



The risk factors for failure and recurrence of LIFT procedure for fistula in ano

Siripong Sirikurnpiboon 

Clinic of Colorectal Surgery, Rajavithi Hospital, Rangsit University College of Medicine, Bangkok, Thailand

ABSTRACT

Objective: Fistula in ano (FIA) is a common anorectal problem. There are several techniques that have been used for treatment; however, all of them carry risks of recurrence and incontinence. Ligation intersphincteric fistula tract (LIFT) is a type of treatment with a promising result of preserving the anal sphincter function. This study aimed to evaluate the outcome and risk factor of LIFT failure and to demonstrate the pattern of recurrence. The research funding was supported by Rajavithi Hospital.

Material and Methods: From January 2015 to January 2020, there were 250 cases of fistula in ano operations. A total of 148 patients underwent LIFT operation. The patients' average age was 39.72 ± 10.55 years and the average follow-up period was 111.86 ± 79.73 days. The average time to diagnose the recurrence was 99.12 ± 30.08 days. In addition, average time to perform a surgery after the diagnosis was 64.67 ± 25.76 days. The study's analyses used data on age, sex, type of fistula, operative intervention, healing time, reinterventions, and recurrence.

Results: There were 22.97% of recurrence among 148 LIFT patients. Half of the patients who underwent the operation had a preoperative imaging study with MRI or endoanal ultrasonography in the first time due to the complexity of the disease. Factors associated with operation failure were collection, fistula tract size more than 5 millimeters, and the failure of ligating the tract in one attempt.

Conclusion: LIFT procedure is one of the several sphincter saving procedures to treat FIA. Recurrence is related with the complexity of the disease. Most of the recurrence is diseases that are easier to treat, such as performing a re-operation or fistulotomy.

Keywords: Fistula in ano, LIFT, recurrence, risk factor

INTRODUCTION

Fistula in ano (FIA) is common in surgical practices. The generally accepted pathogenesis is chronic infection of the anal gland developing between the anal mucosa and skin. However, the treatment for FIA is difficult due to the risk of incontinence. Treatments for FIA are sphincter sacrifice procedure and sphincter saving procedure. Examples of sphincter sacrifice are fistulotomy, fistulectomy, and seton with staged fistulotomy (1). Examples of sphincter saving are core-out fistulectomy, advancement flap, anal fistula plug, fibrin sealing, ligation of intersphincteric tract (LIFT), and video-assisted anal fistula treatment (VAAFT). Ligation intersphincteric fistula tract (LIFT) is one of the sphincter saving procedures with promising results in success rate and postoperative continence (1-3). This study aimed to examine the recurrence group after LIFT to identify risk factors and patterns of recurrence.

MATERIAL and METHODS

A retrospective study in medical records was conducted from January 1, 2015 to January 30, 2020. The ethics committee of Rajavithi Hospital had reviewed and approved this study, with the study number 64020. Inclusion criteria were patients who underwent LIFT operation in Rajavithi Hospital, aged between 18-70 years, and had an imaging study of fistula in pre-operative and follow up time for at least three months. Exclusion criteria were underlying colorectal cancer or pelvic organ cancer, concomitant with inflammatory bowel disease (IBD), and previous pelvic radiation. Definitions of suspect recurrence in this study are non-healing external opening after 12 weeks and the occurrence of new external opening caused by the original internal opening. The fistula in ano classification in this study is based

Cite this article as: Sirikurnpiboon S. The risk factors for failure and recurrence of LIFT procedure for fistula in ano rectal surgery. Turk J Surg 2023; 39 (1): 27-33.

Corresponding Author

Siripong Sirikurnpiboon

E-mail: laizan99@hotmail.com

Received: 11.06.2022

Accepted: 23.01.2023

Available Online Date: 03.03.2023

© Copyright 2023 by Turkish Surgical Society Available online at www.turkjsurg.com

DOI: 10.47717/turkjsurg.2023.5807

on Park's anal fistula classification regarding high and low transsphincteric types, in which low transsphincteric is classified by how the tract involves one-third or less of the sphincter complex.

All data were collected and analyzed with SPSS (version 20.0). Mann-Whitney U test and Chi-square test were used to make comparisons between the groups. Univariate relationships between each independent variable and fistula formation were tested using binary logistic regression. Odds ratio (OR) with 95% confidence intervals (CI) of each variable was determined, and significant variables in the univariate analysis were included in a multivariate model of logistic regression. p-value of less than 0.05 was considered statistically significant.

RESULTS

There were 250 cases of fistula in ano operations in total. The cases were divided into 148 LIFT patients, 51 fistulotomy patients, 10 advancement flap patients, 15 seton and stage fistulotomy patients, 14 core-out fistulectomy patients, and 12 examinations under anesthesia patients.

The recurrence percentage after LIFT procedure was 22.97% (34 patients). Seventy patients who underwent LIFT operation had a preoperative imaging study with MRI or endoanal ultrasonography. The average time for diagnosing recurrence was 99.12 ± 30.08 days (mean \pm SD) (ranged between 60-200 days) and the average time to conduct operation after the recurrence diagnosis was 64.68 ± 25.76 days (mean \pm SD) (ranged from 30-120 days.) Comparative demographic data between failure and success of LIFT procedure is shown in Table 1. Comparative operative data is shown in Table 2. In summary, univariable analysis factors associated with recurrence after LIFT are the type of FIA, presence of collection, tract diameter that is greater than five millimeters, and more than one attempt to ligate the tract. Subgroup analysis of collection shows the presence of collection in both ischioanal and deep post anal space, which have a high risk of recurrence. Multivariable analysis of factors associated with recurrence is shown in Table 3.

Recurrence patterns after LIFT are shown in Table 4. The most common pattern of recurrence was type 2: The remaining internal opening with a new external opening at the intersphincteric wound, which is shown in Figure 1. In this pattern, there were two cases occurred in "complex" due to multiple external openings at the first time of diagnosis. The operations for correction were as follows: Type 1 cases underwent LIFT 4 (36.4%), advancement flap 3 (27.3%), drainage seton with subsequent fistulotomy seton 1 (9.1%), and LIFT with placed drain 3 (27.3%). Type 2 cases underwent fistulotomy 15 (88.2%), LIFT 1 (5.9%), and drainage seton with subsequent fistulotomy 1 (5.9%). Type 3 cases underwent LIFT 1 (50%) and fistulectomy 1 (50%) and type IV cases underwent curettage sinus tract 1 (25%) and observation 3 (75%). Mean follow-up period in all patients was

115.42 ± 115.96 days. Recurrence after the second operation occurred in four cases, two cases after LIFT, 1 after anal advancement flap, and 1 after LIFT with placed drain. All four cases also underwent drainage seton.

DISCUSSION

LIFT is one of the sphincter saving operative procedures for treating fistula in ano. An average success rate is 60-94% (4,5), with up to eight weeks of wound-healing time. Recurrence after LIFT procedure does not have a specific definition; however, the most used definition is non-healing of external wound or an external opening after eight weeks.

Risks of recurrence can be divided into three factors: patients, diseases, and surgeons' experience. First, as for surgeons, this study does not show different results among the group of colorectal surgeons. The learning curve of surgeons in each procedure is the most important factor for an entrusted achievement of the result. However, the learning curve in LIFT does not define it. Nonetheless, Rojanasakul's study reported the high success rate of LIFT (2). Thus, LIFT procedure has been adopted in training and practice of general surgery in Thailand, as well as in this study. A surgeon who has more than 20 years of experience and has self-studied LIFT can perform the operation without any difference in result when compared to other surgeons who have learned the procedure under proctorship. Therefore, it can be assumed that the LIFT procedure is not a difficult procedure, nor does it require a steep learning curve for colorectal surgeons. Regarding the difference from laparoscopic colorectal procedure (6,7), studies show a discrimination of results in rectal cancer in comparison between general surgeons and colorectal surgeons (8). Studies also show the significance of training and the result of surgery by specialists (9,10).

The factor regarding patients, as the previous studies' report has stated, are immunocompromised host (11), Crohn's disease (12), smoking (13), diabetic mellitus (14), obesity (1), and concurrent with rectal cancer (15). These all indicate risks of failure after LIFT procedure. In the postoperative period, the study has reported that regular examination, careful attention, and wound cleansing are helpful for an early diagnosis of recurrence and complications (16).

The disease factor, based on Park's classification (17), indicates that the supra-sphincteric and extra-sphincteric fistulae were at risk of recurrence (4,5,18,19). This study shows that the most common (recurrence) is the transsphincteric type. Possible explanations are an incidence that occurs more than other types, and transsphincteric which includes semi horseshoe and horseshoe. Horseshoe is a factor related to LIFT failure (18); however, the multivariable analysis did not show any significance. The presence of collection in one or both sides of ischioanal or deep post anal space indicates failure of clearance infection in concordance to previous study result (20), which

Table 1. Demographic data between recurrence and success after LIFT procedure

Demographic data	Recurrence (n= 34)	Success (n=114)	p
Sex (%)			0.953
Male	27 (23.1)	90 (76.9)	
Female	7 (22.6)	24 (77.4)	
Age (Mean ± SD)	38.53 ± 10.86	40.08 ± 10.48	0.454
BMI (Mean ± SD)	27.76 ± 9.49	26.03 ± 5.16	0.173
Smoking (%)			1.000
Yes	4 (11.8)	14 (12.3)	
No	30 (88.2)	100 (87.8)	
Co-morbidity (%)			0.800
Yes	27 (79.4)	97 (82.5)	
No	7 (20.6)	20 (17.5)	
Time to surgery after first visit (Mean ± SD) (days)	100.68 ± 95.13	108.28 ± 119.18	0.732
Referred from other hospital (%)			0.435
No	15 (44.1)	61 (53.5)	
Yes	19 (55.9)	53 (46.5)	
Previous surgery			0.359
No	28 (82.4)	101 (88.6)	
Fistulotomy	2 (5.9)	3 (2.6)	
LIFT	4 (11.8)	6 (5.3)	
Fistulectomy	0 (0)	3 (2.6)	
Endoanal advancement flap	0 (0)	1 (0.9)	
Fistula type (%)			0.001
Intersphincteric	0 (0)	3 (2.6)	
Transsphincteric: Low level	1 (2.9)	18 (15.8)	
Transsphincteric: High level	28 (82.4)	92 (80.7)	
Suprasphincteric	5 (14.7)	1 (0.9)	
Presence multiple external opening (%)	19 (55.9)	50 (43.9)	0.217
Type of imaging study (%)			0.038*
MRI	10 (33.3)	20 (66.7)	
EAUS	4 (10.0)	36 (90.0)	
Presence of collection from imaging study (%)			<0.001*
Yes	30 (43.5)	39 (56.5)	
No	4 (5.1)	75 (94.9)	
Detail of collection from imaging study (%)			<0.001*
One side ischiorectal	12 (31.6)	26 (68.4)	
Both ischiorectal	10 (66.7)	5 (33.3)	
Deep postanal with ischiorectal	8 (100)	0 (0)	
Perianal	0 (0)	8 (100)	

shows that horseshoe fistula has risks of recurrence and needs multiple surgeries to correct. A previous study shows types of clearance infection, such as curettage from original LIFT (2) or

LIFT's modification to remove tract, which do not imply an improvement of the cure rate (1). Nevertheless, drainage placement is not strong evidence to show an improved cure rate.

Table 2. Operative data between recurrence and success after LIFT procedure

Operative data	Recurrence (n= 34)	Success (n= 114)	p
Colorectal surgeon experience (%)			0.479
5-10 years	13 (26.0)	37 (74.0)	
11-20 years	11 (18.0)	50 (82.0)	
>21 years	10 (27.0)	27 (73.0)	
Operative time (minutes) (mean ± SD)	48.97 ± 21.45	48.95 ± 22.05	0.996
Operative difficulty			
Tract diameter> 5 mm (%)			<0.001*
Yes	26 (74.3)	9 (25.7)	
No	8 (7.1)	105 (92.9)	
Attempt ligate tract> 1 time (%)			<0.001*
Yes	11 (57.9)	8 (42.1)	
No	23 (17.8)	106 (82.2)	

Table 3. Cox regression analysis factor associated with recurrence after LIFT procedure

Factors	Crude odd ratio	95% CI		p	Adjusted odd ratio	95% CI		p
		Lower border	Upper border			Lower border	Upper border	
Tract diameter> 5 mm	7.105	3.431	14.711	<0.001	6.113	2.902	12.876	<0.001
Attempt ligate tract> 1 time	2.453	1.195	5.038	0.015	1.898	0.920	3.912	0.083
Presence of collection	1.957	1.326	2.889	<0.001	1.272	0.855	1.894	0.236

Table 4. Patterns of fistula recurrence after LIFT procedure

Patterns	Description	n (%)
1: Original fistula	Remain same internal opening and external opening	11 (32.4)
2: Step down fistula	Remain same internal opening with new external opening at intersphincteric wound	17 (50.0)
3: New fistula	Remain same internal opening with new external opening, anywhere outside intersphincteric wound	2 (5.9)
4: Sinus	Remain in external tract	4 (11.8)



Figure 1. Comparison of pictures of recurrence pattern in new external opening at intersphincteric wound.

Early closure of external wound or an opening is one of the factors leading to failure since it has not achieved adequate sources to control in concordance with the previous study, which demonstrates the result of simple fistula surgery (21). This study shows the significance of presence of collection in univariable analysis; however, it does not show statistical significance regarding the type of collection in multivariable analysis. The other risk factor in this study was more than one intraoperative attempt to ligate the tract. The possible explanations may be a difficulty of identifying the tract in narrow intersphincteric space, high tract level, or occurrence of iatrogenic in transection tract, which leads to a poor or improper closure of the internal opening. A previous study has shown the importance of imaging study, which is the success rates of internal opening identifications and preoperative imaging studies. The success rates of rectal endoscopic anal ultrasonography (EAUS) and pelvic MRI in locating internal openings are 70-95% and 90-96%, respectively (22-24). The failure of locating internal opening is the report of the risks of operative failure, which is 20 times relative to the risk score (25). In this study, it showed similar correlation with univariable analysis. This study also showed that an intraoperative fistula tract with a diameter of more than five millimeters is a risk factor of recurrence. Technically, the closure of fistula tract via ligation or suture ligation are at risk of knot sliding, leading to an unaccomplished optimal tension of closure of fistula tract opening. Indirect comparative studies are those regarding fistula laser closure (FiLaC) and laser ablation of fistula tract (LAFT) in fistula tract size that is greater than five millimeters. Results indicate that the shrinkage of the tract is poor (26). Thus, the author suggests that suture buttress at internal sphincter on anal site and buttress on external sphincter on external site may be helpful to improve closure. However, further studies are still in need.

There are three reported patterns of recurrence (27): complete failure, partial failure, and localized failure. Later reports in patterns of recurrence regarding new occurrence of fistula character are intersphincteric fistula, remaining or original fistula, and remaining external tract (28). This study shows two points of concern. First, in comparison with previous studies, the complexity of intersphincteric or partial failure is related to multiple external openings or the presence of collection in the first diagnosis. As a result, the fistulomy in the previous recommendation may not be sufficient for correction. Therefore, the author suggests adding C in order to define the complexity of recurrence pattern. The second concern is the new pattern of recurrence, in which a new external opening occurs at the other site, out of intersphincteric wound, making it different from previous studies. The cause may be failure to close the internal opening, which leads to a new onset of infection of the

new tract. However, this cannot lead to a conclusion that it is a new type of recurrence pattern since this study was conducted in a small sample group. Thus, further studies are still needed.

The limitation of this study was the variable in imaging study due to surgeon's preference and the feasibility of imaging during the study period. In addition, the operation to correct re-recurrence depended on the anatomy of the fistula as well.

CONCLUSION

Fistula in ano is a disease with a lot of myths in curative outcomes depending on diseases, patients, and surgeons. LIFT is one of the operations that has an advantage in sphincter saving, with an ability to perform a reoperation when a recurrence occurs, down stage of fistula in ano. The pattern of recurrence is still undergoing examination and studies; thus, it needs a larger database to demonstrate the number of patterns. Furthermore, there is still a chance to improve the procedure of current techniques. In the future, LIFT may potentially play a fundamental role in fistula surgery.

Ethics Committee Approval: The ethics committee, Rajavithi hospital had reviewed and approved this study, with the study number 64020.

Peer-review: Externally peer-reviewed.

Author Contributions: Concept - SS; Design - SS; Data Collection and/ or Processing - SS; Analysis and/or Interpretation - SS; Literature Search - SS; Writing Manuscript - SS; Critical Reviews - SS.

Conflict of Interest: The author have no conflicts of interest to declare.

Financial Disclosure: The author declared that this study has received no financial support.

REFERENCES

1. Sirikurnpiboon S, Awapittaya B, Jivapaisarnpong P. Ligation of intersphincteric fistula tract and its modification: Results from treatment of complex fistula. *World J Gastrointest Surg* 2013; 5(4): 123-8. <https://doi.org/10.4240/wjgs.v5.i4.123>
2. Rojanasakul A, Pattanaarun J, Sahakitrungruang C, Tantiphlachiva K. Total anal sphincter saving technique for fistula-in-ano: The ligation of intersphincteric fistula tract. *J Med Asso Thai* 2007; 90(3): 581-6.
3. Vogel JD, Johnson EK, Morris AM, Paquette IM, Saclarides TJ, Feingold DL, et al. Clinical practice guideline for the management of anorectal abscess, fistula-in-ano, and rectovaginal fistula. *Dis Colon Rectum* 2016; 59(12): 1117-33. <https://doi.org/10.1097/DCR.0000000000000733>
4. Sirany AM, Nygaard RM, Morken JJ. The ligation of the intersphincteric fistula tract procedure for anal fistula: A mixed bag of results. *Dis Colon Rectum* 2015; 58: 604-12. <https://doi.org/10.1097/DCR.0000000000000374>
5. Zirak-Schmidt S, Perdawood SK. Management of anal fistula by ligation of the intersphincteric fistula tract - a systematic review. *Dan Med J* 2014; 61: A4977

6. Tekkis PP, Senagore AJ, Delaney CP, Fazio VW. Evaluation of the learning curve in laparoscopic colorectal surgery: Comparison of right-sided and left-sided resections. *Ann Surg* 2005; 242(1): 83-91. <https://doi.org/10.1097/01.sla.0000167857.14690.68>
7. Luglio G, De Palma GD, Tarquini R, Giglio MC, Sollazzo V, Esposito E, et al. Laparoscopic colorectal surgery in learning curve: Role of implementation of a standardized technique and recovery protocol. A cohort study. *Ann Med Surg (Lond)* 2015; 4(2): 89-94. <https://doi.org/10.1016/j.amsu.2015.03.003>
8. Bokey EL, Chapuis PH, Dent OF, Newland RC, Koorey SG, Zelas PJ, et al. Factors affecting survival after excision of the rectum for cancer: A multivariate analysis. *Dis Colon Rectum* 1997; 40(1): 3-10. <https://doi.org/10.1007/BF02055674>
9. Saraidaridis JT, Hashimoto DA, Chang DC, Bordeianou LG, Kunitake H. Colorectal Surgery Fellowship improves in-hospital mortality after colectomy and proctectomy irrespective of hospital and surgeon volume. *J Gastrointest Surg* 2018; 22(3): 516-22. <https://doi.org/10.1007/s11605-017-3625-5>
10. Callahan MA, Christos PJ, Gold HT, Mushlin AI, Daly JM. Influence of surgical subspecialty training on in-hospital mortality for gastrectomy and colectomy patients. *Ann Surg* 2003; 238(4): 629-36; discussion 636-9. <https://doi.org/10.1097/01.sla.0000089855.96280.4a>
11. Papavramidis TS, Pliakos I, Charpidou D, Petalotis G, Kollaras P, Sapalidis K, et al. Management of an extrasphincteric fistula in an HIV-positive patient by using fibrin glue: A case report with tips and tricks. *BMC Gastroenterol* 2010; 10: 18. <https://doi.org/10.1186/1471-230X-10-18>
12. Hermann J, Eder P, Banasiewicz T, Matysiak K, Łykowska-Szuber L. Current management of anal fistulas in Crohn's disease. *Prz Gastroenterol* 2015; 10: 83-8. <https://doi.org/10.5114/pg.2015.49684>
13. Ellis CN, Clark S. Effect of tobacco smoking on advancement flap repair of complex anal fistulas. *Dis Colon Rectum* 2007; 50: 459-63. <https://doi.org/10.1007/s10350-006-0829-2>
14. Hamadani A, Haigh PJ, Liu IL, Abbas MA. Who is at risk for developing chronic anal fistula or recurrent anal sepsis after initial perianal abscess? *Dis Colon Rectum* 2009; 52: 217-21. <https://doi.org/10.1007/DCR.0b013e31819a5c52>
15. Salati SA, Al Kadi A. Anal cancer-a review. *Int J Health Sci (Qassim)* 2012; 6: 206-30. <https://doi.org/10.12816/0006000>
16. Tabry H, Farrands PA. Update on anal fistulae: Surgical perspectives for the gastroenterologist. *Can J Gastroenterol* 2011; 25: 675-80. <https://doi.org/10.1155/2011/931316>
17. Parks AG, Gordon PH, Hardcastle JD. A classification of fistula in ano. *Br J Surg* 1976; 63: 1-12. <https://doi.org/10.1002/bjs.1800630102>
18. Garcia-Aguilar J, Belmonte C, Wong WD, Goldberg SM, Madoff RD. Anal fistula surgery. Factors associated with recurrence and incontinence. *Dis Colon Rectum* 1996; 39: 723-9. <https://doi.org/10.1007/BF02054434>
19. Dudukgian H, Abcarian H. Why do we have so much trouble treating anal fistula? *World J Gastroenterol* 2011; 17: 3292-6. <https://doi.org/10.3748/wjg.v17.i28.3292>
20. Koehler A, Risse-Schaaf A, Athanasiadis S. Treatment for horseshoe fistulas-in-ano with primary closure of the internal fistula opening: A clinical and manometric study. *Dis Colon Rectum* 2004; 47: 1874-82. <https://doi.org/10.1007/s10350-004-0650-8>
21. Sangwan YP, Rosen L, Riether RD, Stasik JJ, Sheets JA, Khubchandani IT. Is simple fistula-in-ano simple? *Dis Colon Rectum* 1994; 37: 885-9. <https://doi.org/10.1007/BF02052593>
22. Waniczek D, Adamczyk T, Arendt J, Kluczevska E, Kozińska-Marek E. Usefulness assessment of preoperative MRI fistulography in patients with perianal fistulas. *Pol J Radiol* 2011; 76: 40-4.
23. Almeida IS, Jayarajah U, Wickramasinghe DP, Samarasekera DN. Value of three-dimensional endoanal ultrasound scan (3D-EAUS) in preoperative assessment of fistula-in-ano. *BMC Res Notes* 2019; 12(1): 66. <https://doi.org/10.1186/s13104-019-4098-2>
24. Sirikunpiboon S, Phadhana-anake O, Awapittaya B. Comparison of endoanal ultrasound with clinical diagnosis in anal fistula assessment. *J Med Assoc Thai* 2016; 99(2): 69-74.
25. Sygut A, Mik M, Trzcinski R, Dziki A. How the location of the internal opening of anal fistulas affect the treatment results of primary trans-sphincteric fistulas. *Langenbecks Arch Surg* 2010; 395(8): 1055-9. <https://doi.org/10.1007/s00423-009-0562-0>
26. Giamundo P. Laser treatment for anal fistulas: What are the pitfalls? *Tech Coloproctol* 2020; 24(7): 663-5. <https://doi.org/10.1007/s10151-020-02225-6>
27. Tan KK, Tan IJ, Lim FS, Koh DC, Tsang CB. The anatomy of failures following the ligation of intersphincteric tract technique for anal fistula: A review of 93 patients over 4 years. *Dis Colon Rectum* 2011; 54(11): 1368-72. <https://doi.org/10.1097/DCR.0b013e31822bb55e>
28. Placer Galán C, Lopes C, Múgica JA, Saralegui Y, Borda N, Enriquez Navascues JM. Patterns of recurrence/persistence of criptoglandular anal fistula after the LIFT procedure. Long-term observational study. *Cir Esp* 2017; 95(7): 385-90. <https://doi.org/10.1016/j.ciresp.2017.05.010>

**ORİJİNAL ÇALIŞMA-ÖZET**

Turk J Surg 2023; 39 (1): 27-33

Anal fistül tedavisinde LIFT prosedürünün başarısızlığı ve nüks için risk faktörleri

Siripong Sirikurnpiboon

Rangsit Üniversitesi Tıp Fakültesi, Rajavithi Hastanesi, Kolorektal Cerrahi Kliniği, Bangkok, Tayland

ÖZET

Giriş ve Amaç: Anal fistül (FIA) yaygın bir anorektal problemdir. Tedavi için kullanılan çeşitli teknikler vardır ancak hepsi nüks ve idrar kaçırma risklerini taşır. Ligasyon intersfinkterik fistül traktı (LIFT), anal sfinkter fonksiyonunu koruma konusunda umut verici sonuç veren bir tedavi türüdür. Bu çalışma, LIFT başarısızlığının sonucunu ve risk faktörünü değerlendirmeyi ve nüks paternini göstermeyi amaçladı. Araştırma fonu Rajavithi Hastanesi tarafından desteklenmiştir.

Gereç ve Yöntem: Ocak 2015'ten Ocak 2020'ye kadar anal operasyonlarda 250 fistül vakası vardı. Toplam 148 hastaya LIFT operasyonu uygulandı. Hastaların ortalama yaşı $39,72 \pm 10,55$, ortalama takip süresi $111,86 \pm 79,73$ gündü. Nüksü teşhis etmek için ortalama süre $99,12 \pm 30,08$ gündü. Ayrıca tanı sonrası ortalama ameliyat süresi $64,67 \pm 25,76$ gündü. Çalışmanın analizlerinde yaş, cinsiyet, fistül tipi, operatif müdahale, iyileşme süresi, yeniden müdahaleler ve nüks ile ilgili veriler kullanıldı.

Bulgular: Yüz kırk sekiz LIFT hastasında %22,97 oranında nüks vardı. Ameliyat olan hastaların yarısında, hastalığın karmaşıklığı nedeniyle ilk kez MR veya endoanal ultrasonografi ile ameliyat öncesi görüntüleme çalışması yapıldı. Ameliyat başarısızlığı ile ilişkili faktörler, birikim, fistül yolu boyutunun 5 milimetreden fazla olması ve ilk denemede ligasyon yapılamaması olarak sunulmuştur.

Sonuç: LIFT prosedürü, FIA'yı tedavi etmek için kullanılan çeşitli sfinkter koruma prosedürlerinden biridir. Nüks, hastalığın karmaşıklığı ile ilişkilidir. Nükslerin çoğu, yeniden ameliyat veya fistülotomi yaparak tedavi etmesi daha kolay olan hastalıklardır.

Anahtar Kelimeler: Anal fistül, LIFT, nüks, risk faktörü

DOI: 10.47717/turkjsurg.2023.5807