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Invited Commentary

Commentary on: Risk factors for recurrence after anal fistula surgery: A meta-analysis

Dear Editor,

Cryptoglandular anal fistula is a complex disorder for both patients and colorectal surgeons. It is diagnosed on the basis of clinical features, physical examination, and radiological tests, and has a substantial impact on physical health, social functioning and quality of life (QOL) of patients.

Complex anal fistula management still represents a therapeutic challenge for colorectal surgeons. Successful healing must solve a fragile balance between perianal sepsis control while preserving sphincteric apparatus and the mechanism of continence [1].

For complex anal fistulas, an advancement flap has been described as a gold standard with success rates varying from 59.6% to 70%. However, the reported incontinence rates also vary (0–45%).

Several sphincter-preserving techniques such as LIFT, laser therapy, Fibrin glue, Fistula plug and others have been proposed. These procedures try to avoid incontinence, but high recurrence rates are generally reported (30%–60%) [2].

For this reason, it would be ideal to know the risk factors of recurrence to help to choose a more or a less aggressive therapy. If the type of fistula or the type of patient has a great chance of recurrence, sphincter-preserving techniques should be chosen as multiple surgical interventions will cause more fecal incontinence. On the other hand, if the chance of recurrence is low, more “aggressive” techniques with better definitive results can be chosen [3].

A recently reported meta-analysis [4] revealed significant factors associated with increased risks of anal fistula after anal surgery: high trans-sphincteric fistula, undetected internal opening, presence of horseshoe extensions, seton placement surgery and multiple fistula tracts. For patients with mucosal advancement flap surgery, younger age (< 40/45 years) and presence of horseshoe extensions were identified as contributing risk factors.

It is in this group of patients that we must be extremely careful when performing the more “aggressive” techniques, and should adequately discuss with the patient on the advantages and disadvantages of these surgical procedures. We must increasingly involve the patient in the decision on choosing the surgical technique by offering information about them.

I am sure that the current dogmas in the treatment of anal fistula will change, and we will probably find more useful sphincter preservative techniques in the future.

Conflicts of interest

None.

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A. Arroyo*, L. Sánchez-Guillén
Department of General Surgery, Colorectal Unit, Elche University Hospital, University Miguel Hernández of Elche, Alicante, Spain
E-mail addresses: arroyocir@hotmail.com (A. Arroyo), drsanchezguillen@gmail.com (L. Sánchez-Guillén).

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* Corresponding author.

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