Anal fistula closure with FiLaC: new hope or the same old story?

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Throughout the centuries human beings have suffered from anal fistula.

The history of medicine is full of reports about the treatment of this pathology and, in recent times, when attention has focused on preserving continence and quality of life has become a central issue in medical practice, many new sphincter-saving techniques have been proposed.

Few diseases have such a wide range of severity and anatomical variations. The disease spectrum ranges from simple submucosal fistula tracts to an extrasphincteric fistulas involving multiple tracts and, while the treatment of the simplest ones is easy and safe, the more complex fistulas require expert surgeons and often multiple operations.

The modern surgical approach to anal fistulas includes several sphincter-saving procedures including the closure of the fistula tract with plugs, fibrin glue, or collagen paste without fistulotomy (i.e., laying open) or by means of fistulectomy (i.e., core-out technique) [1]. However, despite several encouraging reports, though few randomized controlled trials, there is still some skepticism among coloproctologists about the effectiveness of these new sphincter-saving procedures.

A pretty new conservative proposal to treat anal fistula involves the use of energy delivery devices (such as laser) to destroy the chronically inflamed connective tissue of the fistula tract by means of a probe inserted into the fistula tract as is reported in this issue of the journal [2]. Actually, the idea of using laser energy is not completely new as it was suggested in two studies in 1981 [3] and 1995 [4] but with different techniques and energy devices.

Giamundo et al. [2] draw attention to two critical aspects of the management of this common and often frustrating anal disease. The first concerns the treatment (or not) of the internal opening of the fistula. Surgeons of my generation have been taught and, in turn, we have taught our students, that the key to success of anal fistula treatment is the closure of the primary orifice, where the bacteria come from. Nowadays the proponents of the LIFT operation say that just the interruption the fistula tract close to the internal opening is enough to get a 70 % or higher primary healing rate [5], even in complex anorectal fistulas [6]. Similarly, FiLaC consists of blind cauterization of the tract without addressing the internal opening with a long-term success rate of 71 % [2].

The second issue concerns the management of the fistula tract itself. Several attempts have been made to help spontaneous healing using biological glues (fibrin [7], collagen paste [8]), plugs of collagen matrix [9, 10] and a plethora of other methods including adipose-derived stem cells [11], but the results in the real world of surgical practice are often disappointing despite some enthusiastic (uncontrolled) reports (but we know from Feinstein that “reports with enthusiasm have no controls and reports with controls have no enthusiasm” [12]). In the FiLaC technique the chronically inflamed connective tissue is “burned” by the laser energy allowing tissue repair by the macrophages and fibroblasts coming from the surrounding healthy connective tissue [13]. The results obtained by the few authors who have used this new technique are really exciting [2, 13, 14] but, since the commonest bias in clinical research is to fall in love with our own ideas or personal technique, we do need to test the reproducibility of this new technique on larger series and to “pass the exam” of randomized controlled trials comparing the new procedure with other surgical techniques used to treat anal fistulas.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

Informed consent For this type of study formal consent is not required.

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