Re-routing of the track. Is it a favorable solution for the treatment of high anal fistulae?

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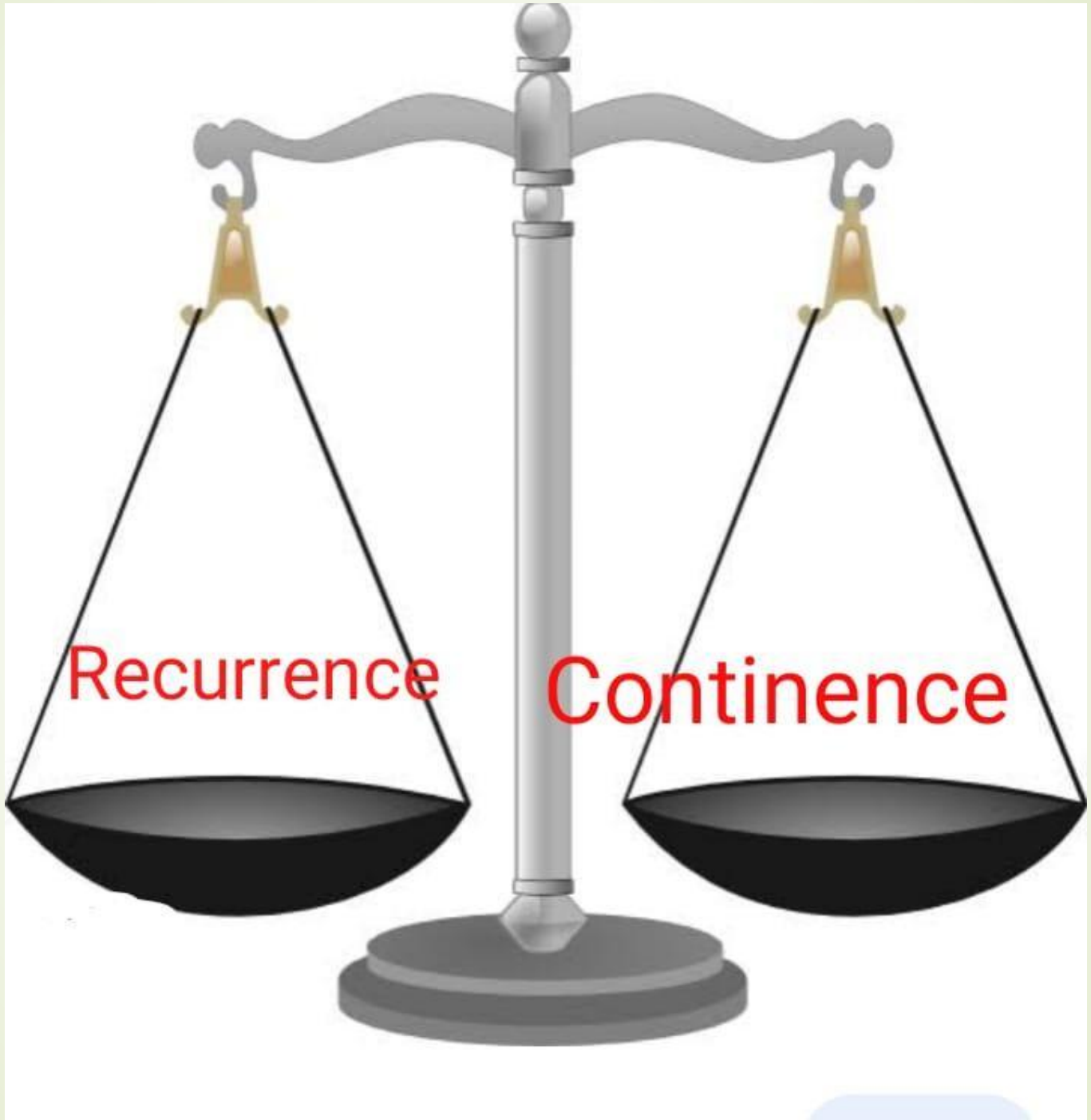
- **Complex anal fistula has been a hot topic in clinic.**
- **Many surgical techniques have been described for the treatment of such anal fistula, including the use of seton, fibrin glue, collagen plugs, rectal advancement flaps, fistulotomy with sphincter repair, and rerouting the fistula tract.**

- **However, the results have been variable, and no one procedure is superior to the others absolutely.**
- **It is worth our concern that the goal of any treatment procedure is to obliterate the tract and to have low recurrence rates while maintaining full continence.**


Recurrence
Continence

- **Recurrence and incontinence are two faces of the same coin, the more that is done to avoid one, the more it is likely to get the other.**

- Rerouting operation was first described by Mann and Clifton. The procedure aimed at converting transsphincteric fistulae into intersphincteric or submucous fistulae, which can then be laid open safely with minimal, or without, sphincter division. It was hoped that rerouting operation can achieve the minimal recurrence of fistulotomy while preserving continence.

Aim of our study

- Is to evaluate the role of re-routing technique regarding fecal incontinence and recurrence.

Patients and methods

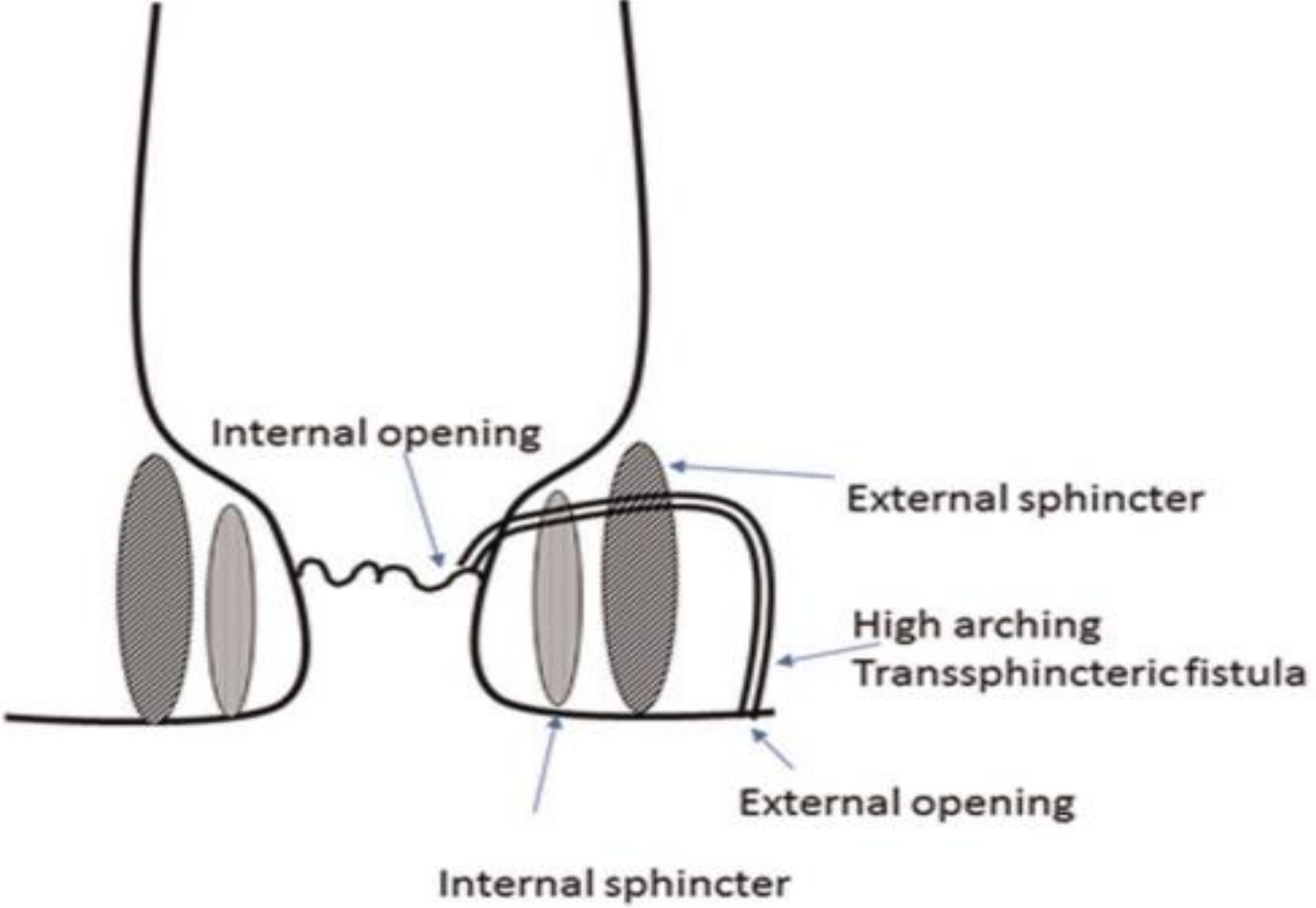
- Eighty three patients were enrolled in this study (52 male and 31 female) with high transphincteric and supra sphincteric fistulae a admitted to general surgery department Assiut university hospital between October 2019 and September 2022 .
- The least follow up 6 months.

- Fistulae were assessed clinically and by MRI when the clinical diagnosis was unclear. Preoperative continence status was assessed using the Wexner incontinence score.

Technique

- All operations were done in the lithotomy position.
- The first stage started by coring out the fistulous track. Dissection stopped at the point where the track traversed the external sphincter, when a circumanal incision was made at the anal verge, centered on the point where the fistulous track pierced the external sphincter.

- The intersphincteric space was entered and dissected to the depth where the fistulous track can be felt.
- The track was then dissected from the external sphincter by simple muscle splitting, and it was pulled to the intersphincteric space.



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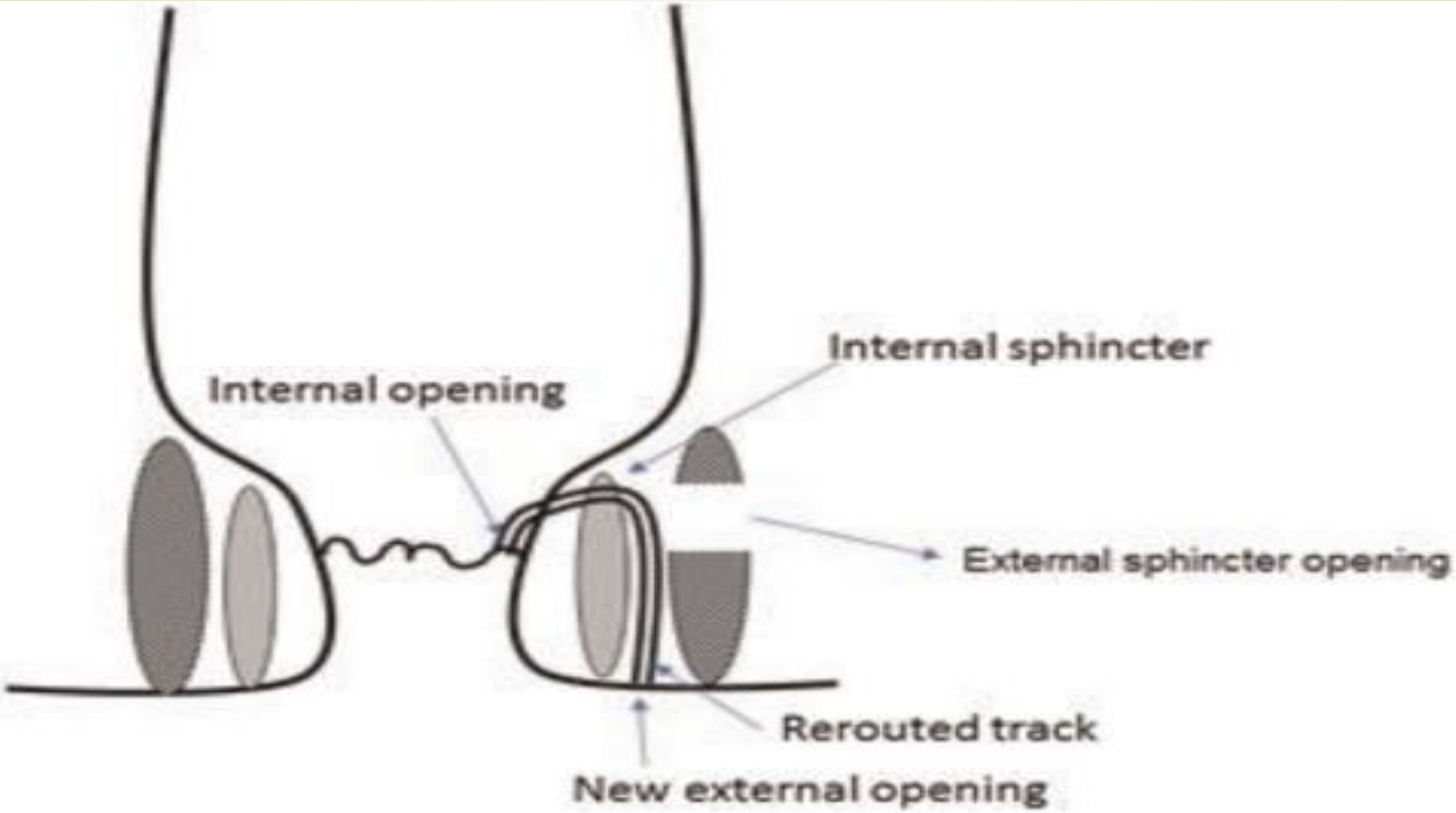

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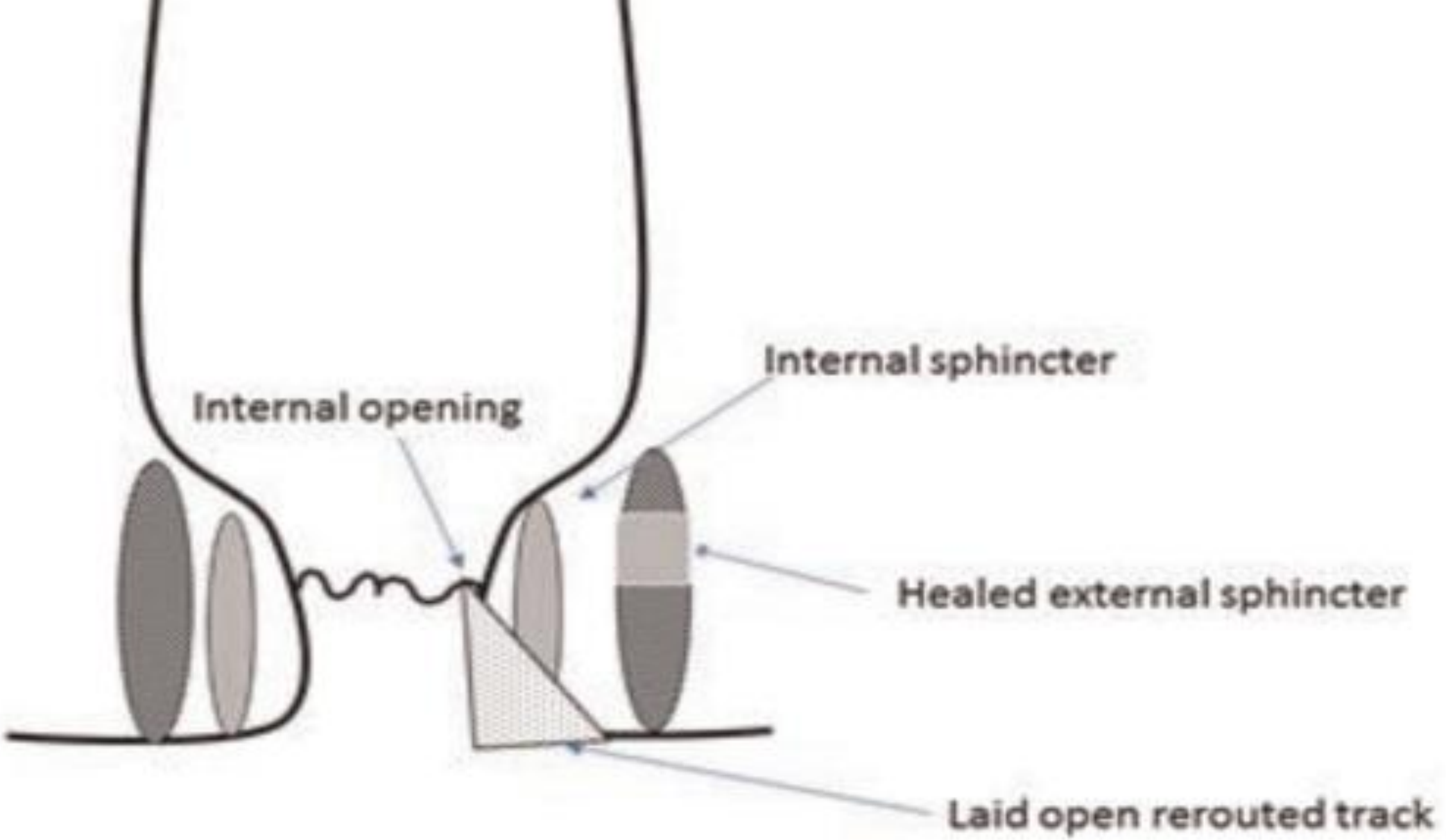
- The second stage was performed (6-8 weeks) after complete healing of the first-stage wound. Under general or spinal anesthesia, and in the lithotomy position, the intersphincteric fistula was probed and laid open.
- This entailed division of the lower most fibers of the internal sphincter.



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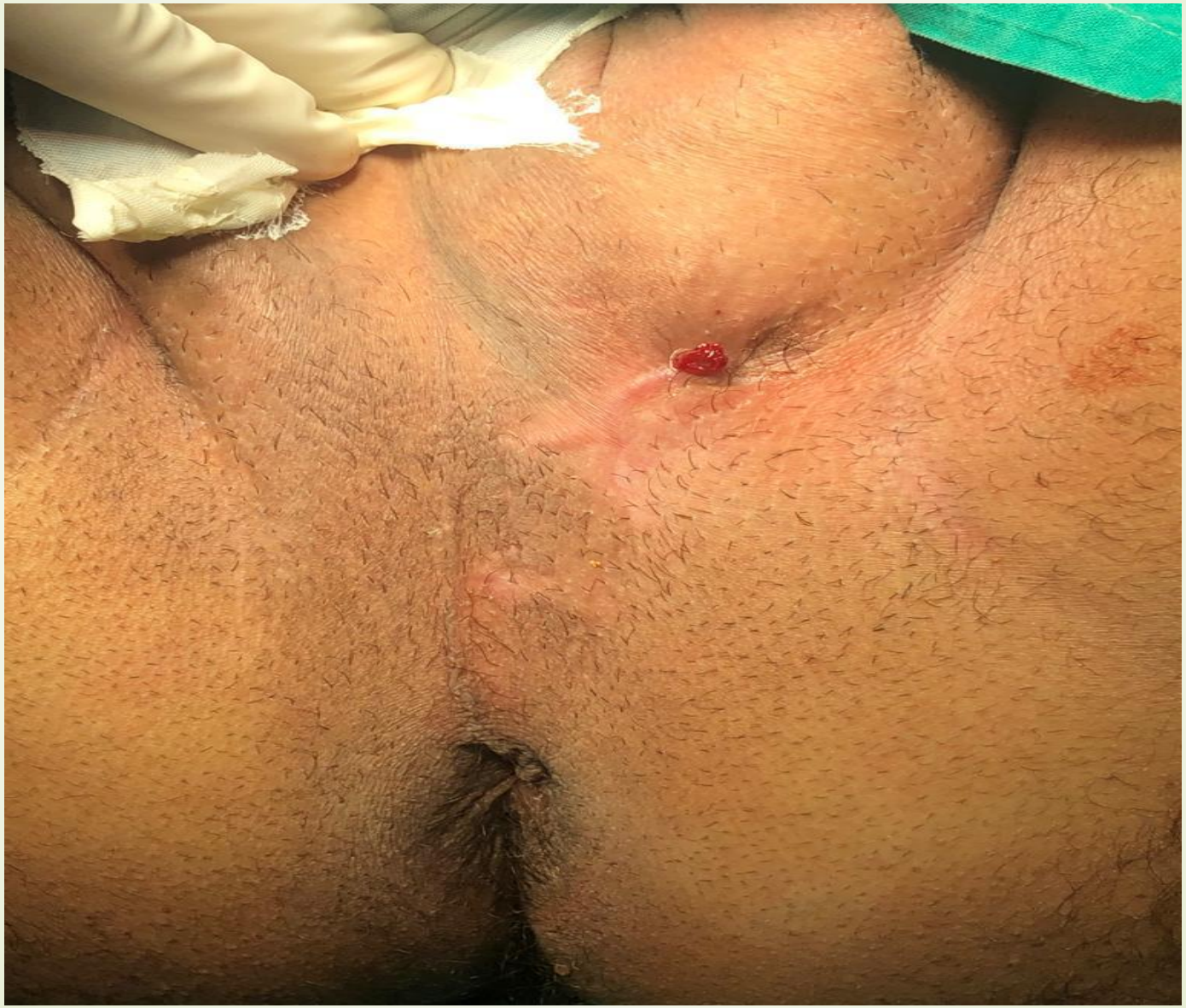
Results

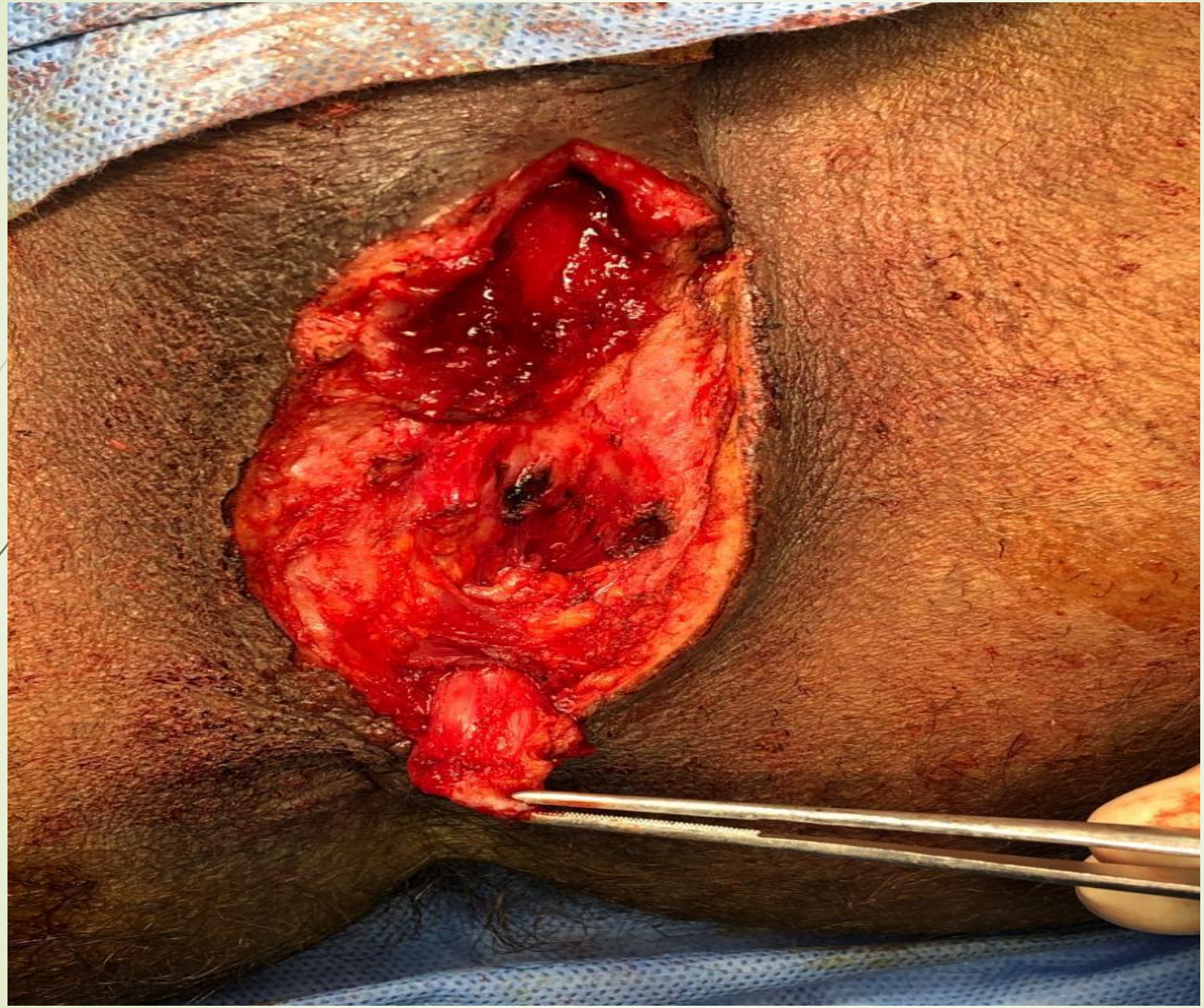
- Recurrence after finishing all stages of the operation occurred in Five patients (6 %).
- In two patients, the recurrent tracks were simple intersphincteric tracks that were treated by fistulotomy, the third patient refused further intervention .

- The last two patients, the track is injured while coring it out in the first stage of the procedure with possible spread of infection to the hole of external sphincter and transphincteric fistula simulating the original one will be seen in the second stage and treated by another two stage rerouting.

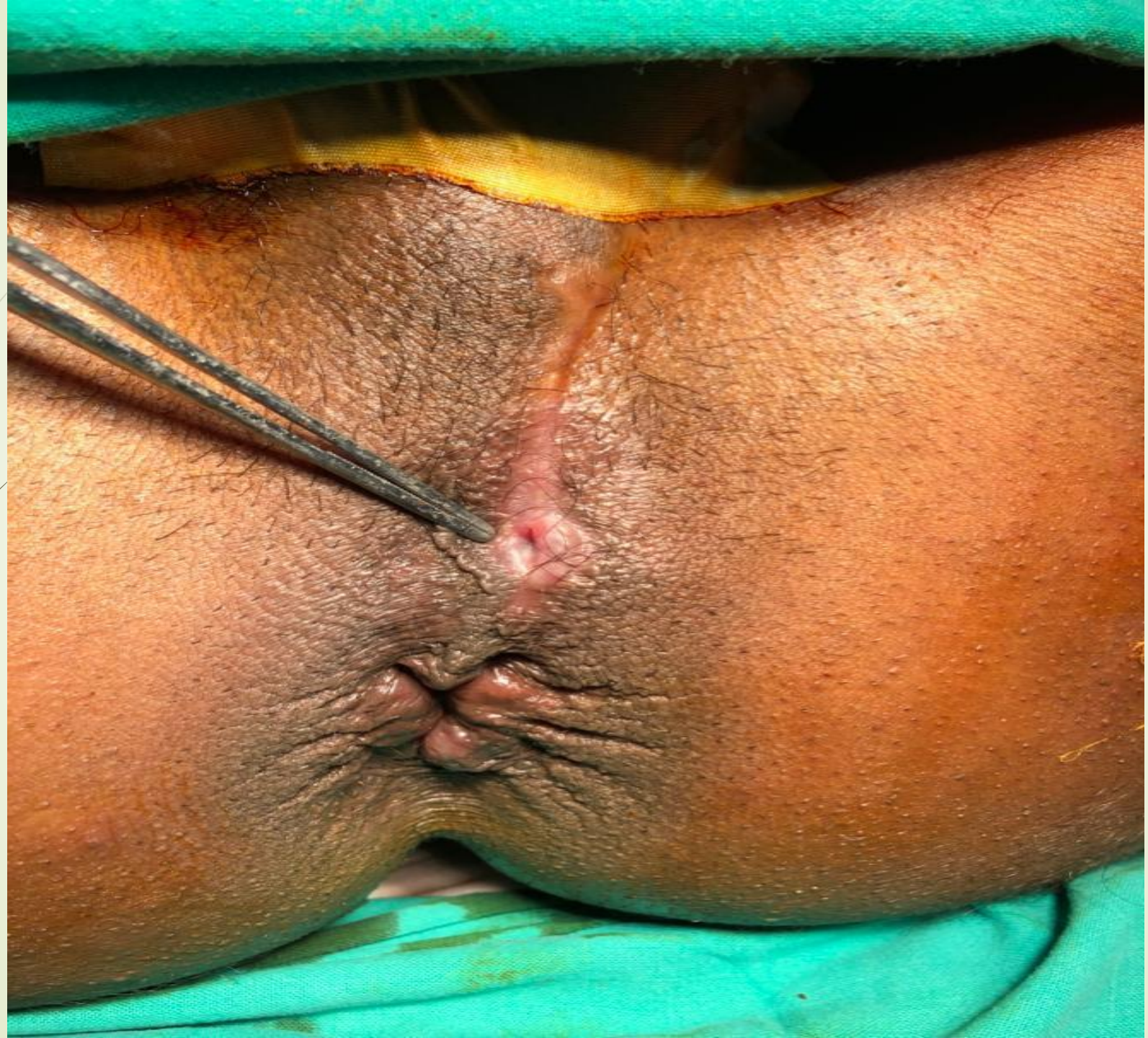
- The postoperative continence status and Wexner score did not differ from the preoperative continence status and score in 79 patients. Four (5%) patients experienced minor postoperative incontinence in the form of gas incontinence in three patients and staining of the underwear in one patient. Two patients improved after training the pelvic floor muscles by regular exercises, and the other two did not improve through the follow-up period.

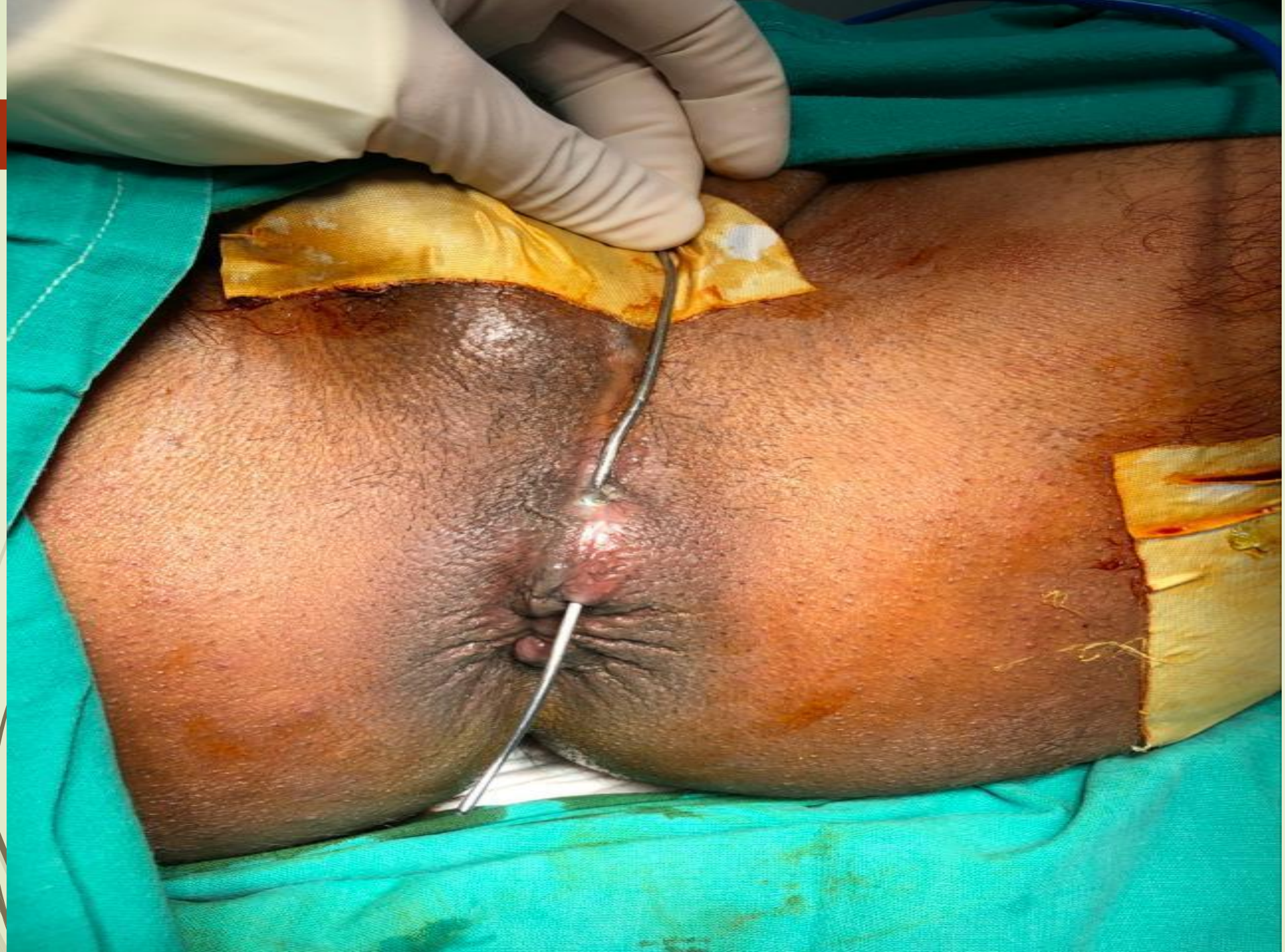
- Two patients (2.4)developed track gangrene that were treated by track excision and completed staged rerouting later on.
- The mobilized fistulous track was thinned out extensively to allow it to pass through the small slit in the external sphincter before it was transposed to the intersphincteric space. This probably jeopardized the vascularity of the track which became gangrenous in its distal part





- After two months





Conclusion

- Rerouting operation is suitable for patients with high arching transsphincteric and suprasphincteric anal fistulae. It is a minimal sphincter-sacrificing operation that is associated with low recurrence and minimal incontinence, thus combining the advantages of fistulotomy and sphincter-preserving fistula surgery.
- We hope that longer follow-up support these results.


Thank you