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COMMENTARY

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Complications in Anal Fistula

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About the Study

In the realm of colorectal surgery, perianal sepsis and fistula is a difficult illness in terms of recurrence and faecal incontinence. Our goal is to see how effective 'one-stage complex anal fistula excision with rebuilding of the anal sphincter without stool diversion' is for faecal incontinence and recurrence. This was a prospective cohort study on 175 patients with complex high peri-anal fistulas who underwent fistulectomy and reconstruction (primary suture repair) of the anal sphincter without stool diversion. Patients were followed up 1 year after wound healing for continence to stool and gases using the Wexner score. Complications can develop either immediately after surgery or later. Several complications may arise soon after the surgical surgery. Urinary retention, significant bleeding or discharge from the fistulotomy site, clot development inside an existing hemorrhoid, and faecal impaction are all possible complications. Anal stenosis, recurrence of the fistula, bowel incontinence, and delayed wound healing are some of the other issues that might occur following the treatment (the wound remains unhealed for longer than 12 weeks). These problems are uncommon, affecting 0% to 18% of individuals depending on the type of fistula and operation performed. The muscles of the anal sphincter might be damaged during fistula surgery, especially when the fistula involves the sphincter muscles. These are in charge of constricting around the anus to keep bowel movements under control. The muscles' strength is harmed when the sphincters are damaged. There may be a loss of bowel control, resulting in faeces seeping from the rectum. Fecal or bowel incontinence is the medical term for this.

This is a rare complication that affects 3-7 percent of all individuals who have a fistula repaired. The danger is determined by the fistula's location and the sort of surgery utilized to remove it. The risk of Seton methods (about 17 percent) is the largest. The anal sphincter muscles can be damaged by surgery in rare situations (the ring of muscles that open and close the anus).You may lose control of your intestines if the muscles are injured, resulting in faeces seeping from your rectum (the area where they are stored). This is referred to as bowel or faecal incontinence. The type of surgery you have and the site of your fistula will determine the chance of incontinence after surgery. If you already had some bowel incontinence before the surgery, it's possible that it'll develop worse.

Anal fistula surgery is a technique that is frequently performed. A precise preoperative diagnosis is critical to minimize recurrence and faecal incontinence due to the different morphology of anal fistulae and their proximity to anal sphincters. Despite the fact that the majority of patients can be diagnosed properly before surgery using a simple clinical examination, endoanal ultrasonography, or magnetic resonance imaging, unexpected results can arise after surgery, making the operation challenging and correct decision-making vital. In this post, we'll go over the challenges and unexpected findings that can arise after anal fistula surgery, as well as how to deal with them. The majority of anal fistulas form as a result of an anal abscess. A number of glands produce a fluid material just

inside your back channel (anus). These glands can get clogged with germs and diseased (abscess). If the abscess grows large enough, it may develop a tunnel that leads to the skin around your back canal. This will form a fistula, which will connect the inside of your back route to a hole in the skin around your back tube. An anal fistula can also develop as a result of long-term intestinal irritation or infection. A tunnel can form from the lining of your back channel to an opening in the skin as a result of this.

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