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A Rare case of long complex ano-scrotal fistula, and its management with partial fistulectomy with seton application and eversion of sac

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ABSTRACT- Ano-rectal sepsis can be complicated by anal fistula during acute phase of sepsis or within 6 months. An anal fistula is characterised by chronic purulent discharge or cyclic pain associated with abscess formation, followed by intermittent spontaneous decompression. Fistula may be simple or complex. The goal of management of fistula is eradication of septic foci, associated epithelization and preserve continence. A study presents a case of 22 years male with ano-scrotal fistula which treated by partial fistulectomy with seton application with eversion of sac, preserving anal continence without leaving any residual septic foci.

Key words-Fistula-in-ano, ano-scrotal fistula, fistulotomy, fistulectomy

I. INTRODUCTION-

Fistula-in-ano is an inflammatory track which has an external opening (secondary) in perineal skin and internal opening (primary) in the anal canal or rectum1. Fistula may be simple or complex. Fistula-in-ano can develop in approximately 40% of patients during acute phase of sepsis or even be discovered within 6 months of initial therapy2. Anal fistula is characterised by chronic purulent discharge or cyclic pain associated with abscess formation, followed by intermittent spontaneous decompression3,4. Fistula with extension into scrotum is one of the rare complications of fistula. In which case scrotum usually painful and present with redness and swelling with pus discharge. Initially it is confused with acute scrotal diseases but on careful examination by palpation a fibrous track is felt from external opening up to scrotum and up to internal opening into the anal canal. Near about 82% ano-scrotal fistulas had anterior opening and they are mostly intersphincteric or transphincteric fistulas5. Fistula-in-ano is considered complex if found to have any of the characteristics: tract crossing more than 30-50% of external sphincter, anterior fistula in female, presence of multiple tracts,Recurrent fistula, pre-existing incontinence, local irradiation and Crohn's disease6,7.

The principle of surgical management is eradication of septic foci, associated epithelization and preserve continence. An ideal procedure for treating a fistula should be minimally invasive with minimal failure rate and morbidity.

II. CASE PRESENTATION –

A newly diagnosed diabetic 22 years male patient presented with complaints of scanty purulent discharge from anal region, right gluteal and scrotal swelling, fever on and off last for 7 days and history of boil at perianal region before 15 days.

On local examination, external opening present at 11 o'clock position near about 4.5 cm away from anal verge, right sided scrotal swelling and fibrous track felt on palpation from external opening upto right side of scrotum, internal opening felt at 6 o'clock position. To confirm the diagnosis as ano-scrotal fistula , USG perineum and scrotum, MRI fistulogram was done.

USG perineum and scrotum, there was pyocele with cellulitis on right side of scrotum with ano-scrotal fistula.

MRI fistulogram shows intersphincteric ano-scrotal fistula.

Patient was operated for partial fistulectomy with seton application with eversion of right sac under spinal anaesthesia with findings external opening at 11 o'clock position, internal opening at 6 o'clock position, fibrous track extended into right scrotum, purulent fluid collection in right scrotal sac.

According to Pus culture sensitivity antibiotics was given with antacids, analgesics. Daily dressing done with betadine and H2O2.

III. DISCUSSION-

Goodsall's rule is helpful in predicting the fistulous track in simple fistula-in-ano. But some

cases are incompatible with this rule. E.g. long track fistula, ano-scrotal fistula etc.

The goal of management of fistula is eliminating the septic foci with preservation of continence. Mostly simple fistula-in-ano are treated with fistulotomy or fistulectomy. The complex fistula is managed with cutting seton. Because of high risk of incontinence, filling track with plug or glue, Fistula laser closure, VAAFT, LIFT, anorectal advancement flap is also used for treat complex fistula.

For avoid recurrence rate, thus the decision of partial fistulectomy with seton application and right sided eversion of sac was undertaken. The septic foci, unhealthy epithelised tissue removed promoting the secondary healing with development of granulation tissue.

IV. CONCLUSION –

The management of complex fistula should be low cost, easy to perform, done with basic equipment, seton application is sphincter preserving with eradication of septic foci.

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