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ANAL FISTULA

This general guide is designed to provide background information to the operation that you will shortly undergo. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir*. It cannot cover in detail every aspect of your individual operation and may not deal with some areas that are of particular concern to you. These can be dealt with individually.

You should feel free to ask about any aspect of your care. All your questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

Further information is available at the web site above. This site also provides links to other sites that may provide additional information.

What is an anal fistula?

An anal fistula is an abnormal tract, or channel, that starts in the anus and opens into the skin surrounding the anus. The majority of anal fistulas start as an infection, or abscess, in one of the glands that line the anal canal. Occasionally fistulas develop secondary to specific pathological conditions, such as inflammatory bowel disease.

As the abscess becomes larger it becomes painful, and 'points' under the skin near the anus. This may burst spontaneously. If so patients often do not come to hospital. Although the abscess settles patients find they are left with a small sinus that leaks from time to time. This is the external opening of the fistula. The cycle of discharge will continue until the underlying fistula is managed. Occasionally the fistula will block and another abscess develops.

If the patient presents to a doctor with an abscess it will be surgically drained. At this time it is sometimes not possible to undertake definitive treatment of the fistula. Sometimes the fistula will be found, but it not thought safe to undertake definite treatment. A loop (suture or plastic) will then be passed through the fistula to 'mark' it. This is called a seton. It will stop an abscess from reforming and when the inflammation has settle surgery will be easier.

Pre-operative preparation.

If you are having elective surgery you should make a special effort to ensure your stools are soft. It is important that you continue to keep your stools soft for at least six weeks after your surgery. A laxative such as Lactulose or husk may be helpful. However, you must not get diarrhoea. You should drink at least 1.5 litres of fluid a day.

Managing a perianal wound.

At surgery a dressing is placed over the raw area. This remains in place for the first 18 to 24 hours. The first change of dressing will be done in hospital. The following day you should have a bath and whilst lying in the bath, this dressing should be gently removed. If

it is a deep wound then it is often necessary to give some pain relieving medication, such as morphine or nitrous oxide gas. Some wounds will need to be formally re-dressed and this requires the assistance of a nurse. In these cases it may be necessary for patients to remain in hospital until the dressing can be undertaken with comfort. In other cases the wound is more superficial and after the first dressing change in hospital patients can be discharged. A community nurse may need to visit you at home. In these cases it is helpful if patients have a bath and remove the dressings themselves prior to the arrival of the nurse.

Managing perianal wounds at home.

Many perianal wounds require nothing further than regular baths or showers and the application of a light dressing to absorb any leakage from the open wound. Your many objective is to keep the wound clean rather than sterile. Leaning forward in the shower, or curling legs up in a bath will open the area and adequate washing obtained. It is not necessary to use salt; this may sting and dries out the skin.

Other cases require a daily visit from a nurse so that the wound can be dressed. In these cases it is helpful if patients have a bath and remove the dressings themselves prior to the arrival of the nurse.

You are encouraged to be as active as possible. There may be some bleeding with your bowel motion for up to one week. Occasionally there is a brisk, larger bleed at ten days. If this occurs you should call my rooms or the hospital.

Work.

Your return to work depends on many factors, including your occupation, age and general health. The single most important factor that will determine your return to work is pain. If you feel comfortable doing a particular activity then it is very unlikely you will do any harm. In general it is sudden, unplanned movements that cause problems.

As a guide patients with sedentary work can return to work after seven days. If you have a manual occupation you will normally be able to return to work after two to three weeks. It will take six weeks to be 100% recovered.

You can resume exercise as guided by discomfort. If you use pain as a guide it is almost impossible to 'over exercise' yourself to the extent that you damage the surgical area. When you return to exercise do not do it in a competitive environment until you feel you can cope.

Pain relief.

Open operations in the perianal area are usually uncomfortable, particularly when the bowels are opened the first few times after the operation. Your post-operative recovery will be slower if you do not have adequate pain relief.

Proper pain relief is very important for both holistic and physiological reasons. Patients often have an understandable reluctance to take pain relieving drugs. This is a mistake and may increase post-operative complications. The principal that underlies all methods of pain relief is that the drugs work best if you anticipate the pain. A small quantity of the drug taken regularly (even if pain free at that time) will work better than waiting for the pain to occur and then taking a larger dose.

Post-operative pain can be minimised with appropriate care. It is important that you do not let your stools become hard and you should follow the advice above, starting before your operation. Many patients find warm baths very soothing and it will do no harm if you have several baths per day. Do not put salt in the bath as this will dry the skin and may burn any open area.

Immediately after the operation you may require an injection to provide you with pain relief, but after that adequate pain relief can normally be achieved by oral medication. Regular

Panadol, regardless of whether you have pain or not, is the foundation on which all pain relieving strategies are based. It should be used on a regular basis to provide background pain relief, regardless of whether you have pain or not, for a week after your surgery. Additional, stronger pain killers and/or anti-inflammatory drugs can be taken on top of the Panadol for break through pain.

Many stronger pain relieving drugs contain codeine or similar drugs and this will tend to cause constipation and a hard stool. This will make defaecation more painful. This is why you must make your stools soft prior to the surgery and continue with a laxative such as lactulose and drink plenty of water. Anti-inflammatory drugs can irritate the stomach and should be taken with food. Normally they can be stopped after seven days.

Follow up

You will need to be reviewed four to six weeks later. Occasionally a further examination under anaesthetic may be required. If the fistula was not managed at the initial operation, it is usually possible to accurately define the anatomy of the fistula and the appropriate treatment can be undertaken.

In approximately 90% of fistulas the cause is infection in one of the anal glands. In these cases the fistula is simply 'laid open' and then dressed as above. In the remaining 10% the anatomy of the fistula may be more complex, or there may be an underlying problem such as inflammatory bowel disease. In these cases the management can be more complex and has to be tailored to each individual patient. These cases often require several operations and can be very taxing to manage.