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General Surgery

MANAGEMENT STRATEGY OF FISTULA IN ANO IN PATIENT OF DMCH DARBHANGA

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ABSTRACT **Background & Method:** The present prospective study, surgical treatment for anal fistula should aim to eradicate sepsis and promote healing of the tract, whilst preserving the sphincters and the mechanism of continence. in carried out at department of general surgery Darbhanga medical college and hospital darbhanga Laheriasarai Bihar. in Surgical OPD and ward, 84 patient admitted from surgery OPD in surgery ward of dmch for definite treatment of fistula in ano were selected for study. The aim of this present article is to review the pertinent literature, describing the advantages and limitations of new sphincter preserving technique. **Result:** During the period of study Two years were surgical patient and 143 (1.43%) are the cases of fistula in ano. Out of 143 we have randomly selected 84 patients for our study group, 62 patient having purulent discharge, 12 patient having serosanguinous discharge while 10 patient having serous discharge.24 patient have pruritus. Continuous pain found in 18 patient while 41 pt have interictal pain. Bleeding P/R found in 10 patient.46 patient has constipation while 22 patient has diarrhoea.we found in our study that 76 (90%) pt of fistula in ano out of 76 (%)gives history of burst open and in 38 patient incision drainage done. **Conclusion:** To improve the healing rates, patient selection is imperative, and control of sepsis, Most of the fistula-in-ano are the end result of cryptoglandular infection. A Fistulogram is useful to outline the course of fistula tract, helps to identify the internal opening and any related abscess. It is mandatory especially in high level fistula, fistula with multiple secondary tract and recurrence fistula to prepare a treatment plan.

KEYWORDS : Aetiopathogenesis, Fistula-in-ano & anal fistula management, fitula laser closure.

Introduction

Surgical treatment for anal fistula should eradicate sepsis and promote healing of the tract,as whilts preserving the sphincters and the mechanism of continence.for the simple and most distal fistule. Fistula-in-ano is an abnormal connection between the epitheliased surface of anal canal or rectum and the perianal skin characterized by chronic recurrent purulent discharge and/or cyclical pain associated with recurrent abscess followed by intermittent decompression.90% of fistula-in-ano are the end result of cryptoglandular infection(1) and rest are the secondary to chronic diseases like crohn's disease ,ulcerative colitis, tuberculosis etc.Recurrence rate was 0 in trans sphincter fistula and 4.9% in supra sphincteric fistula. The technique provided favourable results in the treatment of complex anal fistula while preserving the sphincter function and conservation of faecal continence.

Most of the fistula arise due to sepsis of anal glands which occurs due to obstruction of these anal glands. The density of these anal glands is more on posterior part of anal canal so high incidence on posterior part. The common pathogenesis however is the bursting open of an acute or inadequately treated anorectal abscess in perianal skin(2).

Diagnosis of fistula in ano can be done by history given by patient, careful local examination of perianal region with good source of light, a meticulous digital rectal examination and proctoscopy. In some cases fistulogram are needed(3).

Material and Method

The present prospective study entitled " Management Strategy of Fistula in ANO in Patient of DMCH DARBHANGA" carried out at department of general surgery Darbhanga medical college and hospital darbhanga Laheriasarai Bihar. in Surgical OPD and ward, Department of Surgery , 84 patient admitted from surgery OPD in surgery ward of DMCH Hospital ward for definite treatment of fistula in ano were selected for study.

INCLUSION CRITERIA

1) Identification of specific anorectal lesion i.e. the external opening
2) Discharge from the external opening -persistent, seropurulent /fecal matter causing pruritic and discomfort in perianal region.
3) Past history of perianal abscess and treatment of perianal abscess, which was inadequate or a recurrent attack of perianal abscess.
4) Well informed patient willing to comply with the study protocol.
*Minimum age of patient 16 years
*Maximum age of patient 67 years

EXCLUSION CRITERIA

1) Recurrent fistula after previous fistula surgery
2) All sinus occurring in midline (pilonidal sinus)
3) Patient who presented with fistula which are specific to certain condition
-Crohn's disease
-Active abdominal tuberculosis
-Carcinoma of rectum, Previous radiation therapy
4) Patient unfit and refuse for surgery.

RECORDING OF DATA- A preformed set of questionnaires was prepared in which history, Examination and treatment modalities given and results recorded, a written and informed consent was taken from patients willing to participate in the Study.

To carry out present work help was taken from radiology and pathology department.

STATISTICALANALYSIS

- The observed data was compiled in an excel sheet for all patient
- All statistical analysis was done by the help of statistical software SPSS 23 version
- For quantitative data frequency distribution, measures of central tendency, dispersion and graphical representation was applied.
- For comparison of quantitative variables t test fisher test and for qualitative variables various chi-square test applied.

Results

Table 1: HOSPITAL STATISICS TABLES

YEAR	TOTAL HOSPITAL IPD ATTENDENCE	ATTENDENCE IN SURGERY IPD	NO. OF CASES OF FISTULA IN ANO
Feb 2019 - Dec 2021	38189	6657	80
1 Jan 2018 - 30 June 2021	20282	3325	63
Total	58471	99821	143

During the period of study i.eTwo years in DMCH Ward darbhanga Bihar. total IPD was 58471 out of which 9982 (17.07 %) were surgical patient and 143 (1.43%) are the cases of fistula in ano. Out of 143 we have randomly selected 84 patients for our study group.

Table 2: Distribution of cases according to clinical presentation

Clinical Presentation		No. of Patient
Discharge from external opening	Purulent	62
	Serosanguinous	12
	Serous	10

Pruritus'		24
Pain	Continuous	18
	Intermittent	41
Bleeding P/R		10
Constipation		46
Diarrhoea		22

H/o perianal abscess Burst open 42 Incision and Drainage 38 Table shows 62 patient having purulent discharge,12 patient having serosanguinous discharge while 10 patient having serous discharge.24 patient have pruritus. Continuous pain found in 18 patient while 41 pt have interictal pain. Bleeding P/R found in 10 patient.46 patient has constipation while 22 patient has diarrhoea.we found in our study that 76 (90%) pt of fistula in ano out of 76 (%)gives history of burst open and in 38 patient incision drainage done.

Table 3: Distribution of cases according to Fistula opening.

Fistula opening	External opening		Internal opening	
	No. of patient	%	No. of patient	%
Present	84	100	54	64.2
Absent/ Not located	00	00	30	35.8
Total	84	100	84	100

Table shows internal opening of fistulous tract found by DRE/Proctoscopy in 54 patient (64.2%) and not able to locate in 30(35.8%) cases.

Table 4: Distribution of cases according to level of Fistula

Level	No. of Patient	%
High	04	4.76
Low	80	95.23
Total	84	100

Table shows 80 cases among 84 has low fistula while 4 patient has high fistula.

Discussion

Fistula in ano is a very distressing anorectal condition and pose a significant diagnostic and therapeutic challenge to the surgeon due to diversity and complex nature of the disease(4).

In our study we include 84 patients of fistula in ano out of which65 are male and 19 patients are female. They are admitted in department of general surgery Darbhanga medical college and hospital Laheriasarai Bihar. Detailed history and examination with investigations done and proper surgical treatment given and follow up study done to rule out late complications during the period Two years. In our study we have tried to compare the surgical treatment of fistula in no in dmch ward.

In our study we have seen out of 9982 patient admitted In surgery ward during the period of study in Dmch ward 143 patient (1.43%) are diagnosed as fistula in ano. Out of these 143 we have randomly selected 84 patients for our study group(5).It must be stressed that there is still a need for epidemiological study and the true incidence of fistula in ano has yet to be determined.

We found in our study that maximum number of cases are in age group of 31-40 yrs i.e.(33.7%) followed by 21-30yrs of age i.e. 23.8% so the prevalence of fistula in ano was 59.5% in age group 21-40 yrs of age. Fistula in ano also seen in as young as 16 year of age and as old as 67 yrs of age(6).

Fauldar HS & Andreas ommer et al reveals the incidence of fistula in ano as 2 per 10,000 populations per year and also mentioned that anal fistula is frequent condition with peak incidence between 30-50 years age and males are more affected than females. So our study is compatible with above study about the age group and sex ratio(1,7&8).

Conclusion

To improve the healing rates, patient selection is and control of sepsis, identification of secondary extensions and tracts of the fistula from the anal canal before any attempt of repair is strogly suggested. Most of the fistula-in-ano are the end result of cryptoglandular infection. A Fistulogram is useful to outline the course of fistula tract, helps to identify the internal opening and any related abscess. It is mandatory especially in high level fistula, fistula with multiple secondary tract and recurrence fistula to prepare a treatment plan.

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