Why do we have so much trouble treating anal fistula?.

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Abstract:

Anal fistula is among the most common illnesses affecting man. Medical literature dating back to 400 BC has discussed this problem. Various causative factors have been proposed throughout the centuries, but it appears that the majority of fistulas unrelated to specific causes (e.g. Tuberculosis, Crohn's disease) result from infection (abscess) in anal glands extending from the intersphincteric plane to various anorectal spaces. The tubular structure of an anal fistula easily yields itself to division or unroofing (fistulotomy) or excision (fistulectomy) in most cases. The problem with this single, yet effective, treatment plan is that depending on the thickness of sphincter muscle the fistula transgresses, the patient will have varying degrees of fecal incontinence from minor to total. In an attempt to preserve continence, various procedures have been proposed to deal with the fistulas. These include: (1) simple drainage (Seton); (2) closure of fistula tract using fibrin sealant or anal fistula plug; (3) closure of primary opening using endorectal or dermal flaps, and more recently; and (4) ligation of intersphincteric fistula tract (LIFT). In most complex cases (i.e. Crohn's disease), a proximal fecal diversion offers a measure of symptomatic relief. The fact remains that an "ideal" procedure for anal fistula remains elusive. The failure of each sphincter-preserving procedure (30%-50% recurrence) often results in multiple operations. In essence, the price of preservation of continence at all cost is multiple and often different operations, prolonged disability and disappointment for the patient and the surgeon. Nevertheless, the surgeon treating anal fistulas on an occasional basis should never hesitate in referring the patient to a specialist. Conversely, an expert colorectal surgeon must be familiar with many different operations in order to selectively tailor an operation to the individual patient.