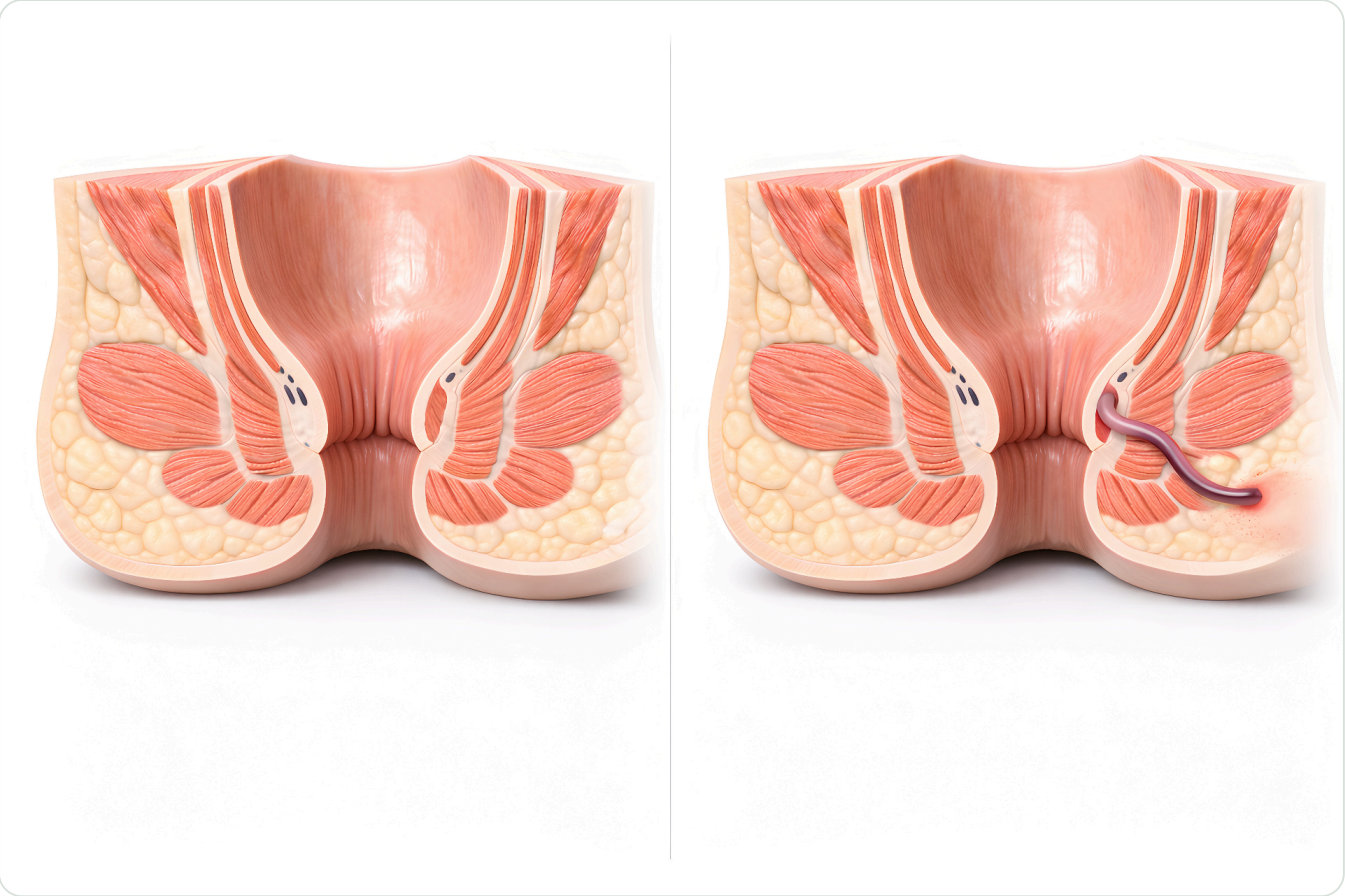
Anal Fistula and Anal Abscess: When an Abscess Becomes Chronic



A perianal abscess (an abscess near the back passage) is one of the most painful acute conditions in the anal area. In up to 30-50% of patients, it subsequently develops into an **anal fistula**, a small chronic tunnel between the bowel and the skin [1,2]. Early and correct treatment is crucial to avoid complications and preserve the function of the sphincter muscle.

What is an anal abscess?

An anal abscess occurs when one of the small glands in the anal canal (the glands of Hermann and Desfosses) becomes blocked and infected. Pus collects and forces its way through the surrounding tissue [3]. The result is a sudden, throbbing pain near the back passage, often accompanied by:

- A visible red and tender swelling near the anal opening

- Fever and generally feeling unwell
- Pain that worsens when sitting, coughing, or having a bowel movement

As a rule, the abscess must be **drained surgically as a matter of urgency** - antibiotics alone are not sufficient [4]. The procedure is performed under a local or short general anaesthetic and provides almost immediate pain relief.

When does it become a fistula?

Even after successful drainage, the channel does not always heal. If the connection between the anal gland and the skin persists, an **anal fistula** is formed. Typical signs include:

- Persistent or recurrent discharge of pus/blood from the back passage
- A small opening in the skin (the fistula opening) that weeps
- Repeated abscesses in the same place

Fistulas are classified according to their path in relation to the sphincter muscle (the Parks classification: intersphincteric, transsphincteric, suprasphincteric, and extrasphincteric) [5]. This classification is crucial for choosing the correct treatment.

Investigation

The diagnosis is made by a clinical examination, often supplemented with:

- **Endoanal ultrasound** - quick and accurate in the hands of an experienced practitioner
- **Pelvic MRI scan** - the gold standard for complex, recurrent, or Crohn's-related fistulas [6]
- **Examination Under Anaesthetic (EUA)** using methylene blue or hydrogen peroxide

It is important to rule out underlying conditions such as Crohn's disease, as the treatment strategy is different [7].

Surgical treatment

The treatment is chosen based on the fistula's path and the amount of sphincter muscle it crosses:

- **Fistulotomy (laying open):** The most effective method, with a healing rate of >90%, but can only be used for low fistulas where a minimal amount of sphincter muscle is involved [8].
- **Seton (silicone drain):** Used as a "draining seton" for active infection or complex fistulas, and can also be used as a slow "cutting seton".
- **LIFT procedure** (Ligation of Intersphincteric Fistula Tract): A good option for trans-sphincteric fistulas, with a healing rate of 60-75% without affecting continence [9].
- **Advancement flap:** Closes the internal opening with a flap of bowel lining; used for high fistulas.
- **Fibrin glue and fistula plug:** Lower healing rates (40-60%) but a minimal risk of incontinence [10].

The choice of method is a balance between the chance of healing and the risk of incontinence - and should always be made by a colorectal surgeon with experience in treating anal fistulas.

What you can do

- See a doctor for any persistent pain, swelling, or discharge of pus from the back passage
- Avoid home treatment with warm compresses if you suspect an abscess - this will delay drainage
- Attend a follow-up appointment after an abscess has been drained, so that any potential fistula is detected early

At our clinic, we offer examination, ultrasound, and surgical treatment of anal fistulas - discreetly and covered by the public health insurance scheme.

References

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