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DIAGNOSTICS AND SURGICAL TREATMENT OF RECTAL FISTULAS

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Abstract:

Rectal fistulas are one of the most common coloproctological diseases. Rectal fistulas account for 15-45% of patients in the structure of colorectal pathology. Patients with chronic paraproctitis account for 0.5-4% of the total number of inpatient surgical patients and 30-35% among patients with rectal diseases (Muravyov A.V. et al., 2012; Zitta D.V. et al., 2013; Zhukov B.N. et al. 2008). The prevalence of the disease is 6-12 per 100 thousand people

Keywords: fistulas of the rectum, colorectal, intrasphincteric, transsphincteric, extrasphincteric, coloproctology

INTRODUCTION. Rectal fistulas are one of the most common coloproctological diseases. Rectal fistulas account for 15-45% of patients in the structure of colorectal pathology. Patients with chronic paraproctitis account for 0.5-4% of the total number of inpatient surgical patients and 30-35% among patients with rectal disease.The prevalence of the disease is 6-12 per 100 thousand people. Many authors point out that surgical intervention in the form of abscess opening and spontaneous pus emptying are the main causes of rectal fistula formation, including incomplete ones. However, as analysis of the literature has shown, there are additional factors contributing to the formation of rectal fistulas, including incomplete internal ones, and more often they are associated with anorectal pathology (cryptitis, hemorrhoids, anal fissures). The Japanese authors conducted a multivariate analysis, which established risk factors for rectal fistula. Currently, there is no classification of incomplete internal fistulas of the rectum, as they are not distinguished as a separate nosological form, which, in our opinion, is associated with a terminological "gap". In the domestic surgical practice the classification proposed by A.N. Rychikh in 1956 is used, in which rectal fistulas are divided into intrasphincteric, or submucosal, transsphincteric and extrasphincteric depending on the relationship with external sphincter fibers. There are also incomplete (there is only an internal orifice) and complete (presence of external and internal orifices) rectal fistulas. Until now, there is no unified definition of incomplete internal fistulas of the rectum and their classification, which does not allow a systematic approach to treatment. Modern research methods (MRI, ultrasound) can greatly facilitate the establishment of fistula architectonics before surgery and thus reduce the risk of anal sphincter insufficiency and disease recurrence. In modern conditions, most surgical treatment methods are aimed at reducing traumatization of anal sphincter and reducing the risk of recurrence of the disease. However, only two modern publications devoted to the treatment of incomplete rectal internal fistulas discuss sphincter-preserving techniques, but they do not evaluate long-term results. It is worth noting that the vast majority of patients with incomplete internal fistulas have previously undergone surgical intervention on the anal sphincter. In this case it is necessary to assess the state of the anal sphincter muscles before and after the surgical intervention in order to prevent the development of anal sphincter insufficiency.

PURPOSE OF THE STUDY. is to improve the results of treatment of patients with rectal fistulas by optimizing diagnostic methods and choosing the volume of surgery.

MATERIAL AND METHODS. The clinical material was based on the data from medical records of 274 patients with rectal fistulas treated in the Samara State Medical University Department of Coloproctology for the period from 2018 to 2022. The patients' age was 18-64 years, women-183, men-91. To study and compare the results of treatment, all patients were divided into the following groups: I- the control group was represented by 37 patients who received standard, conventional therapy, Group II was represented by 237 patients treated with

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new approaches of diagnostics and treatment of patients with rectal fistulas. In the preoperative period all patients underwent a special complex of examination including: collection of complaints and medical history, external examination, finger examination of the rectum, probing, dye test, rectomanoscopy, fistulography in two projections. Statistically, about 92% of patients with fistulas of the rectum attribute the onset of the disease to a previous acute paraproctitis. Very often the disease has a wave-like course, against the background of the existence of the fistula there may be an exacerbation of inflammation with blockage of the external orifice or fistulous passage. In this case an abscess may occur, after its opening and emptying the acute inflammation subsides, the amount of discharge from the wound decreases, pain disappears, the general condition improves, but the wound does not heal completely, there remains a wound not more than one centimeter in diameter, from which periodically purulent discharge continues to emerge. In remission, pain is not characteristic of a rectal fistula. The general condition at this time does not suffer either.

Table 1. Distribution of patients by sex and age

Age	Men	women	Total number of
18-21	14	49	63
22-31	32	78	105
32-41	22	37	54
42-51	9	7	11
52-64	12	9	16
Over 64 years of age	2	3	5
Total	91	183	274

The shape of the external orifice, the fistula orifices and the distance from the edge of the anus are not indicative of the depth of the fistula passage. Sometimes a fistula whose external orifice is relatively far from the edge of the anus passes under the skin, and vice versa, a fistula located near the anus can run parallel to the wall of the rectum and penetrate deep into the sphincter.

Such a sign as palpation of the fistulous passage under the skin is important, though not constant. The presence of such a subcutaneous "cord" is usually characteristic of shallow subcutaneous intra- and transsphincteric fistulas. If the fistula exists for a long time, sometimes tissues around its external orifice become hypertrophied and flattened, which requires preoperative biopsy. Sometimes in the presence of purulent cavities along the fistula, hyperemia, hyperthermia of the skin and a dense, painful infiltrate near the fistulous opening are determined.

In the process of topical diagnosis of extrasphincter fistula of the rectum, determining its main course, branches and leaks, it is important to make sure that in this case the fistula is "complete", when the washing fluid introduced into the external fistula (fistulas) freely passes into the intestine through the internal fistulous opening.

Finger examination allows to find out at once, at least approximately, the tone and strength of sphincter contraction, and also to divide the presence and localization of an internal fistulous opening in the anal canal or at least local painfulness of the anal canal wall. The internal opening of purulent ("banal") cryptogenic fistula of the rectum is usually punctiform, it is defined by a finger as a local painful compacted area of the anal canal wall, surrounded by scars or infiltrates, its size is difficult to determine exactly.

Palp examination combined with fistula probing is the main technique to differentiate between paraproctitis and other pararectal abscesses, such as boils, carbuncle, phlegmon, rectovaginal septum cyst, bartholinitis in women or parourethritis in men.

Fistulas of the rectum	Main . gupp	Counter . Group	Absolute . number	%
Extrasphincteri c	39	24	63	23%
Transfincter	102	9	111	40,5 %
Intrasphincter	96	4	100	36,5 %
Total	237	37	274	100

We used a modified variant of radical surgery, which was used in all 237 patients with rectal fistulas admitted to the clinic during this period.

CONCLUSIONS. Thus, in case of ectrasphincter fistula the latter is excised sparingly in order not to damage the external sphincter of the anus. Scarred stained tissues are excised, and if pus cavities and leaks are found along the fistula they are opened and sanitized. As a rule, after the operation the wound becomes T-shaped. Postoperative local treatment is carried out with the use of wound treatment with antiseptic solutions and ointment with Oflomyelide. Our proposed technique leads to a smoother course of the postoperative period, reduction of pain syndrome, reduction of the risk of anal sphincter insufficiency, acceleration of perineal wound healing, reduction of the frequency of postoperative

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complications, reduction of the duration of patients' stay in the hospital

LITERATURE

1. Davlatov S.S., Sherkulov K.U., Surgical treatment of combined non-tumor pathology of rectum and anal canal (review of literature) Achievements of science and education. - 2022. - № 4 (4). - С. 12-17.
2. Kamolov T.K., Murtazaev Z.I., Sherkulov K.U., Boysariev Sh.U., Kamolov S.J. Causes of postoperative anal sphincter failure. National Association of Scientists. -2016.-#1 (1).- pp. 24-29.
3. Kamalova M., Khaidarov N., Shomurodov K. Microscopic examination of brain tissue in hemorrhagic stroke in uzbekistan //Матеріали конференцій МЦНД. – 2021.
4. Sherkulov K.U. Analiysis of surgical treatment of acute paraproctitis. Problems of Biology and Medicine. 2022, №4 (137) 227-229.
5. Fedorov V.D., Vorobyov G.I., Rivkin V.L. Clinical operative coloproctology. Moscow, Medina - 1994. C-450-453
6. Kalantarov T.K. et al. Is there an alternative to colostomy? Proceedings of the Conference. Krasnogorok, 1997, P-114-115
7. Khaburzania A.K., Petrov V.P., Lazerev G.V., Kitaev A.V. General questions of surgical tactics at gunshot wounds of large intestine //Wounding of large intestine in war and peace time; Materials of conf. Krasnogorsk. 1997.-C. 74-77.
8. Roche.B, Michel J.M., Deleavat J., Peter R/Marti M.C. Travmatic lesionis of anorectum // Swiss Surgery/ - 1998.-№.- P.249-252.
9. Maconi G. Parente F(1999) Hydrogen peroxide enhanced ultrasound-fistulografphy in the assessment of enterocutaneous fistulas complicating Crohn s disease. Gut 45874-878.
10. Aliev S.A., Damage to the Colon in Emergency Surgery // Surgery-2000.-#10. C. 35-41.
11. Revskoy A.K., Lufing A.A., Voinovsky E.A., Klipak V.M. Firearms of abdomen and pelvis: Manual for doctors. 2000-320p
12. Khamdamov B.Z. Indicators of immunocitocine status in purulent-necrotic lesions of the lover extremities in patients with diabetes mellitus.//American Journal of Medicine and Medical Sciences, 2020 10(7) 473-478 DOI: 10.5923/j.ajmm.2020.- 1007.08 10.
13. Khamdamov I.B., Khamdamov A.B. Classification and properties of mesh explants for hernioplasty of hernial defects of the anterior abdominal wall (review) //Биология и интегративная медицина 2021, 5(52), 12-21
14. Kanshin N.N. Peritonitis, unformed and formed intestinal fistulas.-M., 2001 32-48 pp.
15. Ergashovich, K. B., & Ilhomovna, K. M. (2021). Morphological Features of Human and Rat Liver and Biliary Tract Comparisons (Literary Review). International Journal of Discoveries and Innovations in Applied Sciences, 1(4), 27–29. Safronov D.V., Bogomolov N.I. Surgical treatment of diseases and injuries of the colon // Vestn. chir. 2005. No 2 21-25 pp.
16. Van der Hagen S., Baeten C., Soeters P. B., van Gemert W Long-term outcome following mucosal advancement flap for high perianal fi stulas and fistulotomy for low perianal fi stulas.//Colorectal Dis.-2006. -V 21. - P. 784-790.
17. Musaev Kh.N. Surgical treatment of rectovaginal fistulas. Surgery, 2009.-N 9.-S.55-58.
18. Krasnopolsky V.I., Buyanova S.N., Shchukina N.A. Etiology, diagnosis and basic surgical principles for the treatment of intestinal-genital fistulas // Obstetrician. igin. - 2001.- No. 9. - p.21-23
19. Dodica A.N. Treatment of patients with incomplete internal, colovaginal fistulas, after sphincter-preserving operations on the rectum: Diss_cand. Med.sci. - M., 1998. - 122p.
20. Ommer A, Herold A., Berg E. S3-Leitlinie: RectovaginalFisteln (ohneM.Crohn) // Coloproctology. - 2012. - Vol. 34. - P. 211 - 246.
21. Holtmann M., Neurath M. Anti-TNF strategies in stenosingandfis-tulizingCrohn's disease//Colorect. Dis.-2005. -V. 20. -P. 1-8.
22. V. E. Smirnov, P. M. Lavreshin, A. V. Murav'ev, V. K. Gobedzhishvili, and V. I. Linchenko, Russ. Surgical tactics in the treatment of patients with rectovaginal fistulas. //Materials of the All-Russian Conference of Heads of Departments of General Surgery of Universities of the Russian Federation, Rostov-on-Don, 2001.
23. Protsenko V.M. Surgical treatment of colonic-vaginal fistulas: Dis. doctor of medical sciences - M., 1990. - 267s.
24. Shelygin Yu.A., Grateful L.A. reference book on coloproctology. - M.: Litterra, 2012. - 608s.