in-ano is an epithelial-lined tract connecting the anal canal to the perianal skin. Classification of the fistula is determined in relation to the anal sphincters (Park classification and St.James university hospital classification). Treatment focuses on control of the infection and maintaining fecal continence. Many treatment modalities are available, and novel treatments are steadily proposed and tested. This article will review the fundamental principles of fistula-in-ano diagnosis and treatment with interception of fistula track with the application of ksharsutra

Etiology

An anorectal abscess occurs when an anal gland becomes obstructed, resulting in infection and abscess formation. The infection is located near the sphincter complex, and therefore the fistula can traverse the sphincters. One-third of patients undergoing incision and drainage of an anorectal abscess will later develop a fistula.[1] 30% to 70% of patients diagnosed with an anorectal abscess will already have a fistula present on exam.[2]

Epidemiology

Fistula-in-ano is one of the most common anorectal diseases. The prevalence is greater in men than women, with a rate of 12.3 cases per 100,000 and 5.6 cases per 100,000, respectively.[3] The average age at diagnosis is 38 years, with most occurring between 20 to 40 years of age.[4] Risk factors for fistula development include obesity, diabetes, smoking, hyperlipidemia, and a sedentary lifestyle.[5]

Pathophysiology

Simple anal fistulas are thought to be due to glandular obstruction resulting in an anorectal abscess and, ultimately, a fistula. Characteristics of a simple fistula include a single tract, subcutaneous tract, and those that involve less than 30% of the external sphincter. A simple fistula is the easiest to treat and has the lowest recurrence and complication rates.

Complex fistulas include those that involve more than 30% of the external sphincter, fistulas with multiple tracts, recurrent fistulas, and those associated with other predisposing factors, including Crohn disease and radiation treatment.[6] Due to the large involvement of the external sphincter, a simple fistulotomy should not be performed due to the risk of postoperative fecal incontinence. Complex repair or staged repair is preferred to preserve sphincter function.

History and Physical

Patients presenting with fistula in ano often experience significant perineal pain and occasionally drainage. Systemic signs, such as fever, are rare in immunocompetent patients. The pain experienced is often exquisite, preventing a patient from sitting or tolerating a physical exam.

A thorough history and physical examination are necessary to classify the fistula and create a treatment plan appropriately.

Evaluation

A complete rectal exam is essential for the accurate diagnosis of fistula-in-ano. It is important to rule out other anorectal pathology and confirm the diagnosis of a fistula. The rectal exam should include inspection of the perianal skin and any external openings. A digital rectal exam should be performed to evaluate for any masses as well as sphincter tone. The internal opening may also be palpable within the anal canal. Anoscopy may be used to locate and evaluate the internal opening. Fistula probes help identify the tract in most cases, but if unsuccessful, injection of hydrogen peroxide may lead to the identification of the internal opening.

Classification of anal fistulas is based on anatomy, specifically in relation to the sphincter complex. In 1976, Dr. Parks published a paper describing a classification system for anal fistulas that is still widely used today. Four types were described: intersphincteric, transsphincteric, suprasphincteric, and extrasphincteric.^[7] Appropriate classification is essential for adequate treatment and conservation of the external anal sphincter to preserve fecal continence.

- Intersphincteric (45%) – The fistula penetrates through the internal sphincter but spares the external sphincter.
- Transsphincteric (30%) – The fistula passes through both the internal and external sphincters.
- Suprasphincteric (20%) – The fistula penetrates through the internal sphincter and then extends superiorly in the plane between the sphincters to pass above the external sphincter before extending to the perineum. This classification includes horseshoe abscesses.
- Extrasphincteric (5%) – This fistula is very rare. It forms a connection from the rectum to the perineum that extends laterally to the internal and external sphincter. These can be the most difficult to treat due to the need to preserve the sphincter complex.

The classification of the fistula is often diagnosed during an exam under anesthesia in the setting of a simple fistula. Evaluation of complex fistulas, including recurrent disease and fistulas in the setting of perianal Crohn disease, may benefit from pre-operative imaging. MRI, endoanal ultrasound, fistulography, and CT are all proven to contribute to an accurate diagnosis, with MRI being the most sensitive (>90%). A combination of two imaging modalities increases the diagnostic accuracy to 100%.

Treatment / Management

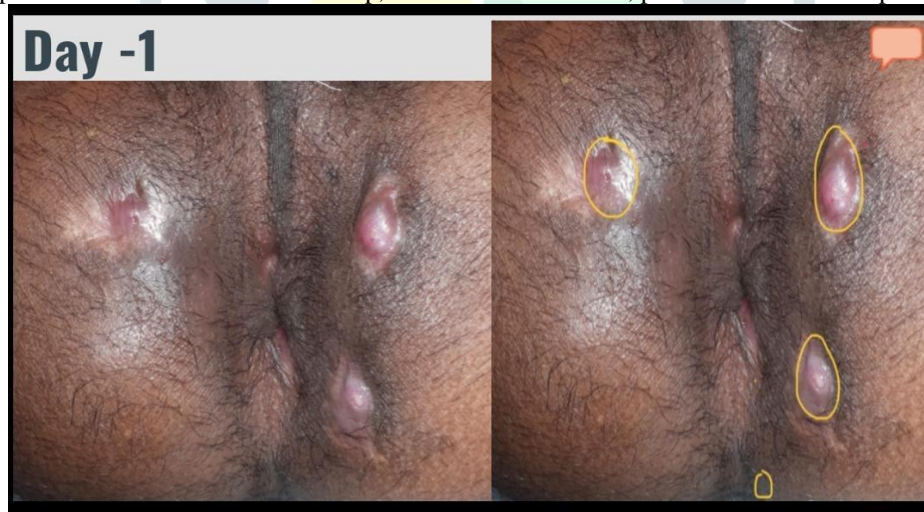
The treatment of an anal fistula depends on the location of the fistula as well as precipitating factors. Most fistulas are treated surgically, through a variety of different procedures depending on external and internal sphincter involvement. IFTAK is very best way to treat for Complex fistula in ano.

After obtaining informed consent, patient was placed in lithotomy position. Under local anaesthesia, probing was done to assess the fistulous tract. A small vertical incision was made at peri anal region at 6 o'clock approx. 1.0 cm away from anal verge at inter sphincteric space and interception of fistulous tract was done. Then normal saline was pushed from external opening and it came out from the intercepted areas (Artificial Window) to confirm the accuracy of IFTAK. Metallic probe was introduced through the window from 6 o'clock and taken out from Internal opening.

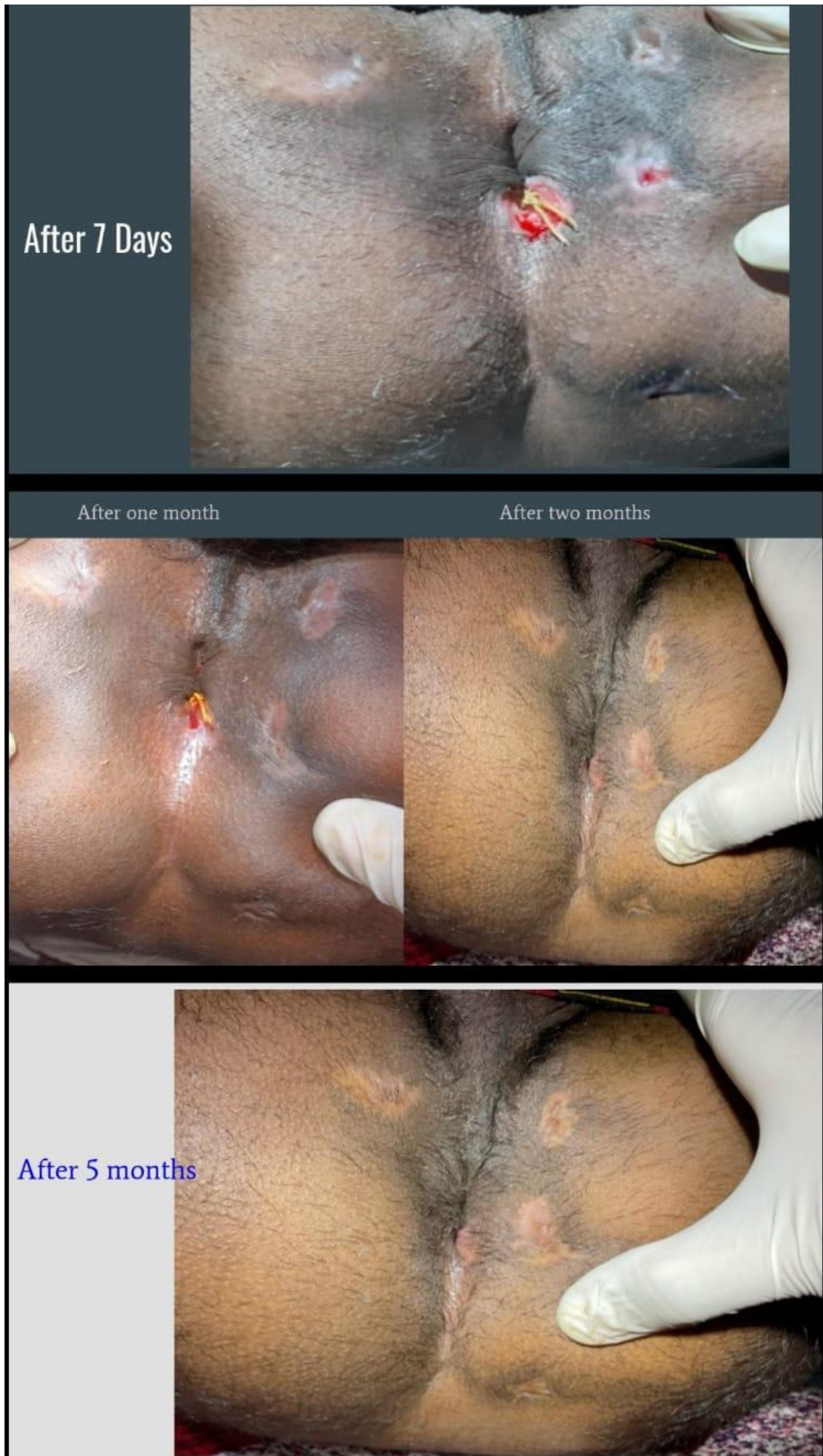
Ksharsutra was placed in the tract, antiseptic dressing and packing done with jatyadi taila. Patient was advised for regular hot sitz bath and cleaning of tracks with jatyadi taila two times a day.

Follow up and outcomes

Weekly follow up advised for Ksharsutra changing. The pus discharge was fluent in first week from the artificially made window, gradually reduced and completely disappeared after 1 months. Pain was also moderate in first week and later on gradually relieved. The discharge from the external opening was also reduced gradually in 20 days and totally dried up in one month, and completed healing was achieved in 2 months after cut through. There was no complication seen during and after treatments and patient got free from all the symptoms. After 5 months of follow up, no recurrence is noted, patient was cured completed.







Conclusion

IFTAK is a safe, effective and advanced technique which minimizes the postoperative time along with betterment in mild post procedural pain and minimum scar mark.

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