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## A complex fistula-in-ano presenting as a soft tissue tumor



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## ABSTRACT

**INTRODUCTION:** Anorectal abscess and fistula are quite commonly encountered diseases. Both of these are the acute and chronic manifestations of the same entity. While abscess are thought to begin as an infection in the anal glands, their spreading into adjacent spaces results in a fistula formation. At many times this spread occurs in a complex pattern which is difficult to map and treat.

**PRESENTATION OF CASE:** This paper describes a complex perianal fistula that presented as a painless benign lump in the upper outer quadrant of the right buttock. The lump initially thought to be a soft tissue swelling was later diagnosed to be a chronic abscess cavity extending medially toward the anal canal in the form of a complex fistulous tract.

**DISCUSSION:** Complex perianal fistulas are difficult to treat and are prone to recurrences. Correct diagnosis and characterization of the fistula is essential to optimize the treatment. Clinical examination alone may not give a correct picture of the actual disease, thereby requiring radiological investigations like MRI.

**CONCLUSION:** Although rare, sometimes common clinical conditions like fistula-in-ano may also present in complex manner. It is important to establish the diagnosis firmly and map the fistula properly before going in for surgery. Complexity of fistulas and improper mapping often leads to recurrences and other complications like incontinence.

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## 1. Introduction

The accurate diagnosis and mapping of perianal fistulas has long been a challenge to surgeons worldwide. Most perianal abscesses originate from an infected anal gland. Obstruction of these glands leads to stasis, bacterial overgrowth, and ultimately abscesses that are located in the intersphincteric groove [1]. These abscesses have several routes of egress, the most common of which are downward extension to the anoderm (perianal abscess) or across the external sphincter into the ischioanal fossa. Less common routes of spread are to the supralevator space or in the submucosal plane. When the abscess is drained, either surgically or spontaneously, persistence of the septic foci and epithelialization of the draining tract may occur and lead to a chronic fistula-in-ano. About 60% of the abscesses do result into such a fistula formation [2].

In the presented case, there was an extra-sphincteric fistulous tract which extended superiorly, traversed the right ischioanal fossa, breached the levator-ani plate and presented as a large and chronic abscess in the subcutaneous region of the right buttock.

## 2. Case report

A 26 years old man presented to our surgical clinic with the complaints of a painless lump in the right buttock region for two and a half years (Fig. 1). The swelling was gradually increasing in size. There was no other significant history that could be linked to the swelling. History of constipation accompanied with use of powdered laxatives was present.

The lump on examination was a non tender freely mobile well defined lump lying superficial in the subcutaneous plane. An initial diagnosis of soft tissue benign tumor was made. As a part of the initial work up all routine blood test along with chest X-ray were done and found to be normal. A fine needle aspiration from the swelling revealed hemorrhagic fluid, smear from which showed inflammatory cells comprising chiefly of polymorphs and a few macrophages. The ultrasonography of the lump also revealed an inflammatory lesion. In view of a non conclusive diagnosis, a decision to get an MRI study was taken.

The MRI study revealed the true nature of the swelling to be an abscess cavity associated to a Grade V perianal fistula via a 7 cm fistulous tract with internal ramifications (Fig. 2). The fistulous tract in its perianal course was seen on the right side in the extrasphincteric region extending superiorly, traversing the right ischioanal fossa with a likely breach of the right levator ani plate. It seemed to terminate medially with no obvious communication to the rectum.

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Fig. 1. The actual position of the lump.

The nature of disease, procedure to be performed and prognosis were discussed with the patient and family. After bowel preparation, the patient was taken to the operation room. Under general anesthesia, the patient was placed in a jack-knife position. An incision was given over the lump and a thick walled abscess cavity was discovered (Fig. 3). The cavity was excised en mass. The communicating tract was identified as a thick tract going medially. The fistula tract was laid open to the level of the levator ani (Fig. 4). At this level, digital examination of the tract was done and no obvious communication to the rectum could be detected. Partial excision and curettage of the tract was done. The edges of the remnant tract were marsupialized to the subcutaneous tissue to prevent it from closing down. The wound was left open and the tract and wound were packed. The post operative period was largely uneventful and the patient was discharged satisfactorily on the first post operative day. He was advised regular dressings in the coming period.

A histo-pathological examination of the specimen obtained showed features consistent with sinus tract with chronic inflammation.

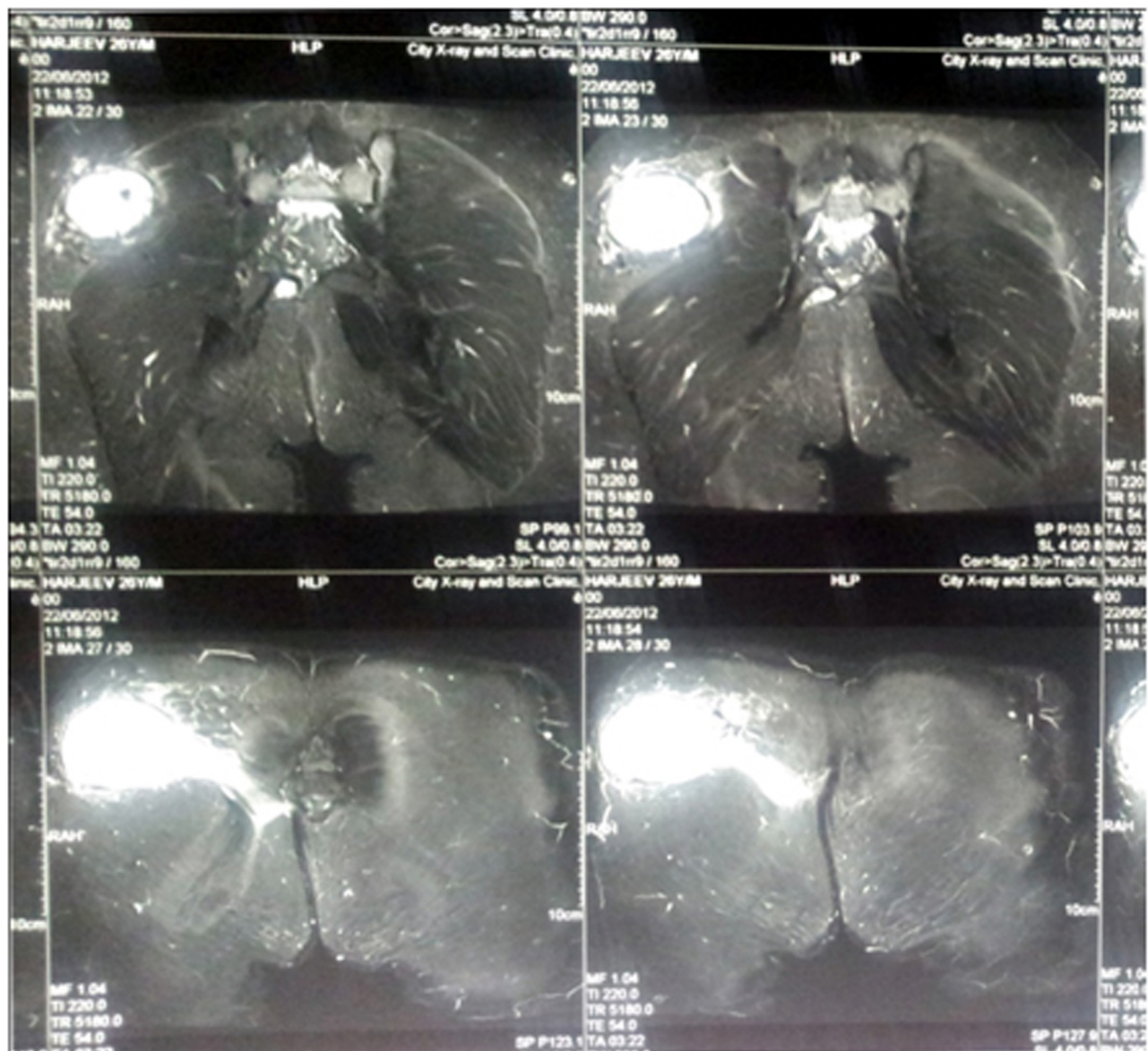


Fig. 2. The pelvic MRI demonstrating the tract and the abscess cavity.

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