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Anal fistula surgery in an outpatient setting: the Dubai experience

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ABSTRACT

Aim: To determine whether surgery for transsphincteric and complex fistula-in-ano can be performed safely as a day case.
Method: This is a retrospective study of 66 patients with transsphincteric and complex anal fistulas, initially managed with preliminary loose Seton followed by fistulectomy and sphincter repair 2–4 months later between March 2011 and March 2014. Patients were seen at the clinic 1 week, 3 months and 1 year post-operatively and were observed for complications and recurrences; incontinence was noted down and was graded according to the Cleveland Clinic score.
Result: Twenty-five patients (38%) had high or complex fistulas and 32 (48.5%) had a history of previous surgery. All cases were done in an outpatient setting. The Seton was kept in situ for 2–5 months (2.6 months) followed by fistulectomy and sphincter repair. Complete healing was achieved within approximately 3.6 weeks (2–8 weeks). Fifty-one patients were followed up successfully for one year. Two patients had temporary flatus incontinence which had resolved over 2–3 months. Recurrence had occurred in 2 (3.9%) patients.
Conclusion: Transsphincteric and complex fistulas can safely be operated on as day case surgeries with high patient satisfaction and less complication in the population we studied.

Cirurgia de fístula anal em regime ambulatorial: a experiência Dubai

Palavras-chave:
Fístula anal
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Cirurgia sem pernoite hospitalar

RESUMO

Objetivo: Determinar se cirurgias para fístulas transesfincterianas e para fistulae in ano complexas podem ser realizadas com segurança em ambiente ambulatorial, sem pernoite do paciente no hospital.
Método: Trata-se de um estudo retrospectivo de 66 pacientes com fístulas transesfincterianas e fístulas anais complexas, inicialmente tratados preliminarmente com seton de drenagem, seguido por fistulectomia e reparo do esfíncter 2–4 meses mais tarde, entre março de 2011 e março de 2014. Os pacientes foram reexaminados no ambulatório uma semana, três meses

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e ano após a cirurgia, tendo sido observados para complicações e recorrências; casos de incontinência foram anotados e classificados de acordo com o escore da Cleveland Clinic.
Resultado: Vinte e cinco pacientes (38%) apresentaram fístulas altas ou complexas e 32 (48,5%) tinham história de cirurgia prévia. Todos os casos foram tratados em ambiente ambulatorial. O seton foi mantido in situ durante 2–5 meses (2,6 meses), seguido por fistulectomia e reparo do esfíncter. A cura completa se concretizou em cerca de 3,6 semanas (2–8 semanas). Cinquenta e um pacientes foram acompanhados com sucesso ao longo de um ano. Dois pacientes tiveram incontinência temporária para gases, resolvida ao longo de 2–3 meses. Recorrência ocorreu em 2 (3,9%) pacientes.
Conclusão: Fístulas transesfincterianas e fístulas complexas podem ser operadas com segurança como casos ambulatoriais, sem permanência hospitalar noturna, com grande satisfação do paciente e menos complicações na população estudada.

Introduction

Most of the proctology cases nowadays are done as day case surgeries without any significant complications. Normally, 'lay-open' fistulotomies and fistulectomies for inter-sphincteric fistulas are done as day cases. High trans-sphincteric and complicated fistulas, which required division of a large portion of the external sphincter, were done as inpatient surgeries mainly due to the fear of incontinence and postoperative pain. The aim of surgical treatment of anal fistula is to cure the disease by preventing recurrence while simultaneously ensuring that fecal continence is maintained. The incidence of post-operative fecal incontinence following fistulectomy has been reported to be 20.3%.[1] It is still not clear which approach is safest to be performed as a day case surgery in terms of risk of immediate or early post-operative complications, as those complications could affect the outcome of the surgery. The optimal treatment of anal fistulas should include minimal complications, low recurrence rates, no hospital admissions and negligible patient inconveniences. The aim of this study is to present an experience of treating fistula-in-ano in an outpatient setting.

Method

Data were collected from records of 66 patients who underwent preliminary Seton placement followed by fistulectomy and sphincter repair 2–4 months later between March 2011 and March 2014. Fistulas were characterized using Parks' Classification. Perianal fistulas were defined as complex if they had multiple external openings, high fistulas if they had an internal opening at the level of the dentate line and low fistulas if they had an internal opening below the dentate line. Patients with concomitant anal pathology or inflammatory bowel disease were excluded from the study. Low fistulas, which were treated by the lay open technique, were also excluded. All patients had an ASA physical status classification of less than 3.

The procedure was performed under general anesthesia with the patient in lithotomy position. After initial evaluation, the external and internal openings were located using a probe and air injection along the tract. A loose Seton was inserted under general anesthesia using 2 braided, non-absorbable sutures (4/0 prolene), which were looped around the fistula tract. It was not tightened at any time during the follow-up nor was it removed until the time of fistulectomy. Two to four months later the complete fistula was excised with immediate repair of the sphincters and the wound was kept open. Seton insertion and fistulectomy were done as day cases. The patients were observed for 4–6 h and were then discharged.

Patients were reviewed at the clinic 1 week, 3 months and 1 year post operatively. During the follow-up period, details of healing (i.e. absence of discharge), recurrence, and complications were gathered. Continence was evaluated according to the Cleveland Clinic score.[2] The excised fistulas were sent for histopathology to rule out inflammatory bowel disease and cancer.

Finally, the data were analyzed using IBM SPSS STATISTICS BASE 21.

Results

After obtaining the ethical committee approval, 66 patients with transsphincteric and complex anal fistulas who were managed with preliminary loose Seton followed by fistulectomy and sphincter repair, were reviewed. Fifty-nine (89.4%) of the patients were male and 7 (10.6%) were female. The overall mean age was 38.5 (range 25–61) years. The types of fistulas are depicted in Table 1.

Thirty-two (48.5%) patients gave a history of previous surgery, 27 of which had incision and drainage of perianal abscesses and 5 of which had previous fistula surgeries. The

Table 1 – Type of fistulas.

Type of fistula	Number	Percent
Low transsphincteric	41	62
High transsphincteric	13	20
Complex	12	18
Total	66	100