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Original Research Paper

Surgery

A RARE CASE OF FISTULA IN ANO PRESENTING WITH A MID THIGH ABSCESS

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ABSTRACT ***Fistula*** in ano can present in more ways than one. Management of these patients are always complex requiring expertise in managing such complex fistulas. We report an atypical presentation of fistula in ano as a mid thigh swelling who had been operated for I&D in the thigh thrice in the past thinking it to be simple thigh abscess .MRI perineum with thigh, clarified the diagnosis and directed the management of this patient.

KEYWORDS : *Fistula* in ano, MRI scans, Sphincters, Thigh abscess.

I. Introduction

Fistula in ano is a benign anal condition; the true prevalence of fistula-in-ano is unknown. The incidence of a fistula-in-ano developing from an anal abscess ranges from 26% to 38% [1]. One study showed that the prevalence of fistula-in-ano is 8.6 cases per 100,000 populations. In men, the prevalence is 12.3 cases per 100,000 populations, and in women, it is 5.6 cases per 100,000 populations. The male-to-female ratio is 1.8:1. The mean patient age is 38.3 years. [2]

By definition this is an abnormal connection between anorectal epithelium and perianal skin. This condition presents as a chronic on and off discharging pus in the perianal area or as an acute exacerbation including perianal/ischiorectal abscess. Various classifications [3] have been described to simplify the management. The aim of the managing this condition is eradication of sepsis, management of fistulous tract and preservation of the anal sphincter integrity. The surgical options include laying opening of a low anal fistula (fistulotomy), Seton insertions (draining or cutting type) especially in complex fistulae [4,5], Complete excision of the tract with sphincter repair (fistulectomy), LIFT (ligation of the intersphincteric fistulotomy tract) technique, VAAFT (Video assisted anal fistula surgery) technique.

Fortunately, advancement in radiological investigations such as MRI and endoanal ultrasound examination has helped in the diagnosis and and both has guided in the management of complex and recurrent fistulae in ano [6,7,8]. The 3D endoanal ultrasound probe has helped to dilineate the tract better than MRI and can be used by the colorectal surgeon intraop also. We report an unusual presentation of fistula in ano extending till thigh identified after MRI scan of the gluteal region.

II.Case report

A 38-year-old male patient presented with complaints of progressively increasing pain and swelling and discharge from the lateral aspect of the right lower thigh since four months , for which incision and drainage was done thrice along with incision and drainage of a right perineal abscess in the past. On DRE, there was an internal opening at 6 o clock position without an external openingg in the Perianal region but a pus-draining opening at the lateral aspect of the right mid thigh. An MRI scan of perineum and thigh was performed to further characterise and define the extent of this tract Surprisingly the MRI scan showed a fistulous tract arising from right posterolateral wall of anorectal junction approx at 7 o' clock located approx 3.7 cams proximal to the anal verge, the tract shows a right posterolateral trans-sphincteric course to reach the right ischia rectal fossa with multiple branches, one short branch extends anteriorly and ends blindly another short branch extend superiorly and end blindly in the superior levator plate. The adjoining right levator muscle appears mildly edematous no evidence of supra levator extension, a third branch extends posterolaterally and inferiorly into the right gluteus maximus muscles texted caudally through the gluteus maximus muscle into the posterior subcutaneous fat of the right upper thigh, here it show multiple branches and communicating with a loculated fluid collection this fluid collection measures approx 6.9x1.3 x3.3 cms. A communication tract from this abscess extends to the skin surface along the posterolateral aspect of the right thigh, within the right gluteus maximus muscle and posterior thigh is thick and measures approx 15 mm in diameter there is diffuse adjoining soft tissue edema. No evidence osteomyelitis.

Figure 1

Figure 1a: Transverse axial fat suppressed T2-weighted images of the pelvis demonstrating the abscess and inflammatory response in the right gluteus maximus, with thick fistulous track heading along the right side of the perineum towards the rectum.

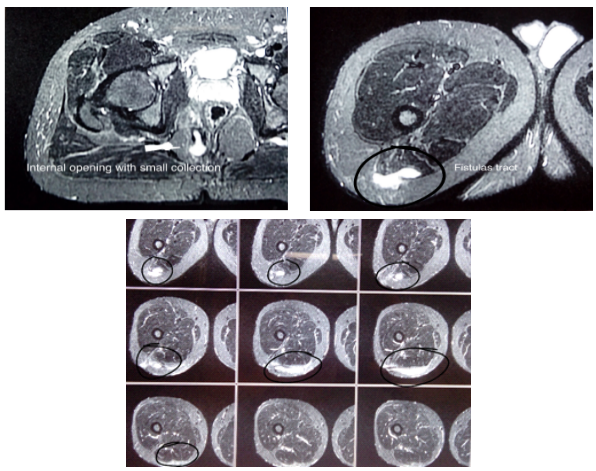
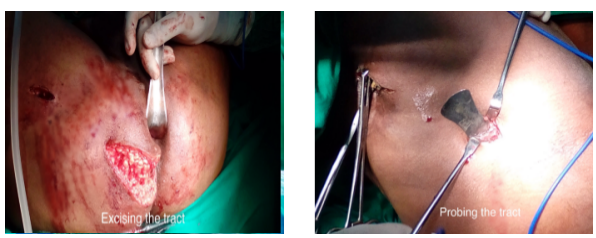
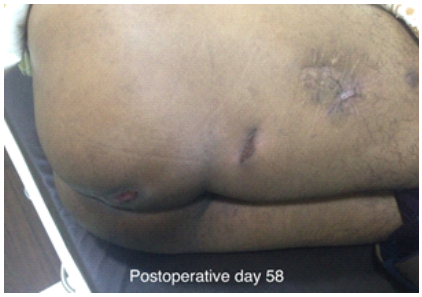


Figure 2 Pre and postoperative images.





III.Management

After assessing the patient and MRI report it was clear that it was a fistula in ano with thigh extension, patient was prepared for surgery. In lithotomy position the external opening in the thigh was excised and the tract was probed, an incision was placed where the tip of the probe was felt on the skin, through which the tract was further probed and a counter skin incision was taken. On reaching the gluteal region the tract was traced, it was high transphincteric, which was extending upto the levator. Intermittently methylene blue dye was injected in the tract to see that we are heading over the right path. The whole tract was excised there were few small side branching with small abscess cavity which was scooped off till all the granulation tissues was out, following which the sphincter were repaired with PDS 2-0 and the anal mucosa was approximated with vicryl 3-0. The gluteal flap was left open for drainage. The tracts in the thigh were scooped thoroughly removing all the granulation tissue from within, which was then packed with roller gauze.

Postoperative management: The wound was dressed daily for one week with irrigating the wound and the track was packed with roller gauze.

IV.Discussion

The various presentations of perianal fistula are attributed to local anatomical planes. A clear understanding of the relationship between anorectal and pelvic anatomy is vital to the management of fistula in ano. The recurrence can be up to 25%. This could be due to inadequate clearance of all tracts, failure to recognise occult sepsis and inadequate preoperative planning.

Review of literature shows that gluteal abscess has not been described as a presentation of fistula in ano. However, Crohn's disease, psoas abscess and pyonephrosis can present as a gluteal abscess [9,10,11]. Although there was no distinct external opening, we feel it was reasonable to classify this case as a suprasphincteric fistula. It had traversed above the sphincters with an internal opening in the anal canal and externally it involved the thigh skin, which was about to discharge pus.

MRI seems to be the preferred diagnostic and preoperative imaging modality to evaluate complex fistula in ano. [7]. We feel that this form of clinical presentation of fistula in ano has been reported less and it highlights the importance of the MRI scanning in the evaluation of problems in the gluteal region. Also a point to mention in the treatment is the complete removal of the fistulous tract even if we have to divide the sphincter muscle which can be repaired effectively with no loss of continence postoperatively .

In conclusion anal fistula has a varied presentation which could be without perianal symptoms. MRI scanning is the investigation of choice in evaluating complex fistulae in ano, and complete excision of the fistulous tract and repair of the sphincter [12].

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