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SURGICAL TREATMENT OF CRYPTOGLANDULAR RECTAL FISTULAS

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ABSTRACT

Rectal fistulas account for 0.8-1.2% of surgical diseases. There are morphological varieties of rectal fistulas with the presence of branched or horseshoe-shaped passages, which are formed during the spontaneous opening of the abscess. Cryptoglandular rectal fistula is a chronic inflammatory process in the crypt, intersphincter space and pararectal tissue, leading to the formation of a fistula. The affected crypt also serves as an internal fistula foramen. The external opening is most often located on the skin of the perineum, less often in the buttocks, scrotal skin, and vagina. The prevalence of rectal fistulas ranges from 8 to 23 cases per 100,000 population. Most often, the disease develops between the ages of 30 and 50, which determines the social significance of the disease. In men, this pathology is more common than in women. The onset of chronic paraproctitis is usually preceded by acute paraproctitis, spontaneous or surgical opening and drainage of the abscess, without eliminating the entrance gate of infection. Specific examinations include digital examination of the rectum, revision with a button probe, sigmoidoscopy, dye test, ultrasound diagnostics with a rectal probe, fistulography. In case of complex extrasphincter arrangement of the passages, the examination is supplemented by magnetic resonance imaging and examination of the function of the obturator apparatus of the rectum. There are a large number of surgical methods for the treatment of rectal fistulas.

OBJECTIVE

Retrospective analysis of the local status, methods of surgical treatment and direct results of operations in patients with chronic paraproctitis of cryptoglandular origin depending on the localization and degree of complexity of the fistula.

MATERIALS AND METHODS

An analysis of the results of examination and treatment of patients operated on the basis of the coloproctology department of the 1st clinic of Samara State Medical University for the period from 2019 to 2023 for cryptoglandular fistulas was carried out. Exclusion criteria were post-traumatic fistulas, fistula form of Crohn's disease, radiation epitheliitis, as well as fistulas formed as a result of tumor disintegration. In total, 365 people were operated on in 5 years, 244 (66.8%) of them were men, and 121 (33.2%) women. According to the age categories, the patients were distributed as follows: under 30 years old – 58 (15.8%), from 31 to 50 – 154 (42.2%), over 51 years old – 153 (42%).

OUTCOMES

The location of the external and internal foramen corresponded in 423 (89.05%) cases. The location of the external fistula foramen was as follows: anterior wall – 142 (28.03%), lateral wall – 123 (24.3%), posterior wall – 142 (47.7%). The internal fistula foramen was localized in the anterior crypts of 155 (32.7%) patients, in the lateral crypts of 29 (6.2%) patients, and in the posterior crypts in 291 (61.3%). Incomplete fistulas were observed in 53 patients (11.2%). In 89 (18.7%) cases, the fistulas were located extrasphincterally, 292 (61.5%) were transsphincterally and 94 (19.7%) were intrasphincterno. Rectovaginal fistulas were reported in 7 (1.47%) cases. In 70 (14.7%) patients, a complicated course of chronic paraproctitis was observed, in the form of multiple removed secondary fistula holes, inflammatory infiltrates in the pararectal tissue, purulent cavities and leaks. The surgeries were performed under spinal anesthesia or general anesthesia and began with the contrast of the fistula tracts with methylene blue, after which the location of the fistula tracts in relation to neighboring anatomical structures was clarified and one or another method of operation was finally chosen. 70 The following types of surgical interventions were used: Excision of the fistula into the lumen of the intestine – 241 (50.7%) Excision of the fistula into the lumen of the intestine with sphincter closure – 172 (36.2%) Excision of the fistula with ligature – 23 (4.84%) Segmental proctoplasty – 39 (8.21%) Intrasphincter and superficial transsphincter fistulas affecting less than one-third of the sphincter portion were excised into the lumen of the intestine, with all methylene blue-stained tissues excised in a single block or in stages. In the presence of an abscess, it was opened with subsequent contrast of the purulent cavity and its radical excision. The question of the need for sphincter suturing was decided individually, based on the results of preoperative manometry, gender, age, location of the defect and the number of muscle fibers crossed. In elderly women with anterior sphincter defect and a high risk of incontinence, a defect of one-third of the sphincter thickness was an indication for suturing. At the same time, young male patients with posterolateral localization of the defect were sutured only if the defect was more than half of the sphincter circumference. In extrasphincter fistulas, preference was given to segmental proctoplasty or ligature method. The choice depended on the degree of complexity of the fistula: the presence of purulent drip or pronounced cicatricial changes around the internal opening did not allow resorting to proctoplasty. In these cases, preference was given to the ligature method: 3 ligatures were performed through the fistula tract dissected before the appearance of sphincter fibers, which were gradually tightened at intervals of 1 week until the last thread erupted. Only drainage ligatures were not used. Segmental proctoplasty was performed with

separation and vertical reduction of the mucosubmucosal or mucomuscular split flap. Lateral flap relocation was not performed. Full-thickness flap reduction was used only in 3 (0.63%) cases. In 7 (1.47%) patients with recurrent extrasphincter fistula, 71 patients underwent radical excision into the lumen of the intestine with complete sphincter crossing and suture. A total of 6 (1.26%) postoperative complications were reported. Two of them had a suppurating wound in the place where a large perineal wound, formed as a result of the excision of many fistula tracts, was partially sutured. This necessitated the removal of sutures and the management of wounds in an open way. In one case, gastric bleeding from an acute ulcer occurred in the early postoperative period, which was stopped by emergency therapeutic fibrogastroscopy. Two patients had early secondary bleeding from the wound, which required surgical hemostasis by suturing and packing. In one case, a patient who underwent segmental proctoplasty for rectovaginal exct of a rasphincter fistula had suture failure with the development of phlegmon, which required the application of a 2-trunk loop sigmostomy and debridement of the soft tissues of the perineum. After 8 months, she underwent a second successful proctoplasty on the disconnected bowel, and after another 4 months, she underwent intra-abdominal closure of the sigmostomy.

FINDINGS

The most common are fistulas with posterior and lateral arrangement of the external and internal openings in men of working age. A differentiated approach is used in the choice of the surgical method, depending on the location of the fistula tract, the degree of sphincter involvement, the severity of cicatricial changes in the internal opening, the presence of infiltrates and purulent leaks. The favorable initial condition of the obturator apparatus allows most patients to resort to fistula excision in the the lumen of the intestine, while the need for sutures on the crossed sphincter is decided individually. Radical surgeries, performed according to indications in a specialized hospital, are accompanied by a small number of complications and favorable immediate results.

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