Seton drainage in high anal fistula

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Dear Editor:

We read the article “Seton drainage prior to transanal advanced flap repair: useful or not?” by Mitalas et al. (Int J Colorectal Dis. 2010; 25: 1499–502) with great interest. This retrospective study touches an important issue in the management of high anal fistulas.

The seton drainage prior to transanal advancement flap repair (TAFR) is performed if there is an associated high blind tract or supralelevator abscess. The aim of this seton is to allow drainage of pus and to control ongoing infection. Subsequently, patient undergoes TAFR or anocutaneous advancement flap repair after subsidence of pus discharge.

This retrospective study compares healing rates of TAFR in two groups, with or without prior seton drainage (68 vs. 210 patients). Authors assumed that selection bias in their study is negligible as there was no difference in the baseline characteristics of these two groups. The authors have not

mentioned data regarding abscesses associated with fistula. The comparison of baseline characteristics of these two groups also does not take into account of presence or absence of abscesses. Moreover, they assumed that prior seton drainage was done by referring surgeons in order to bid time which may not be true as only a part of referred patients had seton drainage. It could be possible that referring surgeon had placed seton selectively in cases with associated sepsis.

Author's conclusion that prior seton drainage in TAFR is not useful seems oversimplification of this complex issue. Deep-seated abscesses are frequently associated with high transphincteric and suprasphincteric fistulas. Value of prior seton drainage in these selected cases cannot be belittled. We believe that randomized controlled trial is highly desired at this moment to settle this critical issue of seton drainage.

Conflict of interest: Nil

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