Tube in tract technique: a simple alternative to a loose draining seton in the management of complex fistula-in-ano: a video vignette

doi:10.1111/codi.13143

Dear Editor,

Tubes have been used to drain perianal abscess [1] but their use in managing fistula-in-ano has never been described. Tube in tract (TIT) is a simple technique and has several advantages over a loose draining seton in the management of complex fistula-in-ano [2]. The skin around a seton may become tight making it less effective to drain thick pus. This does not happen in TIT. In TIT, the diameter of the tube can be selected as required resulting in better drainage. The technique helps to delay closure of the external opening. In patients with long fistula tracts, it can be used as an adjunct to ligation of intersphincteric tract (LIFT), video-assisted anal fistula treatment or advancement flap procedures where there is a need for the inner part of the fistula to heal before the external opening closes. Unlike a seton, in TIT nothing is passed through the internal opening which is thus not kept unnecessarily open. In cases where the internal opening cannot be localized or is surgically closed as in procedures such as mucosal advancement flap, LIFT etc., TIT can still be used to facilitate closure of the long deeper part of the tract by preventing premature closure of the external opening.

In TIT, the external opening is widened. A tube of required length is put in the tract. The outer edge of the tube is at the level of the external opening and is not fixed by any suture. During daily dressings, the tube is taken out and then inserted again after the dressing. This ensures that the tube does not get stuck in the tract.

The method was used in 26 patients, male:female 22:4, age 45.04 ± 13.6 years, and with a median follow-up of 6 months. All patients had a complex fistula (James type, I-1, II-1, III-6, IV-13, V-5; Parks type, I-2, II-19, III-15, IV-0). Of these, 23 (88.5%) were recurrent, 19 (73.1%) had multiple tracts, six (23.1%) had an anterior fistula, five (19.2%) had horseshoe tracts and five (19.2%) had a supravaginal fistula. In the majority of patients [24/26 (92.3%)], the tube remained in place. In two patients the tube fell out on walking and the treatment had to be stopped. Both patients had an anterior fistula with a length of tract of less than 2 cm. As the deeper part of the tract healed, the tube was shortened regularly and subsequently removed. The fistula was cured in 18 (75%) of the 24 patients in whom the tube remained in place.

P. Garg
Department of General Surgery, Indus Super Specialty Hospital, 1042, Sector-15 Panchkula, Haryana, Mohali, Punjab, 134113, India
E-mail: drgargpanka@yahoo.com

Received 10 June 2015; accepted 12 August 2015; Accepted Article online 9 October 2015

References

Supporting Information
The video may be found in the online version of this article and also on the Colorectal Disease Journal YouTube and Vimeo channels:
Video S1. This male patient has a long fistula tract in the right buttock at the 8 o’clock position.