CHRONIC FISTULA IN ANO DUE TO ACTINOMYCOSIS: A CASE REPORT

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ABSTRACT:
Actinomycosis is an infectious bacterial disease caused by Actinomyces species. We present a very rare case of perianal fistula in ano diagnosed after 2 treatment failures occurring due to Actinomycyes.

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المحترم، الشرقية، الهند
داء الشعاب هو مرض يكبتري مع تسبب الأنواع الشعبية. يتم نشر حالة نادرة جداً حول ناسور شرجي تم تشخيصها بعد فشل في علاجها مرتين بسبب الشعبة.

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INTRODUCTION:

Chronic fistula in ano is often due to crypto glandular causes with recurrence being attributed to persistence of the diseased glands in intersphincteric plane. A chance encounter with perianal crohn’s disease reminds us of Fistula in ano due to inflammatory bowel disease.

CASE REPORT:

A 43 year old non diabetic patient presented with a History of perianal fistula initially treated by a local Physician (of alternative medicine) by curettage & caustic application. This was followed by recurrence after about 5 months following which he visited a general surgeon who went for a fistulotomy for management of perianal fistula. At end of 1 year he again presented with an indurated mass at the anal verge (about 7’o clock position as examined in lithotomy posture) which quickly progressed to suppurate and formed fistulous tracts. At time of presentation he did not give any history suggestive of Chronic granulomatous diseases (eg: peri anal Crohn’s disease, tuberculosis) or sexually transmitted disease with perineal fistulation (Water can perineum as a sequel to gonococcal stricture) or colloid cancer of rectum (bleeding per rectum, profuse mucus discharge, rapid progress of symptoms, weight loss). On per rectal examination the sphincter tone was found adequate with an extensive area of induration being felt occupying mostly the right ischiorectal fossa with a suspected internal opening at about posterior midline. There was scanty straw coloured discharge from the perianal fistula external opening; No blood or granular material was seen. A clinical diagnosis of a recurrent peri anal fistula disease was done (probably of crypto glandular access).A MR Fistulogram was advised but refused by the patient on cost considerations. A full length colonoscopy was done to rule out any evidence of Crohn’s disease or any other coexist ant disease in large bowel (particularly illeocecal region as this is the commonest site for inflammatory bowel disease). Pre-operative investigations and imaging(chest X ray) failed to identify any evidence of diabetes, tuberculosis, HIV I/II infection. The patient had no history of any other major illness (including tuberculosis) in past neither had a history of trauma (Penetrating sharp) in the perianal region. He was married and had a normal hetero sexual relationship.

The patient was counselled about the chance for recurrence(contemplating the complex anatomy) and a excision of the indurated mass with fistulectomy could be done successfully. The internal opening was seen away from the dentate line (about 1 cm proximal). Both the sphincter’s were intact at the end of the procedure.

The wound healed by second intention and the excised specimen was sent for histopathology which reported actinomycosis of subcutaneous tissue with perianal fistulation. The patient was prescribed a long term injectable penicillin therapy to complete the management. The patient has followed up at end of 1 year with no recurrence.
DISCUSSION:
Actinomycosis is an infectious bacterial disease caused by Actinomyces species such as Actinomyces israelii or A. gerencseriae. It can also be caused by Propionibacterium propionicus, and the condition is likely to be polymicrobial aerobic anaerobic infection. Actinomycosis is an indolent, slowly progressive infection, normally colonize the mouth, colon, and vagina, characterized by sulfur granule formation. Actinomycosis can affect multiple organs, with local or systemic manifestations. The abdomen is involved in less than 20% of the cases with the ileocecal area being the site most frequently affected. The anorectal region is less frequently involved. Sporadic cases, with lesions varying in extent have been reported. The portal of entry of the actinomycetes is unknown although direct contamination of any anorectal wound by cleansing with leaves or grass may offer a direct contact for the actinomycetes. Male gender and diabetes are risk factors, but the exact pathogenic mechanism remains speculative. The diagnosis is a challenge and often delayed, with a protracted history of masses and sinuses extending into the gluteal and genital region. The treatment, a combination of surgery and antibiotics, is poorly standardized. G. Coremans and his colleagues reported three cases and compare their characteristics to those of published cases, found by a computerized literature search (1968–2002). The lesions, a simple fistula-in-ano or a mass, were diagnosed in an early stage in all three patients. The infection always spread into the scrotum. There were no risk factors other than gender, except in one patient. The diagnosis was suspected by the observation of draining sulfur granules and promptly confirmed by histology in the three cases. All patients healed with antibiotics in addition to simple surgical procedures. Treatment consisted of amoxicillin for two weeks in two cases and more extended antimicrobial treatment in the third. These findings are contrasting with the classic picture of perianal actinomycosis. It is concluded that perianal actinomycosis can occur in the absence of risk factors and that early diagnosis requires a high degree of suspicion. An infection with Actinomyces should be suspected in the presence of lesions containing watery purulent material with sulfur granules. The indication for extended antibiotherapy combined with sphincter damaging surgery may need to be revised in the presence of early detection.

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