Original Research Paper

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Medical Science

A CASE OF LONG ANO-SCROTAL FISTULA PRESENTING AS A PRIMARY SCROTAL DISCHARGE AND ITS MANAGEMENT BY FISTULECTOMY AND PRIMARY CLOSURE.

Dr. MD. M. M. Noor Mohiddin — Fathima Institute Of Medical Sciences

Dr. Shaik Fazila Banu — Fathima Institute Of Medical Sciences

ABSTRACT

Introduction: Fistula-in-ano is an anorectal condition prevalent in the population worldwide. It is an inflammatory track lined by granulation tissue which connects perianal skin superficially to anal canal; anorectum or rectum deeply. It is characterised by chronic purulent discharge or cyclical pain associated with abscess formation followed by intermittent spontaneous decompression. In some cases of men with anal fistulas, the fistula can extend into the scrotum, in which case the scrotum is usually painful and presents with redness, swelling and pus discharge from the external opening that is the secondary scrotal orifice of the fistula and can sometimes be misdiagnosed as scrotal abscess. Fistula with extension into scrotum is one of the rare complications of fistula. Nearly about 82% ano-scrotal fistulas had anterior opening and they are mostly intersphincteric or transsphincteric fistulas.

KEYWORDS :

CASE REPORT

A 35 year old male presented to the OPD with complaint of discharge from scrotum since 6 months

- No history of fever, constipation, bleeding per rectum or discharge per rectum.
- No history of dysuria, no history suggestive of TB, crohn's disease
- The patient had no any other co morbidities like diabetes or hypertension.

The patient had previous history of perianal abscess 6 months back which resolved after taking antibiotics.

Clinical Examination

On examination, pt was moderately built and nourished. Local examination of scrotal and anal region showed one visible external opening on the under surface of scrotum, a little left of the median raphe about 12cm from the anal verge. Some amount of induration was also present around the scrotal opening.

On DRE: internal opening could not be identified.

Investigations

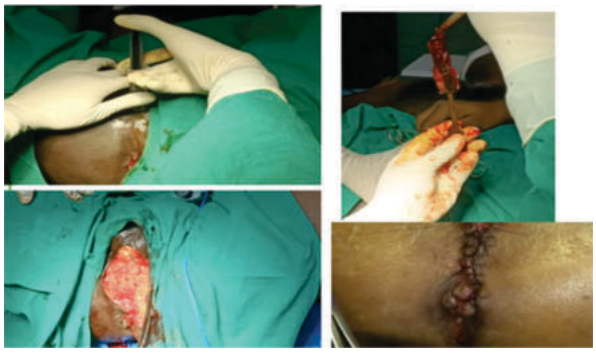
Evaluation - Routine investigations like Hemogram, complete urine routine were done. Urine culture was done to rule out UTI which showed no growth. MR Fistulogram was done which shows - Long curvilinear fistula track arising from the anal canal adjacent to the external anal opening at 12 O'clock position and extending anteriorly upto the root of the scrotum ending with a small abscess. A small blind ending ramification of the track is noted extending along the right side of the midline of perineum. After confirming the diagnosis of ano-scrotal fistula, the patient was put on a prophylactic antibiotic for 5 days and was taken up for surgery.

Operative Procedure

Fistulectomy With Primary Closure: Under strict aseptic precautions, under SA, pt was kept in lithotomy position and per rectal examination was done. H2O2 was taken in syringe and injected through the external scrotal opening. The track got delineated. Through the delineated track, a flexible probe was passed and with one finger in the anus, the other end of the probe was seen exiting through the anus at 12 O'clock position. After confirmation of both the openings, complete excision of fistulous track was done around the probe and secondary ramification was also removed. After giving thorough saline, beta dine and H2O2 wash, primary closure was done. Post op events were uneventful and healing was good.

DISCUSSION

Anal fistula with scrotal extensions could be mistaken for scrotal abscess. Careful history taking; clinical examination and MR Fistulogram will help in diagnosing the condition. There are many methods to treat fistula in ano.Usually fistulotomy or fistulectomy is done for simple fistulas and the wound is laid open. In this case fistulectomy was done as it removes the entire fistula track, removes all the septic foci, removes secondary ramifications and it has low recurrence rate. Primary closure of the wound was done to promote faster healing.



CONCLUSION

Excision of fistulous track and closure can be considered as one of the methodologies in the treatment of long anoscrotal fistulas because along with the removal of fistulous track and septic foci, it also removes the secondary ramifications thereby reducing the recurrence and promoting faster healing.

REFERENCES

1. Cirocco WC, Reilly JC. Challenging the predictive accuracy of Goodsall's rule for anal fistulas. Dis Colon Rectum. 1992 Jun;35(6):537-42.
2. Shindhe PS. Management of rare, low anal anterior fistula exception to Goodsall's rule with Ksarasutra. Anc Sci Life. 2014 Jan-Mar;33(3):182-5.
3. Parks AG, Gordon PH, Hardcastle JD. A classification of fistula-in-ano. Br J Surg. 1976 Jan;63(1):1-12.
4. Kurihara H, Kanai T, Ishikawa T, et al. A new concept for the surgical anatomy of posterior deep complex fistulas: the posterior deep space and the septum of the ischiorectal fossa. Dis Colon Rectum. 2006 Oct;49(10 suppl):s37-44.
5. Kagawa R, Nomura H, Takeda R, et al. [Anatomical course of deep anal fistulous tracts as analyzed by MRI]. Nippon Daicho Komonbyo Gakkai Zasshi. 2008 Apr;61(4):151-60.
6. Tokunaga Y, Sasaki H, Saito T. Clinical role of a modified seton technique for the treatment of trans-sphincteric and supra-sphincteric anal fistulas. Surg Today. 2013 Mar;43(3):245-8