...there is more than one way to approach an anal fistula. The complexity of an anal fistula requires an individual solution, with multiple factors to consider..."
In theory, these flaps can fail, leaving the patient no better off than before the operation.

**Glue?** Fibrin sealant involves injecting the fistula tract with a mixture of fibrinogen, thrombin, and calcium ions through a catheter which is advanced into the fistula tract up to the internal opening. Up to 5 cc’s of the glue is injected, potentially sealing off the tract. Fibrin glue is used to treat complex fistulas as a way to avoid extensive surgery. However, long-term healing of the fistula tract has been disappointing with success rates ranging from 14 - 69%. Extravasation of the sealant and failure of the tissues to incorporate the glue are the most likely cause of failure.

**A Plug?** Two types of fistula plugs have been developed: a collagen plug made of lyophilized decellularized porcine small intestinal submucosa was developed first, followed by the development of another completely synthetic fistula plug introduced in 2009. Results of the collagen plug were disappointing due to plug extrusion, with failure rates up to 71% in some studies. Attempts were made to prevent extrusion including suturing the plug to the fistula’s internal opening but not only did this not always prevent extrusion, but patients also found it uncomfortable. The completely synthetic fistula plug, which is a matrix of polymers polyglycolic acid/trimethylene carbonate (PGA/TMC), acts as a scaffolding for tissue ingrowth to promote healing. The plug consists of a disc sutured to the internal opening with 6 legs attached which are pulled through the fistula tract.

**A Scope?** Another procedure, which is also meant to preserve the sphincteric complex is the VAAFT (Video-Assisted Anal Fistula Treatment) which involves placing a fistula scope into the fistula tract to directly view the tract and locate the internal opening. A unipolar electrode is used to cauterize and seal the fistula tract whilst cleaning the tract of any debris using an endobrush. The internal opening is then closed with sutures. Success rates have been reported to range from 66.7% to 87.5%.

**Need A Lift?** The LIFT (Ligation of Intersphincteric Fistula Tract) has a reported success rate of 94%. The procedure involves an incision in the intersphincteric groove, identification and ligation of the intersphincteric fistulous tract, removal of granulation tissue, and suturing closed the external perianal fistula opening. A LIFT spares the anal sphincters by dividing the fistula tract between the internal and external anal sphincters. No muscle is divided during a LIFT.

**EXPERIENCE, JUDGMENT, AND NATURE.**

As can be seen by the above multiple techniques, there is more than one way to approach an anal fistula. The complexity of an anal fistula requires an individual solution, with multiple factors to consider, including previous surgical attempts, underlying diseases, and the nature and course of the fistula tract.

The successful treatment of the anal fistula requires specialized knowledge and experience. Even with the best of plans and surgical technique, treatment may be prolonged, difficult and unsuccessful. However, ultimately, most fistulas can be treated and cured.