



Ano-Rectal Abscesses and Fistulas

1. PERIANAL SEPSIS

Anal infections commence in mucous glands within the anal canal, at the level of the dentate line, 3 - 4 cm from the anal verge. The glands provide lubrication for the anal canal, and lie anatomically in the intersphincteric plane, between the internal and external sphincter muscles. Infection is initiated by a blockage in the gland, leading to impaired drainage and subsequent infection. There is usually no obvious predisposing cause, although the condition is more common in diabetics, immunocompromised patients, inflammatory bowel disease and is associated with anal fissures.

The infection commonly tracks in the intersphincteric plane to the anal verge, leading to a perianal abscess. Less commonly the infection may spread to the following spaces: sub mucosal, ischorectal, pelvi-rectal.

The treatment includes surgical drainage and a careful examination under anaesthesia. Peri-operative antibiotics are required for the Coliform and anaerobic organisms responsible for the infection. Recurrent ano-rectal infections with or without fistula formation occur in 20% of patients.

2. ANAL FISTULAS

A fistula is defined as a communication between at least two epithelial surfaces. Anal fistulas develop in 15- 20% of patients who have a history of perianal sepsis. Rarely, fistulas may be indicative of underlying Crohn's disease or neoplasia. The differential diagnosis includes hydra-adenitis suppurativa (sweat gland infection) and pilonidal sinus. The clinical presentation is that of an intermittent anal discharge.

Anal fistulas have been classified by the late Sir Alan Parks (St Mark's Clinic, 1978) according to their relation to the external anal sphincter muscle: intersphincteric (80%), transsphincteric (15%), suprasphincteric (5%). Extrasphincteric fistulas have their origin within the rectum. The Parks Classification also subdivides fistulas into "high" and "low" according to their level in relation to the dentate line in the anal canal.

The treatment is surgical and is dependent on finding both internal and external fistula openings. The relationship of these two openings usually follows the Salmon-Goodsall rule, and is confirmed with methylene blue dye injected in the operating rooms. The fistula tract is excised entirely, and the base laid open to heal by secondary intention. Anal continence is dependent on the external anal sphincter muscle (EAS), which is carefully defined at surgery and protected. "Staged" procedures with insertion of a nylon seton are required in fistulas transgressing the EAS.

Despite adequate surgery recurrent fistulas occur in 15% of patients.

Dr Currer has an extensive experience in managing patients with anal fistulas.