board certified
Anna M. Toker, MD
Specializing in Robotic Colo-Rectal Surgery

"I have spent a lifetime mastering the art of surgery and now it is time for an individualized approach to medicine. We have an automated phone system and a small personable staff. I know this system is unorthodox, but it allows us to get to know everyone individually and allows me to spend more time with each patient in a one-on-one environment."

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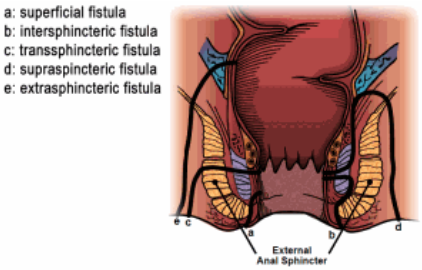
Elite ColoRectal Surgery for Mansfield and Midlothian

Dr. Anna Toker is a full-service colorectal surgeon in Mansfield and Midlothian, focusing on robotic approaches to colorectal surgery and offering sacral nerve stimulation for fecal incontinence.

Abscess/Fistula

Information and treatment options



An anal abscess is an infected cavity filled with pus found near the anus or rectum. An anal fistula (also commonly called fistula-in-ano) is frequently the result of a previous or current anal abscess.

TREATMENT

Up to 50% of the time after an abscess has been drained, a tunnel (fistula) may persist, connecting the infected anal gland to the external skin. This typically will involve some type of drainage from the external opening. Until the fistula is eliminated, many patients will have recurring cycles of pain, swelling and drainage, with intervening periods of apparent healing.

Surgery is almost always necessary to cure an anal fistula. If the fistula is straightforward (involving minimal sphincter muscle), a fistulotomy may be performed. This procedure involves unroofing the tract, thereby connecting the internal opening within the anal canal to the external opening and creating a groove that will heal from the inside out. Fistulotomy is a long-standing treatment with a high success rate (92-97%). This high success rate must be balanced, however with risk of incontinence (ability to control stool) that comes with division of the anal sphincter muscle. Small amount of muscle can usually be safely divided to treat the anal fistula without compromising continence. Therefore, the surgeon must assess whether a fistulotomy is appropriate for a given patient.

In addition to fistulotomy, there are a number of other surgical treatment options for anal fistula which do not involve division of the sphincter muscles. The two most common procedures utilized in these patients are the endoanal advancement flap and the LIFT procedure.

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An endoanal advancement flap is a procedure usually reserved for complex fistulas or for patients with an increased potential risk for suffering incontinence from a traditional fistulotomy. In this procedure, the internal opening of the fistula is covered over by healthy, native tissue in an attempt to close the point of origin of the fistula. Recurrence rates have been reported to be up to 50% of cases. Although the sphincter muscle is not divided in this procedure, mild to moderate incontinence has still been reported.

Another non-sphincter dividing treatment for anal fistula is the LIFT (ligation of the intersphincteric fistula tract) procedure. This procedure involves division of the fistula tract in the space between the internal and external sphincter muscles. This procedure avoids division of the sphincter muscle, and has similar success rate of an endoanal advancement flap.

WHAT IS A SETON?

As mentioned above, if a significant amount of sphincter musculature is involved in the fistula tract, a fistulotomy may not be recommended as the initial procedure. Your surgeon may recommend the initial placement of a draining seton. This is often a thin suture which is placed through the entire fistula tract and the ends of the seton (or drain) are brought together and secured, thereby forming a ring around the anus involving the fistula tract. The seton may be left in place for 6 weeks with the purpose of providing controlled drainage and slow division of the tract. Once all the inflammation has resolved, and a mature tract has formed, a second procedure is performed to divide the rest of the fistula.