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TRICK OF THE TRADE

How to place a seton and prevent it slipping: mission impossible?

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Surgeons need to sharpen their wits when there is a lack of adequate instruments for particular maneuvers or moves, and thus imagination and do-it-yourself skills are also core qualities for surgeons, and many times, the best instrument in the surgical box. An example all colorectal surgeons might know is the placement of a seton in an anal fistula. Tying a seton to a Lockhart-Mummery probe without an eye or hole at the tip is sometimes a hard task to perform, because the seton slips from the probe again and again, until it finally passes the fistula tract. To prevent this, we have developed a trick based on the use of a piece of Abbocath, through which a silk ligature is passed, to "dock" the seton to the fistula probe. It is ingenious and simple and we would like to share it.

The case presented shows a transsphincteric fistula-in-ano with an associated subcutaneous tract. Treatment for these types of fistulas requires the placement of a seton, which sometimes is hard to accomplish, specially without adequate proctology instruments. In our clinical setting, we use grooved Lockhart-Mummery probes, but without an eye at the tip. This probe characteristic is critical when placing a seton, and thus it allows the seton to be securely tied to the probe, preventing it from slipping. Other types of probes, such as lacrimal duct probes, used by other authors are lamentably not available for this purpose.

In these scenarios, we have developed an ingenious and easy way to place the seton. As shown in the video, once the probe is passed through the fistula tract, a short piece of Abbocath (14G in our case, but it depends on the thickness of the probe) is cut and a long 2–0 silk ligature is threaded through it. Then, one end of the Abbocath is firmly docked into the tip of the probe. After this step, the probe is pulled out from the tract, allowing the ligature to pass the tract without effort.

Note that the piece of Abbocath is left far away from both ends of the ligature before the docking maneuver, as a safety, in order to enable the recovery of the Abbocath in the unlikely event that it slips from the probe.

The silk ligature could be the definitive seton, but the authors prefer the vessel loop and the ligature is used to pass the latter through the fistula.

Finally, in this case, we remove the cranial subcutaneous tract of the fistula.

We find this procedure tremendously simple and effective and easier to perform than other methods [1]; Seow-Choen described the use of a "railroad technique" for seton insertion based on the use of an 8-Fr feeding tube. After successful probing of the fistula with a Lockhart-Mummery probe, the tube is used to cap the top of the probe—in same way as we do we the Abbocath in our technique—which is then withdrawn, drawing the feeding tube through the fistula. The seton material has now to be passed through the lumen of the feeding tube, which we sometimes find difficult when the fistula tract is long. A plastic infusion line with an olive-tip malleable metal guide has also been used by Gurer et al. to place a polyamide self-locking cable, but this technique requires more steps and the infusion system is less available than an Abbocath.

Conflict of interest None.

Reference

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