



## Complete Summary

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### GUIDELINE TITLE

Treatment of perineal suppurative processes.

### BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract (SSAT). Treatment of perineal suppurative processes. Manchester (MA): Society for Surgery of the Alimentary Tract (SSAT); 2004. 4 p.

### GUIDELINE STATUS

This is the current release of the guideline.

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

Perineal suppurative processes, including abscesses, fistulas, chronic inflammatory conditions such as pilonidal cysts, hidradenitis suppurativa, and pruritus ani

### GUIDELINE CATEGORY

Evaluation  
Treatment

### CLINICAL SPECIALTY

Family Practice  
Gastroenterology

Internal Medicine  
Surgery

## **INTENDED USERS**

Physicians

## **GUIDELINE OBJECTIVE(S)**

To guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs

## **TARGET POPULATION**

Patients with perineal suppurative processes

## **INTERVENTIONS AND PRACTICES CONSIDERED**

### **Evaluation**

1. Physical examination
2. Digital rectal exam
3. Anoscopy or proctoscopy
4. Evaluation of any underlying diseases

### **Treatment**

#### *Treatment of Abscesses*

1. Needle aspiration
2. Incision and drainage of abscesses (local or general anesthesia)
3. Use of antibiotics
4. Cruciate or elliptical incision
5. Packing of the wound
6. Postoperative use of sitz/tub baths
7. Gram stain of tissue for identifying clostridia

#### *Treatment of Fistulas*

1. Curettage and electrocautery
2. Use of fibrin glue
3. Injection of dilute methylene blue dye, milk or hydrogen peroxide to facilitate visualization
4. Preoperative ultrasound or fistulography
5. Seton application
6. Use of depilatory cream

#### *Treatment of Hydradenitis Suppurativa*

1. Local symptomatic therapy and antibiotics for cellulitis

2. Excision of involved tissue
3. Temporary diverting colostomy

*Treatment of Pruritus Ani*

1. Patient education, reassurance, and follow-up
2. Evaluation for any underlying anatomical pathologies, infectious processes, or neoplasms

**MAJOR OUTCOMES CONSIDERED**

Not stated

**METHODOLOGY**

**METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

**DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

Not stated

**NUMBER OF SOURCE DOCUMENTS**

Not stated

**METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Not stated

**RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

Not applicable

**METHODS USED TO ANALYZE THE EVIDENCE**

Review

**DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not applicable

**METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

The Society for Surgery of the Alimentary Tract (SSAT) guidelines are based on statements and recommendations that were overwhelmingly supported by clinical evidence. Each represents a consensus of opinion and is considered a reasonable plan for a specific clinical condition.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

The guidelines were reviewed by several committee members and then by the entire committee on several occasions. Each guideline was then sent back to the original author for final comment and reviewed again by the committee. Each guideline was approved by the Board of Trustees of the Society for Surgery of the Alimentary Tract and final comments were reviewed by the committee.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

# **RECOMMENDATIONS**

## **MAJOR RECOMMENDATIONS**

### **Clinical Presentation**

Most anorectal infections originate in the crypto glandular area located in the anal canal at the level of the dentate line. Abscesses within these glands can then penetrate the surrounding sphincter and track in a variety of directions. This leads to larger abscesses within the perianal, intersphincteric, ischioanal, and supraplevator spaces. A small number of anorectal abscesses have a non-crypto glandular etiology such as Crohn's disease, atypical infection (e.g., tuberculosis, lymphogranuloma venereum), malignancy, or trauma. Particularly virulent

organisms, immunologic deficiency in the patient (e.g., poorly controlled diabetes, human immunodeficiency virus [HIV]), or localized scarring from previous operations can make the diagnosis more challenging. Fever, rigors, and shock may occur before more subtle localized findings. Pain and swelling are the most frequent complaints. Bleeding, purulent discharge and fevers may also be present. A perianal abscess is usually evident at the anal verge. An inflammatory process in the soft tissues of the buttock would more commonly indicate a perirectal abscess. Pelvic pain and dysuria may herald a supralelevator abscess. The majority of patients with a fistula-in-ano have a history of abscess development with persistent drainage, pain and possibly bleeding. The external opening on the skin is evident and digital rectal exam, anoscopy or proctoscopy may reveal an indurated area in the anal canal corresponding to the internal opening. Fistulae are categorized according to their relationship with the external sphincter complex. The majority of these fistulae are intersphincteric and about one fourth are transsphincteric. If there is any suspicion of an underlying disease such as Crohn's or immune suppression, this should be thoroughly evaluated prior to the formal treatment of the fistula. Pilonidal cysts initially present as an abscess and/or cellulitis in the sacrococcygeal area. Spontaneous drainage often occurs followed by chronic drainage from the secondary sinuses. Some of these may track toward the anus, potentially being confused with a fistula-in-ano or hidradenitis suppurativa. The latter is a chronic suppurative disease of the epidermal apocrine sweat glands. Consequently, it can occur in the perineal/perianal region, in the areolar area of the breasts and quite frequently in the axillae. It is most commonly seen in the second through fourth decades of life and is thought to be hormonally influenced.

In primary pruritus ani, impaired sphincter function predisposes this area to moisture and inflammatory fecal elements from such dietary elements as caffeinated and acidic dietary products. Excessive cleansing or poor hygiene will also initiate an irritative process. Intertrigo, a mixed bacterial infection associated with obesity, may also be involved. Pinworms should be considered in children and exposed adults. Pruritus vulvae, resulting from urinary incontinence or vaginal discharge may spread to the perianal region, and mycotic infections should also be considered in the differential diagnosis.

## **Treatment**

Anorectal pain that prevents a digital examination necessitates an examination under anesthesia. Needle aspiration can demonstrate a collection of pus that is accessible to percutaneous drainage. As with any abscess, incision and drainage is the definitive form of therapy. Antibiotics should also be considered when there is significant cellulitis surrounding the abscess or when the patient is immunocompromised or has cardiac valvular pathology. Perianal and ischiorectal abscesses can usually be drained using local anesthesia if they have tracked to the subcutaneous area. A cruciate incision or an elliptical excision of skin overlying the area of fluctuance is recommended to avoid premature closure of the drainage site during the period of resolution. The surgical incision should be as close to the anal verge as possible, so as to minimize the length of a potential fistulous tract. If the abscess cavity is large, and the procedure is being performed under general anesthesia, digital exploration should be performed to break up any loculations. Packing of the wound is only necessary for initial hemostasis. Adequate drainage, followed by frequent sitz/tub baths, especially after bowel movements, will reduce

the risk of continued infection and recurrence. If there is palpable crepitus, a Gram stain of the tissue/fluid can be helpful in identifying clostridia.

Established operative goals for an anal fistula are to open the tract and remove the epithelial lining by curettage, electrocautery, etc. There has been some success in the use of fibrin glue for these fistulas. Several methods of determining the configuration of a fistulous tract are possible. Any resistance to the passage of a probe should be avoided so as to prevent the creation of false passages. If the internal opening is not evident, injection of dilute methylene blue dye, milk or hydrogen peroxide into the external opening with an angiocatheter may facilitate the visualization. Judicious unroofing of the observable tract may also allow better recognition of the entire tract. Preoperative transanal ultrasound and fistulography are useful diagnostic modalities to be considered. If little or no external sphincter muscle is involved, the external opening and skin overlying the tract may be excised. When greater than half of the external sphincter muscle is involved, or in the patient where sphincter integrity is already at risk, a seton can be applied. In this setting, after the skin and involved internal sphincter are opened, a strip of material is inserted around the overlying external sphincter component and tied snugly. Setons can be fashioned from silk sutures, vessel loops or Penrose drains. During the 1-2 months following the operation, the seton will erode into the muscle and cause an inflammatory response, which prevents significant retraction of the sphincter ends. Either the seton will completely erode through, or the remaining smaller amount of external sphincter can then be transected. A newer alternative, after the seton stabilization period, is the instillation of fibrin glue into the tract after the internal opening is closed with a suture. Treatment in the acute phase of a pilonidal cyst/abscess involves simple incision and drainage. Antibiotics are used if there is significant cellulitis. Any septations should also be disrupted. Because hair and particulate matter are often found within the cavity/sinuses, the use of depilatory cream should be considered to lower the risk of recurrence. The development of chronic sinuses will require further operative intervention for removal.

For hidradenitis suppurativa, unless there are abscesses that need operative drainage, local symptomatic therapy and antibiotics for the cellulitis is initially adequate. Unfortunately, chronicity is common and the drainage and pain can be debilitating. Because the etiology involves the epidermal sweat glands, the only definitive treatment is the excision of involved tissue. Wound healing by secondary intention is frequently chosen, but very large areas may need coverage with surrounding tissue transfers. In order to optimize the healing of complicated wound closures, a temporary diverting colostomy should be considered.

With pruritus ani, patient education, reassurance and close follow-up are imperative. The goal is to attain clean, dry, intact skin. Overzealous cleansing, scratching and colored or perfumed toilet papers should be avoided. Secondary pruritus ani can result from anatomical pathology of the anorectum such as fistulae, fissures and hemorrhoids. Infectious processes, radiation damage and neoplasms can also be responsible.

### **Qualifications for Performing Surgery on Perineal Suppurative Processes**

The qualifications of a surgeon to perform any operative procedure should be based on education, training, experience and outcomes. At a minimum, the

surgical treatment of perineal suppurative processes should be carried out by surgeons who are certified or eligible for certification by the American Board of Surgery, the American Board of Colorectal Surgery, the Royal College of Physicians and Surgeons of Canada, or their equivalent.

### **CLINICAL ALGORITHM(S)**

None provided

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of supporting evidence is not specifically stated for each recommendation.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

Appropriate identification and treatment of perineal suppurative processes

### **POTENTIAL HARMS**

- The potential effect on continence is an important consideration in the treatment of any anorectal suppurative condition. Incision and drainage should be completed with as little involvement of the sphincter musculatures as possible. The risks of fecal incontinence and possible recurrence of the suppurative process should be discussed with the patient before any operative intervention on the anorectum.
- Because of the significant risk for chronic morbidity following an anal fistulotomy in patients with Crohn’s Disease, observation alone should always be considered with asymptomatic fistulae. An interventional alternative is placement of a seton to control the tract(s) and prevent abscess formation. When treating chronic hidradenitis, as with any non-healing lesion, a malignant process should be ruled out by biopsy.
- Topical steroids compromise normal skin resistance to trauma and infection. While topical anesthetic agents provide temporary comfort, they are often sensitizing and can worsen irritation and inflammation. Pruritus ani is usually symmetrical around the anus. Persistent, unilateral lesions should always be biopsied to rule-out a malignant process.

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

These guidelines have been written by the Patient Care Committee of the Society for Surgery of the Alimentary Tract (SSAT). Their goal is to guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs and they are based on critical review of the literature and

expert opinion. Both of the latter sources of information result in a consensus that is recorded in the form of these Guidelines. The consensus addresses the **range** of acceptable clinical practice and should not be construed as a standard of care. These Guidelines require periodic revision to ensure that clinicians utilize procedures appropriately, but the reader must realize that clinical judgment may justify a course of action outside of the recommendations contained herein.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness

### IOM DOMAIN

Effectiveness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract (SSAT). Treatment of perineal suppurative processes. Manchester (MA): Society for Surgery of the Alimentary Tract (SSAT); 2004. 4 p.

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2004 Feb 21

### GUIDELINE DEVELOPER(S)

Society for Surgery of the Alimentary Tract, Inc - Medical Specialty Society

### SOURCE(S) OF FUNDING

Society of Surgery of the Alimentary Tract, Inc.

## **GUIDELINE COMMITTEE**

Patient Care Committee

## **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

Not stated

## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

## **GUIDELINE STATUS**

This is the current release of the guideline.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available from the [Society for Surgery of the Alimentary Tract, Inc. Web site](#).

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-U, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-0461.

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following is available:

- Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.

Electronic copies: Not available at this time.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

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