

Special investigations

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A successful outcome after fistula surgery requires careful assessment of the fistula tract, sphincter integrity and function and patient expectations (especially in terms of risk to continence). Clinical examination will give some indication of functional anal sphincter length, resting tone and voluntary squeeze; these may be more objectively assessed by manometry, whereas EAUS gives useful information about sphincter integrity – the knowledge so gained may well influence surgical strategy. EAUS, especially with hydrogen peroxide instilled through the external opening, is more accurate than clinical examination and is useful to determine whether a fistula is simple or complex (Figure 80.33). MRI is the ‘gold standard’ for fistula imaging. Short tau inversion recovery (STIR) sequencing (a fat-suppression technique) to highlight the presence of pus and granulation tissue without the need for contrast medium has been revolutionary (Figure 80.34). The great advantage of MRI is its ability to demonstrate secondary extensions, which may be missed at surgery and cause persistence (Figure 80.35). Fistulography and computed tomography (CT) are useful if an extrasphincteric fistula is suspected.

Revision #1

Created 2025-12-31 15:29:24 UTC by Omar Ayman

Updated 2025-12-31 15:29:24 UTC by Omar Ayman