Anal Fistula

What is an anal fistula?

An anal fistula is a channel that develops between the end of the bowel and the skin near the anus. It is normally caused by an infection around the anus. The infection causes a build-up of pus (abscess) that leaves a channel once it has drained away. The channel (fistula) persists and causes symptoms such as pain and irritation, smelly discharge from near the anus that can look like pus or blood, and painful swellings (abscess). The end of the fistula may be visible as a hole or small lump in the skin close to the anus – see figure 1.

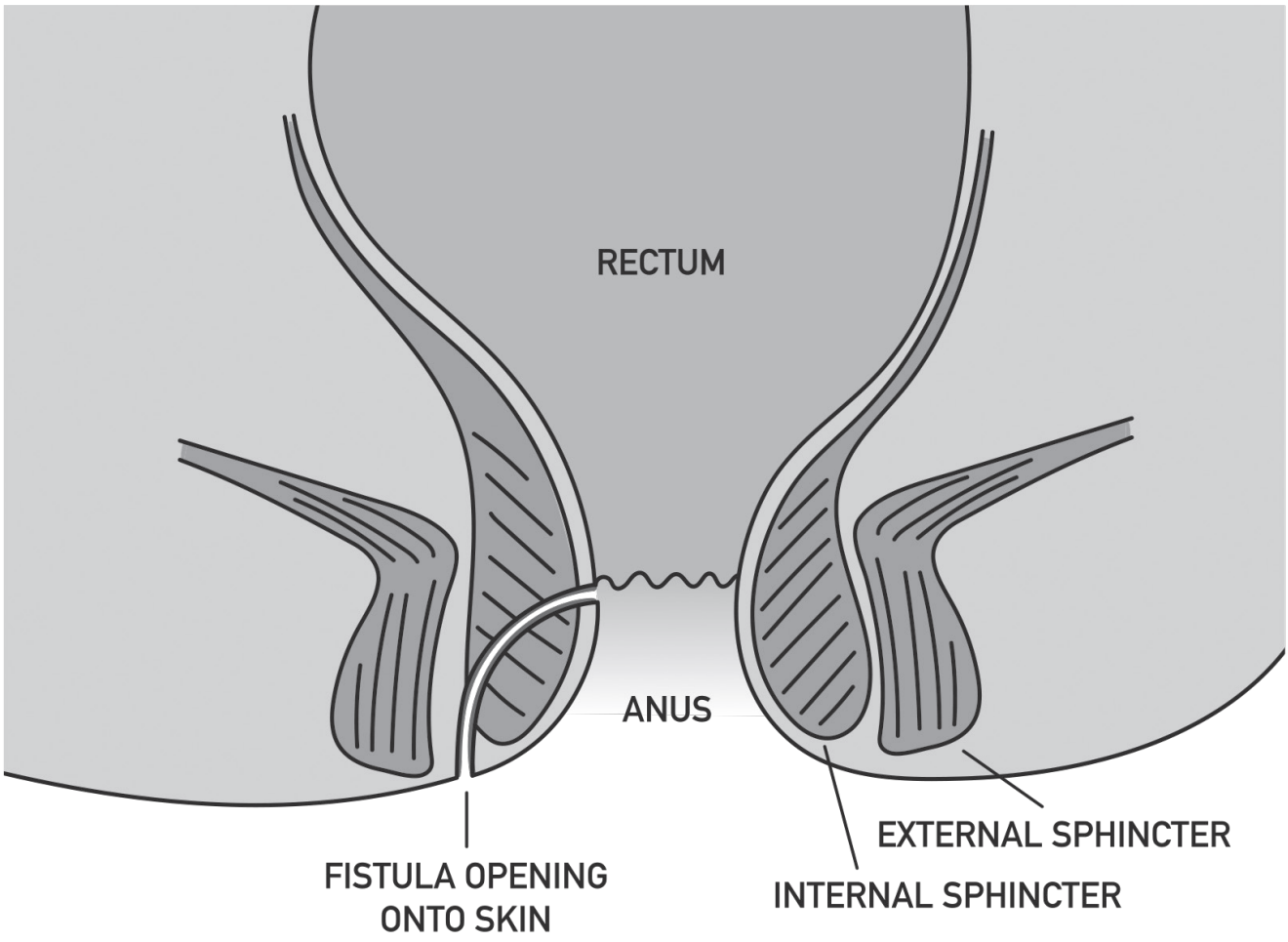

Figure 1 - A fistula is a channel between the end of the bowel (anus or rectum) and the skin near the anus

An anal infection or abscess is quite common and does not always lead to a fistula. More rarely, a fistula develops due to other medical problems such as Crohn's disease (an inflammatory disease of the bowel), hidradenitis suppurativa (long-term skin condition), infection with tuberculosis (TB) or HIV, or following radiotherapy or surgery.

Unfortunately, once an anal fistula has developed, it usually requires surgery as it rarely heals if left untreated.

Treatment

The chosen treatment depends on the patient (how bad the symptoms are, other health problems) and the fistula. Each fistula is different in terms of the path it takes through the muscles around the anus (sphincter muscles). The sphincter muscles are in two layers (internal and external) and a fistula can travel through or between these layers. Before surgery, an MRI or specialised ultrasound scan may be performed to work out the path of the fistula. Some complex fistulas have side branches as well as one main path.

Surgery involves allowing all the infection to drain while at the same time avoiding damage to the delicate muscles (sphincter muscles) around the anus – these muscles are important for maintaining control of your bowels (continence).

It is important to realise that a fistula is often difficult to treat. More than one operation is commonly needed to get the fistula to heal. Sometimes a fistula can be so difficult to heal that the focus of treatment is to allow them to drain well to improve the symptoms.

Fistulotomy (also known as 'laying open')

This involves making a cut along the length of the fistula – see figure 2. It allows all infection to drain and leaves an open wound that takes 1-2 months to heal. This operation is very effective in getting the fistula to heal completely. It does however involve cutting some sphincter muscle and if too much muscle is damaged it can cause incontinence.

It is the most commonly performed operation for anal fistula but is only recommended for those patients whose fistula does not involve too much muscle. 1 in 5 patients may experience new symptoms of urgency (not being able to delay bowel opening), or seepage of mucus / faeces that can stain the underwear, even with operations where there is great care not to damage this muscle.

Seton

A seton is a stitch that is threaded along the fistula. This does not allow the fistula to heal but it does allow any infection to drain easily – see figure 2. A seton controls symptoms and allows the fistula to stabilise prior to planning further operations. Setons are often used for fistulas that involve too much muscle to be treated by a fistulotomy operation. Some fistulas require several operations to get them to heal and this usually involves a combination of seton operations and other secondary operations such as LIFT, flaps, paste, VAAFT or laser / radiofrequency treatment (see below).

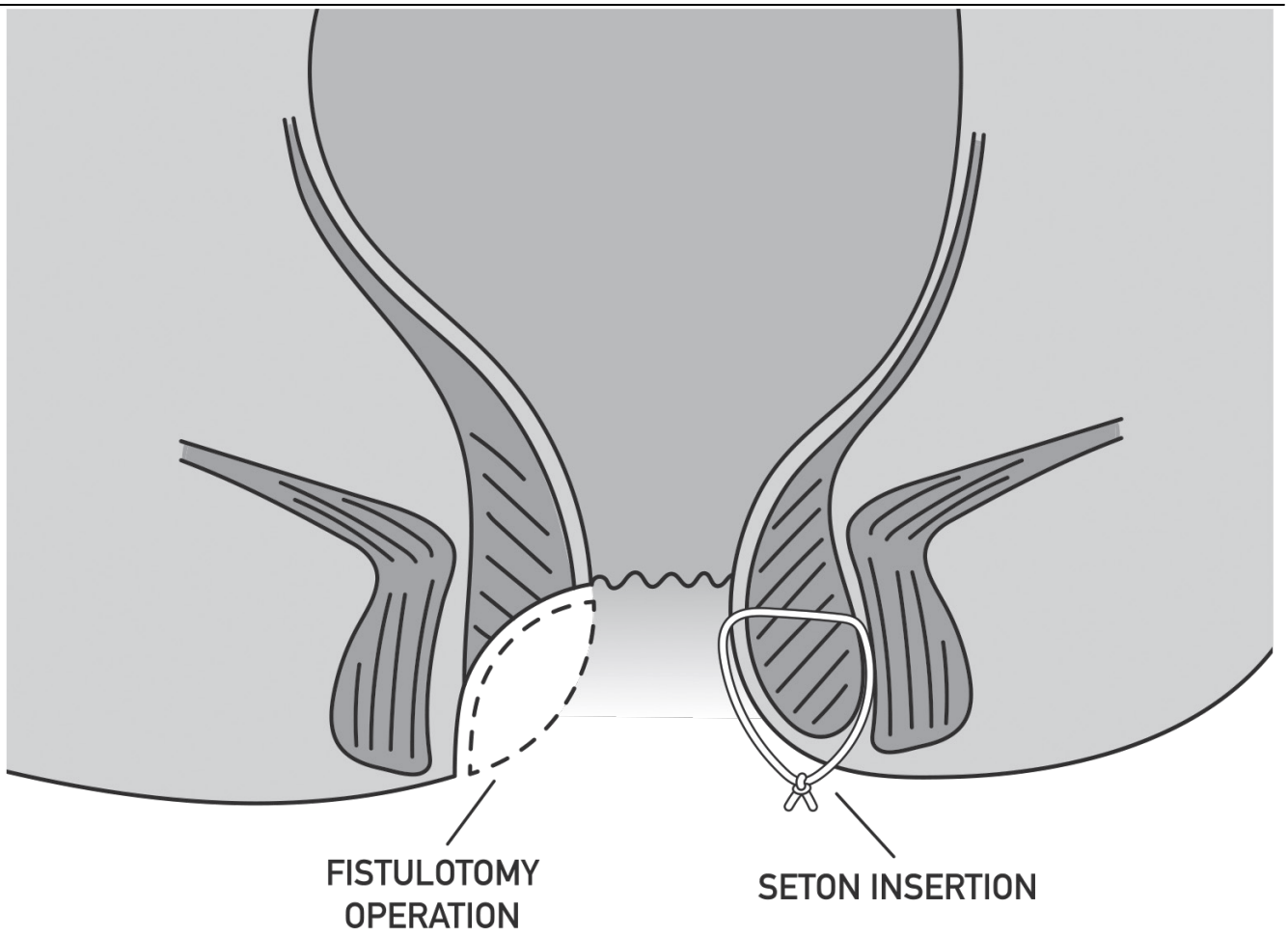

Figure 2: Anal fistula treatment can involve making a cut into the channel (fistulotomy) or insertion of a seton.

LIFT

LIFT stands for “ligation of the inter-sphincteric fistula tract”.
This operation involves making a cut around the anus and finding the fistula between different layers of the sphincter muscles. Once found, the fistula is tied off. This operation can be effective but is not suitable for all types of fistulas. The risk of damage to the sphincter muscles is low.

Advancement flap

For some fistula, the lining of the lower bowel (inside the anus) can be lifted up as a flap and used to cover the opening of the fistula. Like the LIFT procedure, an advancement flap can be effective for fistulas not suitable for fistulotomy. The risk of damage to the sphincter muscles depends on the size of the flap and how much sphincter muscle is within the flap.

Plugs & paste

A plug is a thin strip of material made from collagen that is pulled into the fistula to block or ‘plug’ the space. Similarly, a paste made from collagen can be squeezed into the fistula tract to block it. It is thought that these techniques can be effective in some cases, probably not if the fistula contains side-branches. Again, the risk of damage to the sphincter muscle is low.

VAAFT

This stands for video-assisted anal fistula treatment and involves passing a very small camera along the path of the fistula. This allows the path to be seen (including any side branches) and washes out all the infective material. Cautery is then performed to further clean and help close the fistula. The procedure can be repeated in the future if necessary and the risk of damage to the sphincter muscle is low. VAAFT can be used to help simplify anal fistulas to single tracts. If it is used to attempt to heal the fistula, it is performed in combination with a procedure to stitch or close the opening of the fistula on the inside of the anus.

Laser / radiofrequency treatment

A flexible probe can be passed along the anal fistula and then either laser or radiofrequency energy is delivered to the tip of the probe. This energy heats the lining of the anal fistula in an attempt to directly close the tract.

Complex fistulas

Some anal fistulas are complex as they cross both sphincter muscles (known as trans-sphincteric anal fistulas) and enclose too much muscle to be safely treated by fistulotomy. Operations other than fistulotomy are therefore preferred (such as those described above) which may be referred to as 'sphincter-sparing operations'. Such operations are generally much less effective than fistulotomy. In women, the sphincter muscles can be thin at the front close to the vagina. Any anal fistula located close to the vagina in women is therefore considered to be complex. Other anal fistulas are highly complex due to either side-branches (these can travel to the skin or upwards towards the muscles of the pelvic floor), or abscesses / collections of pus around the anus which are not draining effectively. Collections of pus that circle around the anus, either between or outside the sphincter muscles, are known as horse-shoe collections – see figure 3. These highly complex anal fistulas require operations to simplify them, such as by draining collections or closing side-branches, before operations to get the anal fistula to heal can be considered.

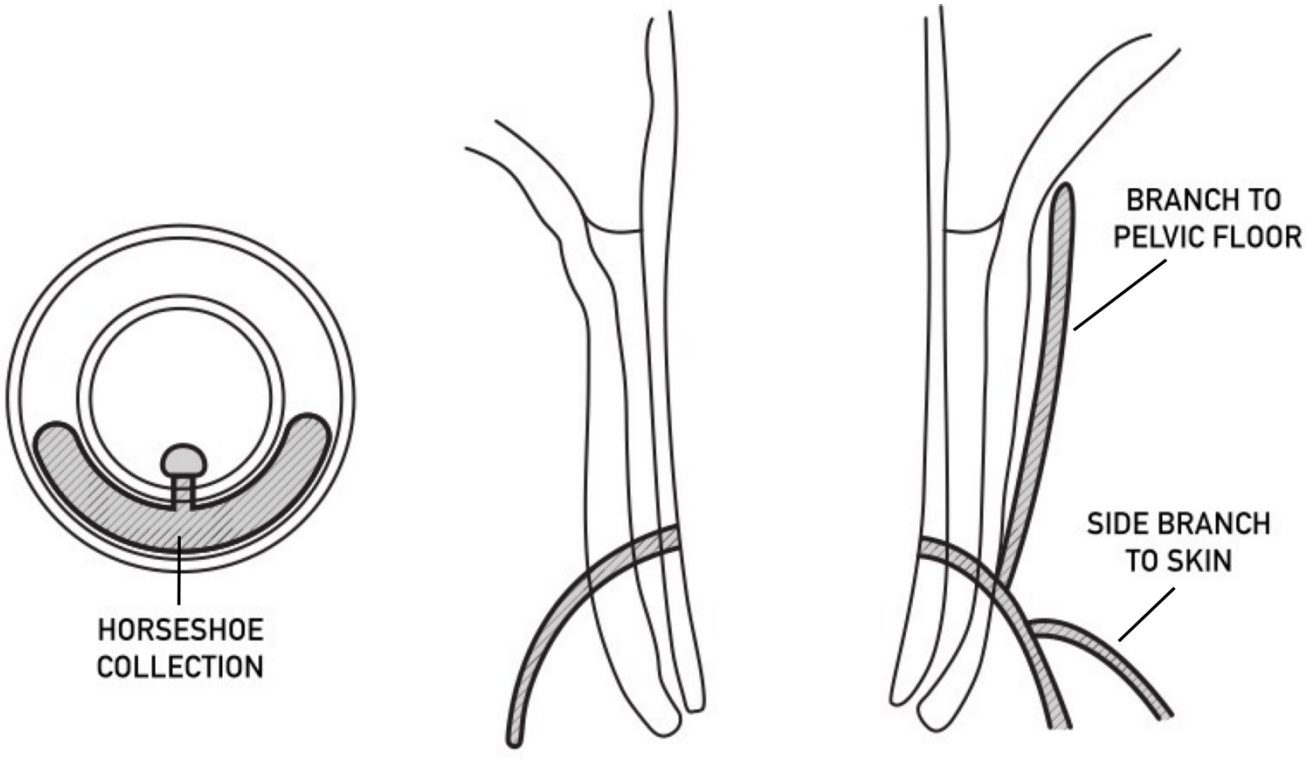

Figure 3: Anal fistulas can be complex with tracts circling between or outside the sphincter muscles (horseshoe) or branches to the skin or upwards to the pelvic floor.

The operation

Anal fistula operations are normally performed as a day-case procedure under a brief general anaesthetic, or a spinal anaesthetic (needle injection into the back). You may have a pre-assessment appointment before the operation to ensure that you are fit for the procedure. Just before the operation, you may be given an enema (some liquid into the anus to empty the lower bowel).

Following the operation you may have a dressing (particularly if you have had a fistulotomy operation). Most dressings are removed prior to leaving the hospital. It is generally recommended that you use a pad (such as a sanitary towel) to catch any discharge from the wound while it is healing. You will be monitored for a few hours in recovery and on the ward before being discharged home. You will be given some painkillers to take home with you. The painkiller, codeine, can cause constipation so you may be given some laxatives to take with this. Keeping the stools soft and maintaining bowel movements with gentle laxatives is important if there is some pain after the operation. Some patients are given an antibiotic called metronidazole for 5 days which can also help with pain relief. It is important that you do not drink alcohol with this antibiotic.

Risks

All operations carry a degree of risk. It is possible that there can be bleeding or bruising around the operation site. Any cut that is made can get infected. No fistula operation is guaranteed to work (result in complete healing of the fistula) and sometimes several operations are required. Operations which damage the sphincter muscle can lead to minor incontinence, such as urgency, seepage and a degree of incontinence to gas and liquid (wet wind).

After the operation

After two weeks, provided you feel well and the pain is controlled, you should be able to resume normal activities including driving, heavy lifting and going back to work. Swimming should be avoided while there is a wound trying to heal. If you have dressings, you may need these to be changed or removed by the nurse at your GP practice. For larger wounds, it may be recommended that a nurse runs a finger along the wound while changing the dressing to prevent the skin from healing over too quickly – this is known as digitation. You may be instructed to digitate the wound yourself. After most anal fistula operations, it is normal to have ongoing discharge of bloody fluid or pus while the area is healing. After going for a poo, washing the area and dabbing dry, or cleaning with alcohol-free wet wipes is more comfortable than wiping. Some patients find a ‘Peri bottle’ useful for washing whilst sat on the toilet. Soaking the bottom in warm plain water (or lightly salted water) in a bidet can be soothing. It is possible to get a bidet that sits on the toilet seat for this purpose.

Some fistulas take several operations to allow them to fully heal. You may be booked for a planned further operation (especially if your operation involved putting a seton along the fistula), or you may be given an appointment for an MRI scan or to be seen in the clinic.

Research

We are a research-active Trust and you may therefore be asked whether you would like to participate in a study or trial. This is entirely voluntary but may help answer questions about fistulas that will improve treatment in the future.

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