



FiLaC + SLOFT SAVIOUR FOR COMPLEX ANAL FISTULA

General Surgery

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ABSTRACT

Objective: The aim of the blurb is to quarry into the wide array of treatment options for complex anal fistulae in order to rank fistula laser tract closure [FiLaC] + submucosal ligation of fistula tract [SLOFT] amongst them. **Background:** Cryptoglandular anal fistulae with recurrence and multiple tracts is one of the many complexities in the management of anal fistulae. **Materials and methods:** FiLaC + SLOFT is a hybrid surgical option combining benefits of ligation of intersphincteric fistulous tract [LIFT] technique and distal laser ablation of fistulous tract. Submucosal ligation and dismantling of fistulous tract takes care of the cryptoglandular source of origin of anal fistulae. Distal closure of the tract is ensured by laser ablation on continuous mode. **Result:** Since the year 2011, FiLaC and LIFT have been individually tried in the treatment of anal fistulae, with success rate ranging from 20-75%. Combining the two is conceptually sound in treating complex anal fistulae. **Conclusion:** Excluding cases of intersphincteric abscess/sepsis, FiLaC + SLOFT has come-up as an assuring operative blend for treating anal fistulae.

KEYWORDS

Anal fistulae, Complex, Cryptoglandular, FiLaC, SLOFT

INTRODUCTION:

Etiologically, 95% of all anal fistulae originate from cryptoglandular complex. This ordain includes complexities arising in the abovesaid anal fistulae, and excludes the rest 5% as a result of neoplasm, radiation, trauma or some associations like Crohn's disease, Ulcerative colitis, tuberculosis etc. Complex cryptoglandular anal fistulae are defined as those tracts that disturb levator-puborectalis sling [grades III-V according to Saint James University Hospital Classification]; traverse more than 30% external sphincter; have multiple tracts and are recurrent or refractory fistulae.

Many issues were called into question, while managing complex anal fistulae. The tracts have to be categorised well according to Saint James University Hospital, preoperatively.

Grade I- simple linear intersphincteric
Grade II- intersphincteric with abscess or secondary tract
Grade III- transsphincteric
Grade IV- transsphincteric with abscess or secondary tract within the ischiorectal fossa
Grade V- supralelevator and translevator extension.

All off-shoots or branches have tried to be delineated as thoroughly as possible. Any associated abscesses or sepsis are to be ruled out. Secondary causes like neoplasm, trauma, radiation; or associated diseases like granulomatous diseases have to dealt with separately, apart from treating anal fistulae.

Proper clinical assessment of anal fistulae tracts during digital rectal examination along with anoscopy and gentle probing can estimate the internal opening and amount of sphincter involved. Pre-existing anal fissure and haemorrhoids are to be looked into. MRI, and second in order, transrectal ultrasound [TRUS] are till date the best imaging modalities for evaluation and final confirmation of the abovesaid findings. The trajectories are illustrated precisely.

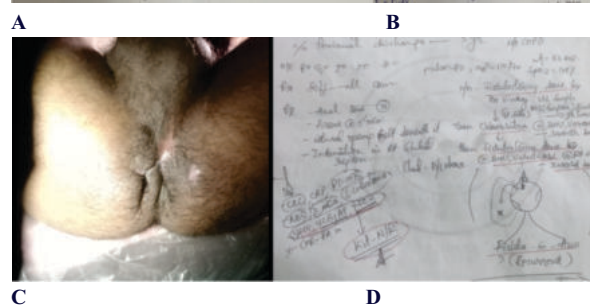
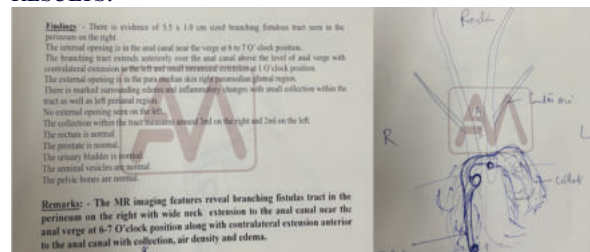
Procedures like fistulotomy, fistulectomy with primary sphincter repair and transanal opening of intersphincteric space (TROPIS) have been claimed with high healing rates in treating complex anal fistulae. FiLaC and SLOFT is an upcoming novel hybrid technique, increasingly claiming success in preceding years in treating anal fistulae.

AIMS AND OBJECTIVES:

The article struggles to establish, the role of FiLaC and SLOFT in the surgical arena to cure complex cryptoglandular anal fistulae. Limitations: Owing to constraint of laser energy use in existing cases of abscesses and sepsis, FiLaC + SLOFT technique can only be applied to those anal fistulae whose existing pus have been vented by draining seton or else. Procedure: A 30 year old male came with four perineal wounds, operated five times previously, last 1½ months back. On digging into the

history, he admitted being treated for pulmonary tuberculosis, but since labs disapproved later, he discontinued. After pre-operative work up including evaluation for tuberculosis too, surgery was planned. Under anaesthesia, internal openings were found @ 6 and 10 o'clock positions at dentate line, which was also suggested by MRI. Fistulous tracts were delineated via probing. Infant feeding tube [IFT] 10 French size was railroaded and radial fibre was inserted into the IFT. As done in SLOFT procedure, a mucosal incision 1 centimetre distal to internal opening was given to approach the tract. Figure of eight stitch was taken as stay sutures to circumscribe the proximal cryptoglandular part of the tract. The laser tract is withdrawn ablating the entire tract. While the stay stitches are tied, the proximal and distal tracts are dismantled. The mucosal incision needs to be closed. Recommended energy used for FiLaC is around 200 Joules for cryptoglandular ablation and 100 Joules/ centimetre for remaining tract. The above said steps were replicated twice to ensure all tracts were ablated. The authors feel that the steps may have to be repeated once or twice to conclude every bit of infected tract. All external openings should be left as such or vented more to allow drainage of the wreck and thus, heal by secondary intention. A part of fistulous tract from any external opening should be sent for histological examination and tissue-PCR analysis to exclude tuberculosis and malignancy, in all cases of complex anal fistulae. Associated anal ailments like piles and fissure were treated at the same setting. Post operative schedules of sitz baths, oxum spray topical application over perianal wounds and diaper usage were explained to the patient. Follow-ups were called for at 3rd, 7th postoperative days and 1 and 6 months [Figures A-D].

RESULTS:



Figures [from upper left clockwise]: **A**- preoperative MRI findings; **B**- preoperative proctography of MRI findings; **C**- preoperative clinical findings; **D**- postoperative 30th day image of operative site.

DISCUSSION:

Since its inception in 2011, FiLaC was studied by P Giamundo et al in 2014 and Target Donnez et al in 2014. FiLaC + SLOFT have been clearly proved superior to FiLaC alone and this surgical hybrid has given comparable results to other peers in the arena[1,2]. FiLaC + SLOFT was tried successfully in the abovesaid case of complex cryptoglandular anal fistula and is likely to go further a long way. Larger reviews and follow-ups definitely await for this technique in complex anal fistula cases. When weighed with procedures like fistulotomy, fistulectomy with primary sphincter repair and TROPIS, this is less likely to interfere with anal continence and thus, has lesser morbidity[3,4,5,6].

CONCLUSION:

FiLaC and SLOFT is a great saviour in the category of sphincter sparing surgeries, to cure complex cryptoglandular anal fistulae. More series with the technique are to be queued up.

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Ethical approval:

not required.

Conflict of interests:

none.

Abbreviations:

FiLaC- Fistula laser tract closure IFT- Infant feeding tube LIFT-

Ligation of intersphincteric fistula tract

MRI- Magnetic resonance imaging

SLOFT- Submucosal ligation of fistulous tract

TROPIS- Transanal opening of intersphincteric space

TRUS- Transrectal ultrasound

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