

STANDARD OPERATING PROCEDURE

Fistula in Ano

1. PURPOSE

To provide a standardized protocol for diagnosis, evaluation, treatment, and follow-up of patients with fistula in ano to:

- Ensure accurate classification
- Prevent recurrence
- Preserve continence
- Reduce complications
- Standardize surgical management
- Improve documentation

2. SCOPE: General Surgery, emergency department, operating theatre, nursing services

3. DEFINITIONS

Fistula in ano: An abnormal tract connecting anal canal to perianal skin.

Internal opening: Opening inside anal canal.

External opening: Opening on perianal skin.

Goodsall's rule: Predicts fistula tract direction based on external opening location.

Simple fistula: Low, single tract, no sphincter involvement

Complex fistula:

- High fistula
- Multiple tracts
- Recurrent
- Associated with Crohn disease
- Anterior fistula in female
- Horseshoe fistula

4. RESPONSIBILITIES

Consultant surgeon: Confirm diagnosis, decide surgical procedure, perform surgery, manage complications

Residents/Medical officers: History taking, examination, arrange investigations, follow up care, documentation

Nursing staff: wound care, Sitz bath instruction, dressing, monitoring

5. CLINICAL ASSESSMENT

History: Symptoms: Perianal discharge, recurrent abscess, pain, swelling, bleeding, pruritus

History of: previous abscess drainage, tuberculosis, Crohn disease, diabetes, previous surgery

Physical examination:

Inspection: External opening, discharge, scar, induration, secondary opening

Palpation: Induration, tract direction, tenderness

Digital rectal examination: Internal opening, induration, mass, sphincter tone

Proctoscopy: Internal opening, associated pathology

6. CLASSIFICATION

Parks classification: Intersphincteric, transsphincteric, suprasphincteric, extrasphincteric

Simple fistula: Low intersphincteric or low transsphincteric

Complex fistula: High trans sphincteric, suprasphincteric, extra sphincteric, recurrent, horseshoe

7. INVESTIGATIONS

CBC, Blood sugar, Renal function, HIV (if indicated), TB workup (if suspected)

Imaging: Not required for simple fistula.

Indications for imaging: Recurrent fistula, complex fistula, multiple openings, suspected horseshoe, Crohn disease

Imaging options: MRI fistulogram (gold standard) – not available here

8. INITIAL MANAGEMENT

If acute abscess present: Incision and drainage first.

Definitive fistula surgery delayed until infection subsides.

Supportive care: Analgesics, antibiotics (if cellulitis), Sitz bath

Antibiotics indication: Diabetes, cellulitis, immunocompromised, sepsis

9. DEFINITIVE MANAGEMENT

Procedure depends on fistula type.

Simple fistula: Preferred: Fistulotomy

Procedure: Lay open tract.

Healing by secondary intention.

Success rate: 90–95%

Complex fistula:

Options: Seton placement:

Indications: High fistula, Sphincter involvement

Types: Cutting seton and draining seton

Advancement flap: Indications: High fistula, recurrent, anterior fistula female

LIFT procedure: (Ligation of intersphincteric fistula tract)

Advantages: Sphincter preservation, good success

Fibrin glue / fistula plug: Selected cases.

Surgical decision principle:

Low fistula: Fistulotomy

High fistula: Seton or sphincter saving procedure.

10. POST OPERATIVE CARE

Monitoring: Pain, Bleeding, Urinary retention, Infection

Medications: Analgesics, stool softeners, antibiotics if needed

Local care: Daily dressing, Sitz bath twice daily, high fiber diet

Avoid constipation.

11. MONITORING

Daily monitoring: Wound healing, infection, discharge, continence status

Watch complications: Recurrence, incontinence, bleeding, abscess

12. DISCHARGE CRITERIA

Patient may be discharged if: Pain controlled, ambulating, passing urine, able to do sitz bath, no bleeding, no fever

Provide education: Wound care, hygiene, diet, follow up

13. FOLLOW UP PROTOCOL

First visit: 1 week – Check wound, infection, healing

Second visit: 3–4 weeks – assess healing progress

Long term: Until complete healing.

Recurrence monitoring: Up to 6 months.

14. DOCUMENTATION

Admission: History, Examination, Classification, Plan

Operative notes: Type of fistula, Internal opening location, procedure performed, sphincter involvement, complications

Post operative notes: wound status, pain, bowel movement, continence

Discharge summary: Diagnosis, procedure, medicines, dressing advice, follow up date, warning symptoms

15. COMPLICATION MANAGEMENT

Early: Bleeding, Urinary retention, Infection

Late: Recurrence, Incontinence, Non healing wound

Management according to hospital surgical protocols.

17. REFERENCES

- ASCRS Clinical Guidelines
- Bailey & Love Short Practice of Surgery
- Sabiston Textbook of Surgery
- Parks classification
- Colorectal Surgery Textbooks